University Hospitals NHS
Coventry and Warwickshire
NHS Trust

PUBLIC TRUST BOARD MEETING TO BE HELD ON THURSDAY 28th JULY 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 30th 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.	**World Class Colleague Award** Chairman / Chief Executive Officer	For Assurance	Verbal	5
8.	**Chairman's Report** Chairman	For Assurance	Enclosure 3	5
9.	**Chief Executive Officer and Chief Officers Reports** Chief Executive Officer	For Assurance	Enclosure 4	5
Performance				
10.	**Integrated Quality, Performance and Finance Monthly Report** Chief Workforce & Information Officer	For Assurance	Enclosure 5	10
Patient Quality and Safety				
11.	**Patient Story** Chief Medical and Quality Officer	For Assurance	Enclosure 6	10
12.	**Patient Experience Quarterly Report** Chief Medical and Quality Officer	For Assurance	Enclosure 7	10
13.	**Board Assurance Framework Quarter 1 Update** Chief Medical and Quality Officer	For Approval	Enclosure 8	10
14.	**Corporate Risk Register Quarterly Update** Chief Medical and Quality Officer	For Assurance	Enclosure 9	10
15.	**Infection Prevention and Control Annual Report 2015/16** Chief Nursing Officer	For Assurance	Enclosure 10	10
16.	**Medical Revalidation and Appraisal 6-Monthly Update**	For Assurance	Enclosure 11	10

ITEM	TITLE	BOARD ACTION	PAPER	TIME
	Chief Medical and Quality Officer			
17.	**Mortality Performance Report – Financial Year 2015/2016** Chief Medical and Quality Officer	For Assurance	Enclosure 12	10
18.	**Safeguarding Children and Adults Report** Chief Nursing Officer	For Assurance	Enclosure 13	10
19.	**End of Life Care Annual Report 2015/16** Chief Nursing Officer	For Approval	Enclosure 14	10
20.	**Quality Strategy (2016 – 2021)** Chief Medical and Quality Officer	For Approval	Enclosure 15	10
21.	**Care Quality Commission – Shaping the future briefing** Chief Medical and Quality Officer	For Assurance	Enclosure 16	10
22.	**Workforce Race Equality Standards (WRES) Annual Report** Chief Workforce & Information Officer	For Approval	Enclosure 17	10
Regulatory, Compliance and Corporate Governance				
23.	**Matters delegated to Board Committees** Chairman	For Assurance	Verbal	5
Feedback from Key Meetings				
24.	**Audit Committee Meeting Report of 11th July 2016** Chair, Audit Committee	For Assurance	Enclosure 18	5
25.	**Quality Governance Committee Monthly Report of 18th July 2016** Chair, Quality Governance Committee	For Assurance	Enclosure 19	5
26.	**Any Other Business**			
27.	**Questions from Members of the Public Relating to Agenda Items**			
28.	**Date of Next Meeting:** **The next meeting of the Trust Board will take place on Thursday 29th September 2016 at 10.00 am, University Hospitals Coventry and Warwickshire**			

Resolution of Items to be Heard in Private (Chairman)

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

MINUTES OF A PUBLIC MEETING OF THE TRUST BOARD OF UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST HELD ON THURSDAY 30TH JUNE 2016 AT 10.00 A.M. IN ROOM 10009/11 OF THE CLINICAL SCIENCES BUILDING, UNIVERSITY HOSPITAL, COVENTRY

AGENDA ITEM	DISCUSSION	ACTION

HTB 16/125 **PRESENT**

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

IN ATTENDANCE

Mrs K Beadling, Head of Communications (KB)
Mr J Murray, Deloitte LLP (observing)
Ms J Prior, Executive Assistant (JP) – note taker
Dr S Sankar, Associate Medical Director for Education (SS) – HTB/16/135
Mrs R Southall, Director of Corporate Affairs (RS)
Mrs D Taylor, Deputy Associate Director of Cancer Services (DT) – HTB/16/139
Mrs H West, Deputy Associate Director of Cancer Services (HW) – HTB/16/139

HTB 16/126 **APOLOGIES FOR ABSENCE**

Mrs B Beal, Non-Executive Director (BB)

HTB 16/127 **CONFIRMATION OF QUORACY**

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

HTB 16/128 **DECLARATIONS OF INTEREST**

There were no conflicts of interest declared.

HTB 16/129 **MINUTES OF TRUST BOARD MEETING HELD ON 1 JUNE 2016**

The minutes were **APPROVED** by the Trust Board as a true and accurate record of the meeting.

HTB 16/130 **MATTERS ARISING**

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

Whilst not strictly a matter arising, RS referred to the recent decision taken under emergency powers to authorise the Chief Executive Officer to sign the Power of Attorney document in connection with the Philippines Nurse Recruitment Project.

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RS wished for it to be recorded that whilst the approval had been given, the document had not been signed and emergency powers had not therefore been enacted. RS advised that MR would give an update on the recruitment programme in the private section of the meeting.

HTB 16/131 **TRUST BOARD ACTION MATRIX**

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

HTB 16/132 **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 16/133 **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, highlighting that enormous effort had been put into achieving the STP submission deadline. AH confirmed that a further meeting with be held with Simon Stevens and Jim Mackey on the 22nd July 2016 to discuss the Coventry and Warwickshire STP.

AH reported that he, together with other Chief Officers, had attended the NHS Confederation Annual Conference. AH commented that many of the key note speakers had focused on the forthcoming referendum and the STP process.

AH confirmed that on the 29th June 2016 UHCW had hosted a Virginia Mason Event. The 4 other Trusts involved with the programme were also in attendance amongst the 160 delegates. The 3 key note speakers included Sir David Nicholson, the retired CEO for NHS England, Marianne Griffiths Chief Executive of Western Sussex Hospitals NHS Foundation Trust, and Peter Simkin from Land Rover. AH advised that the whole day had received very positive feedback and highlighted that Western Sussex Hospitals had achieved a CQC rating of outstanding and had embedded the VMI techniques within their Trust in an 18 month timeframe.

DP asked for a better understanding of STP and commented on the recent correspondence from NHS Improvement in relation to unsustainable services and amalgamating back office functions. AH replied that he was unable to go into details around the STP in a public setting, but assured that the STP comprised emerging thoughts at this stage. DP expressed concern that from a Board perspective the Trust was heading blind into the future and questioned this in light of NED accountability. AH confirmed that accountability was with Chief Officers and reiterated the position with regards to public discussion at this stage Referring to the recent NHSI letter, AH advised that there is reference to elective services that are predominantly provided through agency or locum staff and that these services should be moved to neighbouring Trusts within the STP footprint. AH

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also highlighted the Lord Carter review in relation to Pathology services. AH reiterated that UHCW were already in discussions regarding sharing Pathology, discussions were ongoing in relation to sharing back office support and further discussions needed to be undertaken in relation to Agency at future STP meetings.

EMS suggested that amalgamation of back office functions would be a "fix" for the financial position, although he welcomed the move towards whole system working and action at pace and scale. DP also raised a concern regarding the significant potential for legal challenge around STP plans. AH concurred with this and stated that he has received lots of emails from individuals and members of the public but there had been lots of push back from the STP leaders given that plans were only at the emerging thoughts stage. EMS expressed concerns regarding the argument for keeping this under wraps. AH explained that this was in part due to political sensitivities which was compounded by the national political issues; a further rationale was to ensure that expectations are not raised ahead of approval. AH also confirmed that this subject had been raised at a recent NHS Providers event including competition law issues that may affect the STP. DP suggested that a letter be sent to NHS Providers from members of the Trust Board raising their concerns. AM concluded that this debate should be continued in the Private Trust Board.

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

HTB 16/134 **INTEGRATED QUALITY, PERFORMANCE AND FINANCE REPORT**

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

KM drew attention to page 3 of the report, which highlighted the key areas that were going well, areas that were not going so well and that overall performance had deteriorated. KM then drew attention to page 25, which focused on the reduction of agency spend and sustaining performance in relation to sickness absence. KM commented that the Chief Officers were disappointed with progress in reducing medical agency spend and confirmed that herself, MR and MP were reviewing the situation and that more stringent controls were being implemented. This would comprise of deployment of UHCW nurses, addressing junior doctors within the bank system, refreshing enhanced payments and to raise awareness of the systems available. AM drew attention to the chart on page 24 of the report highlighting the Doctor agency usage that was indicating above the cap rate and asked for clarification of this. KM replied that the original cap had been further reduced, and that steps were being taken to come into line with this. She cautioned however that there were significant challenges ahead. MP highlighted that some of the FY2 and ST2 cap rates were lower than nationally but if the posts cannot be filled then safety issues arise. AM stressed that at future NHS Improvement Chairman's meetings this topic will be the main Agenda item a. KM echoed that this information is submitted weekly but the information that other Trusts submit is not shared so comparator performance is difficult. AM questioned if this information was shared with the Chief Executives and MR replied that all data shared is anonymous.

IB drew the Board's attention to the Trust Heatmap chart on page 8 of the report

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and enquired what the Agency percentage target should be, and whether this could be achieved by the end of the year. IB stressed the need for a clearer idea of where the Trust should be and the impact if the target is missed every month. KM confirmed that each group had been tasked to reduce their Agency spend by 35% but each group faced different challenges. IB emphasised the need to measure this in reality and asked for a clear exposition of where the Trust needed to be and which areas needed particular focus. DM responded that he had recently received a letter from NHS Improvement with a request for plans to be resubmitted within 3 days to show that by March, the figure would be reduced to £1.8m, which would be staggered throughout the year. DM echoed that the aim would be to achieve this but deliverability of this would be a huge challenge. DM also highlighted that another significant challenging was recruiting Consultants within certain specialities as the candidates do not exist.

AM requested that KM review the report to include measurements against internal targets and commented that UHCW is being judged on these submissions. BS commented that the Finance and Performance (F&P) Committee had a better understanding of the measurements and that currently this was a standing F&P Agenda item. **KM**

DM informed members that the Trust was currently £1.9m below plan due to underperformance on income from day case and elective surgery. DM stated that the plan was going to be rephrased and stressed the need for better income performance. He went on to say that part of the problem this year was the extended CIP target and that some of the Groups were further advanced with these savings than others. DM also stressed that changes to funding from NHS Improvement were imminent and this added to the risk to delivery of the financial plan. DM highlighted another risk factor in relation to the Coventry and Warwickshire CCG with regard to under-performance but indicated that that the CCG accounts were reported a month behind the Trust's.

IB referenced A&E performance and enquired where the Trust would have to be to achieve elective performance. DM assured members that the relative performance had been better in May but could not forecast the June position. DE highlighted the need to achieve the activity which would lead to the trajectory being met to attain the income. DE also commented on the large number of outpatients being seen, which is having an impact and referenced the small number ring-fenced beds that were in place to protect the elective pathway. DM concurred and highlighted that theatre performance was also not quite where it needed to be, but was optimistic that this would improve.

DM highlighted that one area of concern was Orthopaedics due to the Consultant vacancies but underlined that Surgery and ENT were improving. DP highlighted the F&P paper on closed theatre sessions and stressed the need for this to be a top priority. BS concurred that this paper also highlighted initiatives around ring fencing beds.

MR commented that there was still work to be done around the pathway and outlined the pre-op service adaptations. MR also drew attention to other causes such as patients being unfit for surgery and non-attendance on the day of surgery. DE also highlighted that during the previous week A&E had seen attendances in excess of over 700 patients and underlined that lots of work was ongoing across UHCW to focus on this. DE drew attention to the "back to the floor" work that he

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was currently undertaking and continued that bed pressures in the early hours of the morning are impacting on the next working day.

AM noted that a grade 3 pressure ulcer and never event had also occurred during the month. MR expressed his disappointment at the report of a pressure ulcer and reassured the Board that a RCA had been undertaken around the use of a certain medical device and gave assurance that there was an on-going drive towards improvement. MP expressed her disappointment with regard to the never event but reassured members that an RCA was also in progress and that a safety message had already been issued to all staff. EMS enquired about the comparisons that UHCW had against other Trusts in these areas and noted that there had been 26 never events reported nationally. MP replied that NHS Improvement publish data from the previous year and highlighted that UHCW had recorded 3 never events, but none of these had lead to serious harm or mortality. MP reassured members that the drive to adhere to policies will continue.

Referring to the discussions held at QGC earlier that month, EMS asked if the number of patients transferred at night to St Cross had increased. MP reassured members that work was on-going in relation to late transfer, which included training of Junior Doctors, booking ambulances for transfer earlier in the day, and a clinical review of patients prior to transfer and proper handover.

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

HTB 16/135 **MEDICAL EDUCATION REPORT**

The Trust Board welcomed SS to the meeting to present the quarterly update. SS introduced himself and outlined to the Board that he had been in post for 8 months and was striving to make improvements around Medical Education. SS gave assurance that the Education Admin Team now had a better working relationship with Warwick University and outlined details of the forthcoming HEE(WM) follow up visit in July to Geriatrics at Rugby St Cross, praising the efforts that the Education Team had made in preparation for this. SS also summarised the progress that is being recognised by HEE(WM) but there were still concerns around 'front door' pressures and associated patient safety issues, which had been identified by trainees. SS gave assurance that enormous effort had been put into making sure the revisit will be successful but highlighted the risk that if HEE(WM) were dissatisfied there remained the possibility of losing training posts.

SS confirmed that the medical outliers concern had now been addressed and that the issue with Locum Consultants and staff had been resolved with a more robust handover process and regular feedback on a monthly basis, which had led to improvements. SS highlighted that work continues around patient consent and junior doctors and confirmed that a Policy had been presented at the recent Training, Education and Research Committee (TERC) for approval.

BS commented that she met regularly with trainees and gave assurance to the Board that there were measurable improvements and that the support from Consultants had come across very strongly.

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SS also confirmed that 232 Consultants had now attained full trainer accreditation which meant that the Trust had been successful in meeting HEE(WM)'s target. SS outlined that undergraduate feedback is improving but there was still work to be done in relation to the fragmentation of work. AM enquired if this was a Trust issue and SS confirmed that this was not the case.

DM then drew the Board's attention to the funding received for Undergraduate teaching and commented that it was less than last year; DM further suggested that the Medical School should be recharged for the Trust's Consultants that teach there. SS concurred with this.

EMS enquired what happens if a Consultant requests that a Junior Doctor takes consent. SS replied that the new Policy is clear that FY1s will not obtain consent and that FY2s can prepare patients, but also clearly states that consent cannot be taken by a Junior Doctor if they are not competent. SS stressed the need for this culture to be embedded.

The Trust Board **NOTED** the work that has been achieved around the on-going work within Medical Education and thanked SS for his update.

HTB 16/117 **SAFER STAFFING BI-ANNUAL REPORT**

MR stated that the report offered assurance to the Board that the Trust is compliant with the standards relating to Safe Staffing and confirmed that robust systems were in place. MR drew attention to some of the areas that still required improvement in particular development of a strategy on how the Trust deploy's its resource. MR went on to say that a significant amount of work had been undertaken on Erostering with the assistance of KM. MR then commented that there had also been a focus on the ward environment, including workstations for nurses. AM asked that future reports focus on the changes since the previous report. DP enquired if the matrons made the decisions in relation to safe care and any potential risks. MR highlighted the process that was in place and clarified that any worrying risks would be bought to his attention immediately.

The Trust Board **NOTED** the comprehensive assessment that had been undertaken and were **ASSURED** by the systems and processes that are in place.

HTB 16/136 **YOU SAID, WE DID UPDATE REPORT: NOVEMBER 2015 – MARCH 2016**

MP presented the report to the Board and highlighted the signage within Radiology, availability of clinic letters, improved blood taking, car parking at St Cross Hospital, pets in therapy and the Mum and I initiative. EMS commended the report.

The Trust Board **NOTED** the actions staff had taken as a result of listening to user feedback.

HTB 16/137 **EQUALITY AND DIVERSITY ANNUAL REPORT**

KM highlighted that the purpose of the annual report was to offer assurance to the Board in relation to Equality Delivery System 2 and the new NHS Workforce Race

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Equality Standard. KM also highlighted the recent Equality Event which had been held during June, together with the success of the Supported Internship Programme. KM also confirmed that a full Workforce Race Equality Standard (WRES) report would be presented at the July Trust Board. KM made reference to the ongoing work in relation to translation and interpreting services and delivery of this in a way that ensures the Trust receives value for money. Exploration of different ways that this service could be delivered is underway.

BS praised the work of the Supported Internship Programme and how this had led to one intern securing a fixed term contract within the Trust and the positive impact this would have on that individual.

The Board **NOTED** the progress of EDS2 Action Plan and the success of the supported Internship programme.

HTB 16/138 **COMPLAINTS AND PALS ANNUAL REPORT 2015-16**

MP presented the Complaints and PALS annual report to Board members underlining that there had been 95 more complaints received than last year. MP made reference to the PHSO considering and making judgements on 15 complaints within the year and confirmed that none had been fully upheld, 7 were partially upheld and 8 were not supported. MP also highlighted over 80% of complaints had been responded to within the 25 day timeframe. MP outlined that many of the complaints refer to communication, attitude of staff, cancellation of appointments and procedures and the highest number of complaints received were focussed on Surgery, Women and Childrens and Orthopaedics. MP also highlighted that since the PALS office had been relocated there had been a significant increase in contacts, which was being monitored on a daily basis.

AM commented that the team had a much better grip of this element compared to the previous year.

BS enquired how the PHSO actions were monitored and delegated down within the groups. MP confirmed that all complaints are monitored by the Groups, and that complaints are a focus of the Quarterly Group Review meetings.

The Board **NOTED** and **APPROVED** the Complaints and PALS Annual Report.

HTB 16/139 **QUARTER 4 AND 2015-16 CANCER WAITING TIMES PERFORMANCE**

DE introduced HT and DT to board members and commended them on their efforts around the Cancer Standards.

HT highlighted to the Board the major key points set out within the report and confirmed that 82.7% of patients were treated within the 62 day target; this was below the national target but in line with the Trust's predicted target of 83%. HT also highlighted the ongoing pressures in relation to Radiology and Pathology areas and gave assurance that there had been an increased improvement in patients receiving their first appointment within 14 days, with many patients being seen with 5 to 7 days.

AM enquired how many patients were not treated within the 62 day target and

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questioned if there were key issues surrounding this. HT replied that there had been approximately 20 breaches but reported that every month 110 patients do receive treatment within the timescales. HT also stressed that Consultants do categorise patients with more aggressive cancers.

DM highlighted that 5 more patients per month would need to be seen for the Trust to reach the 85% target and confirmed that the methodology had been changed in April of this year. DM also pointed out that within the figures were late referrals from other Trusts which impact the numbers. DM also outlined the challenges around the template biopsies undertaken using the robot, which were better for patients but had resulted in a 6 fold increase in the volume for radical prostatectomy.

IB enquired as to how the patient was informed and monitored. DT explained that the GP at the initial consultation would issue a generic leaflet to the patient which explains the 2 week wait referral process. Once the patient had received their diagnosis they were then informed about their treatment plan and the expected timeframes.

IB enquired, in relation to feedback, whether patients needs were being met. HT confirmed that patients are supported by Cancer Clinical Nurse Specialists and the feedback received had been positive. HT also confirmed that each individual MDT had to supply an annual report that included feedback.

With reference to the ambition around patients being treated at +100 days, AH suggested that this could be more ambitious; DM cautioned however that pathway changes and scanning capacity would be required to facilitate this.

EMS commented that the pressure on waiting times would increase going forwards and queried whether the transfer of Dermatology from George Eliot Hospital would bring added pressures. HT commented that one area of concern was IT support and being able to access records between UHCW and GEH, which had proved problematic. DM concurred that there were IT challenges between the 2 sites and this had gone on longer than expected however lessons had been learnt in preparation for any other services that would be transferred in future. It was agreed that an update around the Dermatology service would be provided to QGC.

AM thanked HW and DT for their comprehensive update and commended them on the level of service that they offered. HW commented that UHCW had many good clinicians committed to the Cancer pathway.

The Board **NOTED** Quarter 4 and full year 2015-16 performance against Cancer Waiting Time standards, the cancer site performance, the number of patients treated after 100 days of the 62 day pathway and trends in the 2 week wait referrals. It was **AGREED** that an update around the Dermatology Service would be presented to QGC.

HTB 16/140 **TOGETHER TOWARDS WORLD CLASS PROGRAMME UPDATE**

KM highlighted the ongoing work of the Together Toward World Class programme to the Board, drawing attention to the Innovation Hub, World Class Leadership,

AGENDA ITEM	DISCUSSION	ACTION

Staff Recognition Scheme, Talent Management and a pilot for Talent Conversation, which was a talent rating for the top leaders within UHCW.

KM also highlighted that a successful VMI Event had been hosted by UHCW and that the VMI principles would be branded as the UHCW improvement system, in order to start developing a common "language" across the organisation.

AM drew attention to the recent press article regarding VMI failed accreditation. AH responded that the system of inspection in the USA was different and emphasised that VMI had not "failed" but there was room for improvement in some areas

DP welcomed the move towards the UHCW branding and developments in the TTWC programme but queried awareness across the Trust. AH highlighted that the Staff Survey engagement scores had emphasised awareness of the VMI partnership and went on to reference the thought provoking presentation that had been given by the CEO of Western Sussex Hospitals NHS Foundation Trust at the recent VMI Sharing and Learning Conference around their journey.

In response to a question around key achievements in the TTWC programme, KM emphasised that not all developments are badged specifically as TTWC, giving the examples of the on-going work with the "hello my name is" campaign, work on the intranet and Talent Management. BS enquired if there was a timeframe for introducing a new UHCW internet site and KM replied that there was not at present.

AM drew attention to "patient first" which is covered within Together Towards World Class and VMI, and highlighted that there were 2 definitions; one comes to UHCW and the other is the patient outside of the Trust. AM felt that other organisations are more engaged with the public and KM responded that work was ongoing but this was an area that could be developed, either as a patient experience, communications or equality and diversity initiative. MP suggested that patients could be involved within the RPIW's and EMS concurred with this suggesting that it could be combined within patient engagement.

IB commented that the Trust should be utilizing international benchmarks wherever possible and AH responded that the Trust was a member of Dr Foster Global comparators. IB suggested that the board should receive more detail in this regard and MP advised that a paper would be brought to a future meeting. EMS enquired if the Non-Executive Directors would receive training on values based recruitment in relation to consultant appointment panels and KM agreed to arrange this. **KM**

The Board **NOTED** the Together Toward World Class Programme update

HTB 16/141 **AUDIT COMMITTEE AND AUDITOR PANEL TERMS OF REFERENCE**

RS presented the revised Terms of Reference for the Audit Committee and the Terms of Reference for the Auditor Panel.

The Trust Board **APPROVED** both sets of the Terms of Reference.

AGENDA ITEM	DISCUSSION	ACTION

HTB 16/142 **MATTERS DELEGATED TO BOARD COMMITTEES**

It was agreed that Medical Agency would remain on the Finance and Performance Committee meeting agenda.

It was also agreed that Never Event Comparisons would be an agenda item at the next Quality Governance Committee meeting and that an update on the Dermatology service would be provided.

HTB 16/143 **QUALITY GOVERNANCE COMMITTEE MEETING MONTHLY REPORT 20 JUNE 2016**

EMS highlighted that the new workplan that had been produced for QGC was proving fruitful and expressed his thanks to those involved. The Trust Board members noted the meeting report of 20 June 2016.

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

HTB 16/144 **FINANCE AND PERFORMANCE COMMITTEE MONTHLY REPORT 22 JUNE 2016**

The Trust Board members noted the meeting report of 22 June 2016. No questions were raised.

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

HTB 16/145 **ANY OTHER BUSINESS**

There were no other matters raised by Trust Board Members.

HTB 16/146 **QUESTIONS FROM MEMBERS OF THE PUBLIC**

A member of the public raised a question asking if patients being moved between wards at inappropriate times had contributed to the reported never event. MP replied that patients are not moved unnecessarily and guidance would be sought from a consultant prior to this. MP also confirmed that the investigation into the never event was not connected to a patient being moved.

Another member of the public referenced the Together Toward World Class Programme report and enquired if full patient details are shared between hospitals and GPs. MR advised that the system that was referred to would be a shared record between hospitals, GPs and community services across Coventry and Warwickshire but not nationwide.

HTB 16/147 **DATE OF THE NEXT MEETING**

The next Public Trust Board will be held on Thursday 28 July 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
28 JULY 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	November 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	Scheduled on July's Trust Board agenda	Yes
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	Included within the presentation to be delivered at the AGM in July	Yes

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

AGENDA ITEM 6 ENCLOSURE 2

ACTIONS FROM JUNE 2016 MEETING					
HTB/16/134 INTEGRATED QUALITY, PERFORMANCE AND FINANCE REPORT	AM requested that KM review the report to include measurements against internal targets and commented that UHCW is being judged on these submissions. BS commented that the Finance and Performance (F&P) Committee had a better understanding of the measurements and that currently this was a standing F&P Agenda item.	KM	August 2016	Under review	No
HTB/16/140 TOGETHER TOWARDS WORLD CLASS PROGRAMME UPDATE	EMS enquired if the Non-Executive Directors would receive training on values based recruitment in relation to consultant appointment panels and KM agreed to arrange this.	KM	August 2016	In progress	No

AGENDA ITEM 8 ENCLOSURE 3

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

28 JULY 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:

- Meeting with Kath Kelly and Stuart Annan from George Eliot Hospital
- Board to Board meeting with the Coventry & Rugby Company (Project Co)
- Warwickshire Health and Well-Being Board
- Corporate Trustee Charity Board
- New Charity Trustee Board meeting

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

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

RECOMMENDATION / DECISION REQUIRED:

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

IMPLICATIONS:

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

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

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Chief Executive and Chief Officer Updates**
Author	**Chief Officers**
Responsible Chief Officer	**Andy Hardy, Chief Executive Officer**
Date	**28 July 2016**

1. Purpose

This paper provides an update to the Board in relation to the work undertaken by each of the Chief Officers each month and gives the opportunity to bring key issues in relation to areas within their respective portfolios and external issues to the attention of the Board.

2. Background and Links to Previous Papers

The paper is presented to the Trust Board each month.

3. Narrative

Each of the Chief Officers has provided brief details of their key areas of focus during July 2016:

Mr Andrew Hardy – Chief Executive Officer

Since the last Trust Board meeting I have hosted and participated in the following meetings, discussions and events:

- COG Financial Star Chamber meetings
- Risk Committee meeting
- CEO Direct
- C&W Sustainability & Transformation Programme Board
- UHCW/Project Co Board to Board Meeting
- Key Priority Review Meetings
- VM Guiding Team Meeting
- RD&I Summit at UHCW NHS Trust Innovation Hub Opening
- FMLM Aspiring Medical Directors Event
- West Midlands Clinical Forum
- Warwickshire Health and Wellbeing Board
- Delivered Keynote Address at HFMA Annual Provider Conference
- Meeting with Mark Pawsey MP
- National Launch NSH Improvement Faculty
- Discussions with CIPFA – Chair of CIPFA Health & Integration Faculty Board
- Health and Social Care Scrutiny Board Coventry
- TTWC Programme Board
- Meeting with Chief Officer of Herefordshire & Worcestershire LPC & Coventry LPC
- Participation in A ‘Day in the Life Of’ Programme – Plaster Room Assistant
- Attended (ME) Regional STP Review Meeting
- Meeting with David Rose, Dr Foster (EMEA)
- Meeting with Consultants employed by the Trust in 2016

Consultant Appointments

The Trust has not made any Consultant appointments since the last Trust Board Meeting (30 June 2016).

Policy Issues and Publications:

1. The Department of Health has published a response to the recent Choice in End of Life Care consultation. The response can be found here:

https://www.gov.uk/government/publications/choice-in-end-of-life-care-government-response

2. The Department of Health is consulting in relation to proposed new data security standards. This will be discussed at the Information Governance Committee in the first instance and a response will be provided by the closing date of 7th September.

   https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/535170/NDG_consultation_A.pdf

3. NHS Improvement is consulting upon its proposed Oversight Framework and is hosting a number of engagement events. This has been discussed by Chief Officers and the proposed response will circulated to Board members.

   https://improvement.nhs.uk/resources/have-your-say-single-oversight-framework-consultation/

Mr David Eltringham – Chief Operating Officer

- Throughout July I have continued to focus on improved Emergency Care Pathway performance.

- ED and RTT performance remains challenging. I have spent considerable time on this across the month and have again joined Chief Officer performance reviews with each Group.

- I continue to attend SRG and to drive system wide improvement across the Health Economy.

- I participated in the Phase 2 Leadership Programme Orientation and Q&A sessions.

- I continue to attend Frailty Workshops with our partners across the Health Economy.

- Together with the Chief Information & Workforce Officer, I facilitated a follow up Leadership Compact event, as part of the on-going transformation plan work with the Virginia Mason Institute.

- I met with colleagues from the West Midlands Ambulance Service to discuss the opportunity to establish an Urgent Care Centre at UHCW.

- I attended a regional workshop, led by NHS Improvement, where they set down the national and regional actions and expectations underpinning the A&E recovery plan for 2016/17.

- I met with representatives from Deloitte as part of a piece of work around Board Development.

- I attended a meeting with Russell Smith from HEWM to discuss progress made against the Geriatric Medicine Level 3 report following a visit to Rugby St Cross Hospital on 5 May 2016.

- Together with the Chief Medical Officer I sat on the interview panel for the appointment of a Clinical Director for the newly-created Clinical Diagnostics Group.

- I met with Jeff Worrall (NHS Improvement) and joined him for a conference call with colleagues from NHSI to discuss improvement plans for ED Four Hour standard at UHCW.

- Together with my Chief Medical Officer and Chief Nursing Officer colleagues, I participated in the regular Triumvirate Meetings with the Clinical Director, Group Manager and Modern Matron from each Clinical Group.

- I am currently undertaking a series of 'Back to the Floor' days, aimed at improving Emergency Care Pathway performance.

Mr David Moon – Chief Finance & Strategy Officer

Since the June Trust Board Meeting and, in addition to the routine corporate meetings such as COG; COG Financial Star Chamber; Strategy Group & Board Seminars and Planning Unit; I have undertaken the following commitments:

1. Chaired the weekly CIP Steering Group Meeting.
2. Had conversations with Worcestershire Acute Hospitals NHS Trust over our provision of Neurology and Neurosurgery with them.
3. Met around the future Cancer Alliances.
4. Held numerous meetings with Finance and Strategy Colleagues across Coventry and Warwickshire over the development of the STP.
5. Attended a number of meetings of the Sustainability & Transformation Plan Coventry & Warwickshire Programme Board.
6. Had further HPS review meeting.
7. Attended the HFMA Providers Annual Conference.
8. Attended the Westminster Health Policy Conference on Cancer Care in England.
9. Attended the West Midlands STP Finance lead meeting.
10. Met with colleagues over the Audiology AQP.
11. Met with Provider Finance Director colleagues to agree an STP response to Jim Mackay/Ed Smiths letter.
12. Attended the Pharmacy Procurement Standardisation Group.
13. Held first meeting with CRCCG on the risk share.
14. Met with Simon Collings from Specialised Commissioning over Cancer Alliances and direction of travel.
15. Met with CRCCG on Consultant Connect.
16. Met with CE and officers from the LMC over the STP

Professor Meghana Pandit – Chief Medical & Quality Officer/Deputy CEO

In addition to all the regular meetings such as Chief Officers' Group, Strategy Group, COG Finance Star Chamber, COG Advisory Group, Patient Safety Committee, Risk Committee, Quality Governance Committee, Mortality Review Committee, Serious Incident Group (SIG), Patient Engagement and Experience Committee, Seven Day Services Steering Group, Chief Inspector Hospitals Programme Board, Medical Concerns, Trust Guiding Team, Sign up to Safety and my own clinical work, I have undertaken the following activities since the last Trust Board meeting in June 2016:

- Visited wards informally, speaking to Junior Doctors, Nurses, Pharmacists and Consultant colleagues
- Made Responsible Officer submissions to GMC
- Attended Grand Round
- Chaired Annual Audit Awards Competition
- Met with the Clinical Directors
- Together Towards World Class (TTWC) meeting
- Deputised for CEO
- CEO Breakfast with Consultants
- Key Priority Review meetings
- HEWM Acute Medicine Visit – Level 4
- NHS Innovation Accelerator Dinner, London.
- Joint Academic Strategy Group (JASG)

- Chaired STP meetings for Maternity and Paediatrics work stream
- NHSI IDM meeting
- Invited speaker at the Aspiring Medical Directors Event, FMLM
- Institute for Digital Health Education meeting
- Attended Virginia Mason partnership event
- Filming with CEO for Dr Foster
- Guest Speaker at the Senior Registrar Leadership Course "Safety and the Pursuit of Excellence"
- Third Value Stream – UHCW Improvement System
- Meeting with a demonstration of Job Planning software (Allocate)
- Attended and presented prizes at the Research, Development and Innovation Summit
- Medical and Nurse Director's Network meeting
- Mortality Seminar
- Dr Foster meeting
- Met with Professor Richard Lilford re CLAHRC – collaboration on applied health research
- Board Walkrounds
- CD Interviews – Clinical Diagnostics
- Guardian of Safe Working Interviews
- Board Impact Review – Deloitte
- Paper published in International Journal of Surgery: Does a novel method of delivering the safe surgical checklist improve compliance? A closed loop audit.

Mrs Karen Martin, Chief Workforce and Information Officer

CWIO diary:

During the past month I attended all of the regular Chief Officers meetings including key review meetings with the Clinical Groups. I also chaired the Transforming Workforce Supply, Partnership and Engagement Forum and the Workforce and Engagement Committee meetings during the month.

Other work commitments have included:

- Attending the HMPA Annual Awards dinner held in London
- Holding a Leadership Compact Event jointly with David Eltringham
- A tour of UHCW's Surgical Training Centre and the Simulation Centre
- Attending the West Midlands HR Directors Planning and Network meetings.

Communications:

- The **tenth birthday of University Hospital** celebration was launched on July 1 at the Trust's Research, Development and Innovation summit. There has been a series of birthday events and activities throughout July, including staff thanksgiving services and a celebratory newsletter highlighting achievements.
- A **review of communications activity** shows improvement from last year (2014/15 to 2015/16):
    - National press coverage increased by 94%
    - Facebook increased by 189%, Twitter increased by 24%, Instagram by 815% and we started a LinkedIn account linking to 2,835 followers and 1,023 employees.
    - The number of positive press articles increased by 55%.
    - The average of monthly media queries received is up by 77%.
- The Human Metabolism Research Unit of Warwick Medical School was featured on Channel 4 as part of the Food Unwrapped series on 13 June. It looked at the effect of eating celery on two individuals and featured UHCW's Professor Tom Barber and Research Nurse Alison Campbell. It had viewing figures of 1.9m.
- A positive post on Facebook celebrating the work of **our EU staff** using the national hashtag #loveourEUstaff became the Trust's most popular post ever and was shared more than 100,000 times.
- The **Annual Report** Summary has been completed and the AGM organised.

Workforce:

- Eighty percent of recruitment activity is now on the **TRAC recruitment system**. The transition will be completed this month. The system has already helped managers reduce the shortlisting process from ten days to just over three.
- The Trust's **sickness rate has reduced** further to 3.86%. In the past month 33 long term sickness cases have been managed to either return to work (32) or exit the organisation (1).
- A number of **recruitment initiatives** are underway. A recruitment open-day for Consultant Radiologists was held, with activities including area tours and a meet and greet lunch. The Trust has initiated an internal transfer process for Health Care Assistants; this is to retain staff and improve recruitment timescales, mirroring the scheme introduced for Band 5 nurses. A newly qualified nurse assessment day was held and we aim to have over 50 newly qualified nurses start in the Autumn.
- Work continues on **reducing our reliance on agency use** and agency expenditure. A reduction in agency charges implemented in June has significantly reduced the number of nursing shifts above the capped rate. We are also standardising and reducing rates for medical locums and a series of deep dive reviews of locum staffing are underway, led by Deputy Chief Medical Officers.
- The month saw the launch of StepJockey stair signage across the University Hospital site. This is part of a wider **health and well-being programme** for 2016/17 that will include the implementation of lifestyle and health screening for staff, Pilates classes, walking meetings, walking groups, mindfulness and resilience resources. This work is being tracked through the Workforce and Engagement Committee, and links to the national CQUIN programme.
- Preparatory work has commenced for the **2016 flu campaign** with a target to vaccinate 75% of frontline staff. The campaign will build on improvements made in 2015, with increased use of peer vaccinations, gamification and social media.
- The first quarterly meeting of the seven **Confidential Contacts** with the Chief Executive Officer and Chief Workforce and Information Officer took place this month. Recruitment to these Contact roles continues and the scheme is being promoted through Trust induction and Your Week.
- Following stiff competition, Donna Griffiths, Associate Director of Workforce, has successfully secured a place on the **national Aspirant Director of Workforce programme**.

Equality and Diversity:

- The Trust's procurement hub has completed the recruitment of **interpreting and translating service** providers to a framework contract. This will reduce the cost to the Trust of face to face and phone interpreting services.
- This year's **Changing Futures Together** programme concluded on Friday 24 June. All the interns leaving stated how much they had gained from their experience. A workshop arranged by the Equality and Diversity team will identify best practice, learning and develop more robust processes for the next cohort.
- In support of the **Workforce Race Equality Standard** agenda a small working group has been formed to look at ways to engage the Trust's black and minority ethnic (BME) staff. This will include understanding how other organisations engage with, and sustain engagement, with BME staff.
- The team gave Equality & Diversity training to 105 staff and volunteers this month.

Performance and Programme Management Office (PPMO):

- The Performance team have been scoping a **Carter-related Financial Agency Spend dashboard** jointly with Finance and Workforce colleagues.
- Corporate Analytics and Information System Development (ISD) teams continue to work closely on key **development work streams** including referral to treatment time (RTT) analysis, RTT automation of reports and Carter dashboards.

- The **Programme Analytics** team with commissioning colleagues are reviewing how they might improve the annual planning and ODP cycle.
- The Finance Analytics team continue to track **Cost Improvement (CIP) delivery** and will also lead the identification of a proportion of 2017/18 CIPs by September 2016. The team is also co-ordinating the first quarter CQUIN submission.

Information and Communication Technology (ICT):

- Preparatory work has begun on the refresh of the University Hospital IT network. This has included presentations to Clinical Directors and Group Managers.
- The work done by the ICT Development team on a **Learning Disability Alert has been shortlisted in the Nursing Times Awards.**
- The Development team are encouraging **closer working with trainee doctors**. A working group of ICT staff and trainees will capture the requirements of trainee doctors and better understand how existing IT systems and infrastructure impact clinical teams, this to inform ICT's programme of developments.
- Development of the Trust's new **Unified Communications and Collaboration platform** continues with the Trust's three multidisciplinary team meeting rooms being upgraded, starting this month.
- In preparation for the upgrade of the Trust's core clinical system, CRRS, a series of **software upgrades** have been implemented. These include changes to the VTE (venous thromboembolism) assessment in support of new national standards, introduction of an alert to DNACPR preferences (do not attempt cardiopulmonary resuscitation), links to the new Cardiology IT system and enhanced support for pathology test requests.
- The **ICT Service Desk** software has been upgraded to support the introduction of user automated services, such as password resets.
- The **Blackberry mobile phone service has been decommissioned** with cost savings for the Trust. Trust mobile phone users now use Apple devices.

Professor Mark Radford – Chief Nursing Officer

Internal work:

- Group Key Performance meetings
- VM Sharing and Learning Conference
- Meeting with Warwick Business School and UHCW – Board Study Proposal
- RAPG meeting
- Presentation at the Advanced Nurse Practitioner and CNS Forum
- Met Lynne Wigens, Regional Chief Nurse, Midlands and East

External work:

- Attended the AUKUH Directors of Nursing/Deputy Directors of Nursing meeting on 23 June – Guest Speaker
- Attended the Chief Allied Health Professional Officer's Conference on 23 June – Guest Speaker
- Participated as panel member in NHSI Improvement Faculty launch event – 14th July
- Delivered the closing statement at the 2016 Safer Care Conference in Birmingham – 30 June
- Maternity Care/Staffing Work Stream meeting on London on 4 July
- NHSI Regional Directors of Nursing Event in Birmingham on 11 July
- Attended a Clinical Forum in London on 15 July

NQB Safe Staffing publication- UHCW Case study

UHCW has had a case study – *improving care and safety of at- risk patients – from 'specialling to enhanced care'* included in the updated NQB safe staffing improvement guidance (due for publication imminently). This will be a shorter document than previously and case studies will be

published as a separate resource for use by providers and commissioners. The case study identified the problem, the solution, results and learning points.

Visit by Lynne Wigens Regional Chief Nurse (Midlands and East)
We were very pleased to show Lynne Wigens around some of the wards and units at UHCW. She met Matrons, Ward Managers and staff as she visited surgery SAU, Ward 40, ED and the Lucina Unit. Feedback suggested that she valued the opportunity to familiarise herself with the hospital and get feedback from our staff with regard to key messages to take back to NHSE. All staff spoken to were proud to work at the trust and the teams they belonged to.

Nursing Times Awards – shortlisted for two Nursing Times Awards –
1. Developing Nursing, Midwifery and AHP Research - CARE (Clinical, Academic, Research & Innovation, Environment) Model
2. Designing and developing and effective Learning Disability Electronic Alert

Panel interviews will occur in September and winners to be announced at the Award Ceremony on 26 October 2016

Molnlycke Innovations in Care Award
Sally Sore and Tissue Viability Specialist Nurses – won a Molnlycke Innovations in Care Award. Prize money of £500 has been awarded which the team will help to grow Sally's profile in pressure ulcer prevention. Advisors from their academy visited the Trust to discuss with the team plans for Sally Sore.

Transforming Healthcare Through Clinical Academic Role
Case study submitted relating to the implementation of the CARE Model and implementation of non-medical Clinical Academics at UHCW for inclusion in the AUKUH publication – *Transforming Healthcare Through Clinical Academic Role – A resource for healthcare provider organisations on clinical academic roles for nurses, midwives and allied health professionals*.

Pre-registration Secondments
Seventeen healthcare support workers have successfully secured places and secondments to undertake the following pre-registration programmes commencing September and February:

13 Pre –registration Adult Nursing
1 Pre-registration Child and Young Adults
2 Operating Department Practitioner
1 Occupation Therapy

Fourth National Conference on Advanced Clinical Practice
*The Advanced Clinical Practice Kaleidoscope, d*eveloped by UHCW in partnership with Coventry University will be held on Wednesday 14 July 2016.

Health Education Reforms
Workshop to be held for Ward Managers and Modern Matrons on Thursday 14 July to hear about the proposed changes to funding pre-registration nursing and midwifery and to discuss the implications and practice placement learning.

International Congress in Midwifery
Abstracts, oral and poster presentations are being accepted for an International Congress in Midwifery in Toronto in 2017.

Initial Secondment
Midwife appointed for OASIS and FGM.

Conference in September 2016
An OASIS Conference has been organised for September 2016

National Birthrights Symposium
UHCW are hosting the National Birthrights Symposium in October 2016.

ACP Masters
Three places have been secured for ACP Masters in HDU, high risk antenatal and paediatrics.

Project
Mum + 1 project enables partners to stay in antenatal and post-natal period.

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Integrated Quality, Performance & Finance Report – Month 3 – 2016/17**
Author	**Miss. Lynda Cockrill, Head of Performance and Programme Analytics**
Responsible Chief Officer	**Mrs. Karen Martin, Chief Human Resources and Information Officer**
Date	**28th July 2016**

1. Purpose

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

2. Narrative

The attached Integrated Quality, Performance & Finance Report covers the reported performance for the period ending 30th June 2016.

In the Trust Board Scorecard, 23 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 re-submitted its plan in month 3; the control total remained at £1.1m. The Trust is reporting (in-line with plan) a £1.1m forecast control total surplus; the year-to-date position of £2.7m deficit is in-line plan as at month 3.

The Trust revised its CIP target in its re-submitted plan to £25.5m in month 3. The Trust is forecasting delivery of £20.9m against £21.6m potentially identified savings. This gives a potential under-delivery of £4.6m against the revised target.

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 June 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: 28th July 2016

University Hospitals Coventry and Warwickshire NHS Trust

Integrated Quality, Performance and Finance Reporting Framework

Reporting period: June 2016

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Executive Summary

University Hospitals Coventry and Warwickshire NHS Trust

23 KPIs achieved the target in June

	Indicators achieved	Indicators in exception	Indicators in watching status	Total indicators
Excellence in Patient care and experience	17	16	3	36
Delivery of value for money	2	3	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	**23**	**25**	**5**	**53**

KPI Hotspot

What's Good?

- MRSA bacteremia – Trust Acquired
- Sickness Rate
- Diagnostic Waiters – 6 weeks and over

What's Not So Good?

- A&E 4 hour wait
- RTT 52 week wait
- Delayed Transfers as a Percentage of Admissions

The Trust's overall performance has improved 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 have been two further breaches of the RTT 52 week wait standard this month, details of which are outlined in the group summary of underperformance section for RTT. The 62 day urgent referral to treatment performance failed to meet the 85% standard for a second consecutive 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.

Performance against the KPIs pertaining to patient outcomes is positive. The Trust continues to deliver against the infection control targets (MRSA bacteremia and Clostridium Difficile). There has also been improvement in all of the indicators that underpin the overarching Harm Free Care KPI. The progress against the staff sickness rate KPI has been maintained for the third consecutive month with performance of 3.84% being reported against a target of 4%.

The Vacancy rate compared to funded establishment indicator has improved further this month, although remains above the target of 10%. This is reflected in the agency costs against total costs which has decreased from 9.2% to 8.6%. The Trust is reporting a year-to-date deficit of £2.7m which is in-line with the year-to-date planned control total deficit. 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 June 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	5	8	↓	10	42	42	CNO	
MRSA Bacteremia - Trust Acquired - Cumulative	0	0	→	0	0	0	CNO	
Serious Incidents - Number	13	11	↑	15	15	15	CMO	
Never Events - Cumulative	1.0	1.0	→	0	0	1	CMO	
Same Sex Accommodation Breaches	0	0	→	0	0	0	CNO	
HSMR - Basket of 56 Diagnosis Groups	108.9	109.3	↓	RR	RR	RR	CMO	
Harm Free Care	95.8%	96.2%	↑	95%	95%	95%	CNO	
Patient Experience								
Friends & Family Test Inpatient Recommenders	88.9%	88.0%	↓	95%	95%	95%	CMO	
Friends & Family Test A&E Recommenders	80.1%	81.8%	↑	87%	87%	87%	CMO	
Complaints per 1000 Occupied Bed Days	1.55	1.82	↓	0.99	0.99	0.99	CMO	
Complaints Turnaround <= 25 Days (1 month in arrears)	98%	88%	↓	90%	90%	90%	CMO	
Theatres								
Theatre Lists Started within 15 mins of Start Time	37.6%	35.1%	↓	75%	75%	75%	CMO	
Surgical Safety Checklist - WHO	99.97%	100.00%	↑	100%	100%	100%	CMO	
Emergency Care and Patient Flow								
A&E 4 Hour Wait	80.9%	81.7%	↑	95%	95%	95%	COO	
12 Hour Trolley Waits in A&E	0	0	→	0	0	0	COO	
Ambulance Turnaround within 30 minutes	82.5%	81.6%	↓	100%	100%	100%	COO	
Delayed Transfers as a Percentage of Admissions	5.7%	7.6%	↓	3.5%	3.5%	3.5%	COO	
30 Day Emergency Readmissions (1 month in arrears)	8.4%	8.2%	↑	8.68%	8.68%	8.68%	COO	
Number of Medical Outliers - Average per Day	69	73	↓	50	50	50	COO	
Length of Stay - Average	7.2	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	1.3%	1.7%	↓	0.8%	0.8%	0.8%	COO	
Breaches of the 28 Day Readmission Guarantee	7	12	↓	0	0	30	COO	
18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears)	89.3%	88.4%	↓	92%	92%	92%	COO	
RTT 52 Week Waits Incomplete (1 month in arrears)	1	2	↓	0	0	0	COO	
Referral to Treatment Incomplete - Backlog Size (1 month in arrears)	2888	3117	↓	2067	2067	2067	COO	
Diagnostic Waiters - 6 Weeks and Over	0.47%	0.17%	↑	1%	1%	1%	COO	

Trust Scorecard

Reporting Month June 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)	95.1%	97.5%	⇧	93%	93%	93%	COO	
Cancer 2 Week Wait Breast Symptom (1 month in arrears)	100.0%	98.6%	⇩	93%	93%	93%	COO	
Cancer 31 Day Diagnosis to Treatment (1 month in arrears)	99.5%	97.1%	⇩	96%	96%	96%	COO	
Cancer 31 Day Subsequent Surgery Standard (1 month in arrears)	96.1%	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)	94.5%	97.4%	⇧	94%	94%	94%	COO	
Cancer 62 Day Urgent Referral to Treatment (1 month in arrears)	76.6%	79.4%	⇧	85%	85%	85%	COO	
Cancer 62 Day Screening Standard (1 month in arrears)	100.0%	94.1%	⇩	90%	90%	90%	COO	
Cancer 104 Day Waits - TDA Measure (1 month in arrears)	3.5	2.0	⇧	0	0	0	COO	
Deliver value for money								
Liquidity Days	-21.1	-21.0	⇧	-20.4	-23.8	-24.3	CFSO	
Capital Services Capacity	1.0	1.0	⇨	1.3	1.6	2	CFSO	
Income & Expenditure Margin	1	1	⇨	-4.6	1.3	3	CFSO	
Forecast Income & Expenditure Compared to Plan - £'000	600	1100	⇧	1100	1100	1100	CFSO	
CIP Delivery - £'000	2850	4978	⇧	5570	25512	20858	CFSO	
Agency expenditure as a % of pay bill	9.2%	8.6%	⇧	TBC	TBC	TBC	CWIO	
Employer of choice								
Personal Development Review - Non-Medical	87.94%	87.73%	⇩	90%	90%	90%	CWIO	
Personal Development Review - Medical	72.71%	71.81%	⇩	90%	90%	90%	CWIO	
Mandatory Training Compliance	88.39%	88.63%	⇧	95%	95%	95%	CWIO	
Sickness Rate	3.86%	3.84%	⇧	4%	4%	4%	CWIO	
Staff Turnover Rate	9.00%	8.96%	⇧	10%	10%	10%	CWIO	
Vacancy Rate Compared to Funded Establishment	14.78%	14.54%	⇧	10%	10%	10%	CWIO	
Staff Survey - Recommending as a Place of Work	78.69%	78.69%	⇨	44.1%	44.1%	44.1%	CWIO	
Leading research based health care organisation								
Patients Recruited into NIHR Portfolio - Cumulative (2 months in arrears)	4372	260	⇩	334	4006	4006	CMO	
Commercial Income Invoiced £000s - Cumulative (1 month in arrears)	69	137	⇧	200	1200	1200	CMO	
Peer Reviewed Publications - Calendar Year Cumulative (3 months in arrears)	3	4	⇧	24	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)	3.6	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	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Sickness Rate	4%	4.14%	4.01%	4.27%	4.56%	4.69%	4.86%	4.8%	4.51%	4.25%	3.88%	3.86%	3.84%
Staff Turnover Rate	10%	9.92%	9.89%	9.30%	9.14%	8.96%	9.03%	9.03%	9.07%	9.10%	9.07%	9.00%	8.96%
Diagnostic Waiters - 6 Weeks and Over	1%	0.02%	0.11%	0.05%	0.07%	0.07%	0.20%	0.57%	0.57%	0.59%	0.79%	0.47%	0.17%

- The progress against the staff sickness rate KPI has been maintained this month, with only six of the fifteen specialty groups remaining above the 4% target in June. The Imaging group has the lowest sickness rate of all specialty groups at 2.25%
- Staff turnover rate has improved over the past four months and is at its lowest level since November 2015
- There has been an improving trend for patients waiting over 6 weeks for diagnostic tests. This can be mainly attributed to the additional capacity that was identified for the cystoscopy patients during June

Deteriorating

(green/amber indicators worsening)

(3 months consecutive deterioration)

Measure	Target	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Personal Development Review - Non-Medical	90%	86.43%	87.18%	86.30%	84.73%	85.50%	87.48%	88.04%	87.70%	88.43%	88.40%	87.94%	87.73%

- The non-medical appraisal rates have fallen for the past three months. Specialist Medicine and Ophthalmology are the worst performing group for this indicator at 70.53%, while Care of the Elderly is the most compliant group at 99.38%. Groups are challenged by Chief Officers on their compliance against this target during monthly accountability meetings and quarterly performance reviews

Deteriorating

(red indicators worsening)

(3 months consecutive deterioration)

Measure	Target	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears)	92%	87.7%	87.6%	87.8%	87.5%	88.2%	86.4%	87.2%	89.0%	89.7%	89.3%	88.4%	
Delayed Transfers as a Percentage of Admissions	3.5%	4.4%	6.1%	5.8%	6.8%	6.6%	5.4%	7.9%	7.0%	6.6%	5.4%	5.7%	7.6%
Last Minute Non-clinical Cancelled Operations - Elective	1%	0.9%	0.8%	0.5%	0.9%	0.9%	0.8%	2.0%	1.1%	0.8%	1.2%	1.3%	1.7%

- The RTT incomplete performance remains challenging due to capacity and numbers of patients in the backlog. Weekly access meetings are in place to discuss performance and the plans being put in place to address the under-achievement of the target.
- One of the aims of the Trust's newly established Emergency Care Pathway Recovery Group is to work with partners to reduce DTOC and improve discharge performance across all areas.
- The number of last minute non-clinical cancelled elective operations has increased primarily due to a lack of available beds which is a consequence of the delayed transfers and subsequent reduced flow of patients through the Trust.

Failed Year End Target

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

- A wrong route administration of medication never event was declared in May 2016. Details were in included within May's Integrated Quality, Performance and Finance Report

Trust Heatmap

University Hospitals Coventry and Warwickshire NHS Trust

Performance Summary

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:					June 2016	
Group Level Indicators																	
Excellence in patient care and experience																	
Clostridium Difficile - Trust Acquired - Cumulative	2	2		1	0	0	0	0	1	0	0		2			8	10
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	67.3	98.0		113.3	81.9	99.7	71.0	134.7	64.0		125.0					109.3	100
Harm Free Care	97.7%	96.8%	100.0%	96.6%	95.7%	96.4%	94.9%	98.2%	88.2%	95.5%	95.4%		94.3%			96.2%	95%
Friends & Family Test Inpatient Recommenders	93.3%	85.8%	77.6%	85.9%	94.4%	85.4%	90.7%	92.7%	86.1%		93.1%					88.0%	95%
Friends & Family Test A&E Recommenders			79.4%						77.2%							81.8%	87%
Complaints per 1000 Occupied Bed Days	0.91	0.67	11.44	1.86	0.75	2.67	2.49	0.99	5.41	3.02	0.00		0.37			1.82	0.99
Complaints Turnaround <= 25 Days (1 month in arrears)	100%	100%	67%	100%	100%	33%	100%	100%	100%	100%	100%	100%	100%	100%	100%	88%	90%
Theatre Lists Started within 15 mins of Start Time	75.0%	23.1%		37.3%		29.6%	46.8%	69.1%	6.9%	22.7%						35.1%	75%
Surgical Safety Checklist - WHO	100.00%	100.00%		100.00%		100.00%	100.00%	100.00%	100.00%	100.00%						100.00%	100%
30 Day Emergency Readmissions (1 month in arrears)	8.1%	10.0%		4.1%	1.1%	6.9%	3.1%	8.2%	7.5%	12.5%	11.8%					8.2%	8.68%
Number of Medical Outliers - Average per Day	3	30		N/A	N/A	2	N/A	N/A	4		34		N/A			73	50
Last Minute Non-clinical Cancelled Operations - Elective	0.0%	0.0%		3.2%	0.0%	3.1%	3.2%	0.9%	1.2%	0.0%						1.7%	0.8%
Breaches of the 28 Day Readmission Guarantee	N/A	N/A		2	N/A	6	1	0	3	N/A						12	0
18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears)	95.1%	92.0%		93.2%	97.9%	83.2%	84.8%	91.9%	91.0%	97.3%	100.0%					88.4%	92%
RTT 52 Week Waits Incomplete (1 month in arrears)	0.0	0.0		1.0	N/A	0.0	1.0	0.0	0.0	N/A	0.0					2.0	0
Referral to Treatment Incomplete - Backlog Size (1 month in arrears)	106	18		151	5	1538	505	181	592	21	0					3117	2067
Diagnostic Waiters - 6 Weeks and Over	6.47%			1.06%		0.55%						0.01%				0.17%	1%
Cancer 2 Week Wait GP Referral to OP Appointment (1 month in	100.0%			100.0%	100.0%	97.2%	100.0%	96.9%	98.4%							97.5%	93%
Cancer 31 Day Diagnosis to Treatment (1 month in arrears)	100.0%			100.0%	100.0%	94.9%		100.0%	100.0%							97.1%	96%
Cancer 31 Day Subsequent Surgery Standard (1 month in arrears)	100.0%			100.0%	N/A	94.3%		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%	100.0%							100.0%	98%
Cancer 31 Day Subsequent Radiotherapy - Group (1 month in arrears)	100.00%			71.43%	100.00%	99.07%		100.00%	93.33%							97.37%	94%
Cancer 62 Day Urgent Referral to Treatment (1 month in arrears)	72.2%			N/A	100.0%	74.5%		61.5%	100.0%							79.4%	85%
Cancer 62 Day Screening Standard (1 month in arrears)						93.8%		100.0%								94.1%	90%

Trust Heatmap

University Hospitals Coventry and Warwickshire NHS Trust

Performance Summary

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:			June 2016
Group Level Indicators																	
Deliver value for money																	
Agency expenditure as a % of pay bill	8.8%	24.6%	-1.7%	18.2%	4.6%	10.6%	3.9%	1.8%	6.5%	7.2%	15.1%	10.6%	1.7%	5.1%	11.0%	8.6%	
Employer of choice																	
Personal Development Review - Non-Medical	86.47%	84.81%	84.38%	84.90%	84.75%	94.69%	93.37%	91.23%	70.53%	88.89%	99.38%	87.82%	96.59%	91.48%	81.05%	87.73%	90%
Personal Development Review - Medical	55.26%	71.43%	72.41%	61.11%	83.33%	70.41%	N/A	85.71%	50.82%	85.00%	100.00%	66.67%			90.91%	71.81%	90%
Mandatory Training Compliance	91.39%	93.59%	89.42%	89.49%	92.75%	92.80%	90.33%	94.03%	92.07%	95.86%	86.56%	95.46%	94.94%	95.18%	85.71%	88.63%	95%
Sickness Rate	2.27%	3.76%	3.62%	4.34%	3.58%	3.70%	2.97%	5.16%	4.83%	4.02%	2.89%	2.25%	2.85%	5.46%	6.18%	3.84%	4%
Staff Turnover Rate	7.95%	6.16%	7.27%	9.06%	6.62%	6.36%	6.59%	8.42%	15.73%	4.52%	6.47%	11.57%	10.66%	11.71%	12.77%	8.96%	10%
Vacancy Rate Compared to Funded Establishment	13.19%	20.33%	18.89%	22.95%	17.14%	14.72%	15.96%	12.57%	13.22%	10.07%	29.22%	11.66%	18.74%	8.17%	16.35%	14.54%	10%
Staff Survey - Recommending as a Place of Work	66.67%	77.42%	N/A	84.31%	67.19%	80.10%	86.11%	79.57%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	78.69%	44.1%
Leading research based health care organisation																	
Patients Recruited into NIHR Portfolio - Cumulative (2 months in arrears)	2	1		4	32	61	30	109	5	1	0		0	0		260	334
Peer Reviewed Publications - Calendar Year Cumulative (3 months in	1	0	0	0	0	1	0	0	1	0	0	1	0	0	0	4	24
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
Doctor Trainers Provisionally Accredited																	100%

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

University Hospitals Coventry and Warwickshire NHS Trust

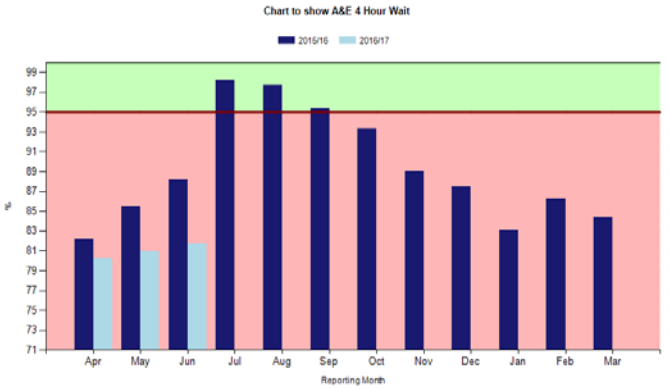
The Trust continues to struggle with performance around the 4 Hour A&E Standard and for May posts a below standard performance of 81.74%. Patient attendances in A&E are slightly above average whilst admissions through A&E are slightly below average, however, overall discharge performance was poor.

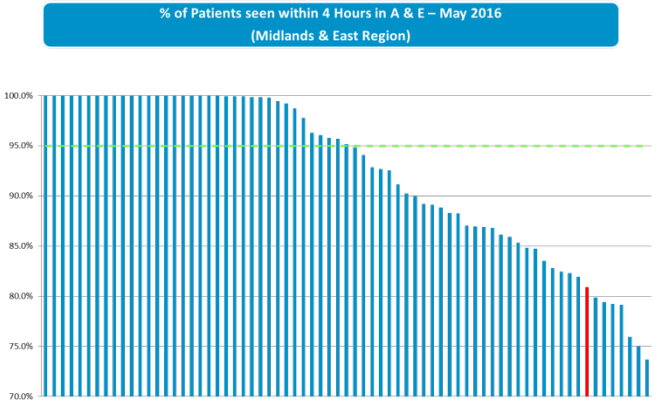
The Trust takes its performance very seriously and is striving to improve its standing through numerous initiatives internally as well as in conjunction with our community partners. An action plan has been constructed to recover ED performance which includes;

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

- The System as a whole continues its SRG approved work around the 3 principle work streams of:
  - No-one goes to hospital who can be managed elsewhere in the community.
  - No-one is admitted to hospital who doesn't have an acute hospital need.
  - No-one waits more than 24 hours to leave hospital once they are medically fit for discharge.





Patient Flow metrics

Measure	Target	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Number of Medical Outliers - Average per Day	50	30	29	48	58	54	74	88	69	65	61	69	73
Diagnostic Waiters - 6 Weeks and Over	1%	0.02%	0.11%	0.05%	0.07%	0.07%	0.20%	0.57%	0.57%	0.59%	0.79%	0.47%	0.17%
Last Minute Non-clinical Cancelled Operations - Elective	0.8%	0.9%	0.8%	0.5%	0.9%	0.9%	0.8%	2.0%	1.1%	0.8%	1.2%	1.3%	1.7%
Length of Stay - Average	6.0	7.1	6.3	6.5	6.5	6.7	7.6	6.9	7.4	7.1	7.3	7.2	7.2

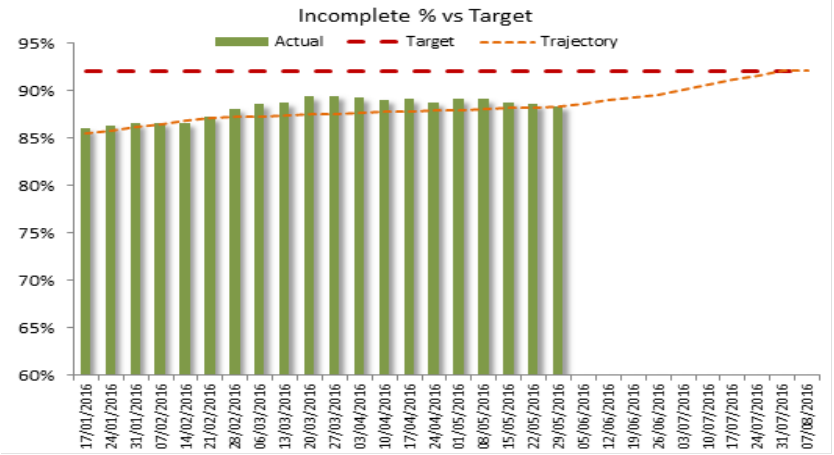
Neurosciences (3.2%), Trauma and Orthopaedics (3.2%) and Surgery (3.1%) were the groups with the highest percentage of cancelled operations in June. Bed availability on the wards remains the main reason for cancelling operations. Specialist Medicine & Ophthalmology (1.2%) and Women & Children (0.9%) were also groups not achieving the 0.80% target.

The numbers of patients awaiting diagnostic tests has remained greater than ten thousand for a second consecutive month with June's position of 10,473 patients the highest ever reported for the Trust.

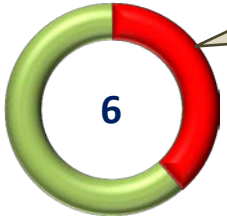
The main areas for delays which are related to capacity remain in cystoscopy and cardiology – echocardiography. The specialty groups attend the Access meeting each week to discuss and identify additional capacity.

Group summary of performance – Referral To Treatment

University Hospitals Coventry and Warwickshire NHS Trust

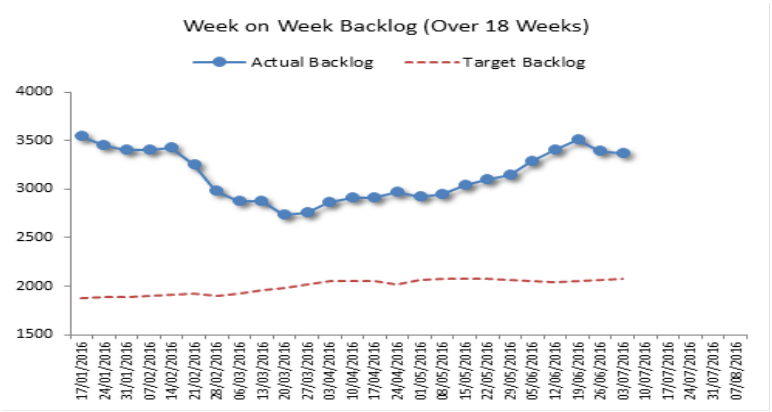


6 out of 10 groups achieved the incomplete target



Underperforming groups
- Surgery (83.2%)
- Trauma & Orthopaedics (84.8%)
- Specialist Medicine and Ophthalmology (91.0%)
- Women & Children (91.9%)

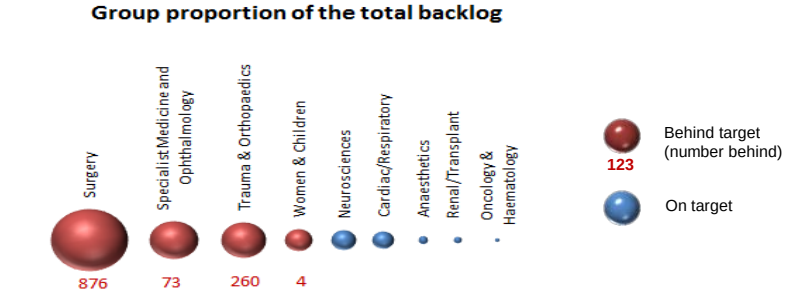
The delivery against the RTT incomplete target has dropped slightly in May with the Trust reporting 88.4% against the 92% target. The Trust did meet the monthly target of 88.3% against the NHSI improvement trajectory that was submitted earlier in the year, however the targets are looking increasingly challenging to meet over the forthcoming months due to revisions in reporting rules for RTT which has removed the ability of Trusts to suspend patients who are unavailable for appointments.



The backlog has grown to a total of 3117 patients this month with the Surgery group having the largest proportion of the Trust's total. Surgery is 876 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 two 52 week incomplete pathway breaches in May. One patient was transferred from George Eliot Hospital after 52 weeks. The second patient was a prisoner.

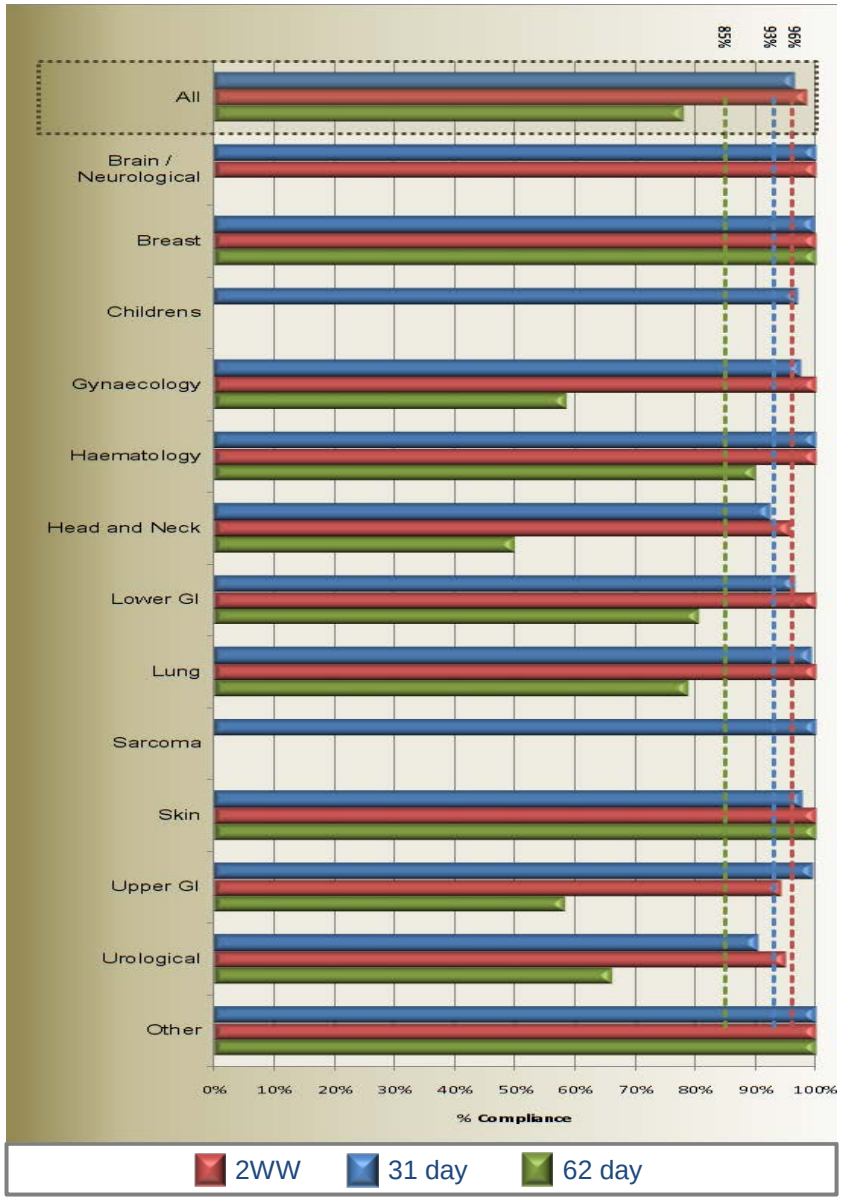
The change in reporting rules relating to suspensions is also having an impact on the number of 52 week wait patients the Trust is seeing.

Performance Summary

Group summary of performance – cancer standards

University Hospitals Coventry and Warwickshire NHS Trust

Performance against cancer standards by tumour site – 2016/17 YTD



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

The 62 Day Cancer Waiting Times Standard was not achieved with 79.4% of patients treated against the 85% standard.

The Trust achieved 100% for 31 day subsequent treatment chemotherapy.

104+ day target not met

May has seen a reduction in the number of patients who were treated on or after day 104
There were 2 breaches (3 patients) of the target:

- 0.5 Gynaecology
- 1.5 Urology

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

There were 17.5 breaches of the 62 day standard during May:

- 2.5 Gynaecology
- 4 Head and Neck
- 2.5 Lower GI
- 2.5 Lung
- 6 Urological

May 2016 performance

Standard:	May-16	DoH Tolerance
TWW suspected cancer	97.50%	93%
TWW breast symptomatic	98.60%	93%
31 day - 1st treatment	97.10%	96 %
31 day - subsequent treatment -surgery	96.10%	94%
31 day - subsequent treatment -chemo	100%	98%
31 day - subsequent treatment - radio	97.40%	94%
31 day - subsequent treatment - other	-	No tolerance set
31 day - rare cancers	-	No tolerance set
62 day - 1st treatment	79.40%	85%
62 day - national screening programme	94.10%	90%
62 day - consultant upgrade	93.30%	CCG tolerance = 85%
62 day - treated on or after day 100+	2	CCG Tolerance = 0
62 day - treated on or after day 105+	2	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.

Overall performance against quality and safety indicators has improved slightly with one more indicator moving into achieved status this month. One more indicator has moved into exception, whilst fewer remain in watching status.

All four of the indicators that underpin the Harm Free Care KPI have shown improvement this month.

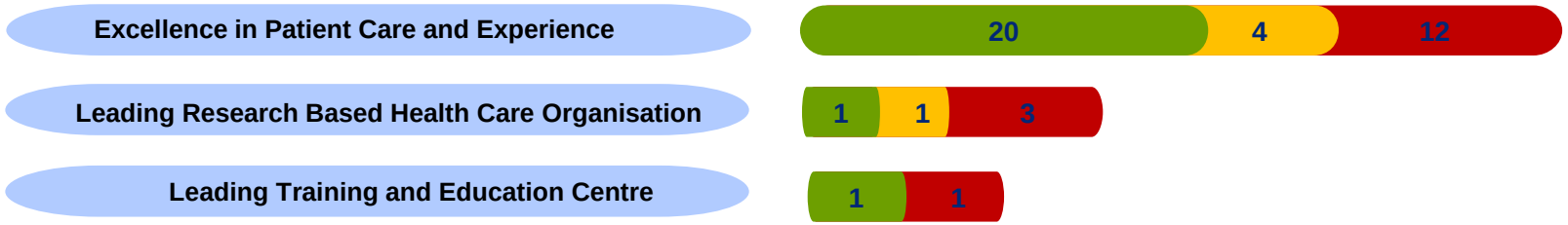
22 KPIs achieved the target in June

Quality & Safety Scorecard	Indicators achieved	Indicators in exception	Indicators in watching status	Total indicators
Excellence in Patient care and experience	20	12	4	36
Leading research based health care organisation	1	3	1	5
Leading training and education centre	1	1	0	2
All domains	**22**	**16**	**5**	**43**

There has historically been a lag in the closure of Patient Safety Incident (PSI) at UHCW. Over the last couple of months this has been addressed by the Quality (Safety and Risk) teams in a focussed way and as such the time between reporting and closure is becoming shorter, resulting in a higher percentage of 34.9% against the Reported Harmful Patient Safety Incident KPI.

The FFT Response rate target of 35% for inpatients is challenging. In order to meet this target an average of 3800 patients would need to be surveyed every month. Based on 2015 data UHCW currently surveys an average of 2700 inpatients a month. a plan to improve response rates would include; extra volunteer recruitment, potentially using an external survey firm and introducing an FFT ward of the month. The most common themes for patients not recommending the Trust continue to be parking, food and drink and doing things on time.

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



Trust Scorecard – Quality and Governance Performance Committee

Reporting Month June 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	5	8	↓	10	42	42	CNO	
MRSA Bacteremia - Trust Acquired - Cumulative	0	0	→	0	0	0	CNO	
MRSA Decolonisation Score	100.0%	100.0%	→	95%	95%	95%	CNO	
MRSA - Elective Screening	88.7%	91.5%	↑	95%	95%	95%	CNO	
MRSA - High Risk Emergency Screening	79.5%	78.7%	↓	TBC	TBC	TBC	CNO	
Serious Incidents - Number	13	11	↑	15	15	15	CMO	
Serious Incidents - Overdue	13	6	↑	0	0	0	CMO	
Medication Errors Causing Serious Harm	1	0	↑	0	0	0	CMO	
Reported Harmful Patient Safety Incidents (1 month in arrears)	25.1%	34.9%	↓	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	→	15	15	15	CMO	
Never Events - Cumulative	1.0	1.0	→	0	0	1	CMO	
Same Sex Accommodation Breaches	0	0	→	0	0	0	CNO	
HSMR - Basket of 56 Diagnosis Groups	108.9	109.3	↓	RR	RR	RR	CMO	
SHMI - Quarterly (6 months in arrears)	106.50	106.30	↑	RR	RR	RR	CMO	
Harm Free Care	95.8%	96.2%	↑	95%	95%	95%	CNO	
Pressure Ulcers Grade 3 and 4 - Trust Associated (1 month in arrears)	1	0	↑	0	0	1	CNO	
Falls per 1000 Occupied Bed Days Resulting in Serious Harm	0.2	0.1	↑	0.04	0.04	0.04	CNO	
Eligible Patients Having VTE Risk Assessment (1 month in arrears)	95.9%	96.0%	↑	95%	95%	95%	CNO	
C-UTI	99.8%	100.0%	↑	99%	99%	99%	CNO	
Transfer of Patients at Night (UH to Rugby)	31	26	↑	0	0	0	COO	
Patient Experience								
Friends & Family Test Inpatient Recommenders	88.9%	88.0%	↓	95%	95%	95%	CMO	
Friends & Family Test Inpatient Coverage	24.9%	23.9%	↓	35%	35%	35%	CMO	
Friends & Family Test A&E Recommenders	80.1%	81.8%	↑	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	51	58	↓	32	32	32	CMO	
Complaints per 1000 Occupied Bed Days	1.55	1.82	↓	0.99	0.99	0.99	CMO	
Complaints Turnaround <= 25 Days (1 month in arrears)	98%	88%	↓	90%	90%	90%	CMO	
Theatres								
Surgical Safety Checklist - WHO	99.97%	100.00%	↑	100%	100%	100%	CMO	
National Quality Requirements								
Valid NHS Number - Inpatients (2 months in arrears)	99.3%	99.1%	↓	99%	99%	99%	COO	
Valid NHS Number - A&E (2 months in arrears)	97.7%	97.4%	↓	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 June 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	82.5%	81.6%	↓	100%	100%	100%	COO	
Ambulance Turnaround within 60 Minutes	99.5%	99.1%	↓	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	2	↓	0	0	0	COO	
Leading research based health care organisation								
Patients Recruited into NIHR Portfolio - Cumulative (2 months in arrears)	4372	260	↓	334	4006	4006	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)	3	4	↑	24	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)	3.6	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

Performance Trends

University Hospitals Coventry and Warwickshire NHS Trust

Improving

(3 months consecutive improvement)

Measure	Target	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-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 the 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 three 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)

- None of the indicators that are achieving their targets this month have deteriorated for three consecutive months. In the last report, the KPI for eligible patients having a VTE risk assessment was highlighted in this section. It should be noted that performance against this indicator has improved for June's reporting

Deteriorating

(red indicators worsening)

(3 months consecutive deterioration)

Measure	Target	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Ambulance Turnaround within 60 minutes	100%	99.8%	100.0%	99.9%	99.9%	99.7%	100.0%	99.7%	99.6%	99.8%	99.6%	99.5%	99.1%

- The system has been changed to capture ambulance turnaround times electronically rather than using the manual written process previously used and therefore an improvement in this indicator should be seen as the process becomes embedded. Work has also been undertaken in both the walk-in and ambulance triage areas to improve flow

Failed Year End Target

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

- A wrong route administration of medication never event was declared in May 2016. Details were in included within May's Integrated Quality, Performance and Finance Report

Ward Staffing Levels - Monthly by Trust

Entry Date : June 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)	7981	7567	7901	99.0%	7777	7293	7591	97.6%	6158	5681	6138	99.7%
Health Care Support Worker (HCSW)	4192	4205	4220	100.7%	3571	3597	3583	100.3%	2894	2865	2929	101.2%
Specials	1	401	286		1	390	212		0	414	223	
Specialist Trained Neonatal Nurse	271	266	272	100.4%	264	262	263	99.6%	293	276	295	100.7%
Registered Nurse	56	54	57	101.8%	44	39	39	88.6%	45	36	37	82.2%
Nursery Nurse (NN)	65	62	65	100.0%	68	67	68	100.0%	61	61	62	101.6%
Enhanced Care Team (ECT)	0	119	99		0	118	98		0	112	95	
Total (non Specials)	12565	12273	12614	100.4%	11724	11376	11642	99.3%	9451	9031	9556	101.1%

Ward Staffing Levels - Monthly Ward Scorecard - Exceptions

Entry Month : June 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)	Comments
22ECU	93.1%	112.3%	100.0%	100.0%	9.1	Drop in RN fill rate on days due to a high level of sickness/vacancies and a high number of DNA by TSS & Agency staff
30	94.6%	95.7%	99.4%	115.6%	6.6	RN fill rate on days dropped (vacancies and sickness)
33 Gastro	99.2%	120.0%	96.6%	123.3%	6.7	Sustained improvement across all domains for fill rates
43	90.0%	141.6%	100.0%	129.6%	6.1	Reduced RN fill rates from previous months, high level of RN vacancies
AMU1	92.2%	100.1%	98.7%	103.3%	10.3	Inability to fill all RN days shifts due to vacancies. TSS and Agency unable to fill all gaps
Labour Ward	85.6%	94.8%	90.0%	90.0%	18.3	High level of sickness that could not be filled, 10 new WTE starting across maternity services in coming months
Mulberry Ward	89.5%	97.9%	100.0%	104.9%	6.9	Drop in RN fill rates on days caused by vacancies and inability to fill with TSS or Agency
Total Fill rate	**94.9%**	**106.5%**	**100.3%**	**113.4%**	**8.2**	**Overall RN fill rate for days has dropped by 5%**

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.

Indicators within Delivery of Value for Money section are being revised in-line with recent guidelines from NHSI. Whilst existing KPIs within this section are within tolerance of plan, two of the revised KPIs are not within tolerance of plan, as a result an escalation report has been produced. Further details on revised KPIs have been provided in the Integrated Finance Report that is submitted to Finance and Performance Committee.

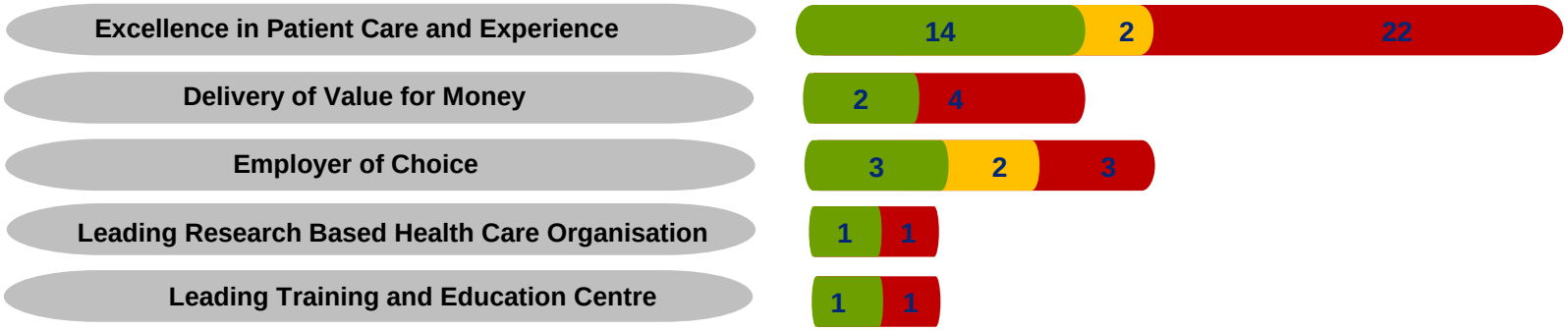
21 KPIs achieved the target in June

	Indicators achieved	Indicators in exception	Indicators in watching status	Total indicators
Excellence in Patient care and experience	14	22	2	38
Delivery of value for money	2	4	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	**21**	**31**	**4**	**56**

The progress against the staff sickness rate KPI has been sustained for the third consecutive month with performance of 3.84% being reported achieving the 4% target. Mandatory training compliance has remained at a similar level this month and is still falling short of the target while performance against PDRs also 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 forthcoming NHSI targets 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.

With the exception of the Day Surgery unit, all indicators for theatre efficiency and utilisation deteriorated in June.



Trust Scorecard – Finance and Performance Committee

Reporting Month June 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	80.9%	81.7%	↑	95%	95%	95%	COO	
12 Hour Trolley Waits in A&E	0	0	→	0	0	0	COO	
Ambulance Turnaround within 30 minutes	82.5%	81.6%	↓	100%	100%	100%	COO	
Ambulance Turnaround within 60 Minutes	99.5%	99.1%	↓	100%	100%	100%	COO	
Delayed Transfers as a Percentage of Admissions	5.7%	7.6%	↓	3.5%	3.5%	3.5%	COO	
30 Day Emergency Readmissions (1 month in arrears)	8.4%	8.2%	↑	8.68%	8.68%	8.68%	COO	
Number of Medical Outliers - Average per Day	69	73	↓	50	50	50	COO	
Length of Stay - Average	7.2	7.2	↑	5.96	5.96	5.96	COO	
Non emergency care								
Last Minute Non-clinical Cancelled Operations - Elective	1.3%	1.7%	↓	0.8%	0.8%	0.8%	COO	
Breaches of the 28 Day Readmission Guarantee	7	12	↓	0	0	30	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)	89.3%	88.4%	↓	92%	92%	92%	COO	
18 Week Referral to Treatment Time - Admitted (1 month in arrears)	74.1%	75.5%	↑	90%	90%	90%	COO	
18 Week Referral to Treatment Time - Non-admitted (1 month in arrears)	90.6%	91.5%	↑	95%	95%	95%	COO	
RTT 52 Week Waits Incomplete (1 month in arrears)	1	2	↓	0	0	0	COO	
Referral to Treatment Incomplete - Backlog Size (1 month in arrears)	2888	3117	↓	2067	2067	2067	COO	
E-referral Appointment Slot Issues – National data (1 month in arrears)	31.2%	30.4%	↑	3%	3%	3%	COO	
Diagnostic Waiters - 6 Weeks and Over	0.47%	0.17%	↑	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)	95.1%	97.5%	↑	93%	93%	93%	COO	
Cancer 2 Week Wait Breast Symptom (1 month in arrears)	100.0%	98.6%	↓	93%	93%	93%	COO	
Cancer 31 Day Diagnosis to Treatment (1 month in arrears)	99.5%	97.1%	↓	96%	96%	96%	COO	
Cancer 31 Day Subsequent Surgery Standard (1 month in arrears)	96.1%	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)	94.5%	97.4%	↑	94%	94%	94%	COO	
Cancer 62 Day Urgent Referral to Treatment (1 month in arrears)	76.6%	79.4%	↑	85%	85%	85%	COO	
Cancer 62 Day Standard plus 31 Day Rare Cancers (1 month in arrears)	77.4%	79.4%	↑	85%	85%	85%	COO	
Cancer 62 Day Screening Standard (1 month in arrears)	100.0%	94.1%	↓	90%	90%	90%	COO	
Cancer 62 Day Consultant Upgrades (1 month in arrears)	93.9%	93.3%	↓	85%	85%	85%	CMO	
Cancer 104 Day Waits - TDA Measure (1 month in arrears)	3.5	2.0	↑	0	0	0	COO	
Theatre Productivity								
Theatre Efficiency - Main	68.1%	64.1%	↓	85%	85%	85%	COO	
Theatre Efficiency - Rugby	70.1%	68.7%	↓	85%	85%	85%	COO	
Theatre Efficiency - Day Surgery	58.0%	59.0%	↑	70%	70%	70%	COO	
Theatre Utilisation - Main	84.7%	82.5%	↓	85%	85%	85%	COO	
Theatre Utilisation - Rugby	76.3%	75.7%	↓	85%	85%	85%	COO	
Theatre Utilisation - Day Surgery	70.5%	71.2%	↑	70%	70%	70%	COO	
Surgical Safety Checklist - WHO	99.97%	100.00%	↑	100%	100%	100%	CMO	
Theatre Lists Started within 15 mins of Start Time	37.6%	35.1%	↓	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 June 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	-21.1	-21.0	↑	-20.4	-23.8	-24.3	CFSO	
Capital Services Capacity	1.0	1.0	→	1.3	1.6	2	CFSO	
Income & Expenditure Margin	1	1	→	-4.6	1.3	3	CFSO	
Forecast Income & Expenditure Compared to Plan - £'000	600	1100	↑	1100	1100	1100	CFSO	
YTD Income & Expenditure Compared to Plan Trust - £'000	-2377	-2731	↓	-2741	1100	1100	CFSO	
CIP Delivery - £'000	2850	4978	↑	5570	25512	20858	CFSO	
Agency expenditure as a % of pay bill	9.2%	8.6%	↑	TBC	TBC	TBC	CWIO	
Employer of choice								
Personal Development Review - Non-Medical	87.94%	87.73%	↓	90%	90%	90%	CWIO	
Personal Development Review - Medical	72.71%	71.81%	↓	90%	90%	90%	CWIO	
Mandatory Training Compliance	88.39%	88.63%	↑	95%	95%	95%	CWIO	
Sickness Rate	3.86%	3.84%	↑	4%	4%	4%	CWIO	
Staff Turnover Rate	9.00%	8.96%	↑	10%	10%	10%	CWIO	
Vacancy Rate Compared to Funded Establishment	14.78%	14.54%	↑	10%	10%	10%	CWIO	
Staff Survey - Recommending as a Place of Work	78.69%	78.69%	→	44.1%	44.1%	44.1%	CWIO	
Enrolled on Leading Together Programme - All	67	88	↑	100	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)	69	137	↑	200	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)	3.6	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

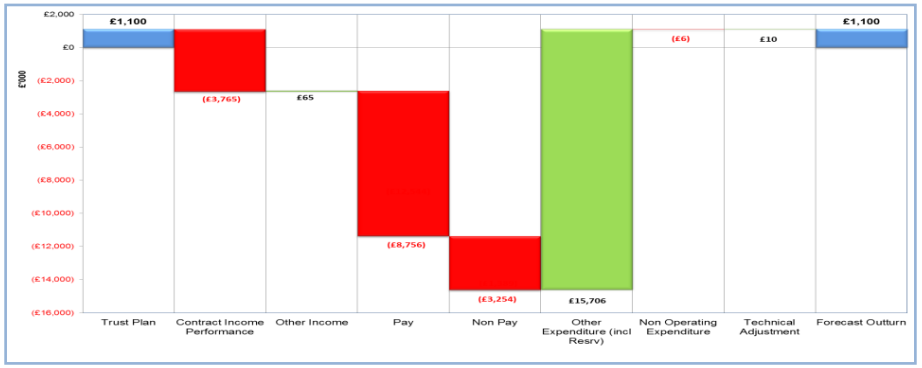
DoT
↑ Improving
→ No change
↓ Falling

Finance | Headlines June 2016

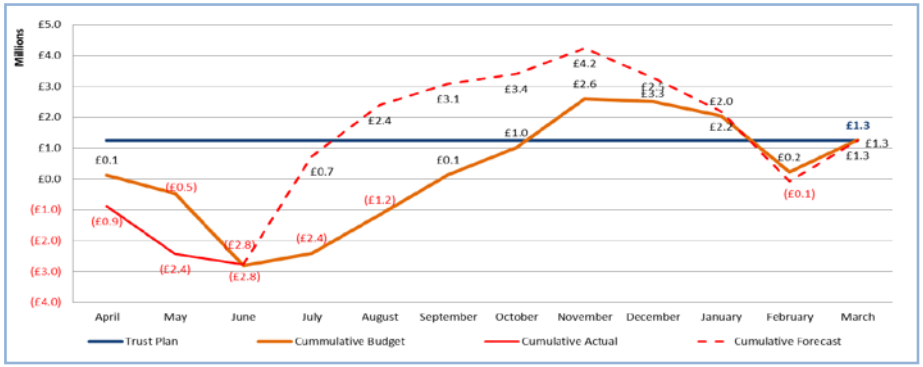
The Trust reports a £1.1m forecast control total surplus which is in-line with plan in Month 3.

The Trust resubmitted its plan in month 3; the control total remained at £1.1m. The Trust is reporting a year-to-date deficit of £2.7m which is in-line with the year-to-date planned control total deficit.

Trust Position Post Technical Adjustment



Net Surplus / (Deficit) position



Updates on Control Total

Movements within the control total is largely driven by pay overspends (2.5% adverse to plan), non-pay overspends (1.6% adverse to plan) and contract income (1% adverse to plan).

Updates on Net Surplus/(Deficit) position

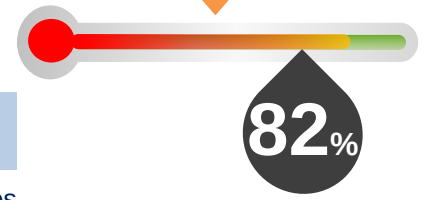
The Trust plans to hit its net surplus position of £1.3m by year-end. The year-to-date position is a £2.8m actual which is in-line with plan.
The incline in M4 onwards is partly driven by expected improvement in activity income and control in non-substantive pay expenditures.

CONTACT & ACITIVITY INCOME

1 % under-performance

Contract income from activities reports an adverse variance of £2.1m YTD and £3.8m on outturn.

Under-performance on income is largely driven by shortfall in elective activities, outpatient procedures, and penalty provisions.



Cost Improvement Programme is £20.9m against £25.5m target.

The Trust has identified £21.6m of potential savings: below the required target by £3.9m

FRP

Trust has a revised FRP target of £12.1m.

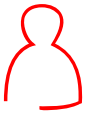
Method of delivery has been identified for all schemes; £5.6m has risk associated, whilst £1m is yet to be transacted.

Capital

A reduction in Gross Capital Expenditure of £7.6m from initial plan of £53.6m.

Pending DoH approval on capital programme, approval is only considered on contractually committed and urgent schemes

£8.4m



AGENCY SPEND

£8.4m actual spend on agency spend year to date.

Trust is forecasting £29.9m spend on agency against target of £26.6m as at month 3.

SOCI – Finance and Performance Committee

Reporting Month June 2016

University Hospitals Coventry and Warwickshire NHS Trust

3 months ended 30th June 2016	Plan	Full Year		Variance to plan		Year to date		Variance to plan	
	£'000	Budget (£'000)	Forecast (£'000)	£'000	%	Budget (£'000)	Actual (£'000)	£'000	%
Contract income from activities	507,856	506,921	503,156	(3,765)	(0.7%)	126,030	123,917	(2,113)	(1.7%)
Other income from activities	24,369	24,030	23,980	(50)	(0.2%)	5,954	5,940	(14)	(0.2%)
Other Operating Income	75,105	75,846	75,961	115	(0.2%)	18,936	19,401	465	(2.5%)
Total Income	**607,330**	**606,797**	**603,097**	**(3,700)**	**(0.6%)**	**150,920**	**149,258**	**(1,662)**	**(1.1%)**
Pay costs	(356,672)	(356,971)	(365,727)	(8,756)	(2.5%)	(90,636)	(89,335)	1,301	(1.4%)
Other operating expenses	(197,423)	(198,631)	(201,885)	(3,254)	(1.6%)	(50,461)	(51,290)	(829)	(1.6%)
CIP gap to target delivery			4,654	4,654		0	0		
Additional savings required			7,038	7,038		0	0		
Reserves	(6,199)	(4,181)	(167)	4,014	96.0%	(1,206)	0	1,206	100.0%
Total Operating Expenses	**(560,294)**	**(559,783)**	**(556,087)**	**3,696**	0.7%	**(142,303)**	**(140,625)**	**1,678**	**1.2%**
EBITDA	**47,036**	**47,014**	**47,010**	**(4)**	**(0.0%)**	**8,617**	**8,633**	**16**	**(0.2%)**
Profit / loss on asset disposals	0	22	27	5		6	27	21	
Depreciation	(20,894)	(20,894)	(20,894)	0		(5,223)	(5,215)	8	
Interest Receivable	115	115	115	0		31	23	(8)	
Interest Charges	(465)	(465)	(465)	0		(107)	(105)	2	
Financing Costs	(22,278)	(22,278)	(22,278)	0		(5,542)	(5,538)	4	
Unwinding Discount	(34)	(34)	(35)	(1)		(34)	(35)	(1)	
PDC Dividend	(2,214)	(2,214)	(2,214)	0		(555)	(555)	0	
Impairments		0	(10)	(10)		0	(10)	(10)	
Net Surplus/(Deficit)	**1,266**	**1,266**	**1,256**	**(10)**	**(0.8%)**	**(2,807)**	**(2,775)**	**32**	**1.1%**
EBITDA %	7.7%	7.7%	7.8%			5.7%	5.8%		
Net Surplus %	0.2%	0.2%	0.2%			(1.9%)	(1.9%)		
Technical Adjustments:									
Donated/Government grant assets adjustment	(166)	(166)	(166)	0	0.0%	66	35	(31)	47.0%
Impairments	0	0	10	10		0	10	10	
Trust Position Post Technical Adjustment	**1,100**	**1,100**	**1,100**	**0**	**0.0%**	**(2,741)**	**(2,730)**	**11**	**0.4%**

The Trust reports a £1.1m forecast control total surplus in-line with plan in Month 3.

The Trust resubmitted its plan in June'16; the Control total was maintained at £1.1m.

Contract income is forecast at £3.7m adverse to plan driven by under-performance against activity plans, risks and penalties. The variance is due to under-performance on electives and outpatient procedures. Groups are looking at measures to ensure targets are met from month 4 (July'16) onwards.

Operating expenditure is £3.7m favourable to budget. Group expenditure forecasts £12m adverse to budget; largely driven by over-spends on Medical costs of £3.1m, and under-delivery against CIP position by £4.7m.

The under-delivery of CIP target continues to drive the non-pay forecast variance as at Month 3 supported by favourable position on reserves.

The Trust is reporting a year to date deficit of £2.7m which is in-line with year-to-date plan. This is primarily due to under-performance against activity targets noted above, offset by favourable reserves.

SOFP – Finance and Performance Committee

Reporting Month June 2016

University Hospitals Coventry and Warwickshire NHS Trust

3 months ended 30th June 2016	Full Year			Year To Date		
	Plan (£'000)	Forecast Outturn (£'000)	Variance (£'000)	Plan (£'000)	Actual (£'000)	Variance (£'000)
Non-current assets						
Property, plant and equipment	383,985	383,970	(15)	347,109	346,937	(172)
Intangible assets	5,087	5,087	0	5,087	5,087	0
Investment Property	8,230	8,230	0	8,230	8,230	0
Trade and other receivables	25,939	25,939	0	32,712	32,879	167
Total non-current assets	**423,241**	**423,226**	**(15)**	**393,138**	**393,133**	**(5)**
Current assets						
Inventories	13,274	13,274	0	13,274	13,628	354
Trade and other receivables	29,308	29,647	339	40,633	38,202	(2,431)
Cash and cash equivalents	2,760	2,760	0	2,747	3,990	1,243
	45,342	**45,681**	**339**	**56,654**	**55,820**	**(834)**
Non-current assets held for sale	0	0	0	0	0	0
Total current assets	**45,342**	**45,681**	**339**	**56,654**	**55,820**	**(834)**
Total assets	**468,583**	**468,907**	**324**	**449,792**	**448,953**	**(839)**
Current liabilities						
Trade and other payables	(59,767)	(60,101)	(334)	(69,902)	(67,108)	2,794
Borrowings	(5,860)	(5,860)	0	(1,561)	(1,561)	0
DH Interim Revenue Support loan	0	0	0	0	0	0
DH Capital loan	(3,774)	(3,774)	0	(2,489)	(2,489)	0
Provisions	(194)	(194)	0	(2,159)	(4,074)	(1,915)
Net current assets/(liabilities)	**(24,253)**	**(24,248)**	**5**	**(19,457)**	**(19,412)**	**45**
Total assets less current liabilities	**398,988**	**398,978**	**(10)**	**373,681**	**373,721**	**40**
Non-current liabilities:						
Trade and other payables						
Borrowings	(261,175)	(261,175)	0	(263,168)	(263,175)	(7)
DH Interim Revenue Support loan	(17,053)	(17,053)	0	(12,479)	(12,479)	0
DH Capital loan	(20,192)	(20,192)	0	(11,314)	(11,314)	0
Provisions	(2,260)	(2,260)	0	(2,454)	(2,454)	0
Total assets employed	**98,308**	**98,298**	**(10)**	**84,266**	**84,299**	**33**
Financed by taxpayers' equity:						
Public dividend capital	60,741	60,741	0	59,330	59,330	0
Retained earnings	(14,330)	(14,340)	(10)	(18,405)	(18,372)	33
Revaluation reserve	51,897	51,897	0	43,341	43,341	0
Total Taxpayers' Equity	**98,308**	**98,298**	**(10)**	**84,266**	**84,299**	**33**

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 audited position of the previous financial year 2015/16.
- The Trust has incorporated a review of its capital programme which led to a reduction in the 2016/17 capital programme by £7.6m. This has resulted in the withdrawal of the additional capital investment loan above the already approved £12.85m deferred from 2015/16.

Efficiency Delivery Programme – Finance and Performance Committee

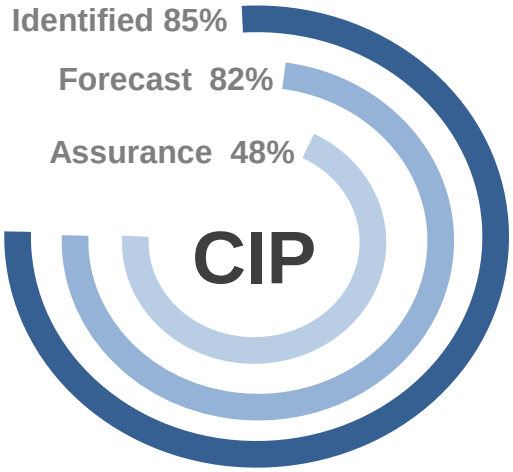
Reporting Month June 2016

University Hospitals Coventry and Warwickshire NHS Trust

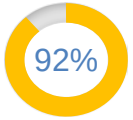
Finance Summary

Overview

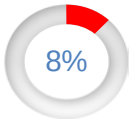
- The Trust has revised its CIP target from £21m (initial plan) to £25.5m in its revised plan submission made in June'16.
- To achieve the £1.1m surplus; the Trust is required to deliver a £25.5m internal CIP for 2016/17. £19.9m is expected to be achieved by cost reduction and/or income from new services from clinical and core groups whilst £5.6m is expected to be delivered from increased productivity, and continued improvement to counting and charging.
- Groups have documented 242 schemes worth £21.6m (85%) against a target of £25.5m with an unidentified value of £3.9m as at Month 3.
- The Trust is reporting a £20.9m forecast delivery against a target of £25.5m giving an 82% forecast position as at Month 3.
- As at Month 3, the Trust is reporting a £5m (90%) delivery against a £5.5m target .



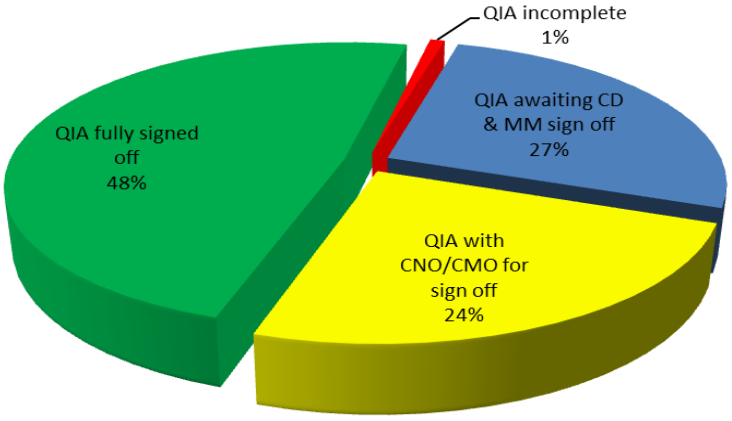
The **Financial Recovery Programme** is a further £12.1m target above the Trust CIP plan. £8.4m delivered against plan as at month 3.



£11.1m (92%) of the FRP has been transacted in Month 3. A high proportion (£5.6m) is reliant on agency expenditure reductions. Although identified, this scheme has delivery risk associated.



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



A **quality impact assessment (QIA)** is required for all CIP schemes regarless 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).

242 schemes have been documented to support the delivery of 2016/17 target. 48% of these schemes have had a full QIA review and are now signed-off

The **Value of Unapproved CIP schemes** as at Month 3 is £8.9m

Workforce Information | Headlines May 2016

(excluding bank and ad-hoc locums)

University Hospitals Coventry and Warwickshire NHS Trust

Staff in Post | Variation from Workforce Plan

	30th June 2016	TDA Plan	Variation from Plan	Last Month's Variation from Plan	ISS
WTE	6,701.99	6776.00	-74.01	-64.19	570.1
WTE including ISS	7272.09				
Headcount	*7617				739
Headcount including ISS	8356				

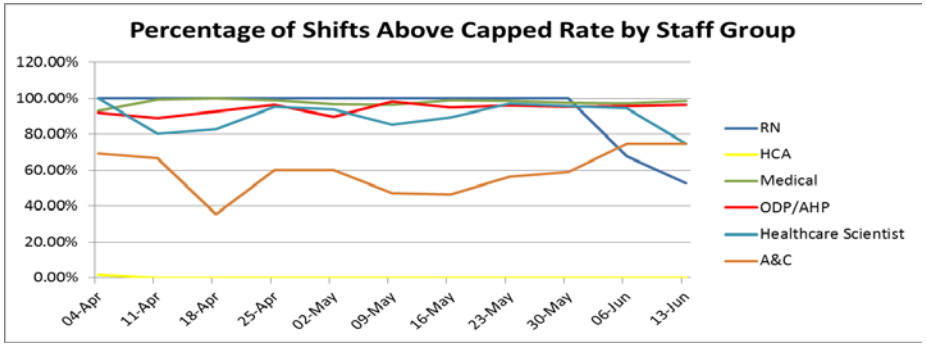
*The above figures do not include 1218 bank only staff who do not have contracted hours.

Staff in Post | Monthly Variation

Staff Group	Staff In Post WTE 31st May 2016	Staff In Post WTE 30th Jun 2016	Variance (WTE)	%Variance
Add Prof Scientific and Technic	214.28	214.09	-0.19	-0.09%
Additional Clinical Services	1547.89	1551.70	3.81	0.25%
Administrative and Clerical	1141.23	1150.23	9.00	0.78%
Allied Health Professionals	379.11	378.42	-0.69	-0.18%
Estates and Ancillary	5.00	5.00	0.00	0.00%
Healthcare Scientists	307.83	308.43	0.60	0.19%
Medical and Dental	938.27	940.80	2.52	0.27%
Nursing and Midwifery Registered	2125.02	2115.12	-9.90	-0.47%
Students	38.20	38.20	0.00	0.00%
Totals	**6696.84**	**6701.99**	**5.15**	**0.08%**
ISS	**575.30**	**570.10**	**-5.20**	**-0.91%**

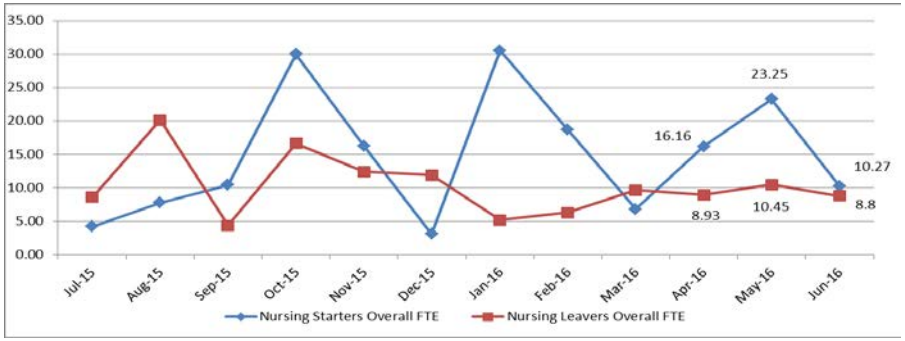
- The Trust's staff in post is 74.01 WTE behind the workforce plan of 6776.00 WTE.
- The Trust's monthly staff in post has increased by 5.15 WTE from May 2016 figures.
- Note that payroll have some staffing issues which have affected the reporting of the starters figure for June at the time this report was produced.

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.
- Standardised rates for medical locums took effect from 18th July. Although this will not move them under the April cap, it will provide 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 10.27 WTE continuing the upward trend against leavers 8.8 WTE.
- The forecast Nursing starters for next month is twelve.

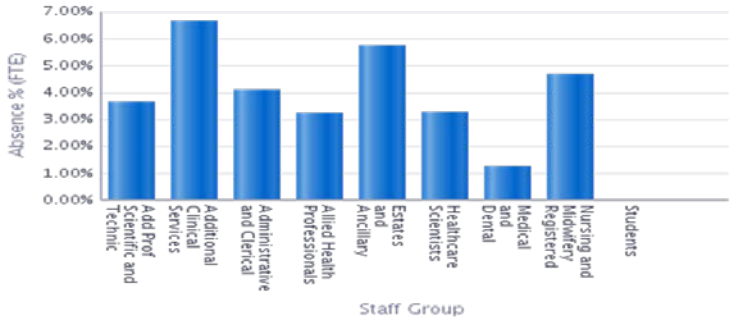
Workforce Information | Headlines

University Hospitals Coventry and Warwickshire NHS Trust

Absence | *Specialty Group*

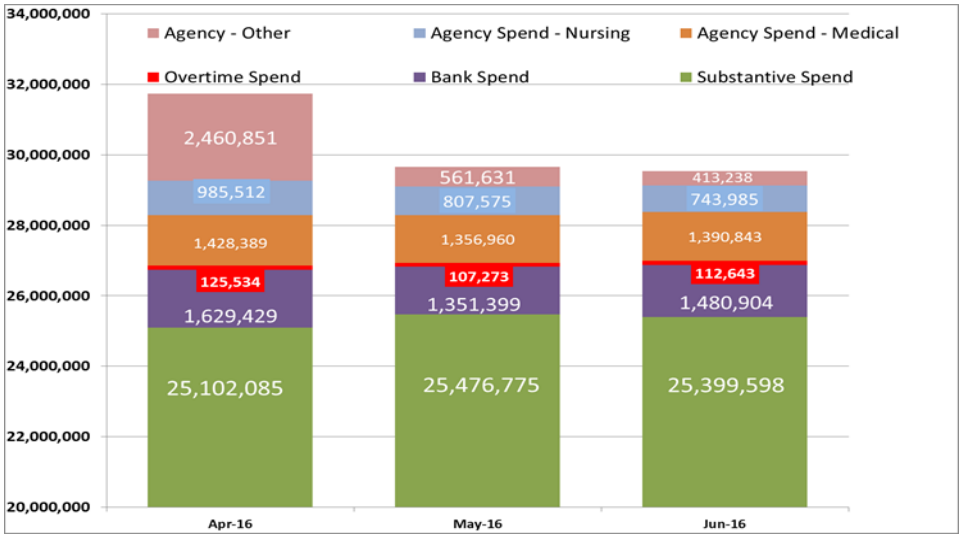
Specialty Group	% Abs Rate (WTE)
Cardiac & Respiratory	2.27%
Care of the Elderly	2.89%
Clinical Support Services Specialty Group	5.46%
Core Functions	2.40%
Emergency Department Specialty Group	3.62%
Hospital of St Cross	2.85%
Imaging	2.25%
Neurosciences Specialty Group	4.34%
Oncology and Haematology	3.58%
Pathology Network Cov & Warwicks	6.18%
Renal Specialty Group	3.76%
Specialist Medicine & Ophthalmology	4.83%
Surgery Specialty Group	3.70%
Theatres and Anaesthetics Specialty Group	4.02%
Trauma & Orthopaedics Specialty Group	2.97%
Women & Children Specialty Group	5.16%
Totals	3.84%

Absence | *Staff Group* - 12 Months Rolling Period



- The Trust has achieved sickness absence rates below the 4% target for the third consecutive month.
- Only six specialty groups remain above the 4% target, a reduction of two from May.
- In the past month there have been 38 long term sickness cases managed to either return to work (35) or exiting the organisation (3).

Pay Costs | *Provided by Finance*



- Temporary costs equate to 14.02% of the Trusts total pay bill (£29,541,211), this is a decrease of 0.90% from May 2016.
- Agency costs against total costs decreased from 9.19% to 8.63%
- There was reduction in agency usage, apart from Medical, with the total spend reducing by £178k against May 2016.
- Bank and overtime usage increased by £135k and is 5.39% of the total spend.
- The substantive pay bill has decreased by £77k from May to June.
- The overall pay bill for June 2016 is £120k below the May 2016 cost due to the reduction in Substantive pay and agency spend.

Mandatory Training | *Topics*

- Mandatory Training compliance is currently 88.63% an increase of 0.24% against May.
- 3 topics are above 95% (Hand Hygiene Non Clinical, Equality and Diversity & Thromboprophylaxis) with 14 topics between 85% and 95% and 14 topics below 85%.
- 3 topics are below 60%, Moving & Handling Medical & Dental – 3 yearly 56.96%, Advanced Life Support 4 yearly 55.77%, Immediate Life Support 55%.
- 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 56.96% in June 2016.
- Immediate Life Support (55%) is recorded against the Cardiac and Respiratory group and two departments, Cardiac Rehab and ECG.

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	Patient Story
Author	Kristine Horne; Head of Voluntary Services and Julius Mukarati; Alcohol Liaison Clinical Nurse Specialist
Responsible Chief Officer	Professor Meghana Pandit, Chief Medical Officer/Deputy CEO
Date	28 July 2016

1. Purpose

The purpose is for Bess Curtis, A volunteer with Aquarius to verbally share with the Board the story of the role of the volunteers in supporting patients with alcohol addiction, as part of the Alcohol Liaison Volunteer Support Service.

2. Background and Links to Previous Papers

This story forms part of the Patient Story Programme that was agreed by the Board in January 2015.

3. Executive Summary

Patients expressed that there was a gap between the patients and varied professionals being able to relate to their alcohol addiction.

Some patients weren't willing to engage with alcohol support services and found this difficult because they were not ready to change their drinking behaviour. Julius attended one of the Coventry Recovery Community Service meetings where he interacted with individuals in recovery. Julius felt that the hospital patients could benefit from their knowledge and expertise and patients could gain an insight of the benefits of engaging with Community Alcohol Support Services.

Engaging volunteers in the Alcohol Liaison Service is the preferred option as they have the knowledge and life experience to relate to the patients and are willing to share their story, thereby giving patients hope and empowerment to move forward in abstaining from alcohol. The volunteers also help break down the barriers patients may have in engaging with the Alcohol Support Service.

The patients benefit from seeing visible recovery, which gives them encouragement to engage with services thereby reducing their alcohol intake or abstaining from alcohol and this gives them a better quality of life through choosing a healthy lifestyle.

The more patients that engage with services will reduce the number of people attending A&E which will eventually have a cost saving for the Trust and the NHS. For patients they will have more disposable income through reducing their alcohol intake or abstaining from alcohol.

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

Links to the Trust's objective to 'deliver excellent patient care and experience'.

CARE – Improve patient outcomes for mortality, infection control and hospital cleanliness.

Volunteers engage with patients to encourage them to access the alcohol addiction service and share their personal knowledge and experience of how they overcame their alcohol addiction, leading to improved alcohol related mortality rates.

ACHIEVE – Align activity and capacity to achieve the 18 week referral, four hour A&E, and cancer waiting time standards.

Volunteers support patients in A&E to try and get them to engage with services through early intervention, which will help reduce future attendances to A&E.

INNOVATE – Delivering sustainable services through the Sustainability and Transformation Plan and Together towards World Class projects.

Volunteers support alcohol dependent patient's health and wellbeing.

5. Risk

There are no areas of risk to highlight within this patient story.

6. Governance

NHS Constitution

Section 3a - You have the right to receive care and treatment that is appropriate to you, meets your needs and reflects your preferences.

Section 3b – Patients and the public have responsibility to give feedback, both positive and negative about their experience.

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

7. Responsibility

Julius Mukarati, Alcohol Liaison Clinical Nurse Specialist
Kristine Horne, Head of Voluntary Services
Professor Mark Radford, Chief Nursing Officer

7. Recommendations

The Board is invited to **note:** Alcohol Liaison Volunteer Support Service

Name and Title of Author: Kristine Horne, Head of Voluntary Services and Julius Mukarati, Alcohol Liaison Clinical Nurse Specialist

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Patient Experience Quarterly Report**
Author	**Anita Kane, Associate Director of Quality**
Responsible Chief Officer	**Meghana Pandit, Chief Medical and Quality Officer**
Date	**28 July 2016**

1. Purpose

To present the quarterly experience report that brings together information on Compliments, Complaints, PALS, Patient feedback and involvement and health information.

2. Background and Links to Previous Papers

The paper aims to present patient experience information in an easy to read format suitable for public consumption.

3. Narrative

In keeping with the Trust's vision of becoming a national and international leader in healthcare and with its values, this report aims to bring together the work of the Patient Experience function of the Quality Department and to highlight areas of good practice and areas for improvement.

The complaint response rate for the 25 working day standard indicator during April was 98% and in May was 88%. The figure for June and the full quarter will be available in August.

6 new Parliamentary Health Service Ombudsman (PHSO) requests were received this quarter in comparison to 12 in the previous quarter. The PHSO has closed 8 investigations into complaints this quarter (all of which were received in previous quarters). The PHSO decided not to uphold 7 of these complaints; only 1 was upheld, requiring a £500 payment of compensation to the complainant (further information on page 11 of the report).

The PALS service is now able to monitor and report on the performance against the 5 working-day response standard. It is encouraging to note that for quarter 1, performance was 77% against a target of ≥90%. Work continues to improve processes and the service has launched a satisfaction questionnaire to gather feedback for improvement from users. It is pleasing to note that the service is receiving numerous compliments for their help in resolving dissatisfaction.

Privacy and Dignity, Cleanliness, and Kindness and Compassion were the top 3 performing KPIs on Impressions; the Trust's bespoke patient survey system; the lowest 3 performing KPIs were Doing Things on Time, Food and Drink, and Parking.

4. Areas of Risk

Health Information - there are currently no Health Information staff in the Health Information Centre as both retired in quarter 1. Currently the Patient Experience

Administration Specialist is ensuring that patient information leaflets are revised, approved and uploaded in accordance with departmental procedures and policy. A business case is currently being developed that impacts on this service and its staffing structure.

5. Governance

NHS Constitution

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

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

6. Responsibility

Meghana Pandit, Chief Medical and Quality Officer

7. Recommendations

[A] The Board is invited to **note**: the Patient Experience Quarterly Report

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

Date: 15/07/16

University Hospitals Coventry and Warwickshire NHS Trust

We Care

Patient Experience Report Quarter 1 2016-17

28th July 2016

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	Patient Advice and Liaison Service (PALS)
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6	Examples of PALS Enquiries Received
7-8	Developments in Quarter 1
	The Complaints Department
9-11	Overall Performance
12	Most Common Subject for Complaints
13	Learning from Complaints
14-15	Examples of Complaints Received
	The Patient Experience Team
17	Impressions Quarter 1
18	Impressions Graphs Explained Quarter 1
19	The Friends and Family Test (FFT) Quarter 1
20	National Patient Survey Programme
21	NHS Choices and Patient Opinion
	The Health Information Service
23	eLibary Activity
24	Enquiries and Referrals
	Work Stream Updates
26	#Hellomynameis
27	Other Activity

Compliments – Examples of Compliments Received via Feedback and Impressions

"My midwife, Jackie Canterbury, was amazing, she made me feel safe and secure. And I am sure she was reading my mind. She was able to second guess what I was about to ask for… Her experience really showed."

Datix ID 10362

"I was very nervous but the kindness of the staff made me feel relaxed. Also came away with answers."

Day Surgery
Hospital of St Cross
#142236

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

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

= Impressions = Feedback

"Every time I have been to your hospital, it has treated me with every bit of kindness and respect to feel better."

Urgent Care Centre,
Hospital of St. Cross
#142262

"Yesterday afternoon…my mum…was taken by ambulance to Walsgrave A&E after becoming very unwell… It was apparent that he was seriously ill and was taken for treatment in the Major Injuries area of A&E… the level of care experienced by my mum at every level was exceptional. All of the nursing staff, Doctors and Consultants were so attentive, compassionate and professional… It was the NHS at its best."

Datix ID 9696

""I cannot think of any way you could improve, all the staff were fantastic the food was very good and the entire experience was more than excellent"

Ward 22 SAU
University Hospital
#141834

"I am profoundly deaf, and I visited the out of hours service at St Cross… I usually bring my husband, friend or interpreter with me to aid with communication. I had brought a friend but she was not needed… because he had excellent deaf awareness and ensured I could understand all that he said, it was really made easier for me in that respect."

Datix ID 10510

"Medical care was excellent and saw doctors regularly. Nothing was too much trouble. Nurse Samantha and Auxiliary Tracey were outstanding.

Cedar Ward
Hospital of St Cross
#142340

"I am so glad I chose to come to Lucina Birth Centre - most amazing experience!"

Lucina Birth Centre
University Hospital
#142195

"I just want to say a big thank you to Andy Metcalf and orthopaedic team at St. Cross for exceptional care for my grandma… I also wanted to say a big thank you to Melissa Farmer – Discharge Assistant Practitioner for being so helpful and keeping in regular contact…"

Datix ID 10325

"Halfway through three weeks of treatment, nobody could be more helpful from first reception to ongoing therapists in Radiology. A wonderful team of people who work as a team with a ready smile."

Arden Cancer Centre
University Hospital
#142234

"Just a short note to express my thanks & appreciation to all the professional and supportive staff on the intensive care unit, the high dependency unit and ward 11 following my triple bypass operation… Couldn't have asked for a better team."

Datix ID 10326

"Excellent. Fabulous service. Great staff."

Fracture Clinic,
University Hospital
#142233

"Staff was polite and waiting time was short so overall very pleased with the service and the help I received with my health problem."

Urgent Care Centre
Hospital of St. Cross
#140836

Patient Relations
(PALS and Complaints)

Patient Advice and Liaison Service (PALS) – Performance and Enquiries by Subject

New Enquiries received by Quarter

	Q2 (15/16)	Q3 (15/16)	Q4 (15/16)	Q1 (16/17)
Received via telephone	726	667	334	**420**
Received via Feedback@	407	378	172	**304**
Received in person	185	200	94	**119**
Received in writing	32	23	27	**37**
Total Number	1350	1268	627	**880**

Top 5 Enquiries received by subject

Outpatient Appointment (Delays and Cancellations)	**191**
Communication/Information to Patients	**122**
Trust Policies and Procedures	**68**
Admissions, Discharges and Transfers	**68**
Waiting Times for Procedures	**65**

The PALS have experienced a 29% increase in enquiries received in this Quarter compared with Quarter 4 2015-16. The service continued to operate with one PALS Officer vacancy during this period. This position is currently being re-advertised and it is hoped that the service will be at full compliment by the end of October.

The service has implemented a rota where the PALS Officers are assigned to different enquiry methods, such as telephone, face to face and email. This helps ensure the service is working as efficiently as possible, improving the speed in which enquiries are acknowledged and responded to.

The service will be relocating to the Health Information Centre in Quarter 2 and it is expected that this will improve the visibility of the service.

Issues with outpatient appointments, communication and the information provided to patients continues to be the main area of enquiry in this Quarter. Issues with inpatient appointments, complaints handling and the attitude of staff that featured in the top 5 in Quarter 4 2015-16 do not feature in the top 5 this Quarter. They have been replaced by Trust Policies and Procedures; Admissions, Discharges and Transfers and Waiting times for procedures.

It should be noted that enquiries about the attitude of staff, while not featuring in the top 5, have increased from 18 in Quarter 4 2015-16 to 42 in this Quarter.

The top three Specialty Groups receiving enquiries about issues with outpatient appointments are Trauma and Orthopaedics, Ophthalmology and General Surgery.

PALS – Examples of PALS Enquiries Received in Quarter 1

Below you will see a series of examples of PALS enquiries received throughout Quarter 1; the examples below represents the variety of concerns and enquiries that the PALS deal with daily, and provide examples of the outcomes achieved.

ID	Concern	Action & Outcome
9714	Two members of staff told a lady she was pregnant before telling her that they were just joking. The lady was very unhappy and could not understand why the staff would act in such an unprofessional manner.	PALS discussed the concerns with the Ward Manager. The Ward Manager contacted the patient and apologised providing assurance that the staff members would be spoken to regarding their behaviour.
10543	A patient raised concerns about the number of times they had moved wards and they were particularly concerned that they had been told they were fit for discharge as they did not consider this to be the case.	PALS visited the patient on the ward and discussed her concerns in depth. PALS liaised with the Ward Manager and Clinician, and advised the patient of the discharge process when patients medically fit.
10418	A relative raised concerns about their family member witnessing a nurse telling another patient off for using their call bell and for not helping the patient use their asthma inhaler.	PALS discussed concerns with the enquirer and agreed to refer them to the Ward Manager. The Ward Manager apologised for the conduct of the member of staff and encouraged the enquirer to approach herself or the PALS if they had any further concerns.
10541	A lady was unhappy that she had been unable to change an appointment with the Radiology Department and that the department had incorrectly addressed her as Sir.	PALS liaised with the Radiology Waiting List Manager. The Manager offered an apology to the enquirer and provided a more suitable appointment.
9595	A family sought the support of the PALS due to a family member being involved in a serious patient safety incident.	PALS met with the family and discussed their concerns in depth. PALS organised a meeting with a Consultant in the first instance and the PALS have continued to support the family through the Trust's investigation into the incident.

PALS – Developments in Quarter 1

Accessibility

- The PALS are in the process of putting together a business case to extend the service from a 5 day to a 7 day service.
- It has been agreed that the PALS will move from their current office into the Health Information Centre. This is a more open and inviting environment making the service more visible and accessible.
- The PALS have obtained a team pager. This allows PALS Staff that are away from the office to be easily contactable should a patient or a member of staff need their assistance.
- PALS have delivered extended opening throughout Quarter 1. The PALS have received between 0-5 enquiries during each late night opening. This time is also used to facilitate those enquiries where a more lengthy discussion is required.
- The service now also provides a freepost address and can pay the parking fees for users attending meetings with the PALS (or Complaints) teams.

Feedback

- A satisfaction questionnaire has been designed to capture feedback from those using the service. This will be launched in Quarter 2 and will utilise Survey Monkey to collect and analyse the information

Performance Management

- The PALS have continued to improve the data they capture about the enquiries they receive and the speed in which this is entered. As well as allowing for improved performance management, this has enabled the PALS to report on the service's performance against the 5 working day response standard and to carry out more detailed analysis of the enquiries received.

Performance Against the 5 Working Day Standard

- The PALS response rate standard is for ≥90% of enquiries received to be responded to within 5 working days. Building on the work undertaken in Quarter 4 the PALS are now able to monitor and report on performance against the standard. Of the 880 enquiries received this Quarter, 676 (77%) were responded to within the 5 days. A monitoring and reporting structure is now in place to ensure that performance against the 5 working day standard is closely monitored and appropriately escalated to the Head of Patient Relations.

Training and Engagement

- The PALS and Complaints team spoke about the service at July's 'Leadership for Registrars' training and promoted the importance of everyone taking responsibility for recognising and resolving concerns at the earliest possible stage.
- The PALS Officers attended a one day training course on how to use empathy in resolving complaints.

Complaints

- The PALS took receipt of 3 complaints in Quarter 1 . The Head of Patient Relations is made aware of any complaints as soon as they are received and they are responsible for the investigation of the complaint.

PALS – Developments in Quarter 1

In Quarter 1, the PALS received 11 compliments by users of the service.

"Thank you so much to Amanda in PALS for all your help in resolving my concern, you have acted in a very caring and professional manner and this was appreciated."

Datix ID 10123

Enquirer thanked PALS for their assistance and hopes not to need us again however comments she would contact us as she knows she can count on us to assist.

Datix ID 9807

Compliment for Annette Jarret, PALS Officer, for helping to resolve their concern so quickly.

Datix ID 9917

Thank you note to Amanda James, PALS Co-ordinator, for helping to resolve concerns.

Datix ID 9918

Patient very happy with the PALS service, in particular Ellie O'Connell, for supporting her throughout her concern

Datix ID 10122

"I wanted to say a big thank you for the help Amanda in your PALS team gave me today. My elderly mother had many concerns about a scan she was due to have next week. Amanda listened patiently while I explained a number of worries that Mum had and immediately suggested actions she could take to help me manage my Mum's concerns.
Amanda took my phone number and said she'd call back, and true to her word a couple of hours later she called me to explain what she'd done and the outcome of those actions. But best of all she was able to give me reassurance that the test Mum was due to have was far less stressful than we'd thought.
The peace of mind I have now is priceless. I hadn't realised that in trying to allay my Mums fears I'd actually developed concerns of my own. Thanks to Amanda's help both my Mum and I are feeling much more positive.
Thank you Amanda. Really appreciate your help."

Datix ID 10276

"If I could just say the support from the PALS office is gratefully received, and makes a huge difference to the outcomes of issues highlighted on the wards.
Keep up the good work and pass on my best wishes to the team."

Datix ID 10121

Enquirer thanked PALS officer for "checking out my query so efficiently and directing it to the right department" "Thank you once again."

Datix ID 10436

"Not sure what Amanda in PALS did but a huge thank you as I now have my surgery on Friday following my cancellation. A big thank you!"

Datix ID 10313

"Ellie, Thanks a lot for all your help and efforts. I have been told that 21st of July is operation day, so if you could pop in to the ward it would be nice to meet you and say thank you in person. Many thanks"

Datix ID 10360

PALS received a voicemail from an enquirer who thanked PALS for input on expediting an appointment with General Surgery consultant.

Datix ID 9383

Complaints – Overall Performance

This table demonstrates the overall performance of the Trust's key performance indicators with regards to complaints management, and compares April, May and June with the previous 3 Quarters.

	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	April 2016	May 2016	June 2016
Total number of formal complaints	58	47	56	64	47	34	27	36	48	**52**	**51**	**58**
% of complaints acknowledged within 3 days	92%	98%	98%	85%	95%	100%	90%	97%	98%	**96%**	**100%**	**97%**
% complaints responded to in 25 working days	86%	77%	82%	78%	85%	85%	89%	89%	85%	**98%**	**88%**	**Avail 4th August**
Number returned for further local resolution *	13	8	10	10	3	10	10	8	5	**7**	**10**	**9**
Number of PHSO requests	1	1	2	3	1	0	2	7	3	**3**	**1**	**2**

*This number represents the number of complaints received by the Trust for ***further*** local resolution following the original complaint response being received by the complainant. These further complaints can be received up to a year or more after the original response has been sent to the complainant and is not related to the total number of complaints received in the month.

Complaints – Overall Performance (continued)

Total Number of Complaints
We received 161 complaints in Quarter 1, the highest number of complaints received in one Quarter within the last 12 months. Further detail on the subjects of the complaints received in this Quarter is provided on page 11 of the report.

25 Day Response Standard
Despite the high number of complaints received in Quarter 1, 98% of the complaints received in April and 88% of complaints received in May were responded to within the 25 working day response standard. There was 1 breach in April, the quality of the information included in the response was not sufficient. There were 6 breaches in May. 3 were as a result of the Specialty not supplying the information in a timely fashion, 2 were as a result of the complainant wanting to hold a meeting and 1 was due to a joint investigation with Oxford

Uphold Rate
Of the 147 complaints closed within Quarter 1 , 38 were not upheld, 74 were partially upheld and 35 were fully upheld. Not upheld means that no failings were identified, partially upheld means that the crux of the complaint was not upheld but failings were identified and fully upheld means that the crux of the complaint was upheld. Where failings are identified the action the complaint response will confirm what action the Trust is taking to improve.

Further Local Resolution Rate (FLR)
The number of complaints returned for FLR is one of the ways we can monitor the quality and effectiveness of the complaint handling and responses. It is however important to note that complaints can be returned for FLR up to a year or more after the response was issued and the FLR rate should not therefore be used to measure the quality of the complaint handling within any particular Quarter. In Quarter 1, 26 (16.1%) complaints were returned for FLR. This is a reduction when compared to number of complaints returned for FLR in the previous 3 Quarters, which averaged 18%.

FLR Analysis
In order to further improve the quality and effectiveness of the complaint handling and responses, the Complaints Service audits the complaints that are returned for FLR to understand the complainant's reasons for returning the complaint. Of the 26 complaints returned in Quarter 1, 15 complaints were categorised as all the concerns having been addressed but not to the satisfaction of the complainant, 7 as perceived inaccuracies within the response, 1 was unhappy that disciplinary action hadn't been taken and the final 3 raised new complaints.

Accessibility
A Complaints Service must be easily accessible and it is therefore important to monitor the means by which complaints are made to the service. In Quarter 1, 86 complaints were received by email, 69 by letter, 3 via PALS, 2 via MP correspondence and 1 by telephone. In this financial year, the Complaints Service is undertaking a review of how complainants are communicated with and what information they are given throughout the complaints process. This review will consider the complainants preferred methods of communication and any means that may be under utilised, such as the telephone.

Member of Parliament (MP) Enquiries
The Complaints Service continues to manage MP correspondence where the MP is raising concerns on behalf of their constituent about the care or service they have received. The Complaints Service received 20 MP enquiries in Quarter 1, 12 of which concerned issues with appointments and waiting times, 5 were about patient care, 3 about clinical treatment and 1 about admissions, discharge or transfer. These enquiries are managed in accordance with the Trust's Complaint Management Plan to ensure they are thoroughly investigated and a timely response is issued. Any MP correspondence that is considered to amount to a formal complaint will be registered as such and investigated in accordance with the complaints process.

Complaints – Overall Performance (continued)

Parliamentary Health and Service Ombudsman (PHSO)

The PHSO accepted 6 complaints for investigation in Quarter 1 . This is a 50% reduction on the number of complaints they accepted for investigation in Quarter 4 2015-16 and is more in line with previous Quarters. This suggests that the spike in complaints accepted for investigation in Quarter 4 2015-16 was due to a change the ombudsman made to their internal processes to respond to the backlog of cases waiting for a decision on whether or not they should be accepted for investigation.

In Quarter 1, the PHSO decided 9 complaints. Of the 9 complaints decided only one was upheld. This complaint concerned a delay a lady had experienced waiting for a hip operation to be performed by the Hip Preserving Service. The PHSO found no administrative failings but they found the failure to meet the 18 week treatment target to be a failing that had negatively impacted on the patient's health. They recommended we pay the patient £500 compensation for the pain and suffering the patient experienced as a result of the delay.

PHSO Request Received	Specialty	Main Issues	Current Stage
11 Apr 2016	Neurosurgery	Medical staff	Under investigation by the PHSO
25 Apr 2016	Paediatrics	All aspects of clinical treatment, Nursing Care	Under investigation by the PHSO
26 Apr 2016	Emergency Department	All aspects of clinical treatment	Under investigation by the PHSO
3 May 2016	Orthopaedics	Appointments, delays and cancellations (Inpatients), Communications	Under investigation by the PHSO
16 Jun 2016	Rheumatology and Orthopaedics*	Medical staff	Under investigation by the PHSO
16 Jun 2016	Rheumatology	All aspects of clinical treatment	Under investigation by the PHSO

* 2 complaints investigated under 1 investigation by the PHSO

PHSO Request Received	Specialty	Main Issues	PHSO Investigation Closed	Decision
24 Feb 2016	Gerontology	All aspects of clinical treatment, Communication	20 Apr 2016	Not upheld
4 Feb 2016	Rheumatology	Medical Staff	9 May 2016	Not upheld
2 Jul 2015	Endocrinology	All aspects of clinical treatment, Administration	20 Apr 2016	Not upheld
12 Feb 2016	Orthopaedics	All aspects of clinical treatment, Appointments, delay and cancellations (Outpatients)	17 May 2016	Not upheld
27 Nov 2015	Endocrinology	All aspects of clinical treatment	23 May 2016	Not upheld
7 Mar 2016	Gastroenterology	Communication, Failure to follow agreed procedures	6 Jun 2016	Not upheld
25 Feb 2016	General Surgery	All aspects of clinical treatment	7 Jun 2016	Not upheld
21 Oct 2015	Orthopaedics	Appointments, delays and cancellations (Outpatients)	11 May 2016	Upheld (£500 compensation)
15 May 2015	Respiratory Medicine	All aspects of clinical treatment	8 April 2016	Not upheld

Complaints – Most Common Subjects for Complaints

Displayed below are the top five subjects of complaints received by the Trust for April, May and June. For greater detail, a breakdown of the top 5 'sub-subjects' for each subject is also provided.

The subject categories and sub-subject categories have been revised to facilitate reporting to the Health and Social Care Information Centre. The new categories are more specific, allowing for greater analysis and improved reporting of complaints data.

Complaints – Top 5 Subjects (as categorised by the K041a return)	Total	Most Common Subjects for Complaints
Clinical Treatment	103	Delay in treatment (32) Delay or failure in treatment or procedure (22) Delay or failure in acting on test results (6) Injury sustained during treatment or operation (4) Delay or failure in observations (4)
Patient Care Including Nutrition / Hydration	12	Care needs not adequately met (6) Delay or failure in treatment for infection (2) Inadequate pain management (2) Failure to provide adequate care (2)
Values and Behaviours (staff)	11	Attitude of Nursing Staff/Midwives (4) Attitude of Medical Staff (4) Attitude of Admin & Clerical Staff (2) Failure to act in a professional Manner (1)
Admissions, Discharges & Transfers (This does not include discharge due to absence of care package)	7	Discharge Arrangements (2) Discharged too early (2) Transfer against wishes (1) Inadequate discharge planning (1)
Access to treatment or drugs	6	Delay in treatment (3) Length of waiting list (1) Delay or failure in acting on test results (1) Other-Access to treatment or drugs (1)

Complaints – Learning from Complaints

Below you will see an example of a complaint where the investigation was concluded in Quarter 1. This demonstrates the learning opportunities that arise through a complaint investigation and the resulting service improvements.

An unknown male patient was admitted by ambulance due to a suspected overdose and subsequently transferred to the General Critical Care Unit (GCCU). Usual practice is that if an unknown patient is admitted to hospital, they remain as an unknown patient until 24 hours following admission. This is despite if they have been formally identified by a relative during the first 24 hours. However, if a patient passes away within the first 24 hours and they have been formally identified by a family member, then it is appropriate to update their details before the usual 24 hour period has elapsed.

In this case, the patient did pass away within 24 hours and was formally identified, whilst still alive, by his brother. Unfortunately staff in GCCU did not following the correct procedure which resulted in the details not being updated and the patient being transferred to the mortuary still being identified as an unknown male. This then resulted in further problems when the Coroner requested a post mortem as the patient appeared not to have been formally identified. The family were contacted 9 days later and asked to identify the body.

This complaint has identified that staff within GCCU were not aware of the correct procedure for unknown patients who pass away within the 24 hour period who have been formally identified by a relative. The Modern Matron has therefore carried out the following actions:

- All staff in GCCU were informed about the case
- A notice has been created and displayed within GCCU explaining the correct procedure for the amending of details for an unknown patient who passes away within 24 hours of admission and has been formally identified.
- Relatives to be advised about the change of details before they leave the unit.
- Modern Matron for GCCU has liaised with the Administration Manager for the Emergency Department to ensure that processes are in place to prevent such an incident from happening again.

A full explanation has been given to the family, condolences offered and apologies given for the distress caused.

Complaints – Examples of the Complaints Received

The table below shows examples of complaints received by the Complaint Department in April, May and June 2016; it displays the Datix ID number, the main issues and concerns raised by the complainant, and the actions taken as a result of the complaint.

ID	Main Issues of Complaint	Outcome and Actions Taken
9765	**MP Enquiry - Appointment Concern** Constituent contacted MP regarding incorrect priority of a Maxillo Facial appointment.	After contacting the Maxillo Facial Medical Secretary to enquire about the date of his wife's appointment, the constituent was informed that the referral had been registered as 'routine', and not 'urgent' as requested. This fault was corrected and when the constituent rang again approximately two weeks later, the Secretary was able to provide him with a date for his wife's appointment. An apology was made on behalf of the Patient Access Team Manager and the constituent was assured that procedures have been reviewed and that additional training will be provided where necessary to ensure similar errors do not occur in the future.
10045	**Patient Fall** Patient's family have raised concerns that during an inpatient stay at University Hospitals, Coventry the patient was not properly cared for allowing her to suffer a fall. They also complained that the patient had a blood transfusion and the family were not informed of this. The family are unhappy with the level of communication they have received from the hospital.	The fall was reported as a Clinical Adverse Event the same day as it occurred and the incident was reviewed by the Serious Incident Group. This resulted in a full Root Cause Analysis investigation being undertaken. The family will be invited to share the findings of the investigation and the resulting actions. The Trust has apologised for not informing the family and acknowledged that communication should have been better. The relevant staff have been reminded to communicate effectively with relatives and patients. As the patient was of sound mind and able to make their own decisions, it was not necessary to formally discuss or advise the family regarding the blood transfusion.
9901	**Staff Attitude** A complaint was received regarding the manner of a Consultant and that he was abrupt and rude. The purpose of the appointment was to explain the test results the hospital had performed and the patient felt that this did not resolve the symptoms she was experiencing.	The consultant provided the patient with all of the information that she felt was not provided at the appointment. The Consultant recalled the patient being upset by the outcome but confirmed that they explained that further tests would be undertaken. The consultant apologised for the patient's experience and assured her that he had reflected on this and would factor this learning into future practice.

Complaints – Examples of the Complaints Received

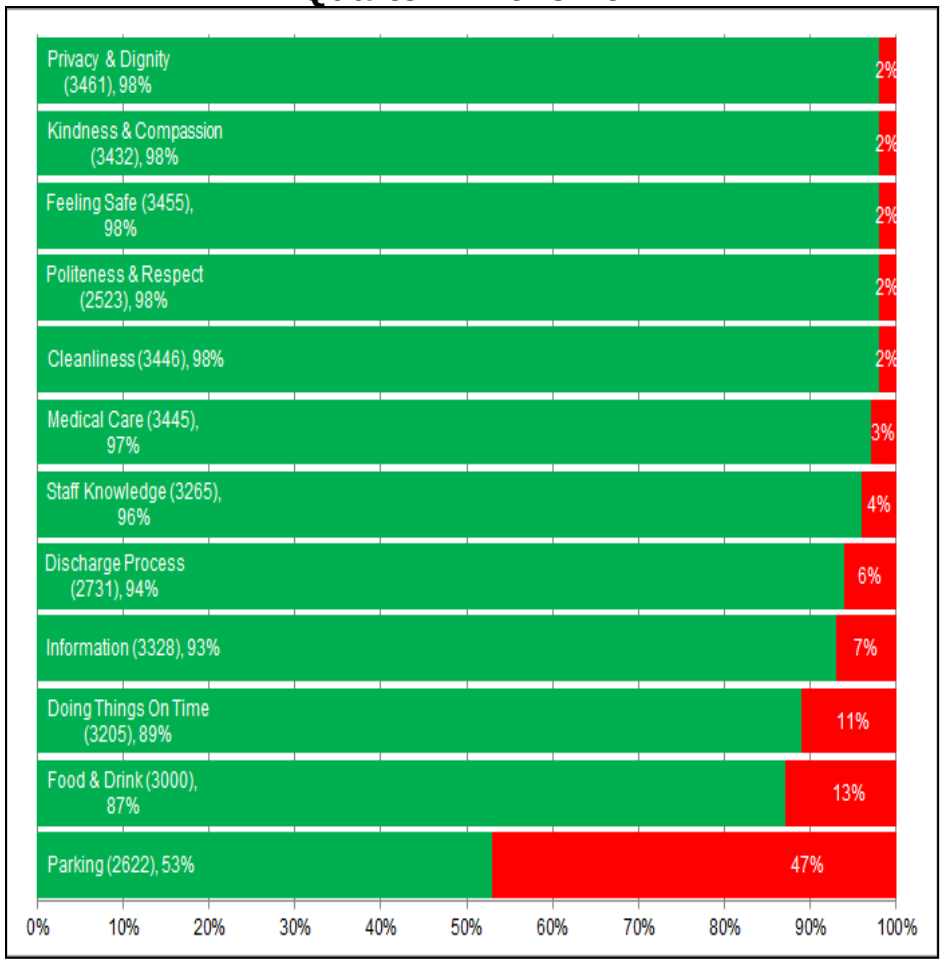
ID	Main Issues of Complaint	Outcome and Actions Taken
9987	**Misdiagnosis** A complaint was received by a couple who were incorrectly told that their baby had been miscarried. During a scan the Consultant failed to identify a heartbeat and due to previous medical history of miscarriages this amplified the stress and trauma experienced by the couple.	A formal complaint response was issued to the couple; they were content with the response but asked to meet with the Consultant to discuss the complaint further. As a result of the complaint, leg poles are now available on the couch that is used to scan women, providing a better view of the pelvis and less chance that the foetal heartbeat is missed. Nursing support is now also available for women throughout the next stage of their care – whether following a miscarriage, or misdiagnosis of a miscarriage. In addition to this the Early Pregnancy Unit (EPU) have improved communication with the Consultant, and they have created a formal pathway allowing a repeat scan to be performed by the nurse, without the need for the patient to request this. The Consultant offered her apologies for the distress that had been experienced and ensured that the complainant felt otherwise content with plans for her pregnancy. Following a previous unfortunate experience on the Postnatal Ward, the Complaints Officer ensured the complainant that she would discuss the circumstances with the Ward manager to ensure that staff were aware of and could anticipate potential anxiety.
9986	**All Aspects of Clinical Treatment** The complainant raised a range of issues, including infection control practises, staff training in inserting a PICC line, clinical decisions to perform a brain biopsy and the impact of this, lack of therapy input, staff behaviour, diet and nutrition and discharge plans,	The clinical teams gave a justification for the decision to perform a brain biopsy and confirmed that discussions relating to the effects of this were had. The Ward Manager has halted agency nurses administering intra-venous lines and further PICC line training will be arranged. Issues around the prescribed diet and meal delays have been communicated by ISS and the ward staff. Evidence of intense therapy input was provided and it was confirmed that the referral to Neuro-rehab therapy was arranged following discharge. Apologies were also given for the distress and upset caused by these events.

Patient Involvement

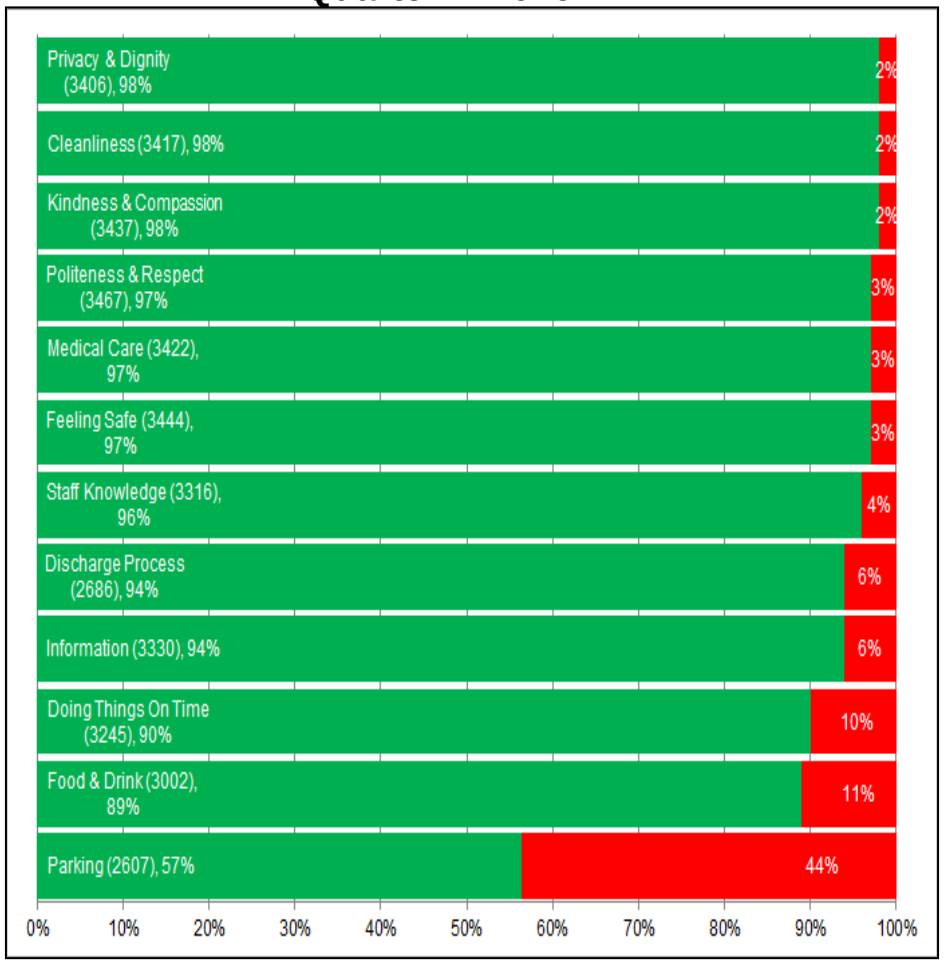
Patient & Public Involvement – Impressions Quarter 1

Impressions is the Trust's bespoke patient survey system which allows feedback from not only patients but relatives, carers and visitors too. The graphs below show feedback from all respondents when asked what service(s) influenced their experience at the Trust and whether the service was, in their experience, mainly good or mainly bad. The green bar shows the percentage (as well as the number in brackets) of respondents who said they had a mainly good impression and the red bar the percentage (as well as the number in brackets) of respondents who said they had a mainly bad impression of the service noted. The graphs below show [any] movement between this year's and last year's Quarter 1. The Top 3 and Bottom 3 Influential Factors are shared at ward level on the Looking After You Nursing Boards. The Trust wide influential factors are detailed on the monthly FFT internal report.

Quarter 1 2015-16



Quarter 1 2016-17



Note: Due to rounding up of percentages, some categories show the same percentage. However, they are listed in the correct order taking account of this rounding up process. Please see overleaf for an analysis of the data contained in these graphs.

Patient & Public Involvement – Impressions Graphs Explained Quarter 1

COMPARISON BETWEEN Q1 2015-16 & Q1 2016-17

A comparison between this year and last year's Q1 shows us that both staff respecting respondents' privacy and dignity and treating respondents with kindness and compassion remain in the top 3 categories with respondents feeling safe in our care, being replaced by cleanliness. Overall, there is minimal difference in the number of respondents feeding back and no difference in the percentages of respondents indicating they had a mainly good experience of privacy and dignity and kindness and compassion.

There is no difference in the order of the bottom scoring categories with parking, food and drink, doing things on time, information, discharge process and staff knowledge remaining in the same order of satisfaction between the Quarters. However, there are slight increases in satisfaction with parking up from 53% to 57% [of respondents indicating they had a mainly good impression], food and drink from 87% to 89% and doing things on time 89% to 90%.

BOTTOM 3 SERVICE AREAS Q1 2016-17 & ACTIONS BEING TAKEN

Parking *(44% of 2607 respondents felt they had a mainly bad experience)*
The recent completion of the improvement to the off site pinch points have greatly improved access at University Hospital. The construction of additional floors of parking areas next to A&E and the FM building is due to start in the next few months and it is hoped that these will improve the parking situation and that this will be reflected in feedback. A review of car parking passes for staff is due to be held at the end of the year which will result in additional car parking spaces for patients and visitors.

Food and Drink *(11% of 3002 respondents felt they had a mainly bad experience)*
Trial of 'menuless' wards on Ward 52 & 53 whereby patients are able to choose, on the day, the meals they want from a range.
New bedside folders for menus are in the process of being developed.

Doing Things On Time *(10% of 3245 patients felt they had a mainly bad experience)*
As noted previously, prolonged discharge times are the subject of several ongoing improvement projects including those being overseen by the Strategic Resilience Group (addressing issues pertinent to the whole local health economy) and the Emergency Care Project Group to name but a few. The latter has been set up to consider patient flow through the AMUs and ambulatory care etc.

Patient & Public Involvement – FFT Quarter 1

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

	April '16 Recommender %	May '16 Recommender %	June '16 Recommender %	Internal Target Recommender %	National Average for Q4
Inpatients	87%	89%	88%	95%	95%
A&E	82%	80%	82%	87%	85%
Antenatal (after 36 weeks) Experience	99%	94%	98%	97%	95%
Birth/Labour Experience	98%	98%	98%	98%	96%
Postnatal (hospital) Experience	94%	92%	93%	93%	94%
Postnatal (community) Experience	98%	99%	99%	97%	98%

	April '16 Response Rate %	May '16 Response Rate %	June '16 Response Rate %	Internal Target Response Rate %	National Average for Q4
Inpatients	26%	25%	24%	35%	24%
A&E	14%	14%	14%	20%	13%
Antenatal (after 36 weeks) Experience	N/A	N/A	N/A	N/A	N/A
Birth/Labour Experience	21%	26%	21%	21%	24%
Postnatal (hospital) Experience	N/A	N/A	N/A	N/A	N/A
Postnatal (community) Experience	N/A	N/A	N/A	N/A	N/A

Met or exceeded the internal target

1% - 5% below the internal target

6% or more below the internal target

Improving the FFT Response Rate

- Exploring the option of having dedicated Patient Experience Volunteers who will be involved in surveying patients on a regular basis.
- Exploring the option of using an external company to survey patients.
- Publishing the FFT results in internal communications once a month identifying wards which have improved in an aim to encourage wards to be more involved.

Patient & Public Involvement – National Patient Survey Programme

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

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

- Quality Health Ltd provides the Trust with its results for each survey via 3 separate reports: Top line results (containing raw figures for the current and previous year's survey) as well as top line recommendations to improve results; Management report (containing full statistical analysis including trends and comprehensive recommendations to improve results); Comments report (containing all the verbatim comments given by respondents).
- The CQC provides the Trust with a benchmark report which compares how the Trust has fared nationally when compared with other Trust's.
- Analysis and actions have been presented at PEEC in July and will be monitored at PEEC via scheduled reports.

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

Survey Type	Year	Status
Inpatient	2015-16	All reports relating to the Inpatient Survey 2015 Results have been received. The results have been presented to COAG with a further presentation scheduled to COF at the end of July. Planned actions include: a gap analysis of current projects that could meet the survey's recommendations. Specialty level reports are in production, further patient/staff involvement activities are to be held to better understand information giving issues, and further awareness raising regarding the results to be organised.
Inpatient	2016-17	1,250 inpatients during July 2016 will be randomly selected to take part in this year's survey with results becoming available in Spring 2017.
Children & Young People – IP&DC	2016	A second national Children and Young People's survey is planned. The sample will be drawn from paediatric inpatients and day case patients during November and December 2016 with the results becoming available in Autumn 2017.
A&E	2016	A national A&E Survey, including minor injury units for the first time, is to be held with a sample drawn from 1,250 attendees during September 2016. It is currently unknown when the results will be available.

Patient & Public Involvement – NHS Choices and Patient Opinion

NHS Choices

Overall University Hospitals Coventry and Warwickshire NHS Trust
Based on 14 ratings

University Hospital, Coventry – Based on 195 ratings

80% of reviews on treatment in Q1 were positive and 20% were negative, this was based on 20 reviews.

Hospital of St. Cross, Rugby – Based on 47 ratings

75% of reviews on treatment in Q1 were positive and 25% were negative, this was based on 8 reviews.

- University Hospital, Coventry received 3 less reviews in Q1 2016-17 than in Q4 2015-16. There has been a 6% reduction in positive reviews and a 6% increase in negative reviews.
- The Hospital of St. Cross received 5 more reviews in Q1 2016-17 than in Q4 2015-16. Positive comments is down by 25% with an increase in negative comments up by 25%.

Patient Opinion

An independent site about experiences of health care services

What's good?
Clean ward; excellent care; safe.

What could be improved?
Appointment cancellation; appointments; not listened to; patronised; person centred.

How have people rated this service?
17 people would recommend this service
8 people would not recommend this service

www.patientopinion.org.uk

Area	Stars (out of 5)	No of ratings
Cleanliness	3	26
Environment	3.8	20
Information	3.2	18
Involved	3.2	44
Listening	3.8	19
Medical	2.7	27
Nursing	2.9	26
Parking	2.5	24
Respect	3.4	45
Timeliness	3.1	45

The Health Information Service

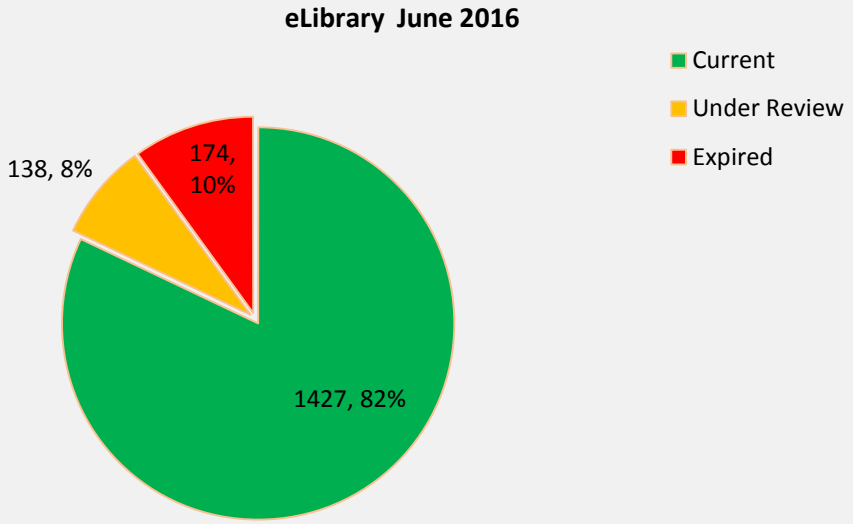
Health Information Centre - eLibrary Activity

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

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

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

	2015 New	2015 Updates	2015 Total	2016 New	2016 Updates	2016 Total
April	28	99	127	6	84	90
May	14	89	103	14	108	122
June	16	89	105	25	108	133
Total	58	277	335	45	300	345



Currently 82% of patient information on eLibrary is up-to-date for this quarter and 10% of patient information leaflets have expired.

Risk

Quarter 1 saw the retirement of both members of staff from the Health Information Service. There is a risk to meeting the internal standard of 90% of current leaflets on eLibrary that impacts on the Trust's ability to provide the most up to date information that could result in patients not receiving the most up to date and evidenced based information that could have a negative impact on recovery, health and well-being. Furthermore a backlog of leaflets to upload onto eLibrary could also develop.

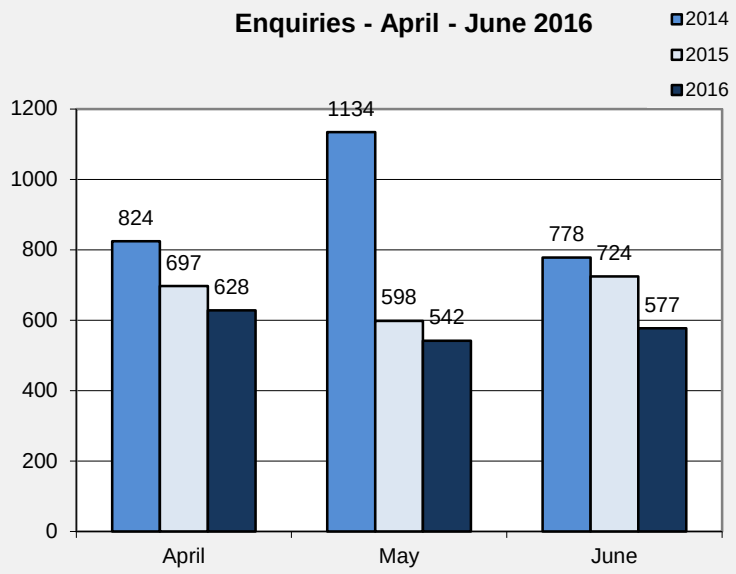
Controls: Patient Experience Admin Specialist will manage the upload, archiving and disabling of leaflets in the interim until recruitment of staff. All policies and procedures are up to date. All HI requests are redirected to a generic inbox. There is a business case in the process of being developed regarding the delivery of this service in the future

Risk has been locally recorded and discussed at July's Operational PEEC meeting.

Health Information Centre - Enquiries & Referrals

Enquiries

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



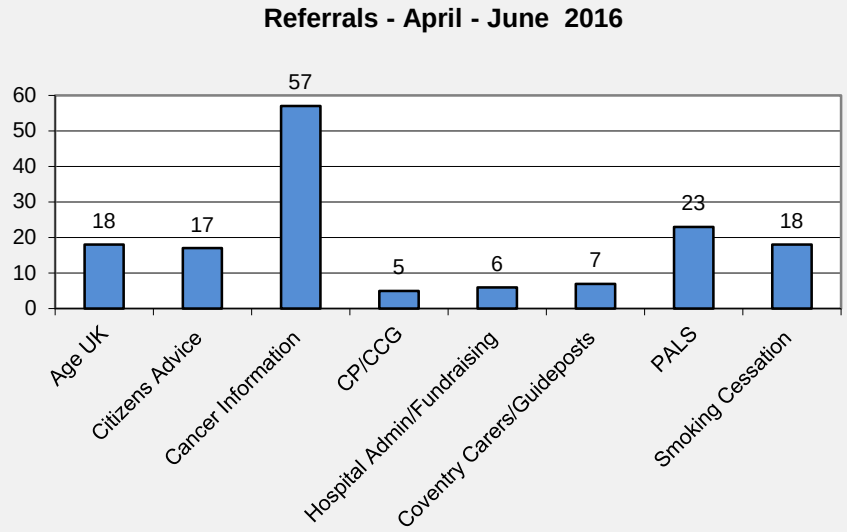
There were over 15 information stands and displays held during this period, including: Bowel Cancer, Carer's Trust, Fibromyalgia, Epilepsy, Dementia, MS, Hand Washing, CCG 111, Age UK, Parkinson's, Sun Awareness, Arrhythmia, Disability Awareness

The top ten health enquiries the Health Information Team received this quarter were about Arthritis, Cancer, Dementia, Diabetes, Ophthalmology, Digestive Disorders, Heart, Mental Health, Special Diets and Parkinson's.

Referrals

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

The table below shows referrals to other teams and agencies. The top three services the team referred people to this quarter were for Cancer Information, Age UK, Smoking Cessation team and PALS.



The high numbers of referrals in regards to cancer information may be due to the Health Information Team supporting the Macmillan Information service (temporarily situated in the Health Information Centre) when the member of staff is away on courses attending meetings, support groups etc .

General Update

#Hellomynameis Campaign

In February 2016, UHCW NHS Trust launched the #Hellomynameis campaign across both sites and within the wider health community as an Always Event. Via social media and our bespoke hashtag, #UHCWhello, the campaign reached over 84,000 people on Facebook and created over 60,000 impressions on Twitter. As well as success on social media, the Patient Experience Team, accompanied by staff from all over the hospital, visited wards to increase engagement, participated in a hospital radio broadcast to raise awareness among the patients, and presented at the Grand Round.

Following the inclusion of a question on the Impressions online survey asking respondents whether staff introduced themselves all of the time, some of the time or not at all, results demonstrate that over 50% of respondents told us that staff members introduced themselves all of the time, indicating a positive start to measuring the effectiveness of the campaign.


Since the launch of the campaign in February, the #Hellomynameis Working Group have continued to promote the importance of the movement among staff through various channels; ongoing and future projects include:

- Awareness raising through Junior Doctor, nursing and HCA training
- Applying #Hellomynameis stickers to telephones
- Targeted work with the Outpatient Department and Switchboard
- A3 awareness posters at ward entrances and large displays on wards identifying key members of staff
- Continued output of photographs and news across the Trust's social media accounts and 'Your Week'
- Focused work in the Emergency Department on implementing the "meet, great, treat" model
- Showing the #Hellomynameis video to new staff at Trust induction

Other Activity

Board Walk Rounds

In Quarter 1 there has been 10 visits to departments and areas by non-executive directors and senior staff. The visits have taken place in AMU2, the Antenatal Clinic, the Arden Cancer Centre, Maternity and Paediatrics, the Coronary Care Unit, Day Surgery, Hoskyn Ward, Ophthalmology Outpatients, Ward 10 and Ward 43. The non-executive directors and senior staff are asked to identify both positive and negative key points, any issues which have been raised and remain unresolved, any issues requiring escalation, and also provide any general comments. Some of the feedback received includes the following:

- ✓ A new member of staff on the Antenatal Clinic commented that staff had been very welcoming towards her, there has been very positive feedback from patients, and a strong linkage between and with other clinics and the ultrasound team
- ✓ Hoskyn ward was described as having a capable team with a good team spirit, as very clean and with a staffing establishment in accordance with national guidance; it was also identified as an example of good practise that nurses are stationed in the bays to support patients and reduce the number of falls
- ✓ The Ophthalmology Outpatients clinic was identified as very efficient, including the use of the electronic check-in system which has reduced check-in time from 2.5 minutes to 0.5 minutes.

Areas of concern will be communicated to the Specialty Group Management for their information and action if required.

Additional Lighting

The pilot scheme on Ward 30 to use discreet night lighting has evaluated well. Wards at the Hospital of St Cross have moved night staff into the bays at night with a discreet lamp. This has also evaluated well. Plan to implement discreet lighting has been scheduled for PEEC.

Customer Care

Dates have been booked in September to run the 'Brilliant Basics' a session designed for staff to gather an awareness, as well as tips and techniques, to promote a better customer service for our users. Cohort one will be aimed at Receptionists predominantly with a further training plan to then be agreed.

Here to Help You booklet

The *'Here to help you'* Booklet is an aid that can be used with the patients, their relatives and carers and staff to promote enhanced communication. A Junior doctor is formally evaluating the effectiveness of the booklet in October , with a view that any amendments can be made prior to full rollout in conjunction with the revised bedside booklet.

University Hospitals Coventry and Warwickshire NHS Trust

Patient Experience Team
Quality Department
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University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Board Assurance Framework 2015/16 and 2016/17**
Author	**Rebecca Southall, Director of Corporate Affairs**
Responsible Chief Officer	**Meghana Pandit, Chief Medical Officer and Deputy CEO**
Date	**28th July 2016**

1. Purpose

To present the quarter 1 update against the Board Assurance Framework for 2016/17 for approval.

2. Background and Links to Previous Papers

The Trust Board approved the Board Assurance Framework (BAF) for 2016/17 at the March meeting. This paper is the first quarterly update against the BAF and represents the position at quarter 1.

3. Narrative

The Board is responsible for identifying and monitoring risks to achievement of the strategic objectives that it sets. This is achieved through the development of a BAF, which is monitored at the Trust Board on a quarterly basis. Audit Committee also has oversight of the BAF to ensure that the annual programme of internal audit activity is driven by risk; this oversight also allows the Committee to discharge its duties in terms of providing assurance around the robustness of the overall system of internal control, of which BAF is an integral component.

3.1 Board Assurance Framework 2016/17

Chief Officers have reviewed risks that are assigned to them and in so doing have considered the current risk rating, have provided updates against the mitigating actions and have added further actions where appropriate. The risk matrix that the Trust utilises to determine risk score is attached to this paper at appendix 2.

Resultantly, the following risks are recommended for a **reduction** in score:

Risk	Description	Proposed Change	Recommendation
1	If we do not reduce vacancies and embed strong controls we will not reduce the need for high levels of costly agency staff. This could impact on the quality of care we provide to our patients and on staff morale, on our ability to comply with national requirements around the agency cap and on our financial plan.	Reduce the likelihood from (4) likely to 3 (possible) and the consequence from (5) catastrophic to (4) major	Risk to remain on the BAF but at a reduced score of 12
3	If we fail to successfully embed the	Reduce likelihood	De-escalate risk to

	TTWC programme and Virginia Mason production system (now UHCW IS) we may not transform patient services and will not realise our vision to become a national and international leader in healthcare	from (3) likely, to (2) unlikely.	Corporate Risk Register as it has now reached its target risk rating.
4	If we fail to agree an STP with our partners, we will not be able to transform the services that we deliver to our patients on sufficient scale to ensure that they are of the highest quality and sustainable for the future and we will not be able to access transformation funding.	Reduce likelihood from (3) likely to (2) unlikely.	De-escalate risk to Corporate Risk Register as it has now reached its target rating.
8	If we do not deliver education and training and offer support to our trainees our surveys will be poor leading to level 3/4 visits from HEWM with a risk of losing trainees and teaching hospital status	Reduce likelihood from (3) likely to (2) unlikely.	De-escalate risk to Corporate Risk Register as it has now reached its target risk rating.

New Risks Recommended for Inclusion of BAF:

The Risk Management Committee has reviewed the risk (ref 2264) detailed at appendix 1 and is recommending that it is escalated to the BAF, given the potential that it has to impact on the Trust's annual and strategic objectives:

The Trust Board is asked to **APPROVE** the inclusion of risk ref: 2264 on the BAF at the recommendation of the Risk Committee.

4. Areas of Risk

If the Trust does not have a robust Board Assurance Framework and system of monitoring in place there is the risk that the strategic objectives will not be achieved, which could have regulatory, reputation and financial implications and could impact on the quality of care that is provided and the sustainability of services.

5. Governance

The Trust Board will monitor progress against the management and mitigation of the Board Assurance Framework on a quarterly basis, at the board meeting that follows the quarter end.

6. Responsibility

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

7. Recommendations

The Board is invited to **NOTE** the Board Assurance Framework as at Quarter 1 and to:

1. Consider and discuss whether the BAF remains representative of the risks that the risks that the Trust is facing
2. Discuss and approve the proposed reduction in risk scores and proposals for de-escalation to the Corporate Risk Register
3. Approve the inclusion of risk ref: 2264 on the BAF.

University Hospitals Coventry and Warwickshire NHS Trust

Enclosure 8

Appendix 1

2264	1-Apr-2016	Interventional Radiology Cover	Local	Safety - Clinical	The number of consultant interventional radiologists is insufficient to ensure that there is out of hours cover all the time. The consequence is that patients may have to have surgical procedures, wait, or be referred onwards. With increase in EVAR service and continued demand on interventional radiologists for other duties - MDT, reporting - There is a risk that interventional cover will not be available within day time hours as well as OOH. Delay to treatment	Delivering safe, high quality & evidenced patient care	HIGH	Meghana Pandit	Mr Mark Easter	Mrs Frances Dawson	14.05.2016 4 consultants + locum cover support on call service Additional locum cover to support day time non vascular intervention.	Job Plan of radiologists do not reflect demand for interventional work and cross cover Only 4 interventional radiologist on call - unlikely to be resolved until new dept open..Continuing to advertise for locum cover. Gaps will occur in on call rota as no cover available Only one of locums can cover on call duties at current time.	HIGH	16	30-Aug-2016	One locum radiologist supporting on-call service 2nd locum available during day for drain insertions and other similar non vascular intervention COM, Group Management Meeting, Interventional Radiologist Meeting	Limited cover provided by the remaining consultant team in the short term. Ad-hoc locum cover to be sought if possible. Longer term plan will require management team input to cover existing job planned timetable to release consultants for intervention.

RISK NUMBER	1	Datix ref: 2524
STRATEGIC OBJECTIVE	To deliver excellent patient care and experience To deliver value for money To be an employer of choice	
ANNUAL OBJECTIVE 3	Increase substantive/flexible workforce in place of agency staff	
EXECUTIVE LEAD	Chief Workforce and Information Officer	
MANAGEMENT LEAD	Associate Director of Workforce	
RESPONSIBLE COMMITTEE	Finance and Performance Committee	
RISK	If we do not reduce vacancies and embed strong controls we will not reduce the need for high levels of costly agency staff. This could impact on the quality of care we provide to our patients and on staff morale, on our ability to comply with national requirements around the agency cap and on our financial plan.	
NEXT REVIEW DATE	31st October 2016	

Controls:

Hard to fill posts identified through Operational Delivery Plans (ODP) and Workforce Plan

There are 3 multi-professional Agency Control groups in place focusing upon Nursing, Medical, AHP/Others, each with a specific action plan, monitored through the Transforming Workforce Supply Committee and reported through to the Workforce and Engagement Committee

Agency controls in place via Clinical Directors and Chief Officers

Recruitment approval process in place via Chief Officers

All key vacant clinical posts are actioned swiftly and are not subject to current pay controls

A range of recruitment activities and initiatives are developed and monitored through the Transforming Workforce Supply Committee and reported through to the Workforce and Engagement Committee

TRAC recruitment system in place to make recruitment processes more efficient

Gaps in controls:

Resourcing Strategy in development and scheduled to be presented at the Workforce & Engagement Committee on 8th September 2016

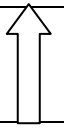
Recruitment KPI's available via TRAC from September 2016

Assurance:

Vacancy rate reported in the Integrated Quality and Performance Report at Trust Board each month together with agency spend.

Key recruitment metrics included within the Integrated Quality and Performance Report (Trust Board)

Tracked at Group Level through monthly workforce report and Performance Framework Agency use reported weekly through NHSI Transforming Workforce Supply Committee and Workforce and Engagement Committee provide assurance to Quality Governance Committee
Gaps in Assurance: Vacancy rate remains above target at the present time Achievement of 10% Trust Wide vacancy rate remains a challenge given the national shortage occupations and difficult to fill posts Ability to meet NHSI agency price caps

RISK RATING	**LIKELIHOOD**	**CONSEQUENCE**	**RISK RATING**	**Progress**
Initial Risk Rating	**4 (likely)**	**5 (catastrophic)**	**20 (very high)**	
Target Risk Rating	**2 (unlikely)**	**4 (major)**	**8 (moderate)**	
Current Risk Rating	**3 (possible)**	**4 (major)**	**12 (moderate)**	

ACTIONS		
Action	**Due Date**	**Progress Update at Quarter 1**
Agree trajectory for reduction in vacancies	30.06.16	Vacancy trajectory not agreed at Group level but there are Group level agency reduction plans which include recruitment plans. These are being reviewed at Group Deep Dive reviews during July.
Development of Attraction and Development Strategy	30.09.16	In development. Being presented to Workforce and Engagement Committee on 8th September 2016.
Development of a recruitment microsite		Completed
Targeted recruitment to Trust Bank to increase numbers of flexible workers	On-going	All new nurses, HCA's and medical starters are now enrolled onto the TSS bank. There has been significant increase in the number of nursing and HCA staff working on the Trust bank over the past 12 months. A TSS improvement plan for all staff groups has been developed including communications and promotion campaigns. A review of pay arrangements for medical bank workers is being undertaken.

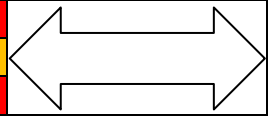
Internal audits around recruitment efficiency/temporary staffing controls part of Internal Audit Plan for 2016/17.	31.07.16	Internal audit completed; moderate assurance. Action plan in place being monitored by the Audit Committee.
Scheduled overseas recruitment campaign for Band 5 nurses	29.07.16	Campaign due to commence on 29.07.16. First cohort expected from January 2017 onwards
TRAC recruitment system to be implemented	31.07.16	Completed
Internal audit around Temporary Staffing planned	31.03.17	Part of the Strategic Internal Audit Plan

Recommendation; good progress is being around reducing agency spend and the vacancy rate and as such, a reduction in the likelihood score from (4) likely, to (3) possible is recommended, together with a reduction in the consequence score from (5) catastrophic to (4) major.

RISK NUMBER	2	Datix ref: 2558
STRATEGIC OBJECTIVE	To deliver excellent patient care and experience To deliver value for money To be an employer of choice	
ANNUAL OBJECTIVE 1	Alignment of demand and capacity to: • Achieve 18-week standard • Achieve agreed 4-hour A&E performance standard • Achieve cancer waiting times standard • Access to diagnostics 6-week standard	
EXECUTIVE LEAD	Chief Operating Officer	
MANAGEMENT LEAD	Director of Operations	
RESPONSIBLE COMMITTEE	Finance & Performance Committee	
RISK	If we do not practice FREED, have good waiting list management processes/practices, work efficiently in theatres and manage waiting lists effectively we will not meet national targets. This could lead to the provision of a poorer standard of care to our patients, staff morale may be impacted, our financial position will be jeopardised and we will suffer damage to our reputation.	
NEXT REVIEW DATE	31st August 2016	
Controls: Daily activity targets to be set for each Group around RTT/cancer in Operational Delivery Plans for 2016/17 Weekly Patient Access meeting Chaired by the Director of Operations Monthly performance reviews with Groups Monthly reporting against all access targets to Trust Board through Integrated Quality & Performance Report Reporting/scrutiny at Finance & Performance Committee		

Weekly monitoring at Chief Officers' Group Formal reporting mechanism for DTOC

Gaps in controls: Late referrals on the cancer pathway result in shared breaches for UHCW. High number of patients that are Delayed Transfers of Care or Medically Fit for Discharge and capacity shortfall amongst partner agencies. Weaknesses identified in recording of activity recording
Assurance: Plans to introduce performance standards for CCGs around DTOC levels Significant assurance level in audit re: data quality in cancer and RTT
Gaps in Assurance: No immediate solution for DTOC issues; this will form part of the System Transformation Plan

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

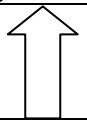
ACTIONS		
Action	**Due Date**	**Progress Update at Quarter 1**
Agree delivery plan with NHS Improvement	30th June 2016	Trajectory agreed
System Transformation Plan to be developed and agreed.	31.03.17	ED action plan now in place agreed at SRG.
Data quality audits around RTT/Cancer waiting times and activity recording in Internal Audit Programme for 2016/17	TBC –part of the IA Plan	Completed; significant assurance
Tertiary referrals audit planned as part of the	TBC – part	

Internal Audit Plan for 2016/17	of the IA Plan	
Planned internal audit around activity recording	TBC – part of the IA Plan	On the internal audit Strategic Plan for 2016/17
Planned internal audit activity around consultant activity.	TBC – part of the IA plan	Consultant activity in Radiology complete; limited assurance. Action plan in place

Recommendation; mitigating actions and plans are in place but no reduction in risk score is recommended at this stage given current performance.

RISK NUMBER	3	Datix ref:2534
STRATEGIC OBJECTIVE	To deliver excellent patient care and experience	
ANNUAL OBJECTIVE 5	Service transformation by: • Together Towards World Class • Participation in the Virginia Mason Programme • Sustainability Transformation Plan	
EXECUTIVE LEAD	Chief Executive Officer	
MANAGEMENT LEAD	Associate Director of Workforce – Learning & Organisational Development KPO Lead – Virginia Mason Programme	
RESPONSIBLE COMMITTEE	Trust Board	
RISK	If we fail to successfully embed the TTWC programme and Virginia Mason System we may not transform patient services and will not realise our vision to become a national and international leader in healthcare.	
NEXT REVIEW DATE	30th September 2016	
Controls: TTWC Programme Board that has oversight of the TTWC work-streams with progress tracking occurring on a bi-monthly basis. Virginia Mason work-programme in place with oversight through Trust Guiding Team (local) and Executive Guiding Board. A combined up-date report is provided to Trust Board on a bi-monthly basis, ensure appropriate oversight and escalation. Work underway to ensure values and behaviours are embedded through all avenues and levers, building on work already undertaken to integrate into existing formal processes and systems (e.g. recruitment, induction, appraisal and recognition schemes)		
Gaps in controls: None		
Assurance: KPO Team in place and trained Successful first Rapid Process Improvement Workshop (RPIW) undertaken. VMI rebranded as UHCW Improvement System National Staff Survey and local staff survey highlight improvements in engagement, resulting from work undertaken across the		

TTWC work-streams TTWC work-streams remain on track to deliver identified priorities for 2015/2016, further priority areas to be identified for 2016/2017
Gaps in Assurance: The UHCW Improvement System is in its early stages of roll out across the organisation Feedback indicates that both TTWC and UHCW Improvement system are not yet widely recognised or understood by all staff

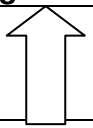
	LIKELIHOOD	**CONSEQUENCE**	**RISK RATING**	**Progress**
Initial Risk Rating	**3 (possible)**	**5 (catastrophic)**	**15 (very high)**	
Target Risk Rating	**2 (unlikely)**	**5 (catastrophic)**	**10 (high)**	
Current Risk Rating	**2 (unlikely)**	**5 (catastrophic)**	**10 (high)**	

ACTIONS		
Action	**Due Date**	**Progress Update as at Quarter 1**
Continued roll of out of UHCW Improvement System	On-going	KPO fully established Regular programme of stand-up events to showcase work and improvements made/further embed through the Trust Report out wall established in the main reception area Development of World Class News, a separate bi-monthly newsletter, agreed for implementation from August 2016 to better promote work underway across both TTWC programme and UHCW Improvement system.

Recommendation; given the progress that has been made and the assurances that are in place, it is recommended that the likelihood of this risk is reduced to unlikely. This results in the target risk rating that was set when the BAF was agreed being met; it is therefore recommended that this risk is de-escalated to the Corporate Risk Register for further monitoring.

RISK NUMBER	4	Datix ref: 2535
STRATEGIC OBJECTIVE	To deliver value for money	
ANNUAL OBJECTIVE 5	Service transformation by: • Together Towards World Class • Participation in the Virginia Mason Programme • Sustainability & Transformation Plan	
EXECUTIVE LEAD	Chief Finance & Strategy Officer	
MANAGEMENT LEAD	Director of Finance & Strategy Associate Director of Strategy	
RESPONSIBLE COMMITTEE	Trust Board	
RISK	If we fail to agree a STP with our partners, we will not be able to transform the services that we deliver to our patients on sufficient scale to ensure that they are of the highest quality and sustainable for the future and we will not be able to access transformation funding.	
NEXT REVIEW DATE	30th September 2016	
Controls: CEO is STP Lead for the Health Economy Footprint for STP agreed as Coventry & Warwickshire Project Board and Project governance arrangements established. Work-streams identified and agreed. Clinical input on work-streams		
Gaps in controls: None		
Assurance: Vision for the Health Economy developed by the Chief Executives from health and social care. Service Transformation Funding available to support developments set out in the plan.		
Gaps in Assurance: STP and implementation plan not yet fully worked up and approved.		

Feedback on June submission not yet available.

	LIKELIHOOD	CONSEQUENCE	RISK RATING	Progress
Initial Risk Rating	**3 (possible)**	**5 (catastrophic)**	**15 (very high)**	
Target Risk Rating	**2 (unlikely)**	**5 (catastrophic)**	**10 (high)**	
Current Risk Rating	**2 (unlikely)**	**5 (catastrophic)**	**10 (high)**	

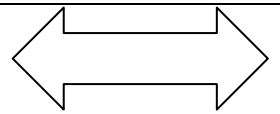
ACTIONS		
Action	**Due Date**	**Progress Update Quarter 1**
Develop governance arrangements	March 2016	Completed
Develop the STP	June 2016	April and June submission undertaken.
Further work to be undertaken to fully develop plan and implementation plan	October 2016	N/A

Recommendation; given the good progress that has been made and the partnership working that is present, it is recommended that the likelihood be reduced to unlikely. This results in the target risk rating being met and it is therefore recommended that this risk is de-escalated from the BAF to the Corporate Risk Register.

RISK NUMBER	5 a	Datix ref: 2527
STRATEGIC OBJECTIVE	To deliver excellent patient care and experience	
ANNUAL OBJECTIVE 2	Improve patient outcomes for: • Mortality • Infection control • Hospital cleanliness	
EXECUTIVE LEAD	Chief Medical Officer	
MANAGEMENT LEAD	Director of Quality and Deputy Medical Director	
REPONSIBLE COMMITTEE	Quality Governance Committee	
RISK	If we do not learn from mortality reviews, introduce the right care bundles and have the right systems in place our HSMR will rise, leading to poor patient care and poor reputation.	
REVIEW DATE	30th September 2016	
Controls: Primary and secondary mortality reviews undertaken Investigations of high relative risks and CUSUM alerts and development of associated action plans Investigation into top ten HRG's contributing to HSMR Actions from RCAs completed and presented to Patient Safety Committee (PSC).		

Gaps in controls: Delay in system change relating to transfer process and handovers Identification of common themes for improving patient care and subsequent actions for improvement
Assurance: Mortality within expected range

Presentations and learning evidenced at Grand Round, PSC, QGC and Trust Board HSMR and SHMI monitoring on Integrated Quality, Performance and Finance report and group performance scorecards Mortality newsletter NHSI and Monitor have recommended our mortality governance and mortality policy for national adoption.
Gaps in Assurance: Delays in obtaining notes for mortality reviews may result in action not being taken as swiftly as required.

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

ACTIONS		
Action	**Due Date**	**Progress Update at Quarter 1**
Regular Mortality reports to Trust Board	Monthly	HSMR and SHMI reported each month to the Trust Board in balanced scorecard.
Deep dive into high contributors to HSMR	September 2016	Work planned but action not yet due.
Grand Round presentations	On-going	Regular grand rounds about themes arising from mortality reviews
Develop more robust benchmarking	September 2016	
Improve intelligence of analysis of mortality data to strive to move to a more proactive approach	September 2016	

Recommendation; no change in the current risk score is recommended at this stage.

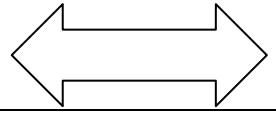
RISK NUMBER	5b	Datix ref: 2536
STRATEGIC OBJECTIVE	To deliver excellent patient care and experience	
ANNUAL OBJECTIVE 2	Improve patient outcomes for: • Mortality • Infection control • Hospital cleanliness	
EXECUTIVE LEAD	Chief Nursing Officer	
MANAGEMENT LEAD	Lead Infection Control Doctor Modern Matron, Infection Prevention & Control	
REPONSIBLE COMMITTEE	Quality Governance Committee	
RISK	If we do not achieve the highest standards for infection control and hospital cleanliness our patients may suffer avoidable harm and we will suffer reputational damage	
REVIEW DATE	30.06.16	

Controls:
Infection control KPIs form part of the Integrated Quality & Performance Report to Trust Board
Root Cause Analysis/PIR process in place for infection control to analyse cause and identify necessary actions
Key performance metrics and dashboards for groups.
ISS Improvement Plan in place
Programme of ICNA Audits in place

Gaps in controls:
Aspects of wider corporate learning from RCAs
Specific controls in emergency MRSA screening
ISS compliance with Improvement Plan
Compliance with Central Line Bundle

Assurance:
Met MRSA and c-diff targets for 2015/16; good performance thus far in 2016/17
Quarterly infection control/DIPC report to the Trust Board

Gaps in Assurance:
Good progress with ISS action plan and improvements evident across the Trust Elective screening targets are still not being achieved Hand hygiene training compliance is still not being achieved

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

ACTIONS		
Action	**Due Date**	**Progress Update at Quarter 1**
Continued monitoring of progress against ISS action plan at QGC	On-going	Good progress being made; assurance at QGC
Month on month improvement in elective screening target compliance	On-going	Improving but further improvement required
Month on month improvement in hand hygiene training compliance	On-going	Improving but further improvement required

Recommendation: good progress is being made but there is further work to be undertaken around improving compliance with MRSA screening and hand hygiene but no reduction in risk score is recommended at this stage given the challenging target.

RISK NUMBER	6	Datix ref:2537
STRATEGIC OBJECTIVE	To deliver excellent patient care and experience To deliver value for money	
ANNUAL OBJECTIVE 7	Information communication & technology architecture to support transformation by: • Determining the mechanism to deliver electronic patient records (EPR) across the local health economy • Upgrading Trust's network infrastructure • Introduction of innovative technologies in support of developments in healthcare services, wherever these services are located • Delivery in support of the locality's emerging Digital Roadmap (underpinned by the Trust's response to the nationally mandated Digital Maturity Assessment)	
EXECUTIVE LEAD	Chief Workforce & Information Officer Chief Nursing Officer	
MANAGEMENT LEAD	Director of Information & Communication Technology (ICT)	
RESPONSIBLE COMMITTEE	Finance & Performance Committee	
RISK	If we do not continue to improve our ICT infrastructure we may not have the ability to transform our services in line with the Trust's strategic objectives and the Sustainability and Transformation Plan, which could impact upon patient safety, our financial position and reputation	
REVIEW DATE	30th September 2016	
Controls: Information Strategy in place, supported by ICT Plan and rolling ICT programme of work Business Continuity plans in place in wards and departments the event that the network is unavailable Trust representatives involved in developing the locality Digital Roadmap ICT restructured to protect time for ICT developments		

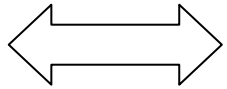
PFI variation for network refresh agreed. Sub-contractors in hand. Single information system is part of STP
Gaps in controls: Limits on capital funding for major IT developments Challenge of recruitment and retention of scarce ICT resources ICT programme of work in second half of FY 16/17 may require more resource than is available Fund for EPR still unidentified Major network incident occurred, lasting four days
Assurance: ICT programme assured by World Class Services Board ICT security assured by Information Governance Committee Locality's Information Services Board assures the development of the Digital Roadmap ICT projects and upgrades managed using standard methods (e.g. Prince2)
Gaps in Assurance: Urgent clinical and service developments needing unplanned ICT resources

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

Action	Due Date	Progress Update
Identify options for delivery of an EPR as part of the Service Transformation Plan	Sept 2016	Identified within the STP
Network refresh to be undertaken	Mar 2017	

Recommended; although good progress is being made and there is now a firm plan for the network refresh no change to the risk score is recommended at this stage.

RISK NUMBER	7	Datix ref: 2538
STRATEGIC OBJECTIVE	To deliver excellent patient care and experience To deliver value for money	
ANNUAL OBJECTIVE	To deliver £1.1m surplus control total	
EXECUTIVE LEAD	Chief Finance & Strategy Officer	
MANAGEMENT LEAD	Director of Finance & Strategy	
RESPONSIBLE COMMITTEE	Finance and Performance Committee	
RISK	If we do not deliver our objectives and work efficiently we will not meet our control target which could jeopardise the sustainability of the Trust in its current form and reputation damage will be suffered.	
REVIEW DATE	30.04.16	
Controls: Financial reporting through monthly finance report to Board Monthly performance reviews/monitoring at Group/Corporate level Financial Recovery Plan in place and being monitored via COG Star Chamber		
Gaps in controls: Operational pressures continue and could impact on availability of STF funding (key targets not being met) Agency spend is reducing but there is further work to be undertaken.		
Assurance: Delivery of CIP in 2015/16 and vast majority of 2016/17 CIP target identified. Delivery of Financial Recovery Plan year 1. Rules around STF funding now clarified		
Gaps in Assurance: Delivery of the £17.2m that will contribute to the achievement of the control total is contingent upon achieving the agreed access targets, resolving operational pressures and reducing agency spend and therefore relates to risks (1) and (2).		

	LIKELIHOOD	CONSEQUENCE	RISK RATING	Progress
Initial Risk Rating	**3 (possible)**	**5 (catastrophic)**	**15 (very high)**	
Target Risk Rating	**2 (unlikely)**	**5 (catastrophic)**	**10 (high)**	
Current Risk Rating	**3 (possible)**	**5 (catastrophic)**	**15 (very high)**	

ACTIONS		
Action	**Due Date**	**Progress Update at quarter 1**
Clear activity/income targets set out in the Operational Delivery Plans for each Group/corporate department	30.04.16	Completed
Monthly performance monitoring at Group/Corporate level	On-going	Monthly reviews taking place
Consultant efficiency audit planned as part of Internal Audit Plan	TBC- part of IA Plan	

Recommendation; no change in risk score is recommended at this stage in the financial year.

RISK NUMBER	8	Datix ref: 2539
STRATEGIC OBJECTIVE	To be a leading training and education centre To be an employer of choice	
ANNUAL OBJECTIVE 6	Reduce level 3/4 deanery visits and improve training surveys	
EXECUTIVE LEAD	Chief Medical Officer	
MANAGEMENT LEAD	Associate Medical Director	
RESPONSIBLE COMMITTEE	Quality Governance Committee	
RISK	If we do not deliver training and education and offer support to our trainees our surveys will be poor leading to level 3/4 visits from HEWM with a risk of losing trainees and teaching hospital status.	
REVIEW DATE	30th September 2016	

Controls:
Action plans in place to address findings of all previous Deanery visits
Clinical Tutor, Associate Medical Director for Education (AMD) & Training and CMO meeting with relevant Groups
Regular Junior Doctor Forums
Educational Supervisor appraisals
Consent Workshops
Outlier management plan
Process in place around transfer of patients from UH to Rugby St Cross at night
Regular NED meeting with junior doctors to identify issues and concerns

Gaps in controls:
Cancellation of Junior Doctor Forum due to operational pressures

Assurance:
De-escalation of following acute and gerontology deanery review in July 2016
PMEC reports to TERC and AMD reports to Patient Safety Committee (PSC)
Training, Education & Research Committee (TERC) and PSC report to QGC
AMD reports to QGC quarterly and to Trust Board 6-monthly.
GMC and JEST survey reports

Gaps in Assurance:
Regular reporting may not address matters not discussed at Junior Doctor Forums or those matters not highlighted internally by trainees.

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

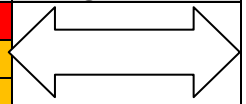
ACTIONS		
Action	**Due Date**	**Progress Update at Quarter 1**
Continue Junior Doctor Forum meetings		In place
PTWR and Handover		In place and will be monitored by PMEC with reports to TERC
Consent issues will be monitored		New policy is on e-library and any non-adherence is escalated to CMO and will be monitored by PSC

Recommendation; following the recent de-escalation, a reduction in the likelihood is recommended which brings the risk within its target rating. It is recommended therefore that the risk is de-escalated to the Corporate Risk Register for future monitoring.

RISK NUMBER	9	Datix ref: 2540
STRATEGIC OBJECTIVE	To deliver excellent patient care and experience To be a leading training and education centre	
ANNUAL OBJECTIVE 12	This risk does not link directly to the annual objectives because it is a risk that was identified in year and with the agreement of the Trust Board has been added to the BAF owing to its potential impact on the strategic objectives of the organisation.	
EXECUTIVE LEAD	Chief Operating Officer	
MANAGEMENT LEAD	Director of Estates and Facilities	
RESPONSIBLE COMMITTEE	Trust Board	
RISK	If we do not deliver the remediation plan and maintain our current high levels of control and risk mitigation the risk of a fire incident developing and harm occurring might increase. There are also consequent risks to the Trust's business (finance and performance), in that in the event of major fire damage to the UH site, the Trust will not be able to deliver the full range of services to the population; this in turn gives rise to risks to the wider health and safety of the population.	
REVIEW DATE	30th September 2016	
Controls: Full range of measures implemented that are supported by the Fire Authority, aimed at preventing fire and at dealing with fire, should one break out. Amendment to the Trust's Fire Strategy to reflect the revised arrangements in place. On-going risk assessment and dialogue with the Fire Authority. Agreed Remediation Plan in place and work is underway and general good progress is being made Provision for unanticipated decant as a result of the works in place.		
Gaps in controls: Some beds will need to be taken out of use for a short period to accommodate some of the work that is required.		

Assurance:
Arrangements for certification of the standard of work agreed.

Gaps in Assurance.
First phase of work will now not be completed by the end of July 2016

	LIKELIHOOD	**CONSEQUENCE**	**RISK RATING**	**Progress**
Initial Risk Rating	**3 (possible)**	**5 (catastrophic)**	**15 (very high)**	
Target Risk Rating	**2 (unlikely)**	**4 (major)**	**8 (high)**	
Current Risk Rating	**2 (unlikely)**	**5 (catastrophic)**	**10 (high)**	

ACTIONS		
Action	**Due Date**	**Progress Update at Quarter 1**
Continue to monitor progress against remediation plan.	On-going	Progress monitored at PFI liaison committee and PFI Board to Board meeting. Issues escalated by Director of Estates where necessary.
Continually assess the risks arising out of fire and make adjustments as necessary.	On-going	Risk assessment is revisited periodically and in line with any developments
Agree schedule of short term bed closures with the operations team	August 2016	Work on-going

Recommendation; no reduction in risk score is recommended at the present time.

Appendix 2

National Patient Safety Agency

Model matrix

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

Table 1 Consequence scores

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

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

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

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring?

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

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

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

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

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

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

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

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

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

Instructions for use

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

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

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

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

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

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	Corporate Risk Register
Author	Chelsea Gilsenan, Trust Risk Manager
Responsible Chief Officer	Meghana Pandit, Chief Medical & Quality Officer
Date	28 July 2016

1. Purpose

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

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

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

2. Background and Links to Previous Papers

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

The monthly Trust Risk Committee supports the Quality Governance agenda in assuring that the Trust delivers high quality, safe services to patients. It oversees and monitors the risk register and ensures that the Trust has the appropriate strategies, processes, systems, policies, and procedures in place to manage risk. The Risk Committee reports to the Quality Governance Committee on a Quarterly basis on all Corporate Risks. In addition, each month the Corporate Delivery Group review the corporate risk register.

The Committee is an executive-led management group chaired by the Chief Executive. On a rolling programme the Chief Officers present their corporate risk portfolio along with the clinical groups bi annual presentation of their risk registers for all moderate and above risks (Risk rating of 8 and above).

3. Executive Summary

At the last report to Trust Board (April 2016) the corporate risk register had 20 "High" rated risks in comparison to 21 "High" rated corporate risks in July 2016. A corporate "High" rated risk is classified as any risk with a rating of 15-25 on the "Corporate Risk Register".

In April 2016, there were 8 risks logged with a risk grading of 20, this is in comparison to 6 in July 2016.

The 6 highest rated corporate risks currently (Risk score = 20) are:

- Risk ID 1936: Obsolete main network infrastructure leading to incidents and lack of network capacity
- Risk ID 1984: RTT Performance
- Risk ID 2136: Inability to keep CAMHS patients safe on an adolescent unit
- Risk ID 2164: Achieving 3.5% DTOC national target
- Risk ID 2185: Cancer (62 day standard)
- Risk ID 2237: Severe shortage of permanent storage capacity in mortuary at UHCW

Of these, 3 risks have remained “High” since April 2016;

- Risk ID 1984: RTT Performance
- Risk ID 2164: Achieving 3.5% DTOC national target
- Risk ID 2185: Cancer (62 day standard)

Since April 2016 the following risks have been escalated to “High” on the corporate risk register;

- **Risk ID 1936: Obsolete main network infrastructure leading to incidents and lack of network capacity**
  Loss of any significant part of the UHCW data network affecting end users access to IT systems. The Trust network is well beyond its refresh date and is suffering sudden disruptive failures. The latest of which occurred 22-24th April 2016. It is becoming increasingly difficult to maintain since the equipment is obsolete. Many of the closets are also full with little or no capacity for expansion. This is a significant risk in particular to the Electronic Patient Record (EPR) programme and other strategic developments such as Emergency Department, Resus and Pathology centralisation.

- **Risk ID 2136: Inability to keep Child and Adolescent Mental Health Services (CAMH’s)patients safe on an adolescent unit**
  Possibility of CAMH's patients self-harming on the paediatric unit. Complexity of CAMH's patients being admitted. High risk of suicide by mis-adventure due to patients with escalating behaviours.

- **Risk ID 2237: Severe shortage of permanent storage capacity in mortuary at UHCW**
  Severely limited storage across the network during times of high death rates and bank holidays particularly during the winter period. This has the potential to lead to reputational damage, stress & upset to relatives. 2 additional temporary storage facilities purchased by the Trust located at Rugby St. Cross providing 24 additional, temporary storage spaces.

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

- Reputational
- Compliance
- Achievement of targets

Please see enclosed “Corporate Risk Register Extract” for details of all corporate risks with a rating of 15 and above.

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

The Trust is committed to ensuring that the management of risk underpins all strategies, processes and activities that lead to the achievement of the aims and objectives of the Trust.

The key aims are to identify and safeguard against any risks which could affect the delivery of the current objectives:

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

The risk management system utilised by the trust to support the functions of Governance (Datix®) has a mandatory requirement for all risks to be linked to the corporate objective they pose a threat to.

5. Governance

Progress on against the mitigation of the “High” rated risks on the corporate risk register will be reported to the Trust Board on a quarterly basis.

6. Responsibility

Meghana Pandit, Chief Medical Officer & Deputy CEO as the Chief Officer responsible for Risk Management

Jenny Gardiner – Director of Quality

7. Recommendations

The Board is invited to **NOTE** the risk register report attached to this header

Name and Title of Author: Chelsea Gilsenan, Trust Risk Manager.

Date: 14th July 2016

ID	Date Identified	Title	Risk Type	Risk Subtype	Description	Risk level (initial)	Executive Lead	Risk Owner	Handler	Current controls	Gaps in controls	Risk level (current)	Rating (current)	Next review date	Assurance	Gaps in assurance	Risk level (Target)
1936	1-Apr-2016	Obsolete main network infrastructure leading to incidents and lack of network capacity	Corporate	Information Technology	Loss of any significant part of the UHCW data network affecting end users access to IT systems. The Trust network is well beyond its refresh date and is suffering sudden disruptive failures. The latest of which occurred 22-24th April 16. It is becoming increasingly difficult to maintain since the equipment is obsolete. Many of the closets are also full with little or no capacity for expansion. This is a significant risk in particular to the EPR programme and other strategic developments such as ED, Resus and Pathology centralisation. Date identified - 6.8.13	HIGH	Karen Martin	Mr Robin Arnold	Mr Tejul Gudka	3.8.15 - The adoption of the plan of works into the PFI programme is still ongoing with the amendment to the deed being discussed between involved parties. Once the amendments are made then the work to replace the network can take place. 1.5.16 - UHCW ICT are engaging with the preferred supplier Intrinsic and also preparing schedules of work including the Project planning, reviewing the HLD/LLD engagement with key stakeholders and looking at capacity requirements since the Network Refresh was procured in August 2014.	Depending on the nature and time of the incident, ICT may not be able to immediately restore services. This risk cannot be mitigated without the network refresh is being scheduled through the Trusts PFI. The refresh paperwork is currently between the Project Co. and Trust lawyers. We are awaiting the outcome of this before the purchase orders are given to the preferred supplier to lay 1) Fibre Cabling 2) Professional Services 3) Maintenance and Contracts. Capacity issues are also appearing where we cannot build into the existing infrastructure without the Network refresh ocurring due to hardware and software limitations. 21.04.16 - A major network disrupt started on 21.04.16 lasting for 4 days. This appears to have been caused by the obsolete equipment reaching the limit of its capacity.	HIGH	20	31-Aug-2016	The ICT Team continue to monitor the performance of the Network and are working with Vinci as and when incidents occur. The refresh project will be managed in accordance with Prince 2.	Recent events have shown the risks of hardware/software failure are increasing in frequency and magnitude.	VLOW
1984	1-Apr-2015	RTT Performance	Corporate	Operational	The Trust is failing the RTT standard for incomplete pathways. This will lead to patients waiting a long time for their treatment; a standard within the NHS constitution will not be met; and a corporate target will not be achieved.	HIGH	David Eltringham	Ms Emma Livesley	Ms Emma Livesley	Update: 07/12/2015 (i) revised trajectory agreed and signed off by CCG and SRG. (ii) Revised action plans and performance management tools. (iii) Weekly performance tracker designed and implemented. (iv) Surgical control room set up. (v) Additional theatre lists identified. (vi) Additional resources allocated to validation. (vii) Additional consultants in plastic surgery; Urology; General Surgery; and T&O. Update 10/02/2016 - (i) Weekly review of all Group plans. (ii) Weekly trajectory identified. (iii) Addiitonal monthly performance review by executive team. (iv) Additional and specific RTT objectives set by the Executive team. Update 11/05/16 (i) Additional capacity identified as part of ODP (ii) Targets for theatre efficiency and closed session rates (iii) Daily Delivery Plan launched with Groups. Weekly review of DDP.	No identified gaps in controls	HIGH	20	30-Sep-2016	Signed off by TDA, NHSE & CCG The RTT trajectory will be validated by IMAS (Intensive Support and Management). The Trust's waiting list has been validated and signed off by NHS England. RTT Board with CCG/TDA and UHCW exec membership	None identified	LOW

ID	Date Identified	Title	Risk Type	Risk Subtype	Description	Risk level (initial)	Executive Lead	Risk Owner	Handler	Current controls	Gaps in controls	Risk level (current)	Rating (current)	Next review date	Assurance	Gaps in assurance	Risk level (Target)
2136	1-Apr-2016	Inability to keep CAMHS patients safe on an adolescent unit	Corporate	Safety - Clinical	Possibility of CAMH's patients self harming on the unit. Complexity of CAMH's patients being admitted. High risk of suicide by mis adventure due to patients with escalating behaviours.	MOD	Mark Radford	Ms Kara Marshall	Mrs Sue Ellis	May 2016: ALT team down to one staff member due to resignations. Service will revert to CAMH's core team when team leader unavailable. May 2016 - Ligature cutters available on ward. COO raised this issue of delayed CAMHS response at the system resilience group meeting on 6th June. CWPT confirmed they have communicated plan to manage staff absences to CNO, Mark Radford. Appropriate escalation followed to ALT team when required	No 24/7 cover for CAMHS liason team at present No guarantee for 1:1 nursing or HCA where required	HIGH	20	31-Aug-2016	business case submitted to increase staffing on ward 14 to allow higher ratio of qualified nurse:patients	If business case is not approved If business case is approved but recruitment is not successful	LOW
2164	1-Apr-2016	Achieving 3.5% DTOC national target	Corporate	Strategic	Due to patients' discharges delayed in hospital, reduced patient flow & extended LOS, there is a direct impact upon the performance of the Trust against national targets and also a risk of patients acquiring infections.	HIGH	David Eltringham	Mr Alan Cranfield	Mr Ross Palmer	Remodeling the service provision to focus resource at the front door and inreach to reduce LOS. Introducing the new DTOC guidance locally Update May 2016: IDT establish roles and responsibilities with wider MDT at ward level. Notifications to social services to reduce as MDT managing ward led discharges.	IDT high levels of sickness reducing accuracy of data collected as staff covering additional wards Partners not updating the discharge plan for their patients Daily discharges meetings not effective use of time reduced to twice weekly with agreement of partner engagement to update staus with changes	HIGH	20	22-Sep-2016	Weekly progress chase meeting with partner organisations to agree the DOH guidance Daily discharge meetings with partners, jointly agreed DTOC figure distributed daily Reduced to twice weekly Jun 2015 Working with CCG and partners to review the DTOC process and apply an adapted Worcester model to DTOC from the end Sept 2015 Sept 2015-Senior meeting weekly for 4 weeks to challenge the DTOC position, work jointly with partners to unblock areas of concern and challenge current pathways and processes to improve flow.	The impact of applying the new model is unknown currently	MOD
2185	1-Apr-2016	Cancer (62 day standard)	Corporate	Safety - Clinical	Risk that the Trust is failing the overall 62 day standard. There are a number of high volume specialties including urology, Lung, head & neck cancer and gynaecology where there is a risk of failing the standard. There are potential delays in radiology due to capacity. The Trust continues to experience late referrals from other Trusts.	HIGH	David Eltringham	Mr David Eltringham	Ms Emma Livesley	Update 08/12/2015: (i) Revised Cancer trajectory signed off by the CCG and SRG. (ii) Revised plan for prostatectomy including potentially transferring of activity to alternative providers. (iii) Additional consultants across four tumour sites plus histo pathology recruited. Update 10/02/16: (i) Additional Prostate capacity in place; (ii) Weekly review of all long waiters to ensure there are treatment dates; (iii) Additional consultant started and being trained.	None identified	HIGH	20	30-Sep-2016	Cancer action plan & trajectory signed off at COG Action plan goes to RTT Board, TDA & NHSE Action plan and trajectory reviewed by NHSE / TDA as part of region wide assurance External review of performance management and information reporting Internal audit of information and performance management systems and processes undertaken	None identified	LOW

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2237	1-Apr-2016	Severe shortage of permanent storage capacity in mortuary at UHCW	Corporate	Operational	Severely limited storage across the network during times of high death rates and bank holidays particularly during the winter period. This has the potential to lead to reputational damage, stress & upset to relatives.	HIGH	David Eltringham	Ms Jane Barry	Mr Christopher Wookey	April 2016 2 additional temporary storage facilities purchesed by the Trust located at Rugby St.Cross provideing 24 additional, temporary storage spaces.	Human Tissue Authority inspection due August 2016, HTA will not approve of the long term solution for temporary storage. Capacity of additional storage locations	HIGH	20	30-Sep-2016	Regular review, updates to Chief Officers Pathology Director of Operations to prepare paper for COG	None identified	LOW
2029	23-May-2016	Loss of Clinical Perfusion staff	Corporate	Operational	Insufficient number of qualified staff to cover the service in full. From the 28th June there will be only 5 qualified. Cancellation of operating lists are inevitable.	HIGH	David Moon	Mrs Sara Lee	Mr Paul Sweeney	Clinical perfusionists will continue to honour their contracts in full & where possible minimise disruption to the service. However, there are insufficient hours to cover the service. Locum perfusionists will be required to cover the gaps in service.	When external perfusion agencies are unavailable to provide staffing, cancellations will ocurr	HIGH	16	5-Aug-2016	To the best of their ability & staffing levels allow, UHCW Clinical Perfusion will continue to maintain patient safety & qulaity of service. Managament will be informed of staff shortages immediately so alternate staffing can be utilised.	Absence at short notice may mean that agency personnel will not be available to cover gaps in service.	LOW
2067	24-Apr-2015	Patient Flow (ED 4hr wait)	Corporate	Operational	The risk is that that we do not have the right capacity to meet demand which prevents the attainment of the Constitutional 4 Hour Standard for A&E.	MOD	David Eltringham	Mr Alan Cranfield	Dr Dan Strong	1 - Use of predictive capacity and demand models to identify shortfalls in capacity. 2 - Introduction of MAU, incorporating short stay beds, AEC and GPAU. 3. - The development, with partners, of a frailty service to reduce length of stay and and admission avoid. 4. - The creation of ringfenced surgical capacity to protect a volume of elective activity. 5. - The introduction of a Trigger sytem within ED to provide early alerts to enhance breach avoidance. 6. - The uplift of 3 middle grade doctors to allow capacity to meet demand. 18/5/2016 DS - HR analysis of junior rotas has not identified any capacity to improve staffing out-of-hours within establishment, as all tiers are working to maximum contractual limits. Focus on improving evening performance to reduce backlog going into the night should mitigate overnight performance issues.	Clinical engagement and resources Lack of 7 day working Development of staff	HIGH	16	31-Aug-2016	Hourly monitoring Process & o/c indicators Mortality KPIs - FREED metrics	Complex patient pathways with large numbers of patients affected. Capacity is reliant upon external partnerships, and community pathways being updated limited capacity forces short term plans to deal with constraints	MOD

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2178	1-Apr-2016	DNACPR forms not accompanying patients as they leave the organisation	Corporate	Safety - Clinical	1 - The risk is that a patient will be resuscitated on arrival to the organisation when a previous DNACPR order has been made and not rescinded. The family / patient will be aware of this. □ 2- Potential litigation and or complaints.	HIGH	Meghana Pandit	Dr David Parr	Dr Robert Simpson	12.1.16 - DNACPR tab still under development, due to be piloted Feb 2016.□ 04.03.2016 - Tab pilot imminent. Awaiting final notice from AP-F.□ 06.04.16 Reported at Risk Committee that the tab pilot has commenced.□ 17.05.16 - Still awaiting completion of programming of training package. Pilot area clinical staff briefed re pilot on 20/21/30/31□ 23.06 - no change. Actively chasing. MP CMO aware.	None identified Programming of training packafge is outside our control	HIGH	16	30-Sep-2016	Monitored via incident reporting	None identified	MOD
2195	29-Mar-2016	HPB-compliance with IOG guidelines	Corporate	Strategic	If we do not serve a population of 2 million people we are not able to continue to provide the service according to the recent peer review.	HIGH	David Moon	Mrs Danielle Taylor	Mrs Danielle Taylor	27.04.2016□ Specialised commissioners have confirmed their intent to support a combined UHBFT and UHCW HPB service from 01.04.2017.□ A guiding principles document is in circulation to confirm legal and governance responsibilities and discussions are expected to agree a proposed model of clinical delivery by June 2016	Clinical model yet to be agreed	HIGH	16	30-Sep-2016	Agreed pathways and governance ensuring on-going service at UH	UHCW & UHB met early Apr 2016.	LOW
2290	2-Apr-2016	Insufficient controls and adherence to safety procedures may lead to system failures and Never events	Corporate	Safety - Clinical	If staff do not follow policies and procedures there is a risk that patients will come to avoidable harm through the occurrence of a never-event or other clinical incident.	HIGH	Meghana Pandit	Dr Anne Scase	Sr Carolyn Bradshaw	Following a review on mechanisms that are in place and have been applied following previous incidents and are now incorporated into ongoing training, an intention to apply innovative techniques and processes was agreed.□ This has resulted in the following actions being completed and techniques and principles being developed:□ □ Audio surgical safety checklist.□ Audit of process for counting & checking equipment.□ Human factors training.□ Feedback to manufacturer re packaging of different types of prosthesis.□ Review of storage of prostheses.□ Theatre list planning.□ □ 25/11/15 NatSSIPs and LocSSIPs implementation being scoped Trustwide.□ □ 02/03/16 Discussed at Risk Committee. 3 wrong-site surgery NEs occurred during 2015/16. Risk rating raised.□ □ 18/05/16 Theatre safety team developed. Leading with video of SSC, development of team brief chart, completed daily, and debrief to be rolled out once video shown to staff.□	NatSSIPs and LocSSIPs to be implemented by Sep 2016	HIGH	16	1-Sep-2016	Trustwide never events gap analysis was conducted September 2015, where specialties identified any gaps to be addressed Never event reported in 2015/16 has since been de-registered Theatre "safety champions to be appointed, safety committee and safety board instigated involving theatre staff and clinicians. April 2016. Safety video and competency pack being introduced for all theatre staff. May 2016.	None identified	MOD

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2392	1-Apr-2016	Agency Staffing Expenditure 2016/17	Corporate	Financial	Failure to control and reduce agency staffing expenditure	HIGH	David Moon	Mr David Moon	Mr Alan Jones	Budgetary control processes.□ □ Financial Recovery Plan (proposal to introduce strengthened agency staffing controls).□ □ Monthly operational delivery meetings.□ □ Quarterly performance review meetings.□ □ New controls over the use of agency staff implemented in July 2015□ □ Additional TDA controls introduced in November 2015	New controls over the use of agency staff to be implemented in July 2015	HIGH	16	31-Jul-2016	Monthly reports to the Trust Board and Finance and Performance Committee.	Continuing high levels of agency spending and use of non-framework agencies Full compliance with revised Trust and TDA controls not assured	LOW
2395	1-Apr-2016	Financial Recovery Plan	Corporate	Financial	Failure to develop and deliver a financial recovery plan which meets the statutory breakeven requirements	HIGH	David Moon	Ms Susan Rollason	Mr Alan Jones	Financial recovery plan signed off by Board and reviewed at F&P□ □ Budgetary control processes.□ □ Monthly operational delivery meetings.□ □ Quarterly performance review meetings.□ □ Finance Star Chamber.	None identified.	HIGH	16	31-Jul-2016	Monthly reports to the Trust Board and Finance and Performance Committee.	Plan not approved by the TDA	LOW
2416	4-May-2016	Confidentiality Breaches	Corporate	Information Governance	If documents contaning highly sensitive and confidential patient information e.g. handover sheets, continue to be printed and misplaced breaches of confidentiality will occur; the Trust will be exposed to the risk of a fine from the ICO and patients may be harmed/lose trust and confidence in the organisation.	HIGH	David Eltringham	Mrs Rebecca Southall	Ms Harjit Matharu	Confidentiality Policy□ Annual IG training.□ □ 6/04/16 Risk not approved, reviewed or updated for over 3 months, therefore closed.□ □ 04/05/2016 Risk re opened at the request of the Risk Committee HM to update	None identified	HIGH	16	1-Jul-2016		None identified	LOW

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2546	8-Apr-2016	Delayed discharge for fast track patients	Corporate	Operational	This risk is shared across the Trust. Fast Track patients are delayed in UHCW awaitng POC or NH's, or become too unwell to leave the hospital due to the current process.	HIGH	Mark Radford	Mr Alan Cranfield	Ms Kerrie Manning	IDT screen and educate the ward staff on the completion of fast track referrals throughout the day.□ □ Progress chase meeting twice weekly to clarify the day the referral was received, delays in the receipt, and whether the referral was declined / accepted. □ □ Ensure all fast track referrals received by 14:30pm on Fri are checked and processed.□ □ Ensure all fast track referrals are checked as priority Monday morning.□ □ Twice daily updates from CHC SPA regarding the progression of sourcing.□ □ Twice weekly meetings with senior staff to escalate concerns and support to resolve blockages□ □ Reported via progress chase to CHC to discuss with commissioning and explore why the patient has been declined by a NH	Daily updates do not always result in an imminent discharge Escalation at the twice weekly meeting does not always result in an imminent discharge UHCW have no authority over the CHC SPA function and the process There is nothing in the NH contracts to specify a time frame from referral to assessment to decision.	HIGH	16	19-Oct-2016	Completion of Fast track audit Escalated to the CCG work stream in progress to explore the CHC SPA process Escalated to the EOL committee meeting, letter sent from Mark Radford to CHC leads.	No Authority to implement / influence a change in the CHC process as managed externally.	LOW
67	1-Apr-2016	Medicines Management - Drug Security	Corporate	Safety - Clinical	Reviewed yearly and updated following Patient Safety Committee Review. □ □ 1 Facilities: Drug Security is compromised due to insufficient resources (poor storage facilities) within Trust to action best practice for the safe storage of medication. The Trust has experienced breaches in drug security as a result of lack of secure facilities.□ □ 2 Practice: Drug security compromised due to practice where doors to clinical rooms, drug trolleys and drug cupboards are left unlocked.□ □	MOD	David Eltringham	Mr Mark Easter	Mr Mark Easter	1 Facilities:□ 15th January 2015 - PSC reviewed risk following presentation of November 2014 Trustwide medicines security audit. Agreed risk rating remains red (High Risk). Options appraisal conducted re. facilities how to make facilities fit for purpose, preferred option Trustwide robotics. □ □ Business case presented at PU November 2015 - to go out to tender.□ □ 2 Practice - Monthly Medicines Management Training Workshops to be continued throughout 2015/16 and CD training added to nurse preceptorship programme. □ □ Medicines Management training programme added to induction via market place.□ □ Feb 2016 - Update on status Annual Medicines Management Audit results show improvement in compliance with drug security. (Attached report summary in documenation). Business case for electronic medicines cupboards approved at planning board and mini competition tender underway. □ □ May 2015: Clinical areas assessed via self-assesment based on RPS review of Duthie. Heat map of issues added in documents. Report to be completed and presented to director of quality. SOme areas have yet to comply with recommendation to install self-closing arms on clinic room doors, and to remove latch facility on digi-lock. ITU areas and Theatres theatres struggling to comply with requirements to lock away medications. Estates to confirm if cabinets installed at build comply with BS2881. Additional cabinets purchased by some areas due to requirement to segreate patients own medicines from stock, require review - may not be secure enough to withstand attack, and not securely attached to wall/floor. □ Controlled Drugs cabinets across the organisation appear to be of appropriate constuction but assurances required from estates regarding the appropriate locks (number of key differs) and secure attachment to wall/floor, in line with the misuse of drugs act.	Co-ordination for monitoring assessment action plan delivery and completion Audit & Assessment - routinely these are on the day spot checks and may not reflect true practice Medicines Managment (Drug Security) Training is not delivered to all healthcare professionals Under reporting of drug security incidents	HIGH	15	1-Sep-2016	Monitored at Patient Safety Committee Monitored at Medicines Management Committee	Drug security risk assessments to be undertaken and added to all wards and departments risk register	LOW

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461	1-Apr-2016	Management of non-gynaecological patients to Ward 23 (medical and surgical)	Corporate	Operational	High numbers of outlying patients regularly placed on surgical and non-medical Wards. This impacts on bed capacity and elective theatre lists. Placing patients in an area that they are not ideally suited. This also has potentially increased infection control and financial consequences. Gynaecology nursing staff are required to care for these specilaty patients alongside gynaecology and gynaecological oncology patients, patient care could be compromised as a result of this. Situation on Ward 23 specifically may be further compounded by reconfiguration with maternity services at GEH which will require 12 beds to be used.	MOD	David Eltringham	Ms Emma Livesley	Sr Sue Harrington	Meeting 28.06.2016 held between Surgery and Gynaecology with Director of Operations present. Surgery have undertaken an audit of the number of female urology patients in a 2 weeks period who would be suitable for admission to Ward 23 however this identified that not enough patients met the criteria required. Audit is being revisited to include males and females but Surgery have significant concerns that changes to their patient base would increase their outliers which carries the same risks as for Gynae medical outliers. Director of Operations has requested a briefing paper updating on the options propsed and discussed.	Outlier doctors are shared among specialties and therefore we can experience delays in patients being reviewed	HIGH	15	31-Aug-2016	Outlier patients are reviewed on a daily basis by a dedicated team which is shared amongst specialties	Medical and Surgical outliers are monitored but plans are limited to manage these patients The ability to manage the number of outliers we accept in relation to planned elective TCI's	LOW
2279	1-Apr-2016	Trustwide Clinical Staffing Vacancies	Corporate	Workforce (HR)	High agency usage in most wards. Some impact on mandatory training compliance. Impact of additional open beds (short term over winter in renal, cardiology, daysurgery) requiring additional staffing.	HIGH	Mark Radford	Linda Abolins	Linda Abolins	Daily staffing review and management by Matron. Change to working practice, flexibility of working hours, use of bank and agency staff. Daily escalation process in place and report to CNO Recruitment Lead Nurse in post since 1st December 2014 with a specific focus on registered and non-registered nurse recruitment/ retention. HR review and streamline of recruitment process. Targeted plans and actions for areas with particular pressures e.g. renal haemodialysis, gerontology, neurosciences Creating some short term (6 months) Band 3 posts in areas of highest risk- e.g. neurosciences and gerontology Consideration of recruiting mental health nurses for key specialties. There are a number of difficult medical posts that the Trust is actively trying to recruit to. These posts are temporarily being covered by locum doctors. April 2015 UHCW active participation to recruitment fayres in Ireland. Process in place to monitor use of agency staff, with non framework RN requests, and HCSW framework requests requiring Chief Officer sign off. TDA target of no more than 12% of total nursing budget to be spent on agency staff, with a reduction over next 3 years year on year. New national guidance on agency caps came into force end November 2015, currently implications for UHCW being worked through. Recruitment monitored by COG, on monthly IPR and monthly workforce report to F&P Committee/ Trust Board.	Timescale from advert to staff on site has improved but ongoing work to streamline this and reduce further to no longer than 3 months Agreement to employ greater number of newly qualiifed staff (work to look at support required for this) as experienced B5 staff not avaialble to match current vacancy levels.	HIGH	15	30-Dec-2016	Reduced external agencies from 24 to 12, all framework , better quality assurance Monitored at COG, F&P Committee, NMC and quarterly Performance Reviews New Enhanced Care Team commenced in October 2015. Further recruitment to 10wte vacancies in February 2015 Twice yearly Safer Staffing report to Trust Board Deep dive review (of quality metrics) on those wards with 1:12 staffing at night received at QGC in june 2015. HCSW recruitment excellent and vacancy numbers reduced to below 30 across Trust Bi annual review of risk assessment at Nursing and Midwifery Committee Nursing metrics reviewed monthly	Vacancy rate remains high despite active recruitment activities	MOD

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2472	25-Jan-2016	LACK OF HYBRID OPERATING THEATRE	Corporate	Safety - Clinical	A hybrid operating theatre is an operating theatre which has a fixed image intensifier and equipment for performing vascular surgery. Modern vascular surgery requires good quality imaging and stock of equipment kept in theatre to perform modern surgical techniques. These cannot be carried out using the current facilities in both elective or acute settings. Hence patients are being offered 'older' techniques which have a higher morbidity and mortality rather than modern techniques. In addition, staff are being exposed to higher levels of radiation than would occur if we had a fixed system for imaging. A hybrid operating theatre is recommeded by the MHRA for the above reasons on safety grounds.	HIGH	David Moon	Dr Anne Scase	Mr Asif Mahmood	No current controls in place. Access to interventional radiology on an adhoc basis. Working party for hybrid theatre. 11/03/16 Risk escalated to "corporate" at Theatre Management meeting. To be approved by D Moon.	Use of interventional radiology is sub-optimal, with no immediate access to surgery.	HIGH	15	30-Sep-2016	Monitored through incident reporting & Mortality review	None identified	LOW
2552	1-Dec-2014	Haemodialysis Capacity	Corporate	Safety - Clinical	Haemodialysis capacity does not meet current demand, leading to routine dialysis being carried out, out of operational hours. This is drain on staff resource. As a consequence staff are leaving and patient safety maybe compromised.	HIGH	David Moon		Mr Bob Grunnell	Use of portable NXStage dialysis machine for stable chronic HD in patients. Daily review of capacity and demand in all units. Home dialysis actively promoted. Regular transfer of patients between units to ensure all slots are utilised. Business plan approved for city centre satellite unit.		HIGH	15	5-Aug-2016			VLOW
2559	1-Apr-2016	Radiographer Resources	Corporate	Operational	(Previously risk ID 850) Difficulty recruiting to posts in timely manner CT insufficiently resourced to cover weekend without overtime / Agency High vacancy factor throughout General and CT/MRI Difficult to recruit to Ultrasound Increased use of Agency staff to backfill vacancy - cost Increased risk of error = Reputational risk	HIGH	Mark Radford	Mr Mark Easter	Ms Tracey Humphreys	Rolling recruitment programme CT/ MRI capacity case	National shortage of radiographers	HIGH	15	12-Jul-2016	Discussed at GMM, Modality Meetings and with finance Regular meeting with Resources to oversee recruitment	Non identified	VLOW

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1936	1-Apr-2016	Obsolete main network infrastructure leading to incidents and lack of network capacity	Corporate	Information Technology	Loss of any significant part of the UHCW data network affecting end users access to IT systems. The Trust network is well beyond its refresh date and is suffering sudden disruptive failures. The latest of which occurred 22-24th April 16. It is becoming increasingly difficult to maintain since the equipment is obsolete. Many of the closets are also full with little or no capacity for expansion. This is a significant risk in particular to the EPR programme and other strategic developments such as ED, Resus and Pathology centralisation. Date identified - 6.8.13	HIGH	Karen Martin	Mr Robin Arnold	Mr Tejul Gudka	3.8.15 - The adoption of the plan of works into the PFI programme is still ongoing with the amendment to the deed being discussed between involved parties. Once the amendments are made then the work to replace the network can take place. 1.5.16 - UHCW ICT are engaging with the preferred supplier Intrinsic and also preparing schedules of work including the Project planning, reviewing the HLD/LLD engagement with key stakeholders and looking at capacity requirements since the Network Refresh was procured in August 2014.	Depending on the nature and time of the incident, ICT may not be able to immediately restore services. This risk cannot be mitigated without the network refresh is being scheduled through the Trusts PFI. The refresh paperwork is currently between the Project Co. and Trust lawyers. We are awaiting the outcome of this before the purchase orders are given to the preferred supplier to lay 1) Fibre Cabling 2) Professional Services 3) Maintenance and Contracts. Capacity issues are also appearing where we cannot build into the existing infrastructure without the Network refresh ocurring due to hardware and software limitations. 21.04.16 - A major network disrupt started on 21.04.16 lasting for 4 days. This appears to have been caused by the obsolete equipment reaching the limit of its capacity.	HIGH	20	31-Aug-2016	The ICT Team continue to monitor the performance of the Network and are working with Vinci as and when incidents occur. The refresh project will be managed in accordance with Prince 2.	Recent events have shown the risks of hardware/software failure are increasing in frequency and magnitude.	VLOW

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1984	1-Apr-2015	RTT Performanc e	Corporate	Operational	The Trust is failing the RTT standard for incomplete pathways. This will lead to patients waiting a long time for their treatment; a standard within the NHS constitution will not be met; and a corporate target will not be achieved.	HIGH	David Eltringham	Ms Emma Livesley	Ms Emma Livesley	Update: 07/12/2015 (i) revised trajectory agreed and signed off by CCG and SRG. (ii) Revised action plans and performance management tools. (iii) Weekly performance tracker designed and implemented. (iv) Surgical control room set up. (v) Additional theatre lists identified. (vi) Additional resources allocated to validation. (vii) Additional consultants in plastic surgery; Urology; General Surgery; and T&O. Update 10/02/2016 - (i) Weekly review of all Group plans. (ii) Weekly trajectory identified. (iii) Addiitonal monthly performance review by executive team. (iv) Additional and specific RTT objectives set by the Executive team. Update 11/05/16 (i) Additional capacity identified as part of ODP (ii) Targets for theatre efficiency and closed session rates (iii) Daily Delivery Plan launched with Groups. Weekly review of DDP.	No identified gaps in controls	HIGH	20	30-Sep-2016	Signed off by TDA, NHSE & CCG The RTT trajectory will be validated by IMAS (Intensive Support and Management). The Trust's waiting list has been validated and signed off by NHS England. RTT Board with CCG/TDA and UHCW exec membership	None identified	LOW
2136	1-Apr-2016	Inability to keep CAMHS patients safe on an adolescent unit	Corporate	Safety - Clinical	Possibility of CAMH's patients self harming on the unit. Complexity of CAMH's patients being admitted. High risk of suicide by mis adventure due to patients with escalating behaviours.	MOD	Mark Radford	Ms Kara Marshall	Mrs Sue Ellis	May 2016: ALT team down to one staff member due to resignations. Service will revert to CAMH's core team when team leader unavailable. May 2016 - Ligature cutters available on ward. COO raised this issue of delayed CAMHS response at the system resilience group meeting on 6th June. CWPT confirmed they have communicated plan to manage staff absences to CNO, Mark Radford. Appropriate escalation followed to ALT team when required	No 24/7 cover for CAMHS liason team at present No guarantee for 1:1 nursing or HCA where required	HIGH	20	31-Aug-2016	business case submitted to increase staffing on ward 14 to allow higher ratio of qualified nurse:patients	If business case is not approved If business case is approved but recruitment is not successful	LOW

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2164	1-Apr-2016	Achieving 3.5% DTOC national target	Corporate	Strategic	Due to patients' discharges delayed in hospital, reduced patient flow & extended LOS, there is a direct impact upon the performance of the Trust against national targets and also a risk of patients acquiring infections.	HIGH	David Eltringham	Mr Alan Cranfield	Mr Ross Palmer	Remodeling the service provision to focus resource at the front door and inreach to reduce LOS. Introducing the new DTOC guidance locally Update May 2016: IDT establish roles and responsibilities with wider MDT at ward level. Notifications to social services to reduce as MDT managing ward led discharges.	IDT high levels of sickness reducing accuracy of data collected as staff covering additional wards Partners not updating the discharge plan for their patients Daily discharges meetings not effective use of time reduced to twice weekly with agreement of partner engagement to update staus with changes	HIGH	20	22-Sep-2016	Weekly progress chase meeting with partner organisations to agree the DOH guidance Daily discharge meetings with partners, jointly agreed DTOC figure distributed daily Reduced to twice weekly Jun 2015 Working with CCG and partners to review the DTOC process and apply an adapted Worcester model to DTOC from the end Sept 2015 Sept 2015-Senior meeting weekly for 4 weeks to challenge the DTOC position, work jointly with partners to unblock areas of concern and challenge current pathways and processes to improve flow.	The impact of applying the new model is unknown currently	MOD
2185	1-Apr-2016	Cancer (62 day standard)	Corporate	Safety - Clinical	Risk that the Trust is failing the overall 62 day standard. There are a number of high volume specialties including urology, Lung, head & neck cancer and gynaecology where there is a risk of failing the standard. There are potential delays in radiology due to capacity. The Trust continues to experience late referrals from other Trusts.	HIGH	David Eltringham	Mr David Eltringham	Ms Emma Livesley	Update 08/12/2015: (i) Revised Cancer trajectory signed off by the CCG and SRG. (ii) Revised plan for prostatectomy including potentially transferring of activity to alternative providers. (iii) Additional consultants across four tumour sites plus histo pathology recruited. Update 10/02/16: (i) Additional Prostate capacity in place; (ii) Weekly review of all long waiters to ensure there are treatment dates; (iii) Additional consultant started and being trained.	None identified	HIGH	20	30-Sep-2016	Cancer action plan & trajectory signed off at COG Action plan goes to RTT Board, TDA & NHSE Action plan and trajectory reviewed by NHSE / TDA as part of region wide assurance External review of performance management and information reporting Internal audit of information and performance management systems and processes undertaken	None identified	LOW
2237	1-Apr-2016	Severe shortage of permanent storage capacity in mortuary at UHCW	Corporate	Operational	Severely limited storage across the network during times of high death rates and bank holidays particularly during the winter period. This has the potential to lead to reputational damage, stress & upset to relatives.	HIGH	David Eltringham	Ms Jane Barry	Mr Christopher Wookey	April 2016 2 additional temporary storage facilities purchesed by the Trust located at Rugby St.Cross provideing 24 additional, temporary storage spaces.	Human Tissue Authority inspection due August 2016, HTA will not approve of the long term solution for temporary storage. Capacity of additional storage locations	HIGH	20	30-Sep-2016	Regular review, updates to Chief Officers Pathology Director of Operations to prepare paper for COG	None identified	LOW

ID	Date Identified	Title	Risk Type	Risk Subtype	Description	Risk level (initial)	Executive Lead	Risk Owner	Handler	Current controls	Gaps in controls	Risk level (current)	Rating (current)	Next review date	Assurance	Gaps in assurance	Risk level (Target)
2029	23-May-2016	Loss of Clinical Perfusion staff	Corporate	Operational	Insufficient number of qualified staff to cover the service in full. From the 28th June there will be only 5 qualified. Cancellation of operating lists are inevitable.	HIGH	David Moon	Mrs Sara Lee	Mr Paul Sweeney	Clinical perfusionists will continue to honour their contracts in full & where possible minimise disruption to the service. However, there are insufficient hours to cover the service. Locum perfusionists will be required to cover the gaps in service.	When external perfusion agencies are unavailable to provide staffing, cancellations will ocurr	HIGH	16	5-Aug-2016	To the best of their ability & staffing levels allow, UHCW Clinical Perfusion will continue to maintain patient safety & qulaity of service. Managament will be informed of staff shortages immediately so alternate staffing can be utilised.	Absence at short notice may mean that agency personnel will not be available to cover gaps in service.	LOW
2067	24-Apr-2015	Patient Flow (ED 4hr wait)	Corporate	Operational	The risk is that that we do not have the right capacity to meet demand which prevents the attainment of the Constitutional 4 Hour Standard for A&E.	MOD	David Eltringham	Mr Alan Cranfield	Dr Dan Strong	1 - Use of predictive capacity and demand models to identify shortfalls in capacity. 2 - Introduction of MAU, incorporating short stay beds, AEC and GPAU. 3. - The development, with partners, of a frailty service to reduce length of stay and and admission avoid. 4. - The creation of ringfenced surgical capacity to protect a volume of elective activity. 5. - The introduction of a Trigger sytem within ED to provide early alerts to enhance breach avoidance. 6. - The uplift of 3 middle grade doctors to allow capacity to meet demand. 18/5/2016 DS - HR analysis of junior rotas has not identified any capacity to improve staffing out-of-hours within establishment, as all tiers are working to maximum contractual limits. Focus on improving evening performance to reduce backlog going into the night should mitigate overnight performance issues.	Clinical engagement and resources Lack of 7 day working Development of staff	HIGH	16	31-Aug-2016	Hourly monitoring Process & o/c indicators Mortality KPIs - FREED metrics	Complex patient pathways with large numbers of patients affected. Capacity is reliant upon external partnerships, and community pathways being updated limited capacity forces short term plans to deal with constraints	MOD
2178	1-Apr-2016	DNACPR forms not accompanying patients as they leave the organisation	Corporate	Safety - Clinical	1 - The risk is that a patient will be resuscitated on arrival to the organisation when a previous DNACPR order has been made and not rescinded. The family / patient will be aware of this. 2- Potential litigation and or complaints.	HIGH	Meghana Pandit	Dr David Parr	Dr Robert Simpson	12.1.16 - DNACPR tab still under development, due to be piloted Feb 2016. 04.03.2016 - Tab pilot imminent. Awaiting final notice from AP-F. 06.04.16 Reported at Risk Committee that the tab pilot has commenced. 17.05.16 - Still awaiting completion of programming of training package. Pilot area clinical staff briefed re pilot on 20/21/30/31 23.06 - no change. Actively chasing. MP CMO aware.	None identified Programming of training packafge is outside our control	HIGH	16	30-Sep-2016	Monitored via incident reporting	None identified	MOD

ID	Date Identified	Title	Risk Type	Risk Subtype	Description	Risk level (initial)	Executive Lead	Risk Owner	Handler	Current controls	Gaps in controls	Risk level (current)	Rating (current)	Next review date	Assurance	Gaps in assurance	Risk level (Target)
2195	29-Mar-2016	HPB-compliance with IOG guidelines	Corporate	Strategic	If we do not serve a population of 2 million people we are not able to continue to provide the service according to the recent peer review.	HIGH	David Moon	Mrs Danielle Taylor	Mrs Danielle Taylor	27.04.2016 Specialised commissioners have confirmed their intent to support a combined UHBFT and UHCW HPB service from 01.04.2017. A guiding principles document is in circulation to confirm legal and governance responsibilities and discussions are expected to agree a proposed model of clinical delivery by June 2016	Clinical model yet to be agreed	HIGH	16	30-Sep-2016	Agreed pathways and governance ensuring on-going service at UH	UHCW & UHB met early Apr 2016.	LOW
2290	2-Apr-2016	Insufficient controls and adherence to safety procedures may lead to system failures and Never events	Corporate	Safety - Clinical	If staff do not follow policies and procedures there is a risk that patients will come to avoidable harm through the occurrence of a never-event or other clinical incident.	HIGH	Meghana Pandit	Dr Anne Scase	Sr Carolyn Bradshaw	Following a review on mechanisms that are in place and have been applied following previous incidents and are now incorporated into ongoing training, an intention to apply innovative techniques and processes was agreed. This has resulted in the following actions being completed and techniques and principles being developed: Audio surgical safety checklist. Audit of process for counting & checking equipment. Human factors training. Feedback to manufacturer re packaging of different types of prosthesis. Review of storage of prostheses. Theatre list planning. 25/11/15 NatSSIPs and LocSSIPs implementation being scoped Trustwide. 02/03/16 Discussed at Risk Committee. 3 wrong-site surgery NEs occurred during 2015/16. Risk rating raised. 18/05/16 Theatre safety team developed. Leading with video of SSC, development of team brief chart, completed daily, and debrief to be rolled out once video shown to staff.	NatSSIPs and LocSSIPs to be implemented by Sep 2016	HIGH	16	1-Sep-2016	Trustwide never events gap analysis was conducted September 2015, where specialties identified any gaps to be addressed Never event reported in 2015/16 has since been de-registered Theatre "safety champions to be appointed, safety committee and safety board instigated involving theatre staff and clinicians. April 2016. Safety video and competency pack being introduced for all theatre staff. May 2016.	None identified	MOD

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2392	1-Apr-2016	Agency Staffing Expenditure 2016/17	Corporate	Financial	Failure to control and reduce agency staffing expenditure	HIGH	David Moon	Mr David Moon	Mr Alan Jones	Budgetary control processes. Financial Recovery Plan (proposal to introduce strengthened agency staffing controls). Monthly operational delivery meetings. Quarterly performance review meetings. New controls over the use of agency staff implemented in July 2015 Additional TDA controls introduced in November 2015	New controls over the use of agency staff to be implemented in July 2015	HIGH	16	31-Jul-2016	Monthly reports to the Trust Board and Finance and Performance Committee.	Continuing high levels of agency spending and use of non-framework agencies Full compliance with revised Trust and TDA controls not assured	LOW
2395	1-Apr-2016	Financial Recovery Plan	Corporate	Financial	Failure to develop and deliver a financial recovery plan which meets the statutory breakeven requirements	HIGH	David Moon	Ms Susan Rollason	Mr Alan Jones	Financial recovery plan signed off by Board and reviewed at F&P Budgetary control processes. Monthly operational delivery meetings. Quarterly performance review meetings. Finance Star Chamber.	None identified.	HIGH	16	31-Jul-2016	Monthly reports to the Trust Board and Finance and Performance Committee.	Plan not approved by the TDA	LOW
2416	4-May-2016	Confidentiality Breaches	Corporate	Information Governance	If documents contaning highly sensitive and confidential patient information e.g. handover sheets, continue to be printed and misplaced breaches of confidentiality will occur; the Trust will be exposed to the risk of a fine from the ICO and patients may be harmed/lose trust and confidence in the organisation.	HIGH	David Eltringham	Mrs Rebecca Southall	Ms Harjit Matharu	Confidentiality Policy Annual IG training. 6/04/16 Risk not approved, reviewed or updated for over 3 months, therefore closed. 04/05/2016 Risk re opened at the request of the Risk Committee HM to update	None identified	HIGH	16	1-Jul-2016		None identified	LOW

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2546	8-Apr-2016	Delayed discharge for fast track patients	Corporate	Operational	This risk is shared across the Trust. Fast Track patients are delayed in UHCW awaitng POC or NH's, or become too unwell to leave the hospital due to the current process.	HIGH	Mark Radford	Mr Alan Cranfield	Ms Kerrie Manning	IDT screen and educate the ward staff on the completion of fast track referrals throughout the day. Progress chase meeting twice weekly to clarify the day the referral was received, delays in the receipt, and whether the referral was declined / accepted. Ensure all fast track referrals received by 14:30pm on Fri are checked and processed. Ensure all fast track referrals are checked as priority Monday morning. Twice daily updates from CHC SPA regarding the progression of sourcing. Twice weekly meetings with senior staff to escalate concerns and support to resolve blockages Reported via progress chase to CHC to discuss with commissioning and explore why the patient has been declined by a NH	Daily updates do not always result in an imminent discharge Escalation at the twice weekly meeting does not always result in an imminent discharge UHCW have no authority over the CHC SPA function and the process There is nothing in the NH contracts to specify a time frame from referral to assessment to decision.	HIGH	16	19-Oct-2016	Completion of Fast track audit Escalated to the CCG work stream in progress to explore the CHC SPA process Escalated to the EOL committee meeting, letter sent from Mark Radford to CHC leads.	No Authority to implement / influence a change in the CHC process as managed externally.	LOW

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67	1-Apr-2016	Medicines Management - Drug Security	Corporate	Safety - Clinical	Reviewed yearly and updated following Patient Safety Committee Review. 1 Facilities: Drug Security is compromised due to insufficient resources (poor storage facilities) within Trust to action best practice for the safe storage of medication. The Trust has experienced breaches in drug security as a result of lack of secure facilities. 2 Practice: Drug security compromised due to practice where doors to clinical rooms, drug trolleys and drug cupboards are left unlocked.	MOD	David Eltringham	Mr Mark Easter	Mr Mark Easter	1 Facilities: 15th January 2015 - PSC reviewed risk following presentation of November 2014 Trustwide medicines security audit. Agreed risk rating remains red (High Risk). Options appraisal conducted re. facilities how to make facilities fit for purpose, preferred option Trustwide robotics. Business case presented at PU November 2015 - to go out to tender. 2 Practice - Monthly Medicines Management Training Workshops to be continued throughout 2015/16 and CD training added to nurse preceptorship programme. Medicines Management training programme added to induction via market place. Feb 2016 - Update on status Annual Medicines Management Audit results show improvement in compliance with drug security. (Attached report summary in documenation). Business case for electronic medicines cupboards approved at planning board and mini competition tender underway. May 2015: Clinical areas assessed via self-assesment based on RPS review of Duthie. Heat map of issues added in documents. Report to be completed and presented to director of quality. SOme areas have yet to comply with recommendation to install self-closing arms on clinic room doors, and to remove latch facility on digi-lock. ITU areas and Theatres theatres struggling to comply with requirements to lock away medications. Estates to confirm if cabinets installed at build comply with BS2881. Additional cabinets purchased by some areas due to requirement to segreate patients own medicines from stock, require review - may not be secure enough to withstand attack, and not securely attached to wall/floor. Controlled Drugs cabinets across the organisation appear to be of appropriate constuction but assurances required from estates regarding the appropriate locks (number of key differs) and secure attachment to wall/floor, in line with the misuse of drugs act.	Co-ordination for monitoring assessment action plan delivery and completion Audit & Assessment - routinely these are on the day spot checks and may not reflect true practice Medicines Managment (Drug Security) Training is not delivered to all healthcare professionals Under reporting of drug security incidents	HIGH	15	1-Sep-2016	Monitored at Patient Safety Committee Monitored at Medicines Management Committee	Drug security risk assessments to be undertaken and added to all wards and departments risk register	LOW

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461	1-Apr-2016	Management of non-gynaecological patients to Ward 23 (medical and surgical)	Corporate	Operational	High numbers of outlying patients regularly placed on surgical and non-medical Wards. This impacts on bed capacity and elective theatre lists. Placing patients in an area that they are not ideally suited. This also has potentially increased infection control and financial consequences. Gynaecology nursing staff are required to care for these specilaty patients alongside gynaecology and gynaecological oncology patients, patient care could be compromised as a result of this. Situation on Ward 23 specifically may be further compounded by reconfiguration with maternity services at GEH which will require 12 beds to be used.	MOD	David Eltringham	Ms Emma Livesley	Sr Sue Harrington	Meeting 28.06.2016 held between Surgery and Gynaecology with Director of Operations present. Surgery have undertaken an audit of the number of female urology patients in a 2 weeks period who would be suitable for admission to Ward 23 however this identified that not enough patients met the criteria required. Audit is being revisited to include males and females but Surgery have significant concerns that changes to their patient base would increase their outliers which carries the same risks as for Gynae medical outliers. Director of Operations has requested a briefing paper updating on the options propsed and discussed.	Outlier doctors are shared among specialties and therefore we can experience delays in patients being reviewed	HIGH	15	31-Aug-2016	Outlier patients are reviewed on a daily basis by a dedicated team which is shared amongst specialties	Medical and Surgical outliers are monitored but plans are limited to manage these patients The ability to manage the number of outliers we accept in relation to planned elective TCI's	LOW

ID	Date Identified	Title	Risk Type	Risk Subtype	Description	Risk level (initial)	Executive Lead	Risk Owner	Handler	Current controls	Gaps in controls	Risk level (current)	Rating (current)	Next review date	Assurance	Gaps in assurance	Risk level (Target)
2279	1-Apr-2016	Trustwide Clinical Staffing Vacancies	Corporate	Workforce (HR)	High agency usage in most wards. Some impact on mandatory training compliance. Impact of additional open beds (short term over winter in renal, cardiology, daysurgery) requiring additional staffing.	HIGH	Mark Radford	Linda Abolins	Linda Abolins	Daily staffing review and management by Matron. Change to working practice, flexibility of working hours, use of bank and agency staff. Daily escalation process in place and report to CNO Recruitment Lead Nurse in post since 1st December 2014 with a specific focus on registered and non-registered nurse recruitment/ retention. HR review and streamline of recruitment process. Targeted plans and actions for areas with particular pressures e.g. renal haemodialysis, gerontology, neurosciences Creating some short term (6 months) Band 3 posts in areas of highest risk- e.g. neurosciences and gerontology Consideration of recruiting mental health nurses for key specialties. There are a number of difficult medical posts that the Trust is actively trying to recruit to. These posts are temporarily being covered by locum doctors. April 2015 UHCW active participation to recruitment fayres in Ireland. Process in place to monitor use of agency staff, with non framework RN requests, and HCSW framework requests requiring Chief Officer sign off. TDA target of no more than 12% of total nursing budget to be spent on agency staff, with a reduction over next 3 years year on year. New national guidance on agency caps came into force end November 2015, currently implications for UHCW being worked through. Recruitment monitored by COG, on monthly IPR and monthly workforce report to F&P Committee/ Trust Board.	Timescale from advert to staff on site has improved but ongoing work to streamline this and reduce further to no longer than 3 months Agreement to employ greater number of newly qualiifed staff (work to look at support required for this) as experienced B5 staff not avaialble to match current vacancy levels.	HIGH	15	30-Dec-2016	Reduced external agencies from 24 to 12, all framework , better quality assurance Monitored at COG, F&P Committee, NMC and quarterly Performance Reviews New Enhanced Care Team commenced in October 2015. Further recruitment to 10wte vacancies in February 2015 Twice yearly Safer Staffing report to Trust Board Deep dive review (of quality metrics) on those wards with 1:12 staffing at night received at QGC in june 2015. HCSW recruitment excellent and vacancy numbers reduced to below 30 across Trust Bi annual review of risk assessment at Nursing and Midwifery Committee Nursing metrics reviewed monthly	Vacancy rate remains high despite active recruitment activities	MOD

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2472	25-Jan-2016	LACK OF HYBRID OPERATING THEATRE	Corporate	Safety - Clinical	A hybrid operating theatre is an operating theatre which has a fixed image intensifier and equipment for performing vascular surgery. Modern vascular surgery requires good quality imaging and stock of equipment kept in theatre to perform modern surgical techniques. These cannot be carried out using the current facilities in both elective or acute settings. Hence patients are being offered 'older' techniques which have a higher morbidity and mortality rather than modern techniques. In addition, staff are being exposed to higher levels of radiation than would occur if we had a fixed system for imaging. A hybrid operating theatre is recommeded by the MHRA for the above reasons on safety grounds.	HIGH	David Moon	Dr Anne Scase	Mr Asif Mahmood	No current controls in place. Access to interventional radiology on an adhoc basis. Working party for hybrid theatre. 11/03/16 Risk escalated to "corporate" at Theatre Management meeting. To be approved by D Moon.	Use of interventional radiology is sub-optimal, with no immediate access to surgery.	HIGH	15	30-Sep-2016	Monitored through incident reporting & Mortality review	None identified	LOW
2552	1-Dec-2014	Haemodialysis Capacity	Corporate	Safety - Clinical	Haemodialysis capacity does not meet current demand, leading to routine dialysis being carried out, out of operational hours. This is drain on staff resource. As a consequence staff are leaving and patient safety maybe compromised.	HIGH	David Moon		Mr Bob Grunnell	Use of portable NXStage dialysis machine for stable chronic HD in patients. Daily review of capacity and demand in all units. Home dialysis actively promoted. Regular transfer of patients between units to ensure all slots are utilised. Business plan approved for city centre satellite unit.		HIGH	15	5-Aug-2016			VLOW
2559	1-Apr-2016	Radiographer Resources	Corporate	Operational	(Previously risk ID 850) Difficulty recruiting to posts in timely manner CT insufficiently resourced to cover weekend without overtime / Agency High vacancy factor throughout General and CT/MRI Difficult to recruit to Ultrasound Increased use of Agency staff to backfill vacancy - cost Increased risk of error = Reputational risk	HIGH	Mark Radford	Mr Mark Easter	Ms Tracey Humphreys	Rolling recruitment programme CT/ MRI capacity case	National shortage of radiographers	HIGH	15	12-Jul-2016	Discussed at GMM, Modality Meetings and with finance Regular meeting with Resources to oversee recruitment	Non identified	VLOW

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Infection Prevention and Control Annual Report 2015/16**
Author	**Infection Prevention and Control team**
Responsible Chief Officer	**Mark Radford, Chief Nursing Officer & Director of Infection Prevention & Control**
Date	**28 July 2016**

1. Purpose

To present to Annual Report which details the outcomes against the infection prevention and control strategy for the year 2015-16.

2. Background and Links to Previous Papers

An Annual Report is presented each year to supplement the quarterly reports that are provided to the Trust Board and the performance information that is contained within the Integrated Quality and Performance Report that is also submitted each month. There is a requirement within the *Code of Practice for health and adult social care on the prevention and control of infections and related guidance* for the Director of Infection Prevention and Control (the DIPC) who is directly accountable to the Chief Executive to produce an annual report and to release it publicly.

3. Narrative

The year 2015-16 saw a national improvement in healthcare associated infections that are required to be reported against nationally. The Trust performed well against each of these and was rated the best performing teaching hospital for all three categories combined; MRSA, MSSA and Clostridium difficile. Whilst this national recognition is very welcome, the relentless focus on the infection prevention and control agenda will continue as we progress into 2016/17 to ensure that the rightfully challenging targets are met and that there are improvements in non-reportable areas.

4. Areas of Risk

This annual report links to our annual objective to improve patient outcomes for infection control and relates to Board Assurance Framework risk (5b).

5. Governance

The DIPC is required to produce an Annual Report to the Trust Board each year. This is supplementary to the regular cycle of reporting and ensures that the infection prevention and control agenda is a top priority for the Trust Board.

6. Responsibility

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

7. Recommendations

The Trust Board is asked to **NOTE** the work that has taken place around the infection prevention and control agenda during 2016/17 and to **APPROVE** the Annual Report.

INFECTION PREVENTION & CONTROL
Annual Report 2015-16

1. Introduction

This report seeks to provide the Trust Board with an update on both our mandatory reporting requirements and key infection prevention issues 2015-16.

2. Mandatory reporting

The final numbers for the four infections subject to the national mandatory reporting scheme are shown in Table 1.

Comparison of our performance with other large teaching Trusts is shown at appendix 1.

Table 1

MRSA, MSSA & *E. coli* bacteraemias, *C difficile* infection			
Period	**Apportioned figures**	**National Ceiling**	**Rate per 100,000**
April-15 - March 16			**Bed days**
MRSA bacteraemia	**0**	**0**	**0.0**
C. difficile	**38**	**42**	**9.9**
MSSA bacteraemia	**22**	**Not applicable**	**5.7**
***E. coli* Bacteraemia**	**294**	**Not applicable**	**76.8**

3. Staphylococcus aureus bacteraemias

3.1 MRSA

This year saw UHCW NHS Trust declare zero trust apportioned meticillin resistant staphylococcus aureus (MRSA) Bacteraemia.

We have seen a significant improvement on 2014/15 where 9 cases were declared. This prompted a review including regional and national expertise to identify areas that may have been a causative factor. The reviews all failed to identify a single area that gave significant cause for concern. The decision was taken to review fundamentals of care, educating and reminding staff of the importance of these interventions. All organisations can become complacent when results are not highlighting particular issues. The continued good performance of both Clostridium difficile and MSSA rates in particular reinforced the theory that although we felt our infection prevention practices across the trust were not poor , it would be timely to remind staff and to improve upon our position. Although no definitive causes were identified, a program of work was implemented in a range of practice areas.

The focus of the educational campaign was to work on the ward areas with staff, to revisit the fundamentals of infection prevention, screening, hand hygiene, decolonisation etc.

This appears to have been well received. It was important to ensure that data collected via audit was both meaningful to the teams and applicable to them.
The creation of an infection prevention and control dashboard ensured that responsibility and accountability belonged with the teams in alliance with the infection prevention and control team. The infection prevention dashboard was discussed at infection quality review monthly meetings with the matron teams and at divisional meeting before the executive team, who held those areas with less than optimum results to account.

Figure 1

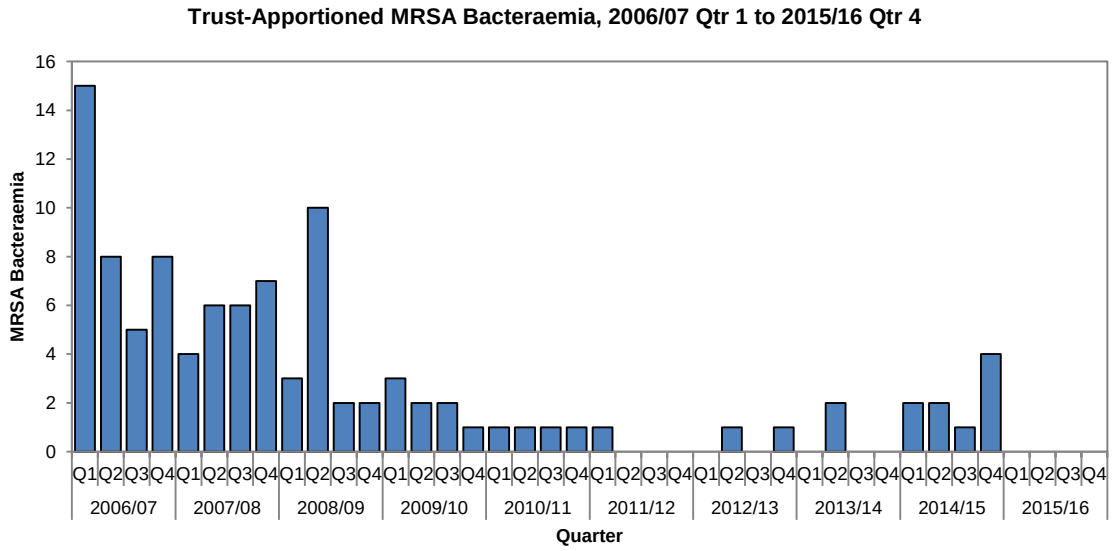
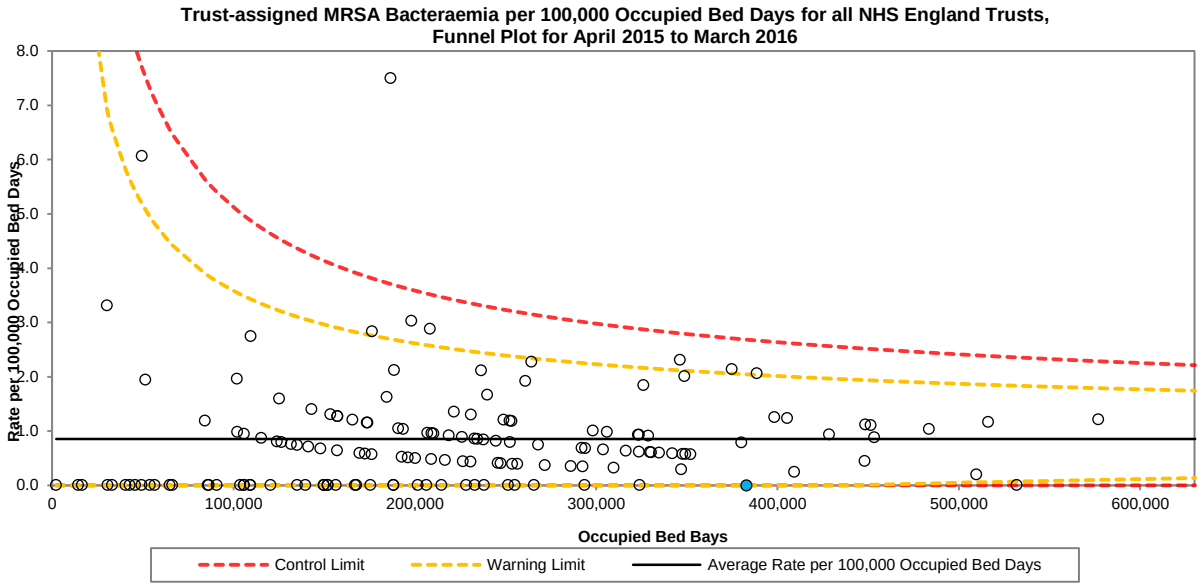


Figure 2 shows the PIR assigned MRSA BSI rates per 100,000 bed days[1], 2015/16, in comparison with other Trusts in the West Midlands. This shows that UHCW (blue circle) performs well against other Trusts in the West Midlands.

Figure 2



[1] Bed occupancy figures taken from NHS England KH03 Bed Availability and Occupancy returns

3.2 MSSA

The number of Trust apportioned MSSA bacteraemias is 22 (Figure 3). At this point last year we had reported 15 cases.

We identified an issue in the Neonatal unit, where five cases were reported between June and August. The previous year there were no cases in the neonatal unit. An outbreak management team was formed and Neonates have interrogated their practices and developed an action plan which is monitored monthly by the neonatal action group chaired by the deputy director of nursing. At the request of UHCW, the TDA undertook a peer review in September to ensure that the outbreak was being managed appropriately and to provide any further advice. UHCW received the TDA report in October.

Despite the seven cases attributed to the neonatal unit for the 2015-16 year UHCW still performed well nationally appearing in top performing third of the table. (DH mandatory enhanced surveillance data) see appendix 1.

Figure 3

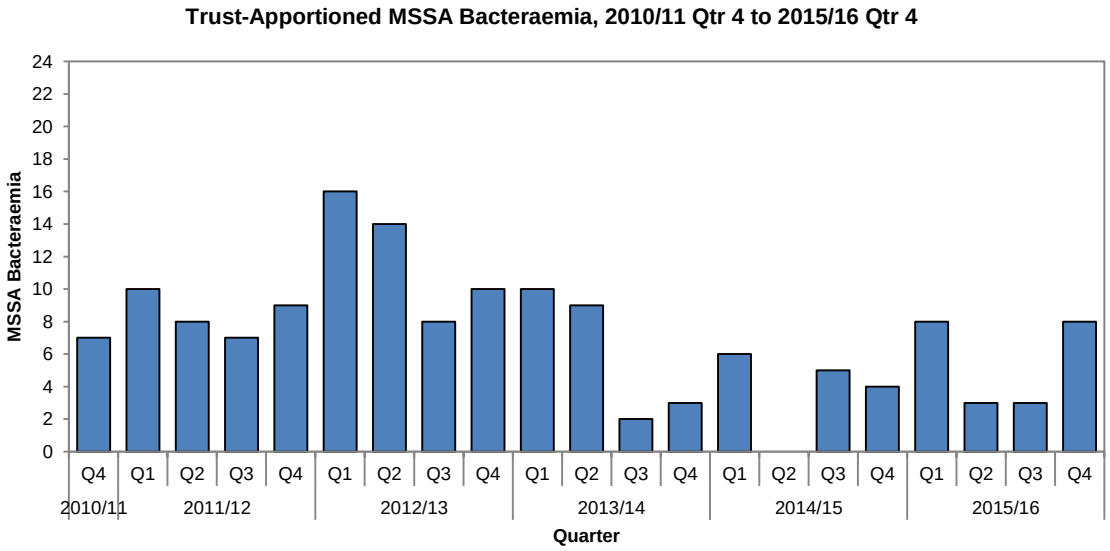
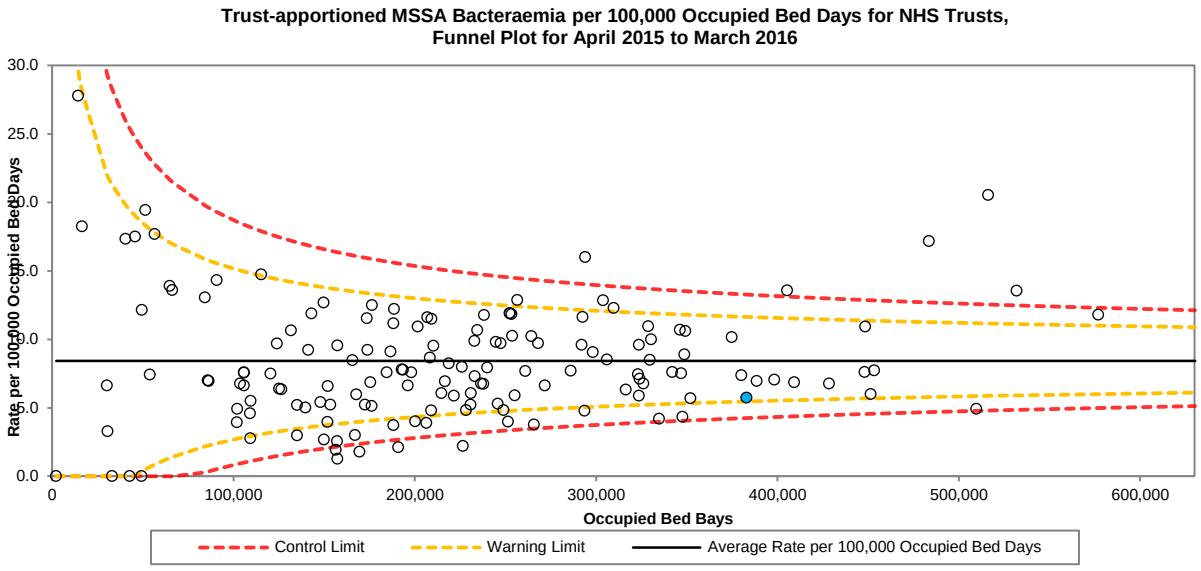


Figure 4



3.3 Clostridium difficile

The Trust reported 38 hospital acquired cases for the year 2015-16. This places the Trust at 4 cases below the national trajectory but also 2 below the internally set upper limit of 40. 2014-15 we had reported 41 cases. The annual trajectory limit is challenging but we continue to work towards reducing these numbers further. We have refined our RCA process to improve our understanding of causative factors and to include the requirement of a discussion around lapses of care. Any case that breaches the trajectory is subject to a financial penalty of approximately £10,000. If the case is assigned as no lapse of care with the agreement of the CCG then the penalty will not apply. Our paperwork has been amended to record a discussion around "lapses of care" between the CCG, TDA and the Trust. Figure 5 below shows the number of trust-apportioned Clostridium difficile infections (CDI).

Figure 5

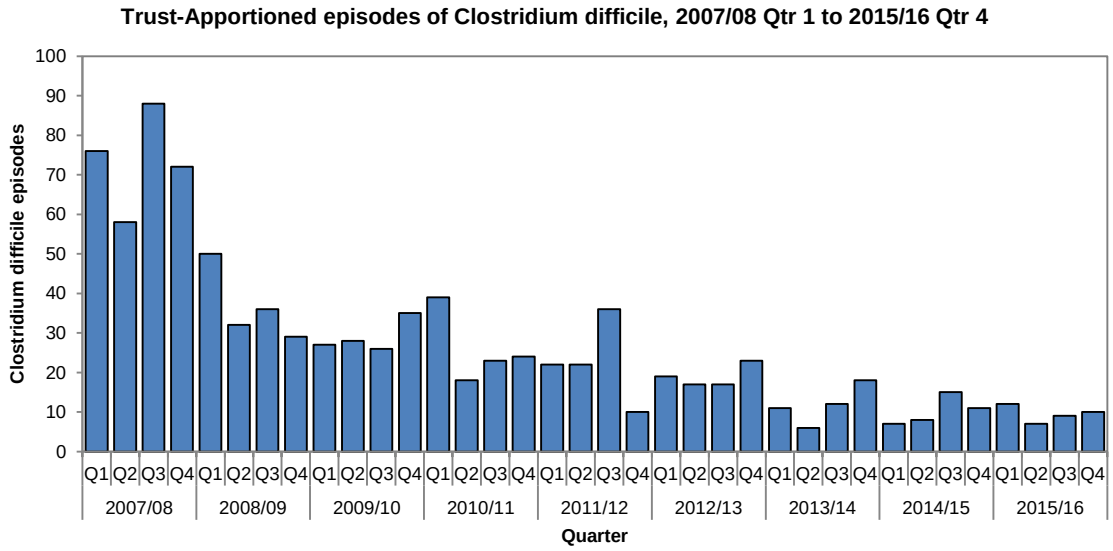
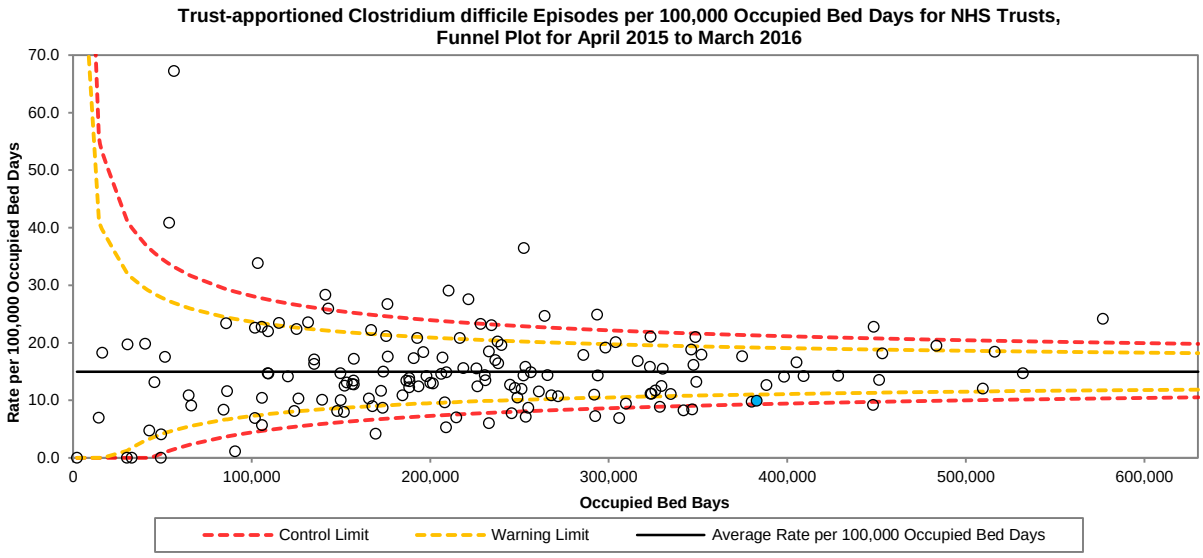


Figure 6 compares UHCW performance with other West Midlands Trusts. This illustrates a favourable performance.

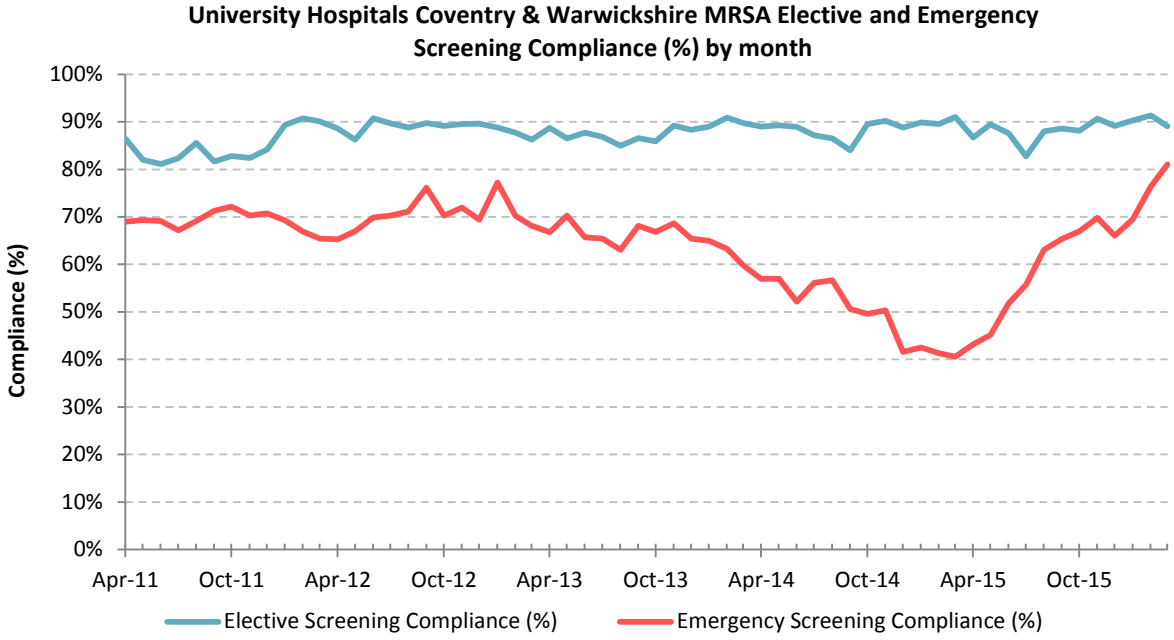
Figure 6



4. MRSA screening compliance

The following chart shows compliance with MRSA screening of both emergency and elective cases up to March-16. The improvement in emergency screening continues.

Figure 7



Focused work by the IPC team at ward level, to understand what factors hinder compliance, and how to address the issues has been initiated to improve compliance, most notably in the emergency pathway. Utilising the monthly infection review meeing Matrons are encouraged to discuss what works in their areas and to ahere practices. Data is individualised down to patiens level and we can identify were processes impact upon the success of screening. We have identified that an increase in waiting list times means that although patients are screened, they fall out of the arbituary time period allocated.

A pathway has been agreed with Preoperative assessment and this has resulted in the department consistantly reporting above 95% compliance. We still have work to do with direct admissions to departments and some of this is around the issues with waiting list management. We are taking these issues back to the areas.

5. MRSA New Acquisitions

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

A monthly compliance audit of all areas shows that our rate of decolonisation has been increasing month on month, from April 2015 decolonisation rate of 58 %, to 100% in March 2016.

Figure 8

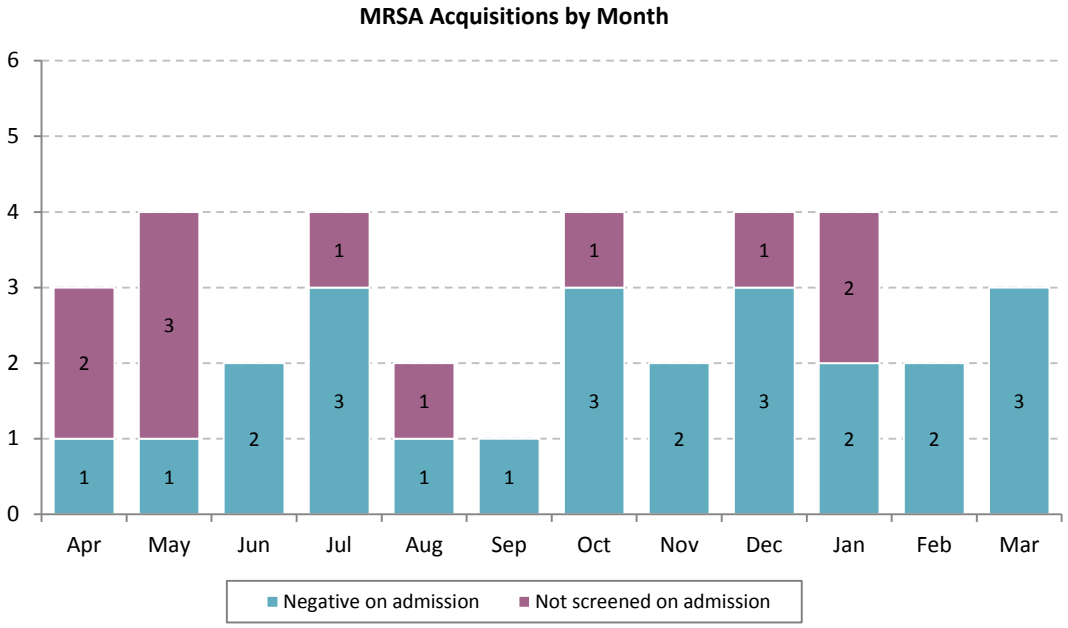
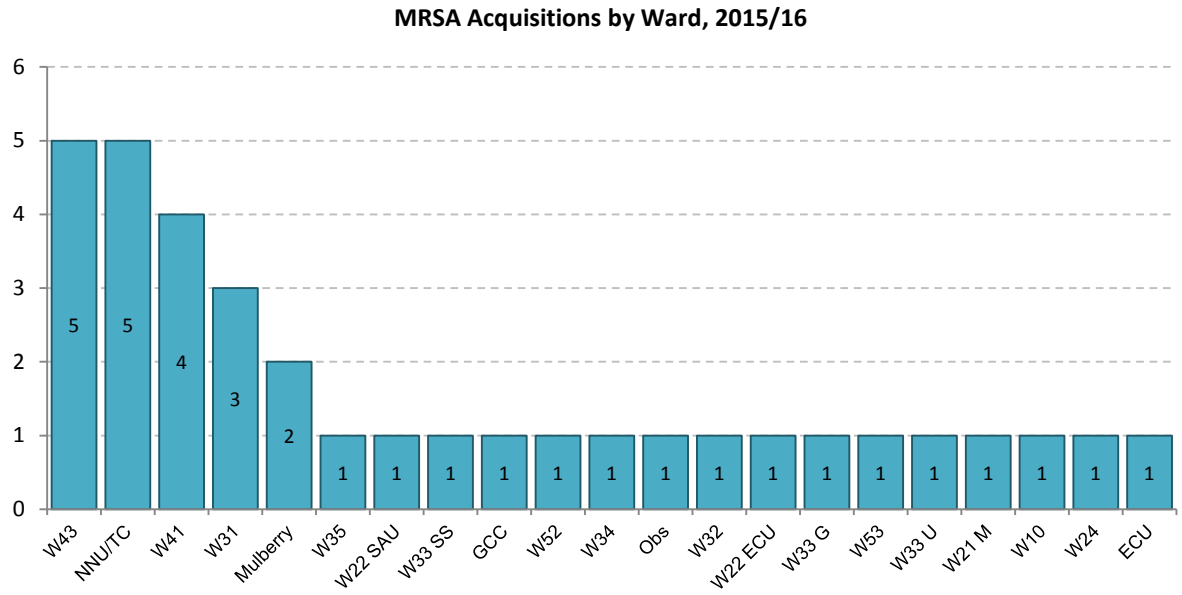


Figure 9



6. Influenza

UHCW NHS Trust saw large numbers of positive influenza cases this year particularly within Q4. Despite the numbers being higher than normal, the ward staff were competent in their management, isolating promptly and using correct PPE. However we continue to see positive results particularly of Flu A which is the strain most associated with outbreaks. UHCW NHS identified one incident of transmission in Hospital, this occurred during January 2016 once identified it was effectively managed and there were no further episodes. .The infection prevention team continue to work closely with ward staff to support and educate, we contact each ward area that has submitted a swab for influenza to ensure they are correctly managed and to reassure ourselves that staff understand what is required, staff are proving to be knowledgeable and competent. The rate of staff vaccination was 64% this was some ay above the national rate at 50%. This campaign was led by the occupational health department and undoubtedly had a positive impact upon our management of influenza and protection of patients.

7. Tuberculosis (TB) incidents

A joint meeting with CCG and the TB regional team have progressed to develop an algorithm for the management of TB. The development of a whole health economy pathway is a welcome development in our management of patients and any potential contacts of TB. The meetings facilitate healthy discussion and cooperative working between, CCG PH England, GPs and other regional centres such as South Warwick and George Elliot. Coventry has a high number of TB cases, nationally we are considered to be second highest outside London, which has the highest number. From March 2015-16 we were notified of 67 cases of potential TB. Each of these cases requires investigation by the IPC team to identify any risks to other patients and staff. If the respirator team consider there to be a risk patients are either sent a letter informing them of the potential risk or if considered appropriate asked to attend for screening. This all requires co-ordination of a number of teams and the collating of a list of potential contacts. TB culture can be slow to isolate in the laboratory often taking over 6-8 weeks because this

is a slow growing organism. We do not routinely contact trace or inform before this time as we need to also allow a period of time for any organism to grow in order to identify it, within the potential contact. This often causes and anxiety as it may appear that the response from the organisation was slow.

8*. M chimera* infection, cardiothoracic surgery

We continue to monitor the ongoing issues with the Heater cooler units that are suspected of transmitting M. Chimera to patients following cardiac valve surgery. This is an international issue and we are following the guidance produced by the National task and finish group. We do however continue to monitor for M. Chimera from our heater cooler unit's water tanks. The numbers of units isolating the mycobacterium are reducing and this is thought to reflect good disinfection procedures, however nationally this is still an evolving story as many cases are still not being identified, the incubation period can be up to four years, until GPs and all centres are aware of the link between cardiac surgery and the development of this unusual form of TB we will not know the extent of the issue. However the group monitoring at UHCW have a stringent plan for surveillance and action required. All patients undergoing surgery are now informed of the potential risks.

9. Cleaning

The Trust continues to work with Project Co and ISS to address the issues around cleaning

Table 2 shows the average scores per quarter.

Period	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16
Average ICNA Score	82%	79%	80%	83%

Table 3 shows the average scores by month

Month	Average ICNA Score
Jan-16	80%
Feb-16	85%
Mar-16	85%

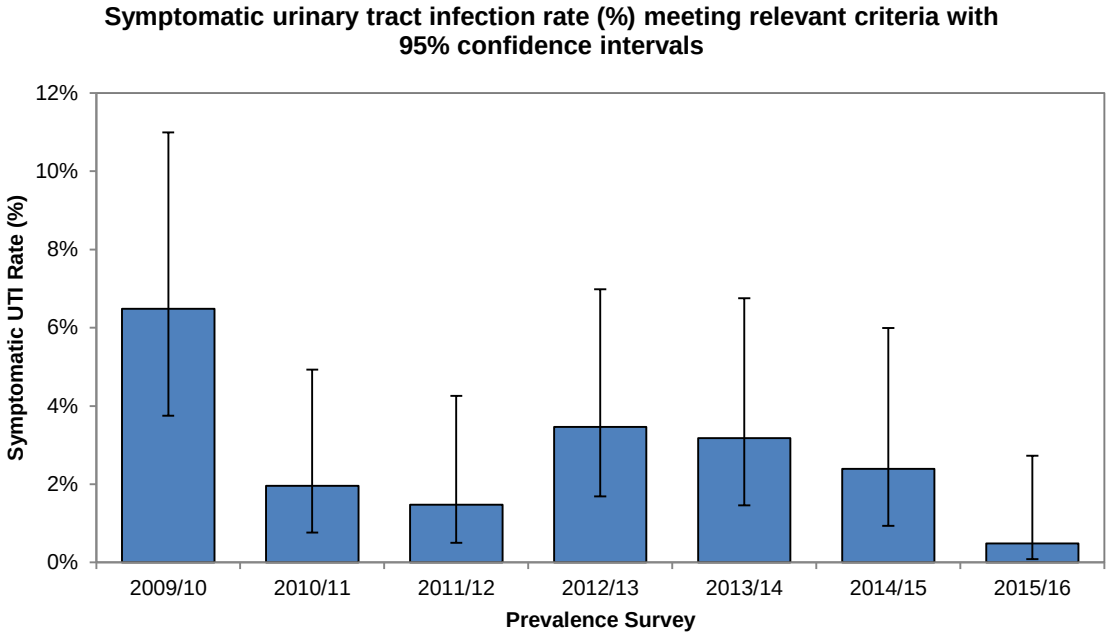
Cleaning and the management of cleaning across the trust continue to cause concern. The lack of consistency is scoring across the Trust requires that in order to have some assurance of the standards the IPC and performance teams are undertaking frequent audits. However rather than providing assurance, this is causing some confusion. The Maximiser audit carried out by ISS is the standard that is managed contractually. This is a quality assurance audit to assure the Trust that the cleaning staff are performing against national cleaning standards. The Infection control nurses association (ICNA) audit takes a snapshot view a risk assessment approach to understand the risks of transmission of organisms and is undertaken at any point in time. A team is working to amalgamate both audits to reduce confusion and increase compliance and team working.

10. Catheter group.

The catheter group now meets bi monthly in an attempt to improve attendance. The community continence team invited the group to alternate the venue between UHCW and the community. The group identified and issue involving patients who were discharged with a catheter who require a trial without catheter (TWOC) Patients were requested to attend ED if there were any issues with the catheter while waiting for their TWOC. The community continence team are now working on improving patient care by ensuring that patients experiencing problems with their catheter can be seen in the community rather that attending ED. The continence nurse specialist continues to target education around improving catheter care, utilising the monthly saving lives data. The continence specialist is also working on finalising a trust bladder scan guideline and continues to provide and education and support around bladder scanning.

The Infection Prevention and Control team continue to undertake yearly Catheter associated urinary tract infection (CAUTI) prevalence audits which has shown year on year improvements. Figure 10

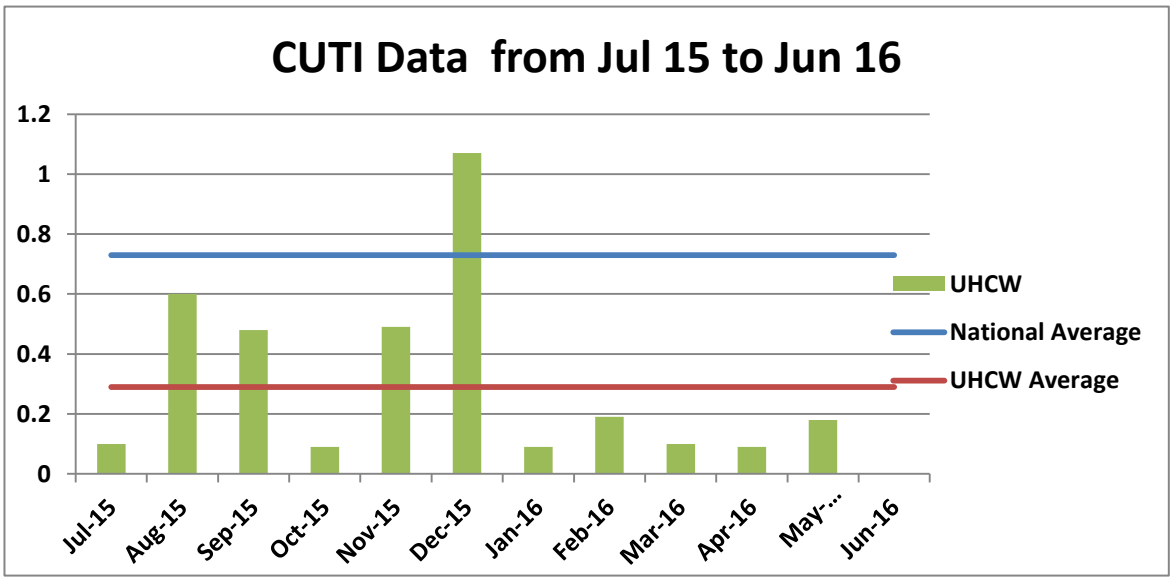
Figure 10



Satiety Thermometer

UHCW continues to perform well against the national average for catheter associated urinary tract infections (CAUTI) in the National data reporting for the Satiety Thermometer.

Figure 11



11. Hand Hygiene

The hand Hygiene figures below are based on the tradition of compliance with the Ayliffe technique using the UV glow box. Figure 12 illustrates the compliance of various groups. This gives a trust compliance of 92%

Figure 12

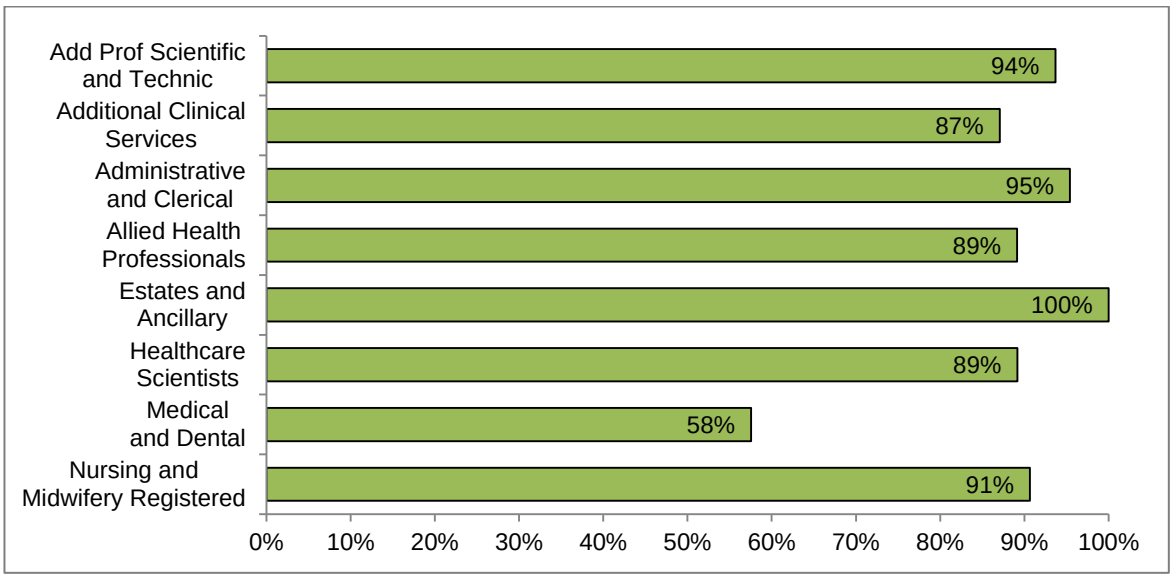


Table 4.

Hand Hygiene over all compliance	Trust compliance.
Hand Hygiene Clinical - Annual	**86.72%**
Hand Hygiene Non Clinical - Initial	**96.53%**

Whilst this is the traditional method of reporting hand hygiene data, it fails to answer whether or not this is appropriately applied in practice. It indicates a need for more training to achieve 95% , it does not however inform us how staff use this knowledge in practice to reduce transmission and harm to patients.

The WHO five moments bundle seeks to identify key opportunities for hand hygiene to prevent transmission. However this is often difficult for staff to translate into practice within their areas, the data needs to be meaningful to them.

Dr Dawson is leading on a innovative piece of work at UHCW based on a four year doctoral thesis to produce meaningful data. This work will identify individualised areas for education and improvement, allowing each ward to effectively analyse and change their behaviour. We are coming to the end of a year long trial which is producing valuable data. The hope is that we can begin using this data as our primary measure for hand hygiene. A paper has been published following phase one and there has been a lot of interest generated nationally.

12. UHCW IPCT Research Publication and Presentation Highlights 2015-2016

- Successful attendance at the national Infection Prevention Society conference, with 5 abstracts submitted and accepted. Highlights included being selected to orally present our work on catheter care, and winning the best poster prize for our work on reducing Clostridium difficile. **October 2015**
- Protect and Connect Trust wide hand hygiene survey completed, with results to be shared in autumn 2016. **April 2016**
- Invited to publish our work on catheter care by Journal of Infection Prevention – paper submitted and under review. **April 2016**
- Innovative work on personal protective equipment educational tool (PPE Wheel) completed – prototype ready for trial during summer/autumn 2016. **May 2016**
- First phase of 2-year “Urgh Factor” research project on hand hygiene behaviour completed. **June 2016**
- Two research abstracts submitted to national Infection Prevention Society conference (under review). **June 2016**
- Continued involvement with the Dyson School of design engineering at Imperial College London. Dr Carolyn Dawson to consult as part of an exercise utilising morphological analysis to solve complex problems in this case Hand Hygiene measurement. This was presented at conference in Nottingham as part of the solving complex problems Human factors conference **May 2016.**

11. Conclusion.

The IPC team are focusing on leadership skills and have reorganised the team to incorporate a more tiered structure: band 7 staff will have responsibility for band 6 staff and all team members are being supported to attend leadership courses.

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

Appendix 1

Trust	Trust-assigned MRSA rate per 100,000 occupied bed days	Trust-apportioned MSSA rate per 100,000 occupied bed days	Trust-apportioned rate *Clostridium difficile* rate per 100,000 occupied bed days	MRSA Z score	MSSA Z score	CDI Z score	Average Z Score
University Hospitals Coventry And Warwickshire NHS Trust	0.00	5.75	9.93	-1.779	-1.782	-2.614	-2.058
University Hospitals Of Leicester NHS Trust	0.20	4.91	11.97	-1.490	-2.849	-1.725	-2.021
Salford Royal NHS Foundation Trust	0.00	7.29	6.01	-1.100	-0.449	-3.876	-1.808
Chelsea And Westminster Hospital NHS Foundation Trust	0.41	5.29	7.73	-0.311	-1.649	-3.098	-1.686
University Hospital Southampton NHS Foundation Trust	0.79	7.37	9.73	0.000	-0.601	-2.715	-1.105
Norfolk And Norwich University Hospitals NHS Foundation Trust	0.58	4.32	16.11	-0.182	-2.764	0.505	-0.813
St George's University Hospitals NHS Foundation Trust	0.91	10.95	8.82	0.000	1.455	-3.006	-0.517
Oxford University Hospitals NHS Foundation Trust	0.93	6.77	14.23	0.000	-1.103	-0.305	-0.469
Royal Liverpool And Broadgreen University Hospitals NHS Trust	0.75	9.70	10.82	0.000	0.640	-1.727	-0.362
Cambridge University Hospitals NHS Foundation Trust	0.63	6.32	16.75	-0.023	-1.205	0.765	-0.155
Hull And East Yorkshire Hospitals NHS Trust	0.57	10.60	13.17	-0.189	1.292	-0.783	0.106
Brighton And Sussex University Hospitals NHS Trust	0.35	7.69	17.84	-0.531	-0.290	1.174	0.118
Guy's And St Thomas' NHS Foundation Trust	0.61	9.99	15.44	-0.095	0.897	0.179	0.327
Royal Free London NHS Foundation Trust	0.93	5.87	21.02	0.000	-1.529	2.614	0.362
Wirral University Teaching Hospital NHS Foundation Trust	0.84	6.73	20.19	0.000	-0.773	1.930	0.386
King's College Hospital NHS Foundation Trust	0.88	7.72	18.09	0.000	-0.409	1.632	0.407
Sheffield Teaching Hospitals NHS Foundation Trust	0.00	13.54	14.66	-2.309	3.693	-0.100	0.428
University Hospital Of South Manchester NHS Foundation Trust	1.19	11.89	14.27	0.339	1.725	-0.175	0.630
Lancashire Teaching Hospitals NHS Foundation Trust	1.01	9.06	19.12	0.075	0.309	1.735	0.706
University Hospitals Bristol NHS Foundation Trust	1.18	11.84	15.78	0.333	1.704	0.285	0.774
University Hospitals Birmingham NHS Foundation Trust	2.13	10.14	17.61	2.117	1.057	1.251	1.475
Bradford Teaching Hospitals NHS Foundation Trust	2.84	12.48	17.58	2.073	1.658	0.816	1.515
South Tees Hospitals NHS Foundation Trust	0.66	12.83	20.07	0.000	2.405	2.147	1.517
Central Manchester University Hospitals NHS Foundation Trust	1.23	13.57	16.53	0.614	3.233	0.765	1.537
Imperial College Healthcare NHS Trust	2.01	8.89	20.94	1.840	0.241	2.682	1.588
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	1.03	17.16	19.44	0.255	5.764	2.400	2.806
Leeds Teaching Hospitals NHS Trust	1.21	11.79	24.10	0.740	2.587	5.180	2.835
University College London Hospitals NHS Foundation Trust	0.79	11.88	36.44	0.000	1.722	7.404	3.042
Nottingham University Hospitals NHS Trust	1.16	20.53	18.40	0.571	7.961	1.919	3.484

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

University Hospitals Coventry and Warwickshire NHS Trust

IC TRUST BOARD PAPER

Title	Medical Revalidation and Appraisal Six Monthly Update
Author	Miss Louise Siddall, Medical Revalidation Support Officer
Responsible Chief Officer	Professor Meghana Pandit, Chief Medical Officer and Deputy CEO
Date	28th July 2016

1. Purpose

This report provides an update on Medical Appraisal and Revalidation within the Trust, confirming the actions taken to date and developments since the report to Board of July 2015. This report is provided for assurance purposes.

2. Background and Links to Previous Papers

Medical revalidation was confirmed as a statutory requirement, by the Secretary of State for Health, on the 3rd December 2012; and was introduced nationwide and in Trust from April 2013. Its purpose is to demonstrate that licensed doctors are up-to-date and fit to practice.

The Trust is regarded as a Designated Body (DB), and all DB's have a statutory duty to support their Responsible Officers (RO) in discharging their duties under the RO Regulations[1]. It is expected that Trust Boards and Executive Management Teams will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- ensuring that appropriate pre-employment checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

This paper follows the last report to the Trusts Board in February 2016 and hence forth will be an annual update rather than biannual update.

3. Narrative

3.1 Medical Appraisal Performance Data

Annual appraisal is the foundation of medical revalidation with a recommendation based primarily on satisfactory appraisal outcomes and patient and colleague multisource

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

feedback. Appraisal for revalidation should support doctors in reflecting on their practice and improving the quality of care they provide.

The Trust has to provide NHS England with assurance of its appraisal rates on a quarterly basis. Data reported below for the appraisal year 1st April 2015 - 31st March 2016 reflects those who have successfully completed an appraisal or where the RO accepts that postponement was reasonable:

- Quarter 1 – 86%
- Quarter 2 – 75%
- Quarter 3 – 81%
- Quarter 4 – 90%

For the last quarter (1st January – 31st March 2016) 217 appraisals were due, 119 doctors did not hold an appraisal meeting in this period. 14 had a valid reason for postponement (e.g. sick leave, maternity, etc.) 53 were still within the 15 month window and 8 have since left the Trust. Overall 423 appraisals were completed this year meaning compliance was at 83%.

All doctors with outstanding appraisals (between 12-15months) are written to at the end of each quarter to remind them of their contractual and professional obligation to participate in annual appraisal. They are instructed to complete an appraisal before the end of the following quarter or to contact a member of the Revalidation Team should they be experiencing difficulty.

Where doctors fail to comply, a GMC early concerns letter is requested from the GMC. There are currently 3 ongoing GMC concerns issued to doctors with appraisals breaching 15-18 months. The letter details the risk the doctor poses to their license to practice should they continue to fail to engage with appraisal along with a date by which they must engage.

3.2 Appraisers

The last appraiser training session was delivered on 24th June 2016 ensuring the Trust currently has 110 trained appraisers.

The Medical Revalidation Appraiser training programme continues to run every 6-months to ensure the appraiser to appraisee ratio is maintained and to give colleagues the opportunity to become a medical appraiser.The last Appraiser Support Group (ASG) was delivered in February 2016.

3.3 Revalidation Recommendations

At the time of submitting this report the Trust has 596 prescribed connections, for which the RO is responsible.

To date 521 recommendations have been submitted to the General Medical Council (GMC) for these connections.

465 recommendations to revalidate have been issued and accepted.

56 deferrals have been requested to date, with 4 of these during this 6 month period due to insufficient evidence to inform a recommendation to revalidate. 2 of the 4 have since been recommended for revalidation.

3.3 Educational Appraisals

Medical Education and the Revalidation Team have worked together to ensure that over 200 doctors in the Trust have now obtained accredited Educational or Clinical Supervisor status.

RMS providers Equiniti 360 Clinical are yet to update the system to the deliver a report on Educational Appraisal completion which was originally requested in a meeting with them on 28th January 2016.

It is hoped with the introduction of such a report function, along with the continued education of medical staff regarding the use of RMS for educational appraisal, will make the process of assurance quicker, easier and more robust.

3.5 NHS England Visit

Representatives from NHS England Regional Medical Directorate (Midlands & East) visited the Trust on 4th March 2016 to undertake independent verification of the processes that support Medical Revalidation within UHCW.

The visiting team's agenda included meetings with the Responsible Officer, Revalidation Lead, Medical Revalidation Support Officer, selected appraisers and appraisees and representatives from the Human Resources (HR) team.

The feedback report from this visit can be found in Enclosure A.

On the whole NHS England were satisfied with the processes in place at the trust stating the content of existing policies and procedures were up to standard. Further to this they noted good practice in the issuing of a personal letter from the RO to all doctors regarding revalidation recommendations.

Nevertheless, the Trust has been requested to implement a few minor amendments and additions to the medical appraisal policy and confirm with Equiniti an update of the RMS.

In addition it was recommended that the Trust review the first three appraisals of any new appraiser and provide feedback to them regarding this.

These points have been added to the Trusts Action Plan (Enclosure B), with NHS England requiring a progress update by 31st August 2016**.**

3.6. Annual Organisational Audit (AOA)

The AOA provides a tool to assist RO's in assuring themselves and their Boards that the systems underpinning the recommendations they make, arrangements for medical appraisal and responding to concerns, are in place.

The Trust submitted its third AOA in May 2016. Unfortunately we were again required to answer unfavourably to statement 2.2 – 'Every doctor with a missed or incomplete medical appraisal has an explanation recorded'

The introduction of the appraisal postponement process in the Medical Appraisal Policy in March 2015 has yet to glean results. Further education of the medical staffing body has been provided in the last quarterly revalidation update in May to ensure this form is utilised.

To assist in the process of obtaining sufficient reasons for appraisal postponement for doctors who are unable to complete the form e.g. those on long-term sick and maternity leave there is a need for the MRSO to be provided with HR records.

3.7 Other news

There is a need to reconcile the RMS with ESR to ensure KPI figures reported are correct. System are not linked which contributes to disparity in data reported on medical appraisal compliance.
In line with the Medical Appraisal Policy the current process for updating appraisal compliance on ESR is for doctors to inform their Group Managers an appraisal has taken place. However this is likely not occurring. Therefore the MRSO has initiated monthly reports to Clinical Directors and Group Managers of completed appraisal to enable them to update ESR appropriately.
Work is also ongoing with the PPMO and will in turn lead to consultation with Workforce Information to rectify this situation.

3.8 Summary

The Trust has made progress in ensuring that the appropriate infrastructure is in place to support revalidation. There will remain a need to ensure principles and processes are fully embedded across the Trust in order to constantly drive up appraisal rates. This will continue to be facilitated by the CMO as RO supported by the Revalidation Team.

4.**Areas of Risk**

Risk arises out of failing to comply with RO regulations and GMC/NHS England requirements, which could impact negatively on patient safety as well as the Trust's reputation. In order to mitigate the risk it is imperative to ensure commitment to revalidation, rather than compliance, is established across the Trust. This can be achieved with ongoing education.

4. Governance

Revalidation is a statutory obligation with which the Trust must comply. It is also a core element of the Quality Governance Agenda. It is for this reason that reports are made to Trust Board in order to assure members requirements are being met and that governance arrangements are robust.

5. Responsibility

The Revalidation Team is responsible for the implementation and monitoring of the processes that support revalidation. This consists of the following:

- Professor Meghana Pandit, Chief Medical Officer and Responsible Officer
- Dr Mike Iredale, Deputy CMO and Revalidation Lead
- Dr Mathew Patteril, Consultant Anesthetist and Deputy Revalidation Lead
- Louise Siddall, Medical Revalidation Support Officer

7. Recommendations

The Trust Board is asked to **NOTE** the report along with progress made against the action plan to date (Enclosure B) and to **RAISE** any queries or concerns.

The Board is also asked to **APPROVE** any additions to the action plan at Enclosure B and **APPROVE** the 'Statement of Compliance' (Enclosure C) confirming that the Trust as a designated body is compliant with regulations.

Enclosures

Enclosure A – Independent Verification Visit Report

Enclosure B - Action Plan

Enclosure C – Statement of Compliance

Name and Title of Author: Miss Louise Siddall, Medical Revalidation Support Officer

University Hospitals Coventry and Warwickshire NHS Trust

NHS England
Midlands and East

INDEPENDENT VERIFICATION VISIT REPORT

University Hospitals Coventry and Warwickshire NHS Foundation Trust
(UHCW) 4th March 2016

Purpose of Visit

The visit was undertaken following assessment of the organisation's Annual Organisational Audit (AOA) report which outlines the organisations overall position with regard to appraisal and revalidation. The report highlighted that the Trust had a higher than average unapproved, incomplete or missed appraisal rate of 17.2% compared to 8.5% for the same sector. The Trust had also answered no to two questions in the AOA related to no explanations for missed appraisals and no process for obtaining information at employment stage.

NHS England was provided with the following documents prior to the visit:

- Medical revalidation and Appraisal Six Monthly Update Board Report
- Conduct and Capability Concerns in Relation to Medical and Dental Staff V7.0
- Medical Re-Skilling, Rehabilitation & Remediation Policy V1.0
- Medical Appraisal Policy – V2.0

Attendees

University Hospitals Coventry and Warwickshire NHS Foundation Trust
Professor Meghana Pandit, Deputy CEO and Chief Medical Officer Dr Mike Iredale, Deputy CMO & Revalidation Lead
Dr Mathew Patteril, Deputy Revalidation Lead
Wendy Bowes Associate Director of Workforce
Nick Rees, Medical Resourcing Manager
Louise Siddall, Medical Revalidation Support Officer (MRSO)

NHS England, Midlands and East
Chris Parsons, Programme Manager – Revalidation
Soulla Stylianou, Revalidation Project Support Officer

Summary of Findings

University Hospitals Coventry and Warwickshire NHS Foundation Trust (UHCW) is one of the country's largest teaching hospitals and Trusts in the country serving Coventry and Warwickshire across its two sites in Coventry and Rugby. UHCW is also forging links with George Elliott Hospital in Nuneaton and is partnering with the Virginia Mason Institute to apply lean methodology to the healthcare offered at the Trust.

The Responsible Officer Professor Meghana Pandit, is also Medical Director and Deputy CEO, welcomed the visit seeing it as an opportunity to discuss the hospital's current position with regards to appraisal and revalidation. We were content that existing policies and procedures for appraisal and revalidation in general met requirements although some improvements to the medical appraisal policy were suggested along with providing feedback to appraisers.

Responsible Officer

Prescribed Connections: 542
Time Spent in Role: The Responsible Officer had no specific time allocated for the role.
Support/Resources: Appraisal and revalidation activities are carried out by the Responsible Officer supported by the Revalidation Lead, Deputy Revalidation Lead and the Medical Revalidation Support Officer (MRSO). The daily activities around appraisal and revalidation are managed by the full time MRSO who now has some additional administrative support.
Management Arrangements
For the purposes of appraisal and revalidation the Revalidation Lead and Deputy Revalidation Lead report to the Responsible Officer, these posts sit within the Medical Directorate. The MRSO sits within the Governance department and is wholly focused on medical appraisal and revalidation work.

Governance

RO Board Member: The Responsible Officer is a member of the board and presents biannual reports. The Responsible Officer chairs the fortnightly medical concerns meeting. The quality group, chief officer group and patient safety committee all play a role in governance and quality.

AOA, Statement of Compliance, Quarterly Returns: These are submitted by the Responsible Officer. The Trust complies with its obligations around NHS England's Framework for Quality Assurance, in that it completes and submits quarterly reports, Medical Revalidation AOA and Statement of Compliance returns in a timely manner.

Policy Review Process: Medical appraisal and revalidation policy documents are prepared by the MRSO in consultation with the Responsible Officer. The policies are reviewed and updated every three years. They are submitted to the medical negotiating committee and are formally approved by the corporate business records committee. They are not currently ratified at board level.

Appraisal

Policy: We were content the medical appraisal policy met requirements for current processes and procedures. We recommend some minor changes including: adding a scope of access statement; and clarifying that an appraisal should be carried out every twelve months any other period is by exception. We would also suggest that the Trust considers an appraisal window of April to December to allow the revalidation team more time to scrutinise appraisals and carry out training based on themes/issues identified through these reviews. We were advised that the Trust reviews other policies concurrently with the medical appraisal policy to ensure consistency and this was considered good practice. A scope of access statement was advised to ensure there is clarity around who may have access to appraisal documentation.

Appraisal System: The MRSO administers the appraisal and revalidation process via the Equiniti proprietary software system which includes multisource feedback capability. There is an issue with the anniversary appraisal date and there are some difficulties policing instances where delays occur and these issues are being discussed with Equiniti. System issues are contributing to the reporting of lower completion rates.

Currently doctors choose their appraiser and update the appraisal system. The system does instigate notifications but it is understood these are largely ignored by medics and as a result the MRSO also sends out reminders every quarter based on information extracted from the electronic system. Any ongoing non-engagement following intervention from the Revalidation Lead will incur a GMC REV 6 being issued. It is understood the MRSO also keeps track of appraisal and revalidation dates using a spreadsheet. Again these issues are contributing to the low report rates and the difficulty in keeping records. Work is ongoing toward rectifying this situation.

The Trust will appraise long term locums who have worked at the Trust for more than six months if they have a clearly demonstrated connection.

Appraisal Format: Medical Appraisal Guide via the electronic appraisal system.
Appraiser Numbers: The Trust currently has 96 appraisers indicating a ratio of 1:6. The medical appraisal policy however does not specify the minimum and maximum number of appraisals an appraiser can perform. The visiting team suggests the medical appraisal policy specifies the minimum and maximum number of appraisals an appraiser should conduct and review the number available and their distribution. Appraisers are not paid and are expected to perform appraisals within their admin PA time.
Appraiser Training: All new appraisers receive training before undertaking the role and UHCW refreshes appraiser training every three years. The Trust recently conducted top-up training for existing appraisers as well as training new appraisers. The visiting team suggested that UHCW considers quality assuring the first three appraisals of any new appraiser. Quarterly appraiser support group meetings have been instigated although they are not compulsory and it was suggested that the Trust considers making it mandatory to attend at least one of these meetings per annum to remain an appraiser.
Appraiser Support: Support is provided by the MRSO, together with the Revalidation Lead for appraisal specific advice.
Appraiser Feedback: Appraisers will receive anonymised scoring of appraisee feedback from the electronic appraisal system if more than three feedback reports have been received. Some generic feedback is given to all appraisers at the appraiser support group. We discussed providing personalised anonymised feedback to appraisers to help them develop their skills and it is understood that it is the intention of the Revalidation Lead to do this as part of their quality assurance process.
Appraisee Support: Support is mainly provided by the MRSO, and the Trust does provide some training on the electronic appraisal system if required. The visiting team suggested that the Trust consider including a refresher on appraisal and revalidation requirements as part of the induction programme for doctors.
Quality Assurance Process: The Trust's quality assurance process is robust with the Revalidation Lead and MRSO quality assuring 10% of appraisals each quarter against a checklist adapted from an NHS England template. The Revalidation Lead intends to use the outputs to identify themes/issues and to address development needs of both appraisees and appraisers.

Revalidation
The revalidation recommendation process is undertaken by the Responsible Officer with direct support from the MRSO. The Responsible Officer holds regular meetings with the MRSO to discuss revalidation recommendations, any delayed appraisals and the need for deferrals. The Responsible Officer reviews all documentation in relation to revalidation having been collated by the MRSO beforehand. The Responsible Officer will write to every doctor informing them of the recommendation decision, including any deferral. The Responsible Officer will also write to every appraiser if there has been a need to return an appraisal due to lack of evidence or insufficient/missing information.

The GMC Connect account is managed by the Responsible Officer although both the Revalidation Lead and MRSO have access to the system, as do two other individuals within governance. We would recommend that a scheme of delegation is written to reflect access to the account for the management of prescribed connections and the issue of recommendations.

Responding to Concerns
Policy: The Trust has a good Conduct and Capability Concerns in Relation to Medical and Dental Staff policy outlining the procedure for raising and investigating concerns. This policy follows and implements the framework set out in Maintaining High Professional Standards

Remediation Policy: The Trust has a good medical reskilling/ remediation policy in place which is based on NCAS' "Back on Track" document. There are three case managers with training provided by NCAS, external solicitors or in-house and sixteen case investigators who have been trained internally. The Trust intends to refresh case investigator training to ensure skills are maintained, and the visiting team recommended that any internal/external investigator training reflects NCAS standards. The Trust has two ongoing cases at present.

Compliments, Complaints and Incidents Information: Although it is seen as the doctor's responsibility to collect the relevant supporting information of compliments and complaints for their appraisal, the Trust does collate the information on their behalf. The Trust uses the Datix system and the MRSO will populate the relevant information onto the electronic appraisal system at the appropriate time.

Sharing Information

MPIT used: Yes. The MPIT form is being used**.** The Responsible Officer confirmed that the MPIT process was not used at the pre-employment stage, and it was suggested that policy documentation is revised to reinforce this position.

Pre-employment checks: There is a centralised recruitment service, with recruitment via NHS Jobs, and standard NHS checks are undertaken. The Trust uses a recruitment checklist and HPANs are verified as part of this process, and details are also confirmed via the GMC website. Scope of practice, appraisal or revalidation date information is not currently requested as part of the employment process, although this will be considered. The requirement for information regarding current Responsible Officer has been included in checklists. The visiting team suggested that obtaining appraisal and revalidation information at the time of joining was an effective measure.

UHCW has a centralised procurement/staffing service and mainly uses agencies on the HealthTrust Europe or Crown Commercial Service approved framework lists. It is expected that agencies carry out the relevant checks on their locums but UHCW also carries out checks. The Trust's centralised service for booking/checking locums is open every day between the hours of 8am and 8pm. All agencies must provide photo ID's of any locums they are sending to the Trust. UHCW will submit exit reports to the agencies for any locums where there have been issues.

Appraiser/Doctor Interviews

The visiting team interviewed a panel of two doctors and two appraisers. All believed the appraisal system was helpful providing an opportunity to reflect and consider future development although some felt it was just another layer of bureaucracy. One appraiser had been to the support group meetings and both had received the recent top up training. The appraisers did not know whether there was any quality assurance process of their appraisals but would appreciate personal feedback so they could improve. One appraiser knew there was some feedback on the appraisal system but didn't know how to retrieve it. Appraisers tended to seek help from the Revalidation Lead if they had a difficult appraisal or talk to their peers. Doctors were unsure of their appraisal month and believed they did not receive any reminders or alerts that their appraisal was due. One doctor did mention their mandatory training matrix on ESR flagging orange as the only indication. Both doctors preferred to be appraised in speciality. One had been appraised out of speciality but reflected that it was not as constructive.

Doctors had ample time to prepare but commented the electronic appraisal system lengthened the process and was very time consuming. Appraisers spent at least one and a half hours to prepare for an appraisal plus another two hours for the meeting. Doctors confirmed that information regarding complaints and compliments was provided. One had to ask for the information and the other believed the information uploaded onto the system was inaccurate. There was a discussion with both the appraisees and the appraisers regarding scope of practice

and there was some confusion as what should be declared. Both doctors and appraisers would ask either the MRSO for support or their appraiser and peer group.

Good Practice
The Trust has in place a well-resourced and dedicated team providing support to the Responsible Officer. The use of photo ID to identify locums is excellent, and the central reporting office exemplar. The Responsible Officer's personal letter to all doctors regarding revalidation decisions is good practice. The Visiting Team recognises the intention to provide personalised feedback to appraisers and to improve the quality of appraisals.

Actions:

- Review and amend the medical appraisal policy to reflect changes discussed during our visit and highlighted in this report. Include a scope of access statement and a scheme of delegation to define access to and actions on GMC Connect.
  Please provide an update by 31 August 2016
- Confirm Equiniti update their systems to reflect new MAG form content especially around probity and insurance.

Please provide an update by 31 August 2016

Recommendations:

- Consider reviewing first three appraisals of any new appraiser and providing feedback
  Please provide an update by 31 August 2016

NHS England Revalidation Team
Midlands and East

No.	Issue	Action	Timescale	Responsible	Assurance	Progress/Outcome
1.	Compliance with training for RMS.	Continue to communicate the requirement to participate and possible repercussions of failure to engage. Escalation to non-engagement if deemed appropriate.	Ongoing	Revalidation Team & CD's/GM's	All doctors who have been in the Trust for more than 6 weeks have active accounts on RMS.	List obtained from workforce each month
2.	Medical Appraisal Policy up-to-date and relevant	Update the policy to reflect issues raised by Internal audit and remain in line with NHS England's Medical Appraisal Policy	March 2016	MRSO reviewed by Revalidation Lead	Uploaded on eLibrary following approval from Medical Negotiating Committee and Corporate Business Records Committee.	Complete -Registered on eLibrary
		Review and amend to reflect changes outlined in NHS England feedback report	31 August 2016		Uploaded on eLibrary following approval from Medical Negotiating Committee and Corporate Business Records Committee.	New action
3.	Quality Assurance of Appraisers	**a.** Appraiser Support Group (ASG) set up to provide support, the opportunity to share experiences and calibrate appraisals.	Quarterly	Revalidation Lead & Deputy Revalidation Lead	Meetings scheduled and communicated out to appraisers.	Complete – two sessions held. Scheduled to run on quarterly basis. Next date 22/02/16
		b. Develop and implement in-house training for 'revalidation – ready' medical appraisers. To ensure the continued supply of quality trained medical appraisers	September 2014	Revalidation Team assisted by Learning and Development Team (LDT)	Registered with LDT to allow course promotion & booking via ESR. Certified by NHS England/GMC and registered for CPD points.	Ongoing - Three sessions delivered. Still awaiting certification and registration along with registration on ESR
		c. Develop a refresher training course for previously trained	December 2015	Revalidation Team assisted by LDT	All those trained in November 2012 recorded as having completed	Completed on the following dates: - 07/09/15

		medical appraisers			refresher training. Certified by NHS England/GMC and registered for CPD points.	- 02/10/15 - 21/10/15 - 06/11/15 - 20/22/15
		d. Review the first three appraisals completed by new appraisers and provide feedback.	March 2017	Revalidation Team	Those appraisers originally trained on 22/01/16 & 24/06/16 who have facilitated 3+ appraisal have received feedback on their performance.	New Action
4.	Quality Assurance of Appraisals	**a.** Compile Qualitative Assessments of appraisals into a report and share the outcomes with appraisers in order to improve quality of appraisal inputs & outputs	Quarterly	MRSO	Presentation delivered in ASG	Complete: reported to ASG in September 2015 and Appraiser Top-up Training sessions
		b. Utilisation of the RMS report functions to monitor supporting information and appraisal outputs	Ongoing	MRSO	Monitoring of system and advanced reporting functions reviewed. The outcomes will be included in future reports to board and used to inform ASG's.	Ongoing
5.	Process for acquisition/sharing of up-to-date information on prescribed connections internally and externally	Ensure the MPIT is included in pre-employment checks to establish prescribed connections in a timely manner. Inclusion of a HR member of staff in Revalidation Team Meetings (RTM)	February 2015	Revalidation Team & HR Director	Action plans. Acquisition of relevant info by MRSO prior to employee starting contract rather than in retrospect.	Complete: following intervention from CMO & CWIO MPIT was as of 01/08/15
6.	Audit of missed or incomplete appraisals and escalation of those who are non-compliant	With use of RMS, implement a robust process of gaining assurance from individuals who appear to be falling behind in the revalidation process. Utilise GMC early concerns	Ongoing	MRSO supported by Revalidation Team	Record of reasons and more accurate data to present to board along with figures for next AOA.	Update of the RMS now issues warnings and logs late appraisals. Inclusion of appraisal postponement process in Medical Appraisal Policy.

		process (REV 6)				GMC concerns process has been used on four separate occasions for doctors.
		Obtain sickness and maternity information from HR to ensure valid reasons for appraisal postponement are logged	August 2016	Revalidation Team & HR Director	More accurate figures for Quarterly Appraisal Reports to NHS England	New Action
7.	Lack of reflection shown in appraisal	Guidance developed on how to reflect for doctors follow. Workshops.	2015 QA of appraisals	Revalidation Team	Number of doctors shown to be reflecting increases during appraisal year 2015/2016 QA's	QA undertaken 15/07/15 24/11/15
8.	Need for MRSO procedures to be backed-up	Development of Strategic Operating Procedures (SOPs) and hiring of additional administrative support (latter already agreed under the Quality Strategy)	February 2016	MRSO	SOP's Approved by Associate Director of Governance	Band 3 Senior Administrator trained to provide supporting information to doctors. SOPs still to be ratified.
9.	Adherence to NHS England's FQA Core Standards	Review systems and processes against NHS England's FQA core standards	February 2016	MRSO	Report of gap analysis and update of action plan.	NHSE Visit on 4/3/2016
10.	Educational Appraisals	Ensure all Educational and Clinical supervisors have completed an appropriate educational appraisal	July 2016	Revalidation Team & Associate Director of Medical Education	Fully registered pool of Educational and Clinical Supervisors	200 accredited Educational and Clinical Supervisors
12.	Update of Revalidation Management System	Confirm Equiniti will be updating RMS to reflect new MAG form and Educational Appraisal Report function.	August 2016	MRSO	Date by when update is likely to be rolled out obtained in writing.	New Action

Designated Body Statement of Compliance

The ***Board*** of ***University Hospitals Coventry and Warwickshire, NHS Trust*** has carried out and submitted an Annual Organisational Audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

Professor Meghana Pandit completed all modules of RO training in 2012 and continues to regularly attend required quota of RO Networks.

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

The MRSO keeps an accurate record using starter and leaver information provided by HR on a monthly basis. This will be better achieved with the introduction of the MPIT form into pre-employment checks

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

UHCW currently has 110 trained appraisers. The ratio of revalidation ready appraisers to doctors in the Trust is 1:6. A value between 1:5 and 1:20 is deemed sufficient under NHS England guidelines. *The Trust has successfully delivered 5 new appraiser training sessions and 5 top-up training sessions to ensure a sufficient ratio is maintained.*

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

The Trust has delivered three Appraiser Support Groups. These sessions will continue to run on a quarterly basis to develop and support the appraiser body. It will be written into policy about the quota appraisers must attend.

5. All licensed medical practitioners either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

An appraisal postponement form has been introduced with the reviewed Medical appraisal policy in March 2015. Where this form is not used and suitable reasons for appraisal postponement not given prescribed connections are written to at the end of every quarter to determine explanations for not completing appraisal. Where engagement is not forthcoming and a suitable explanation not gleaned the GMC REV6 Early Concerns form is utilised.

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

There is now a process in place for providing information to on significant incidents, complaints and Quality Improvement and Patient Safety meeting attendance directly into doctors' appraisal portfolios.

Mandatory training is logged on ESR and is therefore readily accessible to individuals.

Clinical outcomes data is available on the Trust intranet via the Opera Theatre log and Consultant information pack.

Equiniti 360 Clinical are the Trusts providers of multi-source feedback and any doctor requiring an assessment are registered accordingly by the MRSO. Once an assessment is complete it is the responsibility of the facilitator to provide a copy of the report to the appraisee

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

There is a 'Conduct and Capability Concerns in Relation to Medical and Dental Staff Procedure' in place which is in line with national framework "Maintaining High Professional Standards in the Modern NHS".

The procedure provides comprehensive steps and principles for dealing with concerns raised regarding doctors and dentists, to enable prompt and appropriate action to be taken in the interests of patients, staff and the practitioner.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

The Medical Practice Information Transfer (MPIT) form was implemented in pre-employment checks on 1st August 2015.

Where doctors leave employment with UHCW the MRSO is tasked with the transfer of information. This is currently only provided if requested by the new employing organisation as leavers information provided by HR does not specify the name of new employing organisation.

Further discussion and resources need providing to meet this standard fully.

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licensed medical practitioners have qualifications and experience appropriate to the work performed; and

Medical staffing undertakes all pre-employment checks prior to issuing a contract of employment.

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Yes - Please see Trust Board Report 28.07.16 Agenda item 15 Enclosure 11B

Signed on behalf of the designated body

Name: *Mr Andrew Meehan* Signed: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

[Chairman]

Name: *Mr Andrew Hardy* Signed: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

[Chief Executive]

Date: *28th July 2016*

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Mortality Performance Report – Financial Year 2015/2016**
Author	**Kathy Walker, Mortality Review Facilitator**
Responsible Chief Officer	**Meghana Pandit, Chief Medical and Quality Officer / Deputy CEO**
Date	**28 July 2016**

1. Purpose

The purpose of this paper is to provide an overview of Trust-level mortality data and performance available for the financial year 2015/2016, providing assurance that any highlighted concerns are investigated thoroughly and appropriate action is taken.

2. Background and Links to Previous Papers

Investigating and reporting mortality data enables the Trust to identify ways to improve patient safety and patient outcomes.

3. Narrative

Mortality Review

- The completion rate for primary mortality reviews for 2015/2016 is 96.27%,
- There have been no NCEPOD E deaths since April 2016.

The Trust reviews the care of every patient over the age of 18 who dies whilst in its hospitals. This is referred to as a 'primary mortality review'. During primary mortality reviews, the care received by the patient is graded between A and E – A being "good standard of care", and E meaning "less than satisfactory care". This helps to provide an indication where further investigation may be needed to identify improvements in care.

High completion rates for primary mortality reviews highlight excellent engagement with clinical staff with the mortality review process. 91% of completed primary reviews during 2015/2016 received an NCEPOD grade A highlighting good standards of patient care.

All primary reviews graded B-E have a further 'secondary mortality review'; these are discussed at specialty mortality and patient safety meetings to share the learning and improve patient care. There have been 184 identified opportunities for learning from deaths in 2015/2016, 16% which have been re-graded to NCEPOD A (good care) after a multidisciplinary review (22 cases). The number of NCEPOD E's deaths identified during 2015/2016 is 6, which is a 75% reduction compared to the previous financial year.

Mortality indicators: HSMR and SHMI

- The Trust HSMR value for the latest available 12 months of data (April 2015 – March 2016) is 105.57. This is a high relative risk mortality alert.
- The SHMI value (Jan 2015 – Dec 2015) is 1.063, within the expected mortality range.

The Hospital Standardised Mortality Ratio (HSMR) compares all inpatient deaths to expected deaths. HSMR above 100 indicates more deaths than expected, and a HSMR

below 100 indicates fewer deaths than expected. HSMR has increased since January 2016. Mortality Review Committee continues to undertake investigations into diagnosis groups with a large number of deaths to identify potential improvements in care. Ongoing actions to reduce HSMR include the development and monitoring of care bundles.

The Summary Hospital-Level Mortality Indicator (SHMI) differs from HSMR as it not only includes all inpatient deaths, but also deaths which occur 30 days after discharge. It uses a benchmark of 1 instead of 100. SHMI above 1 indicates more deaths than expected, and a SHMI below 1 indicates fewer deaths than expected.

Palliative Care

- Coding rates for palliative care of deceased patients are 27.8%, which are similar to national levels (25.69%).

Over the last year, the Trust has improved the accuracy of recording palliative care, and is no longer an outlier for low palliative care coding. This is an improvement from the 10.2% palliative care rate in 2014/2015.

Mortality Outlier Alerts

- During 2015/2016, the Trust received a mortality outlier alert for intracranial injury from the Care Quality Commission (CQC) for investigation. Actions are ongoing.

Each month, diagnosis and procedure groups which have generated negative alerts (significantly more deaths than expected) are reviewed at the Mortality Review Committee. During 2015/2016, the Trust has received 81 mortality alerts – 46.9% of which have been positive alerts. There are 2 mortality alert investigations in progress. Actions are reviewed at Mortality Review Committee and Patient Safety Committee.

4. Areas of Risk

Datix ID1454: Inaccurate iPM data resulting in delay in completing mortality review forms

5. Governance

Mortality assurance and reporting is monitored by the Mortality Review Committee chaired by the Deputy Chief Medical Officer. The committee's actions are monitored through Patient Safety Committee, which provides assurance to Quality Governance Committee. Trust Board receives a report on mortality performance every 6 months.

6. Responsibility

The Mortality Review Committee is responsible for assuring the Trust Board that mortality is proactively monitored, reviewed, reported and where necessary, investigated. The committee ensures any lessons and actions are implemented to improve outcomes.

7. Recommendations

[A] The Board is invited to **Note** the Trust's mortality performance for 2015/2016

Kathy Walker, Mortality Review Facilitator (08/07/2016)

University Hospitals Coventry and Warwickshire Mortality Performance Report – Financial Year 2015/2016

1.0 Background to Report

UHCW is committed to accurately monitoring and understanding its mortality outcomes. Reviewing patient outcomes such as mortality is important to Trusts as it helps provide assurance and evidence that the quality of care is of a high standard, and to make sure any issues are effectively addressed to improve patient care. Reviewing mortality helps fulfil 2 of the 5 domains set in the NHS Outcomes Framework:

- Preventing people from dying prematurely
- Treating and caring for people in a safe environment and protecting them from avoidable harm

The Trust uses mortality indicators such as the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Index (SHMI) to compare mortality data nationally. This helps the Trust to identify areas for potential improvement. Although these are not a measure of poor care in hospitals, it does provide a 'warning' for potential problems and help identify areas for investigation.

In addition to this, the Trust has an in-depth mortality review process where each death of an inpatient aged 18 and above is subjected to an initial review of their care and graded according to the standard of care they received. Further reviews are conducted by an appropriate consultant or team if potential problems in care have been identified. This is to encourage learning from patient outcomes.

All mortality processes are overseen by the Trust's Mortality Review Committee, chaired by the Deputy Chief Medical Officer. The Mortality Review Committee reports into the Trust's Patient Safety Committee each month. Furthermore mortality data is reported to the Trust's Quality Governance Committee on a monthly basis and to the Trust Board twice yearly.

2.0 Trustwide Mortality Review – Performance for 2015/2016

2.1 Each inpatient aged 18 or above is subjected to a primary mortality review by the specialty involved in their care at the time of their death. All patients subjected to a review have their care graded by a Consultant, using the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) Classification of Care.

During the financial year 2015/2016 there have been 2036 requested primary mortality reviews, 1960 of which have been completed. This is testament to the support this process receives from specialties and the work conducted by the Clinical Effectiveness Team in continuing to promote this process and provide support wherever necessary.

	Completed Reviews	Total Requested	Rate (%)
2011/2012	1211	1394	86.87%
2012/2013	1728	1901	90.90%
2013/2014	1876	1945	96.45%
2014/2015	2026	2037	99.46%
2015/2016	1960	2036	96.27%

Table 1: Completion rates of primary mortality reviews by financial year

The completion rate for primary mortality reviews during 2015/2016 is lower than previous years, although still high. This does not mean that engagement has decreased. It is reflective of the delay in acquiring patient records to complete the review which are often unavailable for several months due to a post-mortem or an inquest.

The figure below shows the NCEPOD Grade of all completed primary reviews for the financial year 2015/2016. It highlights that 91% of reviews were graded NCEPOD A for 'good care'.

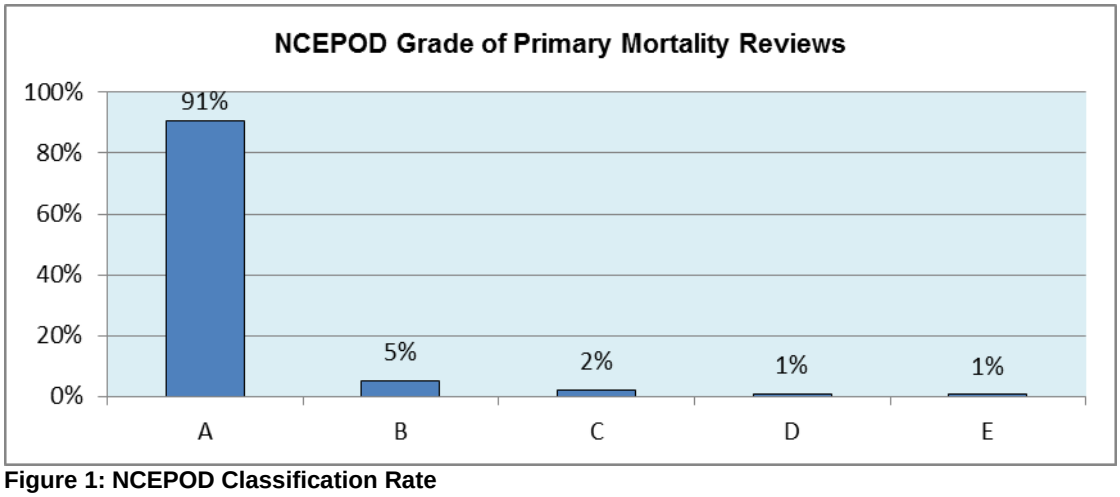


Figure 1: NCEPOD Classification Rate

2.2 All patients who are graded NCEPOD B-D during primary review have a further secondary review completed as the grade highlights that there were aspects of care which could have been improved. The purpose of the secondary review is not to attribute blame to teams, but to identify areas for learning and actions to help improve patient care and avoid similar problems occurring. This is a multi-disciplinary approach and these cases are discussed in specialty meetings to ensure that learning is shared. Theme analyses are

conducted from secondary reviews and shared throughout the Trust to promote improvements in patient care.

For all deaths in 2015/2016 which have had a completed primary mortality review, there were 184 requested secondary reviews (cases graded NCEPOD B-D), suggesting 184 opportunities of learning. This figure is likely to increase as more primary mortality reviews are completed. Of the completed secondary reviews, 16% (22 reviews) of these have been re-graded to NCEPOD A (good care) following discussions with their specialties' team members. The Trust is committed to identifying areas for improvement in an open and transparent manner which is highlighted by the number of cases re-graded.

2.3 Deaths which are graded NCEPOD E have an investigation into their death reviewing all aspects of care. This is completed by the Clinical Director or Mortality Lead for the specialty involved and reported to the Mortality Review Committee. The Committee then discusses the case and agrees appropriate action. Trend analyses for NCEPOD E deaths are also conducted in the Trust to enable identification for improvement areas and to disseminate learning.

The Trust had a corporate objective for 2015/2016 to reduce the number of NCEPOD E deaths to fewer than 15 due to 27 NCEPOD E cases identified in the previous financial year. A review of NCEPOD E deaths was conducted by the Deputy Chief Medical Officer and as a result, extensive work has been undertaken regarding particularly education around escalation of patient observations. There have been 6 NCEPOD E deaths during this financial year – a reduction of over 75%. There have been no NCEPOD E deaths since April 2016.

3.0 Mortality Indicators: Hospital Standardised Mortality Ratio (HSMR)

3.1 The HSMR is a mortality indicator (provided monthly) which looks at inpatient deaths in comparison to 'expected' deaths. Expected deaths are calculated by assigning each patient a mortality risk by accounting for factors such as age, co-morbidities, diagnosis group, gender, palliative coding, and many more. The HSMR includes 56 diagnosis groups which contribute to 80% of inpatient hospital mortality (nationally). The HSMR is calculated using the below calculation:

$$\frac{Acutal\ deaths}{Expected\ deaths} x100$$

Equation 1: HSMR and Relative Risk Calculation

The national benchmark for mortality performance is 100. If the HSMR value is above 100 it indicates that there has been more deaths than expected. If the HSMR value is below 100 it indicates that there have been fewer deaths than expected. If there is a statistically significant difference between the actual number of deaths and expected number of deaths, either a positive alert or a negative HSMR alert will occur.

3.2 HSMR data is received by the Trust 3 months in arrears. The most recent release of data includes mortality for all deaths prior to and including March 2016. The HSMR for the most recent 12 months of data (April 2015 – March 2016) is 105.57. This is a high relative risk for mortality (there is a significant difference between observed and expected deaths). The HSMR value for December 2015 is 109.27 which is within the 'expected' mortality range.

The chart below shows the HSMR trend for UHCW for each month between April 2015 and March 2016. It highlights that UHCW had significantly more deaths than expected during August 2015 (shown in red below). The HSMR decreased in the following months but has begun to rise since January 2016.

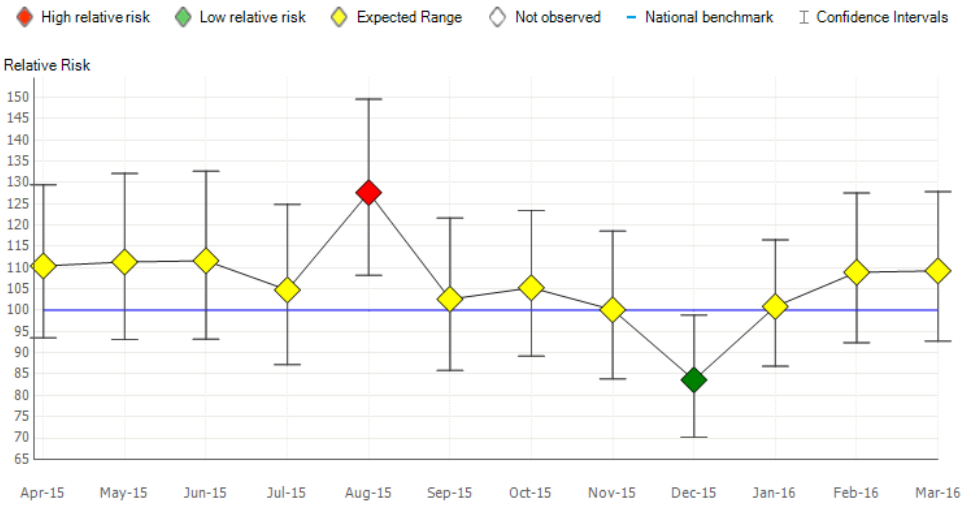


Figure 2: HSMR Trend by Month (April 2015 – March 2016)

4.0 Palliative Care Rate

Palliative care is important within the Trust as it focuses on providing patients with relief from the symptoms, pain, physical stress, and mental stress of a serious illness. UHCW has been one of the lowest Trusts for recording palliative care for several years. Work has been ongoing in the Trust during the year to increase the number of patients receiving palliative care by our Specialist Palliative Care Team including twice daily ward visits to provide additional support to patients and nurses. Due to this, the recording of palliative care has increased. Between April 2014 and March 2015, the palliative care rate for deceased patients at UHCW was 10.2%. However, following changes within the Specialist Palliative Care Team last year, the palliative coding rate of deceased patients has increased to 27.8% (April 2015 – March 2016). The national average for palliative coding during this time is 25.69% indicating that UHCW is now reporting similarly to other Trusts.

5.0 Mortality Alerts

5.1 Each month, diagnosis and procedure groups which have generated negative alerts through Dr Foster (significantly more deaths than expected) are discussed at the Mortality Review Committee, which discusses and agrees appropriate action to address the alerts.

5.2 There are currently 4 investigations in progress. Between April 2015 and March 2016 the Trust received 81 mortality alerts, 46.9% of which have been positive alerts. All negative mortality alerts have been reviewed by the Mortality Review Committee and appropriate actions assigned and monitored for completion.

6.0 Mortality Indicators: Summary Hospital-level Mortality Indicator

6.1 The SHMI is a national indicator published by the HSCIC quarterly and is 6 months in arrears. The national benchmark for the SHMI is 1. Similar to the HSMR, a value below the benchmark indicates fewer deaths than expected, while a value above this highlights more deaths than expected. UHCW reports SHMI data to the Mortality Review Committee on a quarterly basis for review.

6.2 The most recent publication for the SHMI is for January 2015 – December 2015 (published by the HSCIC in June 2016). The majority of Acute Trusts in this publication were within the 'expected' mortality range (78.68%; 107 Trusts). UHCW is also within the expected range in this publication, as the value is 1.063. During this time period there were 2844 deaths recorded compared to 2,676.29 'expected' deaths. The majority of these occurred within UHCW (70.9%).

7.0 Mortality Outlier Alerts

7.1 The Care Quality Commission (CQC) monitors diagnosis groups using statistical data. Outlier alerts are generated when there have been a significantly higher number of deaths than calculated.

7.2 During the financial year 2015/2016 the Trust has received 1 mortality outlier alert to date from the CQC. This was for the diagnosis group 'Intracranial Injury'. The actions from previous Intracranial Injury investigations are ongoing and being monitored regularly by the Patient Safety Committee.

UHCW is committed to seeking an approved transfer policy regarding the acceptance of patients with severe intracranial injuries from referring Trusts. An electronic referral system will rolled out across partner Trusts once a local agreement has been reached on referral thresholds. Champions for this electronic referral system from both University Hospitals Coventry and Warwickshire NHS Trust (UHCW) and South Warwickshire NHS Foundation Trust (SWFT) have been identified and are working together to facilitate this protocol. It is anticipated that this will then be rolled out to Trusts in

surrounding areas such as Worcester Acute Hospitals NHS Trust, and George Eliot Hospital NHS Trust.

7.3 Since April 2016, the Trust has received 2 mortality outlier alerts through audit data: Hip Fracture Mortality reported through the National Hip Fracture Database, and Stroke Mortality, reported through the Sentinel Stroke National Audit Programme (SSNAP). An investigation is ongoing into patients who died following a hip fracture by the Orthopaedics Team and is intended to be completed by September 2016. It will be presented to the Mortality Review Committee on 26 September 2016. In response to Stroke mortality, a response was submitted to the Royal College of Physicians regarding the data quality indicating improvements in reporting since the alert to accurately assess stroke mortality. In July 2016, the Trust received an additional letter from Imperial College London regarding 2 mortality outlier alerts: Heart Valve Disorders and Aortic, Peripheral, and Visceral Artery Aneurysms. There is currently an ongoing investigation into the diagnosis group for Heart Valve Disorders by the Cardiothoracic Team.

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Safeguarding Adults and Children**
Author	**L Maycock Interim Lead Nurse Safeguarding and E Kiernan, Named Nurse Safeguarding Adults**
Responsible Chief Officer	**Mark Radford Chief Nurse**
Date	**28th July 2016**

1. Purpose

To update the Trust Board on safeguarding activity, issues risks and any areas to be addressed

2. Background and Links to Previous Papers

Previous report submitted April 2016

3. Narrative

The Safeguarding agenda is a key area of focus for UHCW and partner agencies. This collaborative working is required to ensure statutory arrangements are met within children and adult services. There are good links with partner agencies across both Childrens and Adults safeguarding arenas and this aids improved safeguarding for Coventry.

Training and awareness raising remains high on the agenda for the team.

4. Areas of Risk

The Trust remains non compliant with our contractual obligations with the CCG in relation to level 3 child protection training, following an increasing cohort being identified as requiring level 3. A training trajectory is in place to address this and to date we are above the planned trajectory.

The Trust has one qualified PREVENT trainer. The demand for training is greater than the capacity to deliver. This is under review at UHCW and partner agencies. The local PREVENT co-ordinator has been delivering training sessions, and a training plan is in place to address the deficit. The Mandatory Training Committee is also appraised of the situation.

5. Governance

The Trust is committed to its' contractual obligations and complying with legislation.

6. Responsibility

Mark Radford, Chief Nurse

7. Recommendations

Additional training events delivered to meet compliance targets, with additional staff trained to support delivery of the sessions and staff supported with release from the clinical area to attend training.

Name and Title of Author: L Maycock Interim Lead Nurse Safeguarding and E Kiernan, Named Nurse Safeguarding Adults
Date: 11th July 2016

Trust Board
Safeguarding Adults & Children's Report
July 2016

1. Introduction

The purpose of this report is to update the Trust Board on recent safeguarding activity, issues and risks for both adults and children and to highlight any areas that need further consideration.

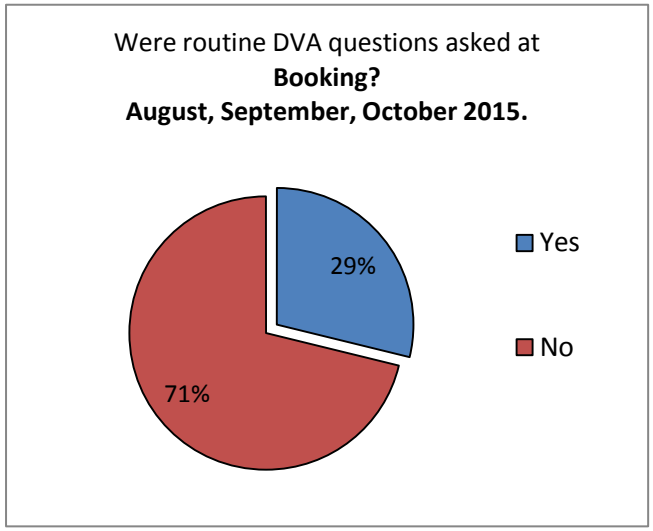
2. Serious Case Reviews (SCR)

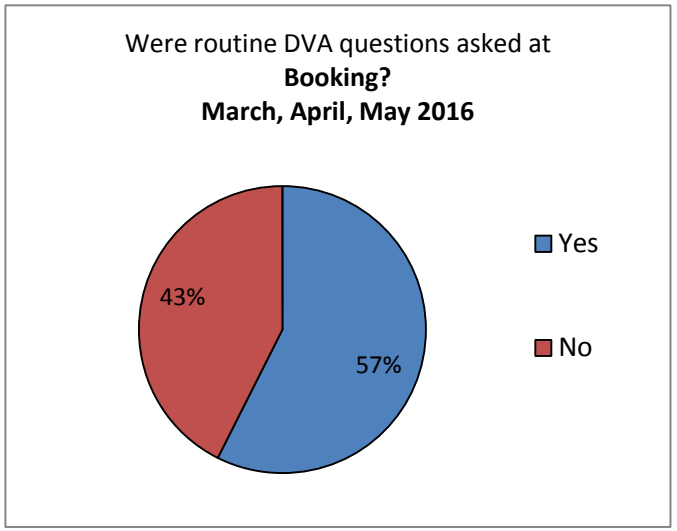
There have been no local SCR publications since March 2016. There is one SCR regarding CSE (Child Sexual Exploitation) expected for publication over the summer months. In addition there is the Child F SCR being undertaken and this report is not yet completed.

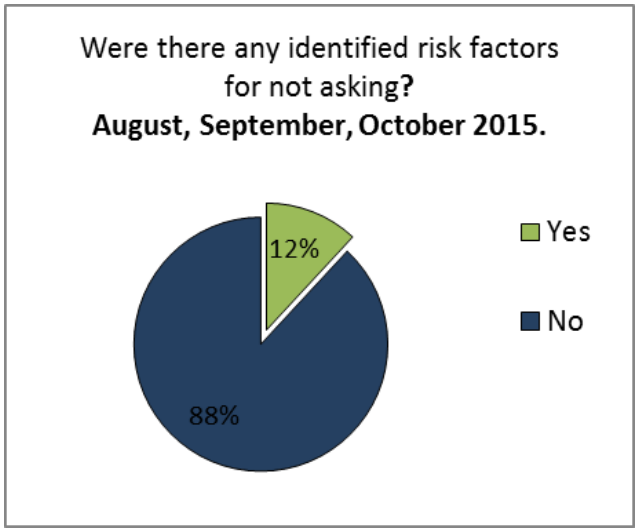
3. Audits

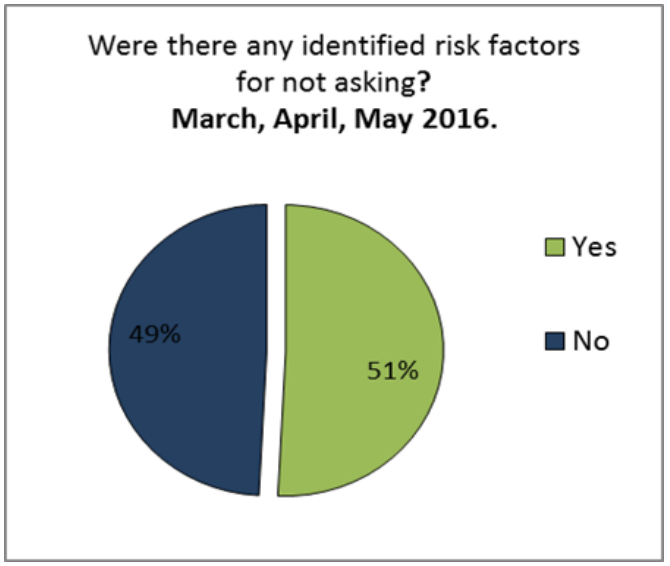
There are two audits which have been undertaken in June 2016. One relating to routine questioning of domestic abuse in the ante natal period, and one comparing policy to practice with communicating cases of female genital mutilation to health visitor colleagues.

The results for the routine questioning in relation to domestic violence are better than in the previous audit but still there is room for improvement. There is an improvement in asking the routine questions at booking – this has risen from 29% to 57%, and in all cases where the question was not asked there was a documented reason as to why it had not been asked. However this was often because a partner was present, therefore we will be working with the community midwifery team to help them consider innovative ways of having a small element of time alone with the women when this is the case. During the timescale of the audit 2 disclosures of abuse were made and appropriate referrals were actioned. With regards to women being asked a second time within the pregnancy about domestic violence and abuse, only 41% had this opportunity given. Only 26% of those not asked had a documented reason as to why, and again it reflected the presence of a partner.


Were routine DVA questions asked at
Booking?
August, September, October 2015.
29%
71%
Yes
No


Were routine DVA questions asked at
Booking?
March, April, May 2016
43%
57%
Yes
No


Were there any identified risk factors
for not asking?
August, September, October 2015.
12%
88%
Yes
No

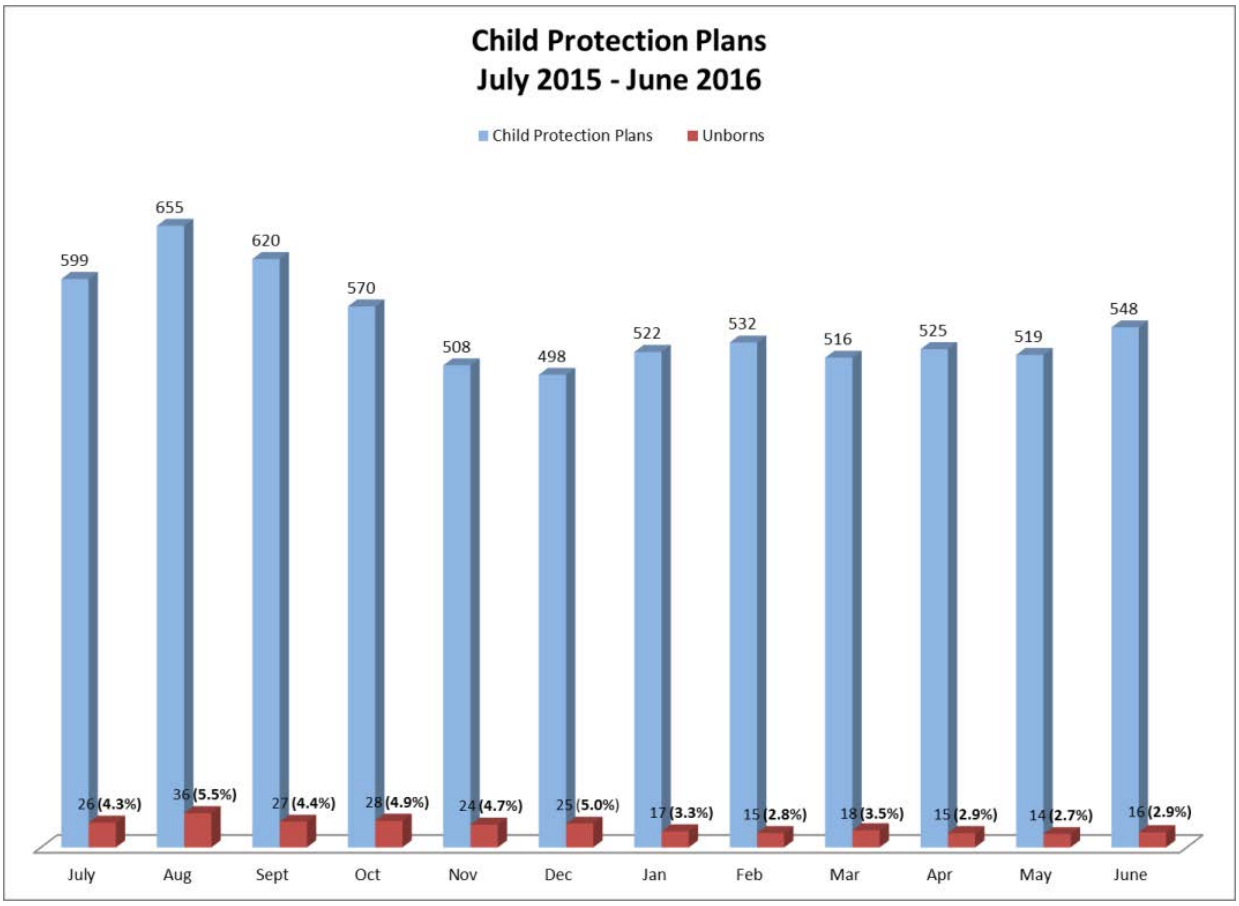

Were there any identified risk factors
for not asking?
March, April, May 2016.
49%
51%
Yes
No

Multi Agency Audits

UHCW have taken part in a number of multi agency audits relating to application of threshold when referring to social care, and care planning for vulnerable children. The results have been discussed and a draft action plan is in circulation with the local authority.

4. Child Protection Plans

There are currently 552 children subject to child protection plans in Coventry. 14 of these are for unborn children. (This equates to 2.5%.) The trend continues to be that there is a reduction of the number of unborn children whom are subject to child protection plans. However there are an increased number of the families in receipt of the Early Help Offer. This continues to comply with the national drivers relating to child welfare and child protection.



The number of referrals submitted to social care by hospital staff from 1st April – 30th June 2016 was 191. Of these, only 22.5% were for no further action.
However, some of these were requests for information from social care, as opposed to referrals for professional concern.

A discussion has been had with social care regarding the process for when staff require information but do not necessarily feel a referral is warranted. It has been agreed that the standard Multi Agency Referral Form shall be used for information

purposes only. To support this, the name of the form has been altered to Multi Agency Referral & Initial Information Form.

5. Training

Training compliance for level 2 in child protection is currently 92.88%.
The level 3 for child protection compliance is gradually increasing and is currently above planned trajectory, as per table below.

Date	Topic	Number of attendees	Compliance	Percentage Compliance
31.5.16	Current Themes in Child Protection	35	411/664	61.90%
27.6.16	As above	33	444/664	66.86%
7.7.16	As above	27	471/664	70.93%
15.7.16	As above	30	501/664	75.45%
8.9.16	As above	30	531/664	79.97%
16.9.16	As above	30	561/664	84.49%
26.9.16	As above	30	591/664	89.01%
10.10.16	As above	30	621/664	93.52%
11.11.16	As above	30	651/664	98.04%
29.11.16	As above	30	681/664	102.56%
12.12.16	As above	30	711/664	107.23%

The current compliance is 70.93%. There are at least monthly level 3 training sessions scheduled until December 2016. There are also additional level 3 training events available via the Coventry Safeguarding Board. Staff book on to these events electronically, and attendance registers are sent electronically to the safeguarding team administrator. Attendees then have their compliance matrix updated on ESR.

6. Child Protection – Information Sharing (CP-IS)

The safeguarding team have been working closely with ICT to plan for the implementation of the CP-IS system. This is an NHS England sponsored work programme dedicated to developing an information sharing solution that will deliver a higher level of protection to children who visit NHS unscheduled care settings. It proposes to do so by connecting local authorities' child protection social care IT systems with those used by staff in NHS unscheduled care settings. The information sharing focuses on three specific categories of child: Those with a child protection plan, those with looked after child status (children with full and interim care orders and voluntary care agreements) and pregnant women whose unborn child has a prebirth child protection plan.

The agreed plan is that there will be a gradual roll out of the system through the trusts unscheduled care departments / settings commencing with Childrens Emergency

Department. Conversations are being held with the team to draw up a process for implementation.

Adults

1. Safeguarding Adults Board

The Adult Safeguarding Board was held here at the hospital in June 2016 and UHCW supported a presentation from the Enhanced Care Team which was very well received. The Board particularly liked the Forget-me-not care Bundle as an example of person-centred working.

Of the two Serious Case Reviews that were referred to the previous report, a decision on one case has been taken that in view of the Coroner's Inquest outcome that a SAR will not be undertaken. The second case is due at Coroners in August and a decision will be made after this.

2. Domestic Violence

In response to Domestic violence and abuse being included in the categories of abuse and neglect in the Care Act 2014. It is important that this is recognised by staff when caring for Vulnerable Adults. From January 2016 Domestic Violence awareness training has been included on the Mental health, Mental capacity and Restraint study day to help raise awareness. The safeguarding team are in the planning stage of developing a campaign around Domestic Violence awareness for later this year.

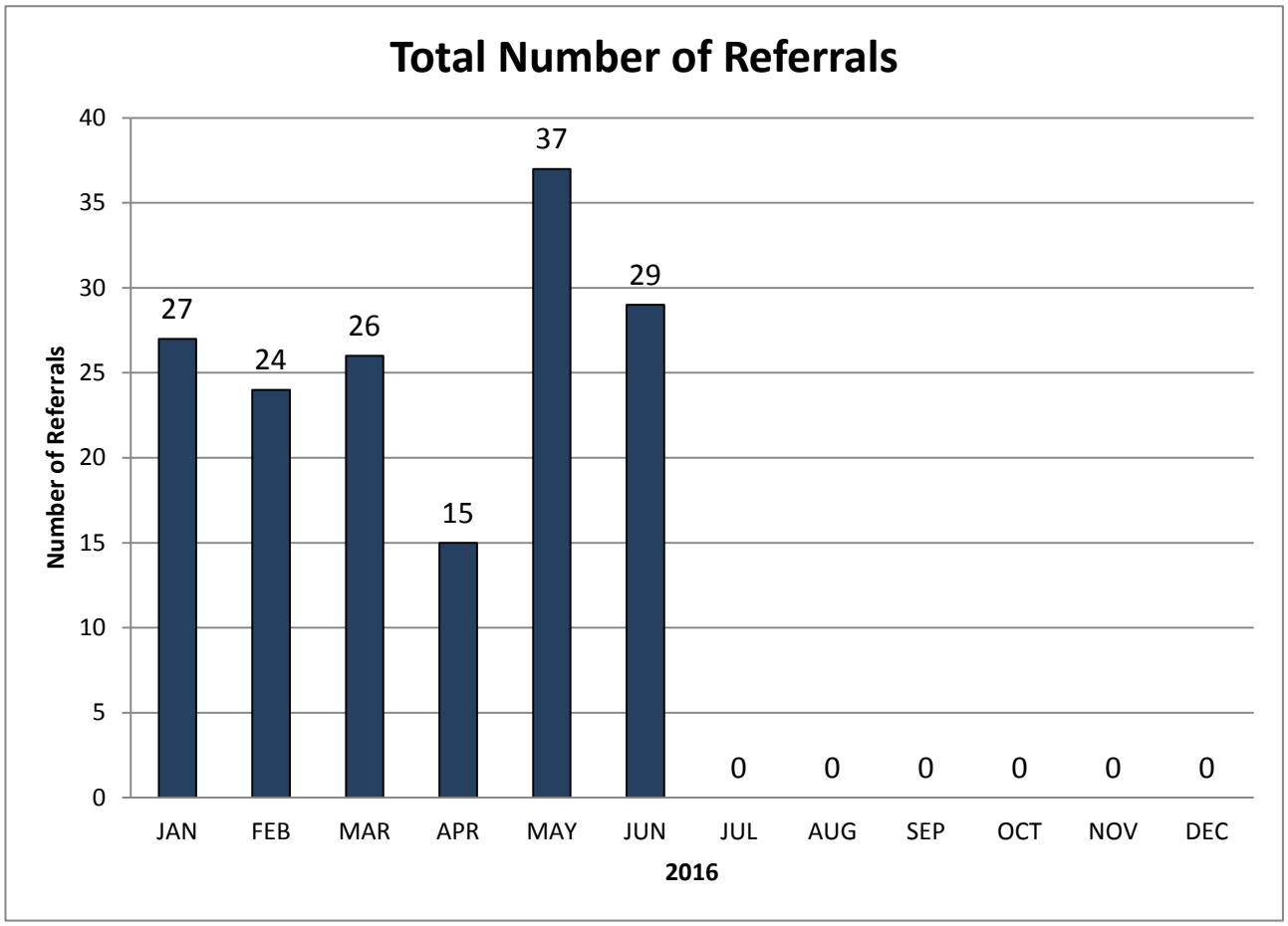
The safeguarding team continue to attend the Coventry Domestic violence operational group and MARAC.

3. Referrals to Adult Safeguarding

There have been some recent changes to the Coventry Pressure Ulcer policy which has resulted in fewer patients with pressure ulcers being referred directly into Safeguarding. The process now would not take a patient with pressure ulcers directly into safeguarding unless there were other concerns about the patient that led the referring professional to conclude that the person was experiencing neglect or abuse. If the pressure ulcer formed part of an overall picture of neglect or abuse then a referral would be made. If this was not the case a then the person with the pressure ulcer would be looked at through the Root Cause Analysis (RCA) process, either in

hospital or the community dependant on where the ulcer occurred. If neglect was determined by the RCA then a safeguarding enquiry would be raised.

The change in process has had an impact on the numbers of people being referred to Safeguarding, however the numbers are rising overall which would indicated that professionals are considering Adult Safeguarding when making their assessment.



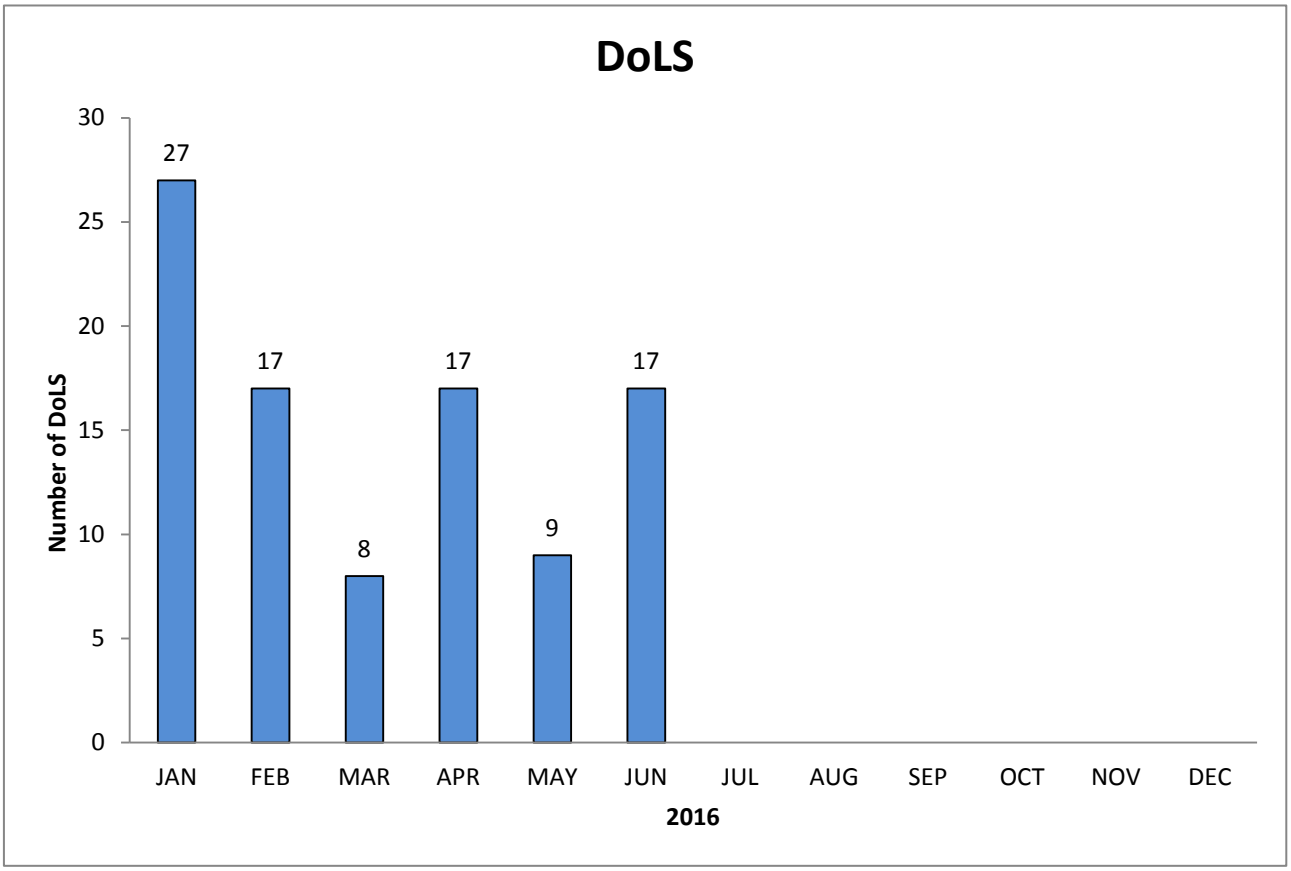
4. CQC Actions

Mental Capacity Act.

One of the actions from the CQC visit last year, was to raise knowledge and practice around the Mental Capacity Act. This has been undertaken in several ways. Firstly by the increased attendance at the Mental capacity, Mental Health and restraint days. These days include a session on the Mental Capacity Act and how it is used in the clinical areas to underpin good practice. The attendance at these days has steadily increased and the average attendance is currently 40 members of staff. This day has also been attended by members of the Hospital Social Services Team, to encourage joint working. Sessions have also been delivered for departments upon request.

Secondly the team have aimed to increase awareness of the Mental capacity act and DoLs by the development and distribution of the Information Folders. The folders have been distributed widely through the hospital and are still being requested by areas in the hospital.

Deprivation of Liberty Safeguards.



The number of applications of Deprivation of Liberty continues to fluctuate, however there was a peak in January this may have been due to applications secondary to patients becoming delirious due to infections.

5. PREVENT

PREVENT training continues in The Mental health, Mental capacity and Restraint study day and also in the level 3 Child Protection study days. There are plans for it also to be incorporated in to the induction programme and then into the mandatory training schedule. This will mean that the total cohort numbers will be accurately reflected via ESR.

Prevent awareness 53.1% Total number requiring = 11,132

Prevent Awareness.	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Feb 2016	March 2016	May 2016
	26.00%	27.26%	29.64%	44.62%	45.12%	48.43%	53.1%

Liz Kiernan was the only trainer within UHCW and has now been signed off as a 'train the trainer' for WRAP. There are now planned sessions to train 16 others to aid delivering the sessions in September 2016.

Workshop to raise awareness of Prevent (WRAP) = 7.79%
Total cohort eligible = 9028

6. Adult Training.

	Sept 2015	Dec 2015	Feb 2016	March 2016	April 2016	May 2016
Level 1	88.31%	88.73%	90.22%	90.97%	90.83%	90.68%
Level 2	89.64%	92.45%	92.94%	93.86%	93.80%	94.32%

Compliance for Adult Safeguarding Training continues to increase overall, with level 2 at almost 95%. There is work to be done in improving the compliance in level 1 and this will be addressed towards the later part of the year.

Conclusion

The safeguarding team continuously work to become more integrated and take a collaborative approach to all aspects of work. Training requirements for both adults and children safeguarding remain a high priority, whilst the team continue to support the staff on a day to day basis in the clinical areas. The team also participate in many multi – agency meetings supporting the work of the LSCB.

The safeguarding team will be expanding over the next few months following on from the successful business case to develop the safeguarding team. Appointments have been made to the band 7 clinical nurse specialist for paediatrics, who will start on 8th August 2016, band 6 paediatrics and band 6 adults.

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**End of Life Care Annual Report 2015/16**
Author	**Dr Sarah MacLaran, Consultant in Palliative Medicine, University Hospital Palliative Care Team and Lead Clinician for End of Life Care**
Responsible Chief Officer	**Mark Radford, Chief Nursing Officer**
Date	**28 July 2016**

1. Purpose

To present the Annual End of Life Care Annual Report 2016/17 to the Trust Board.

2. Background and Links to Previous Papers

This report is the second annual report to Trust Board on End of Life Care (EOLC). The report relates to the 2016/17 year and sets out the work that has been undertaken by the Palliative Care Team during the year.

3. Narrative - Annual Report

The Palliative Care Team is leading with EOLC improvements across the Trust with the Department of Spiritual Care and Bereavement services, with the support of the Chief Nursing Officer and EOLC Committee.

These improvements include continuing rollout of training around the TRANSFORM Programme with support from the Palliative Care Team, to enable wards to implement the TRANSFORM Programme key enablers of Advance Care Planning and AMBER Care Bundle in the TRANSFORM wards, in addition to Care in the Last Days – using the Individual Plan of Care for the Dying Person (in use across the Trust) and Rapid Discharge of patients in the last hours and days of life, which is promoted and supported across University Hospital.

The TRANSFORM programme has been rolled out as follows:

(i) TRANSFORM Programme Phase 1 – commencing 2013
- Ward 35 Oncology
- Ward 40 Elderly Care
- Ward 30 Respiratory
- Ward 20 (now) Elderly Care
- Hoskyn St Cross medical admissions

(ii) TRANSFORM Programme Phase 2 – commencing 2014
- Ward 53 Orthopaedics
- Ward 10 Cardiology
- Ward 50 Renal

Ward 31 Respiratory
Ward 41 Stroke – No QELCA© champion currently
Oak St Cross rehab

(iii)TRANSFORM Programme Phase 3 – commencing 2016
Ward 52 Orthopaedics
Ward 11 Cardiothoracic
Ward 42 Neurology
Ward 43 Neurosurgery

Measuring Performance - Measuring for Improvement

Members of the Palliative Care Team attended a West Midlands workshop on Measuring for Improvement in EOLC on 14th March 2016. The Trust's performance on e-referral date is set out at Appendix 1.

Plan to Meet the Foundations for Good End of Life Care

A review of EOLC in Coventry and Warwickshire was undertaken and was published in May 2016 and a Coventry and Warwickshire EOLC Improvement Plan (appendix 2) was developed, aimed at meeting the National Ambitions for Palliative and EOLC.

Actions that have been taken are as follows:

- Death Cafes organised by the Department of Spiritual Care and Bereavement services.
- Collaboration with Local Partners for national Dying Matters Awareness week including short film produced with Communications, shared using social media and presented with the UHCW results from the RCP Marie Curie National EOLC Audit 'Dying in Hospital' at the Grand Round on 13th May 2016.
- 19 Volunteer 'Care of the Dying Companions' have been recruited to provide a sitting service for dying patients with no relatives or friends. This has made early impact.
- Dove logo for patients in the last days of life has been developed and deployed – emblem displayed outside a patients room with family/carer consent to promote respect and dignity for dying patients and their relatives.
- Six carer 'glideaway beds have been purchased from charitable funded donations to support patients families and carers staying close to their loved ones – promoting comfort care for families.

Further actions include integrated working with Partners locally:

- Myton admissions and discharge nurse now joins the UH Palliative Care Team on a weekly basis and supports with the transition of patients into Myton Hospice

- Nurse Led Beds at Myton Hospice continue to be well utilised by UHCW in-patients referred by the Palliative Care Team
- Fatigue and Breathlessness (FAB) Service at Coventry Myton Hospice – programme of breathlessness management for patients with advanced conditions causing fatigue and breathlessness – pilot was successful and full rolling programme now being organised
- Electronic Palliative Care Coordination System (EPaCCS) known as the "CASTLE Register" (Care And Support Towards Life's End) currently being implemented across Coventry and Warwickshire to provide secure way of sharing an up-to-date clinical summary for patients in the last year of life and their future care preferences for the end of life – in User Acceptance Testing currently via CWPT server and primary/secondary care.

The Local Education and Training Council (LETC) funded a "Let's Get Talking" and "A Difficult Conversation What Can I Say?" communication skills training days for staff across Coventry and Warwickshire being held between June and December 2016.

The enclosed EOLC Report and Action Plan has been presented to the Chief Officer Group, Mortality Review Committee and the Chief Nursing Officer, Lead Clinician for EOLC and Palliative Care Nursing Team Lead also presented this report to the Trust Development Authority/National TRANSFORM Team on 27th April 2016 during their visit to UHCW.

Work is under way with local Partners through the CASTLE Expert Advisory Group towards the eight foundations for Palliative and End of Life Care which will enable achieving the National Ambitions for Palliative and EOLC by 2021. This work is being driven in accordance with the Warwickshire Health and Wellbeing Board EOLC review of Coventry and Warwickshire published in May 2016 and the associated EOLC Improvement Plan which focuses on:

1. Personalised Care Planning
2. Shared Records
3. Education & Training
4. 24/7 access
5. Evidence & information
6. Involving support and caring for those important to the dying person
7. Co-design
8. Leadership

Learning

Themes arising out of Clinical Adverse Event (CAE) forms, together with compliments and complaints are shared across the Trust at the bi-monthly EOLC Committee to ensure that lessons are learned and improvements made where appropriate.

The national AMBER Care Bundle Lead visited the Trust to support the Palliative Care Team and gave a presentation to the EOLC Committee in July 2016. The new version of the AMBER Care Bundle was launched via a National AMBER Care Bundle telephone conference call hosted by the Trust.

Sub-Groups

There are a number of sub-groups in place that support the work of the EoL Committee and they have progressed the following:

- Patient and User involvement: e.g. VOICES, which is a survey of bereaved relatives that is being finalised and is due for implementation in coming months and to go live electronically.
- Bereavement support
- Rapid discharge of patients with a prognosis of weeks, or prognosis of just hours/days
- Education and Training
- Data collection and Measuring for Improvement

4. Areas of Risk

This report links to the Trust's objective to deliver excellent patient care and experience.

The main risks are:

a) Palliative Care Team staffing/recruitment according to meet the Trust's need

   i. clinical demand for reviews of inpatients on day of referral or next day
   ii. 7 day face-to-face service for Specialist Palliative Care
   iii. improvement in education and training for Palliative and EOLC for all staff

b) There is no AMBER Care Bundle Facilitator in the Trust to provide dedicated support for staff managing patients whose recovery is uncertain and who are at risk of dying during the admission

5. Governance

An Annual Report is presented to the Trust Board each year around End of Life Care.

6. Responsibility

Professor Mark Radford, Chief Nursing Officer
Dr. Sarah McLaren, Consultant in Palliative Medicine
Palliative Care Team

7. Recommendations

The Trust Board is asked to **NOTE** and **APPROVE** the End of Life Care Annual Report 2015/16.

Appendix 1 – UHCW Palliative Care Team E-referrals from 1st April 2015 – 31st March 2016

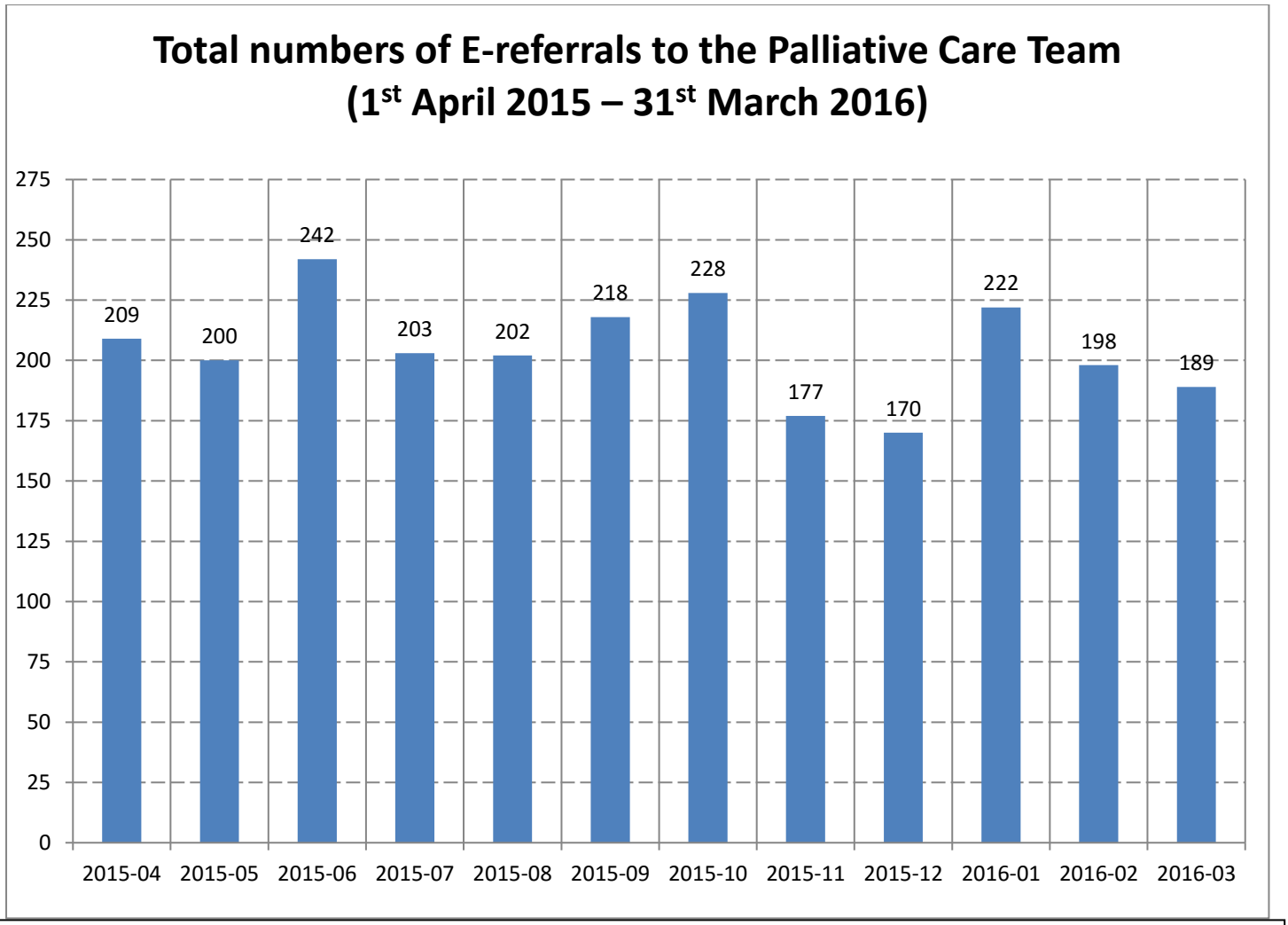
TOTAL number of E-referrals from 1st April 2015 – 31st March 2016 was 2,458

Of note:-

- A patient may be seen several times during one admission, especially if in-patient for weeks-months
- Referral reasons change over time, eg symptom control/ support in last days/ rapid discharge
- Duplicate referrals possible from different members of staff
- Referral reason does not always reflect need at the time - holistic assessment carried out anyway

E-Referral reasons:-

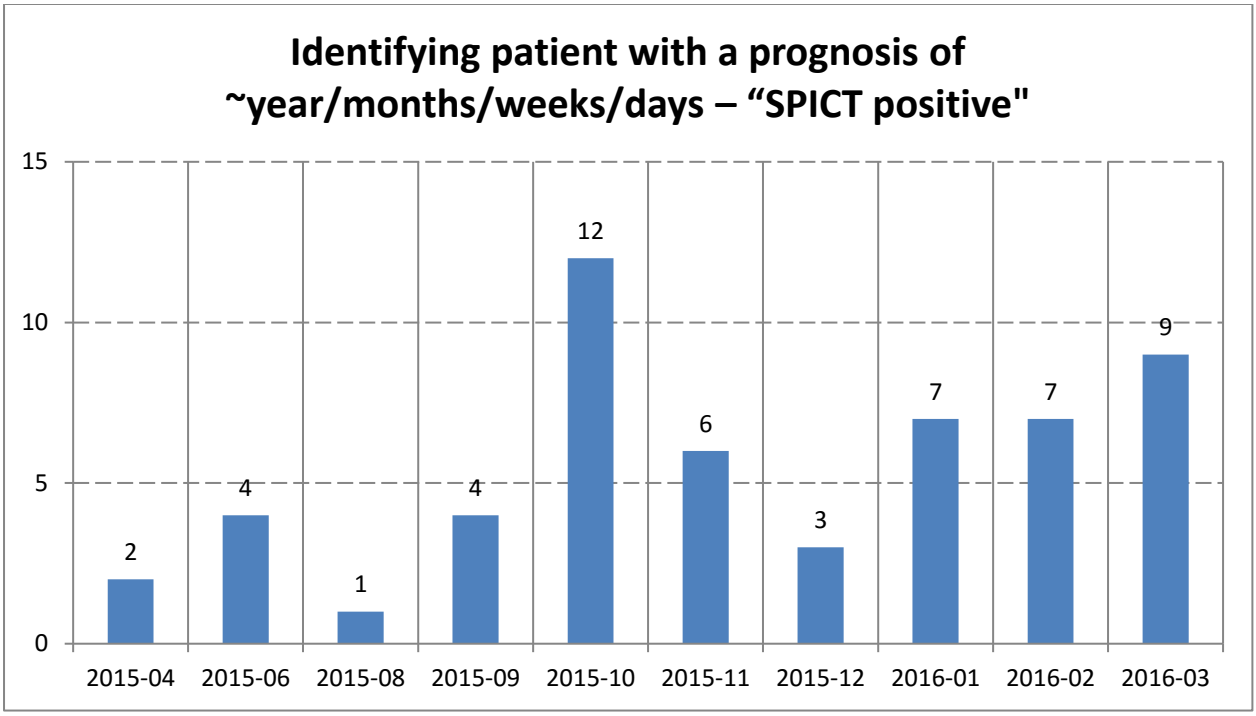
- Identifying patient with a prognosis of ~year/months/weeks/days – "SPICT positive"
- Signposting and advice for professionals (includes patients identified as "SPICT positive")
- Symptom control [symptoms that you are finding difficult to manage]
- Psychological support for
  - Patient
  - Family/ Carers
- Support with Advance Care Planning
- AMBER Care Bundle (TRANSFORM wards only)
- Support for patients in the last days of life
- Support for family/carers of patients in last days of life
- Rapid discharge for patient in last days of life
- Consultant-Consultant referrals:-
  - Challenging ethical decisions towards end of life
  - Complex psychological support for a patient +/- relative(s)
  - Medical assessment of distress
  - Medical assessment of symptoms



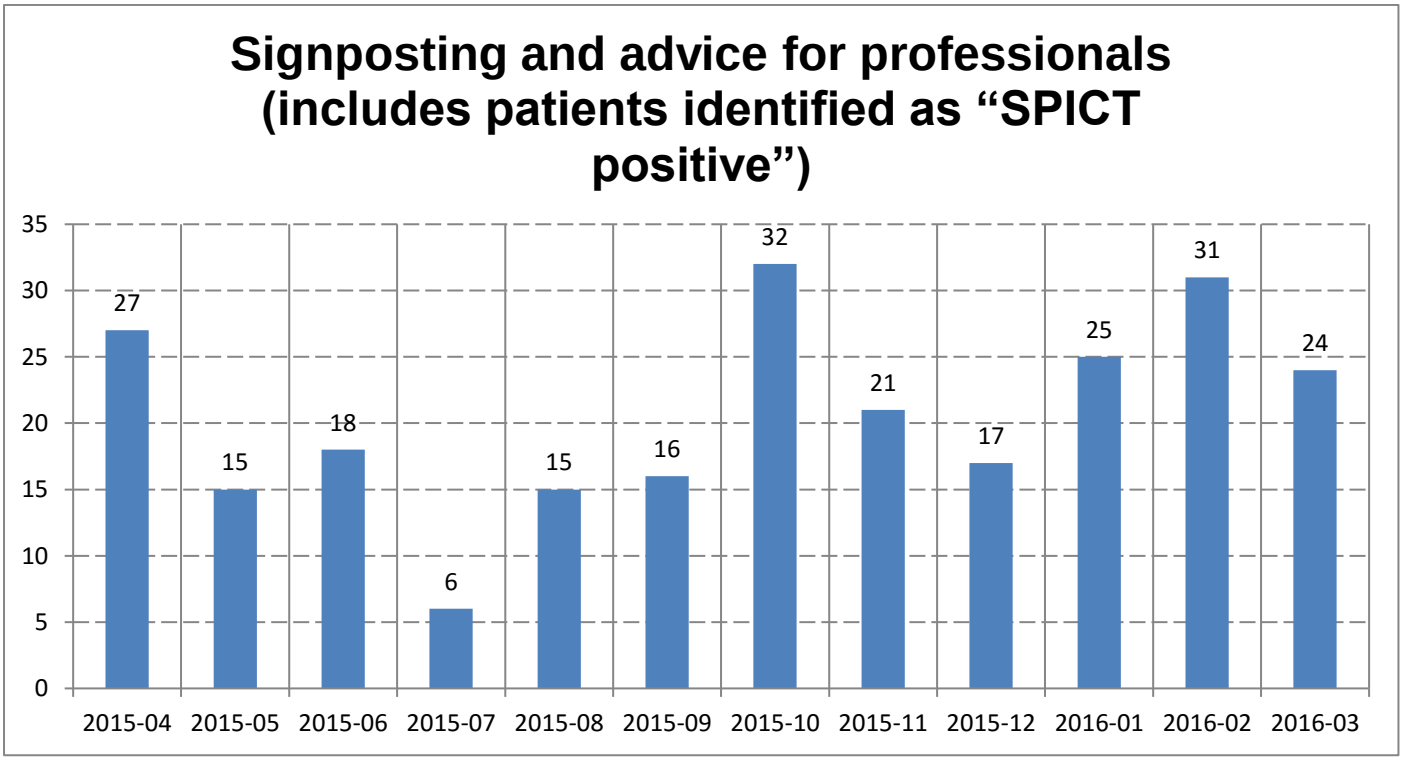
N.B. An error in the data upload of the number of referrals for "Support for patients in the last days of life" which slightly affected the data collection for months of September 2015 – February 2016 was rectified for March data onwards – for details see data for Referral reason for "Support for patients in the last days of life"

E-referrals to the UHCW Palliative Care Team from 1st April 2015 – 31st March 2016 for

- **Identifying patient with a prognosis of ~year/months/weeks/days** – "SPICT positive"

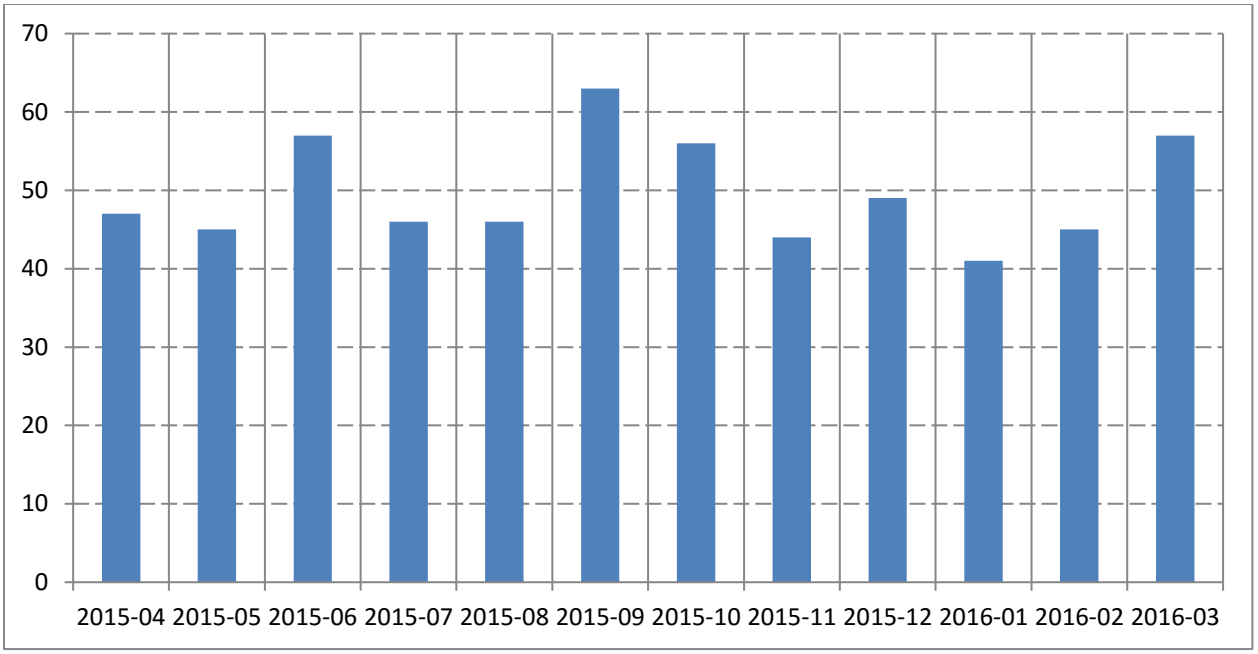


- **Signposting and advice** for professionals (includes patients identified as "SPICT positive")

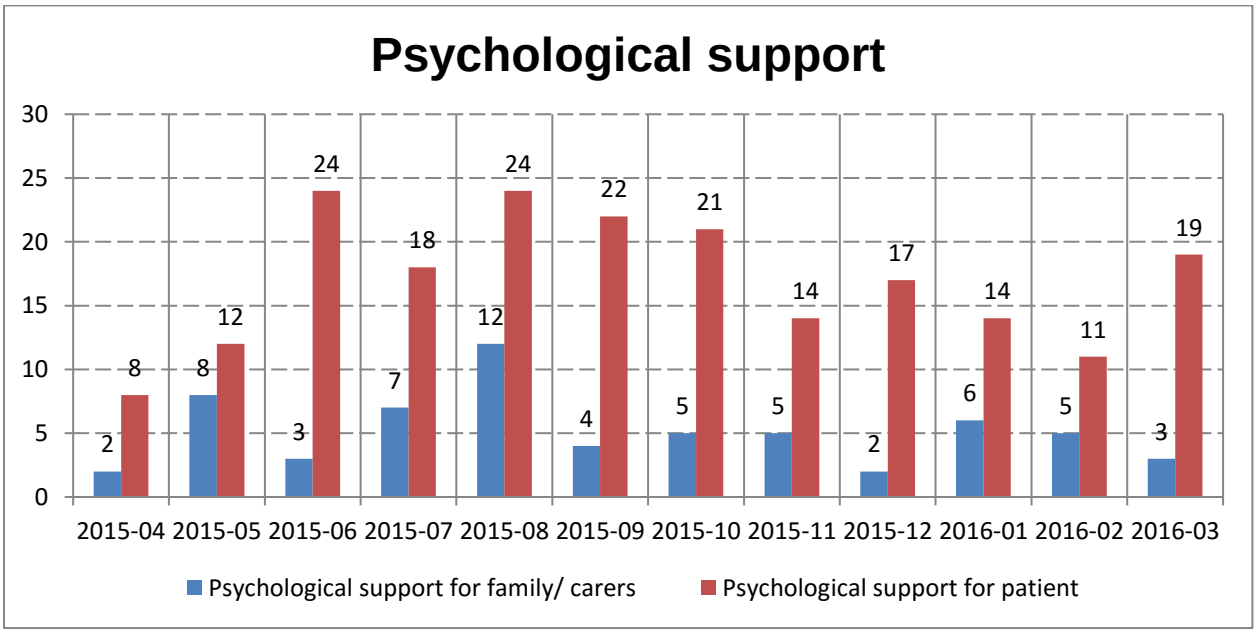


E-referrals to the UHCW Palliative Care Team from 1st April 2015 – 31st March 2016 for

- **Symptom control** [symptoms that you are finding difficult to manage]

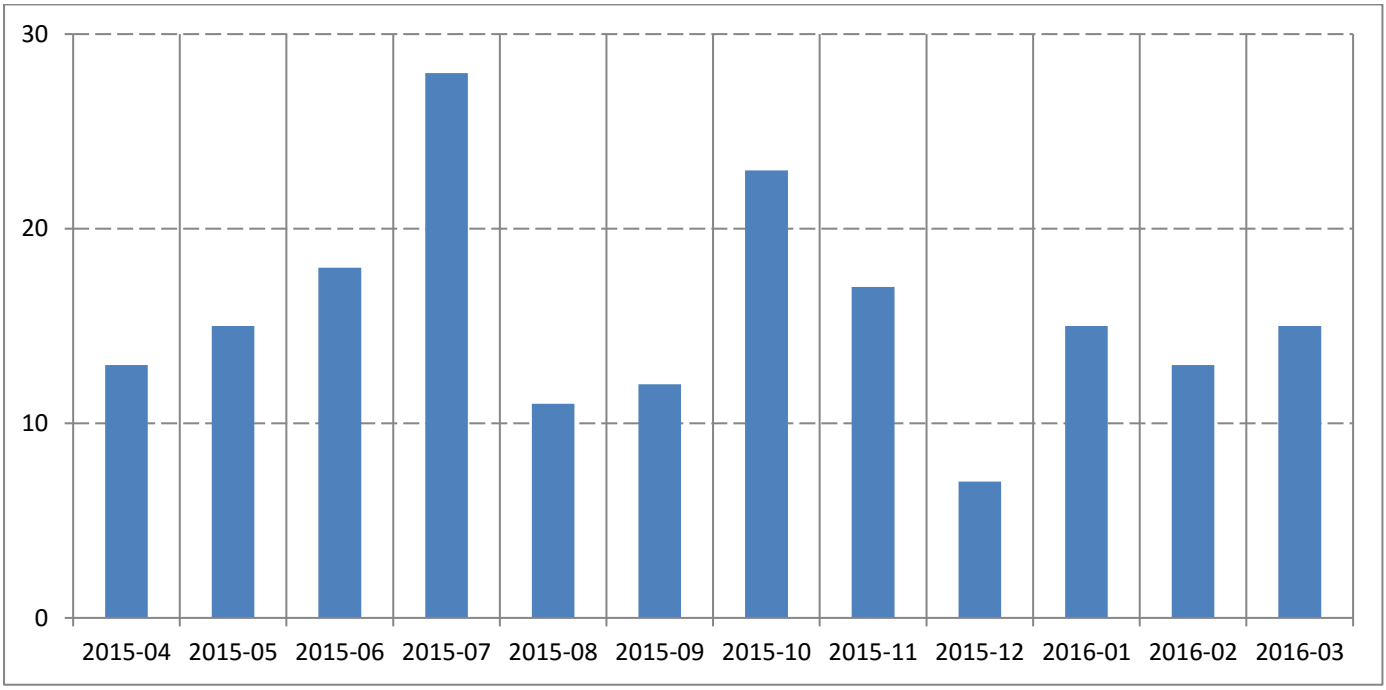


- **Psychological support for**
  - **Patient**
  - **Family/ Carers**

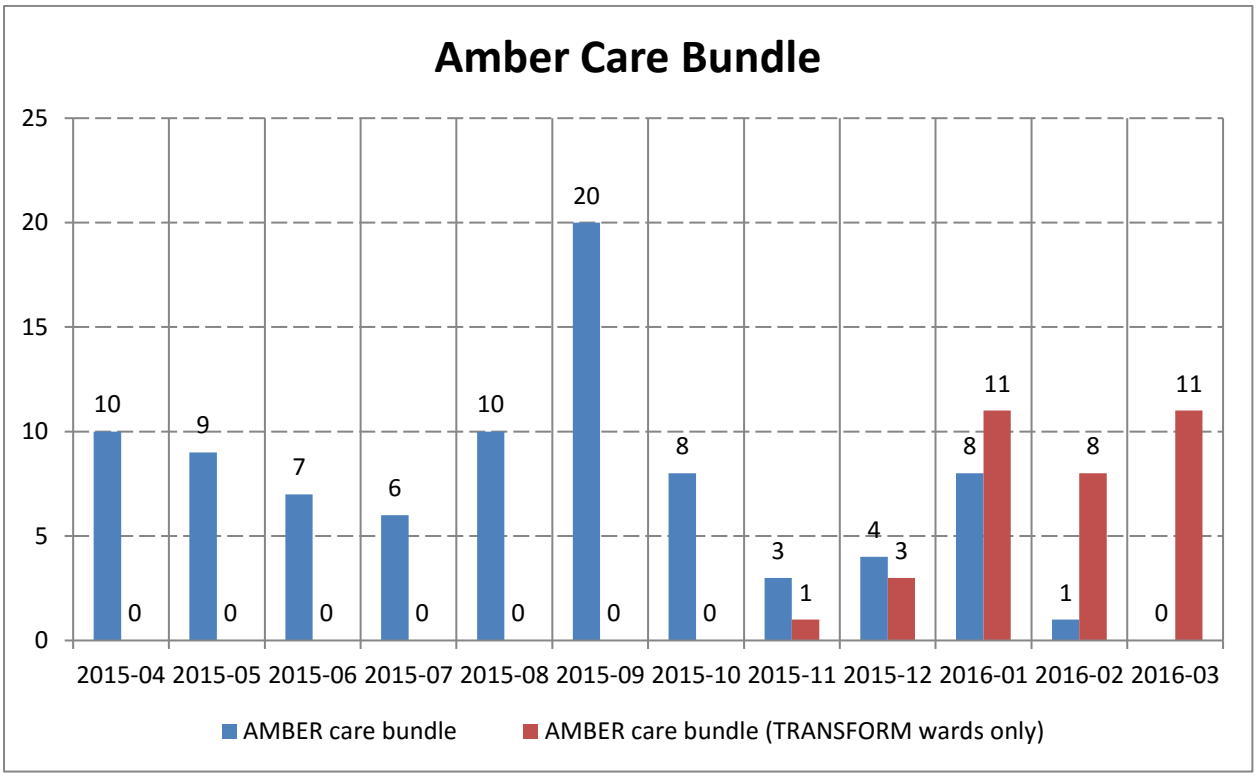


E-referrals to the UHCW Palliative Care Team from 1st April 2015 – 31st March 2016 for

- Support with **Advance Care Planning**

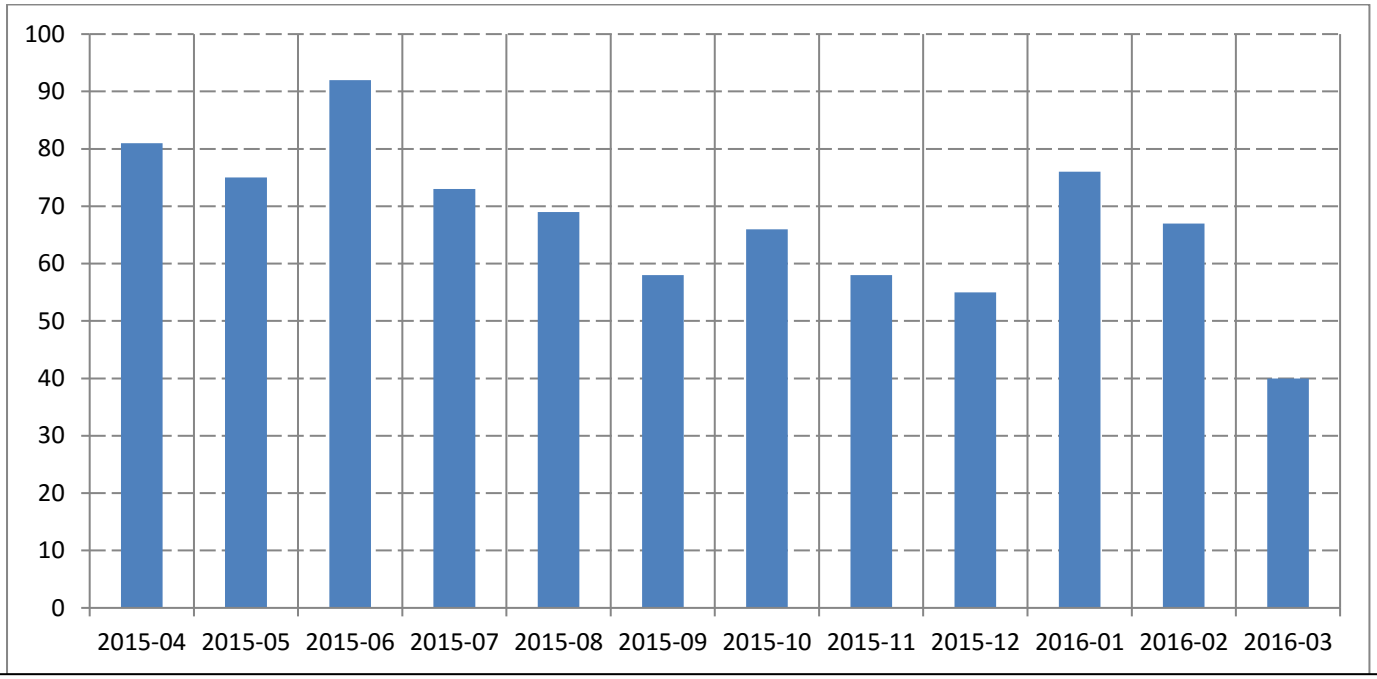


- **AMBER Care Bundle** (TRANSFORM wards only)



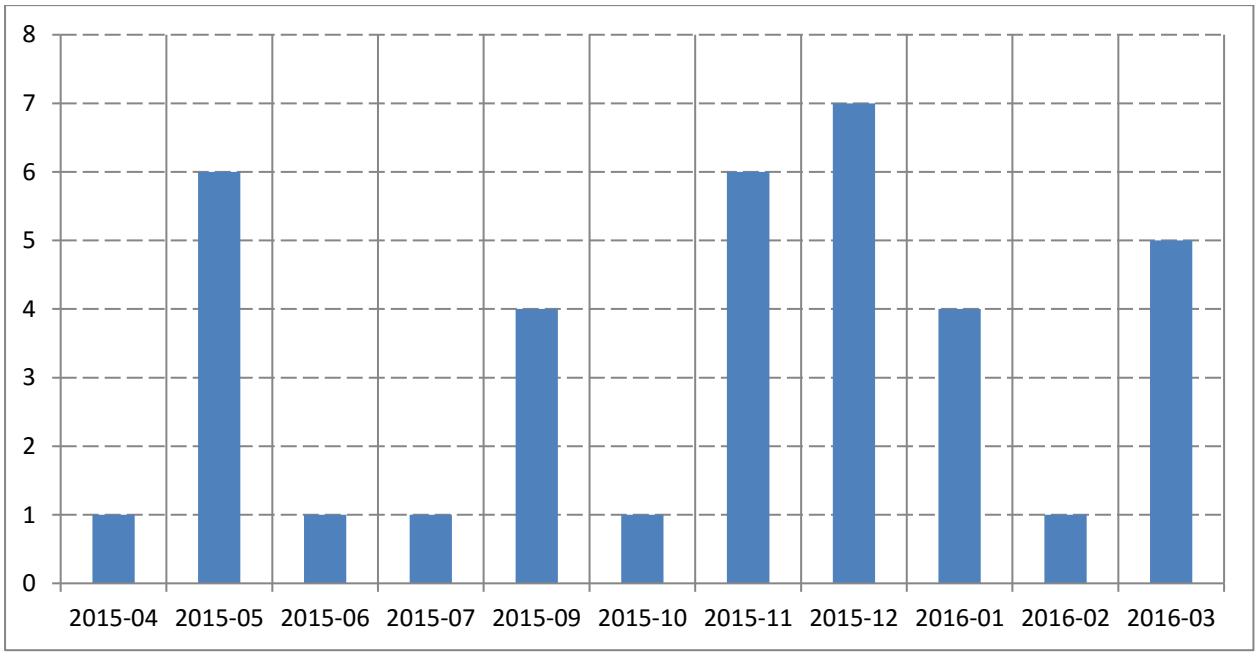
E-referrals to the UHCW Palliative Care Team from 1st April 2015 – 31st March 2016 for

- Support for **patients** in the last days of life



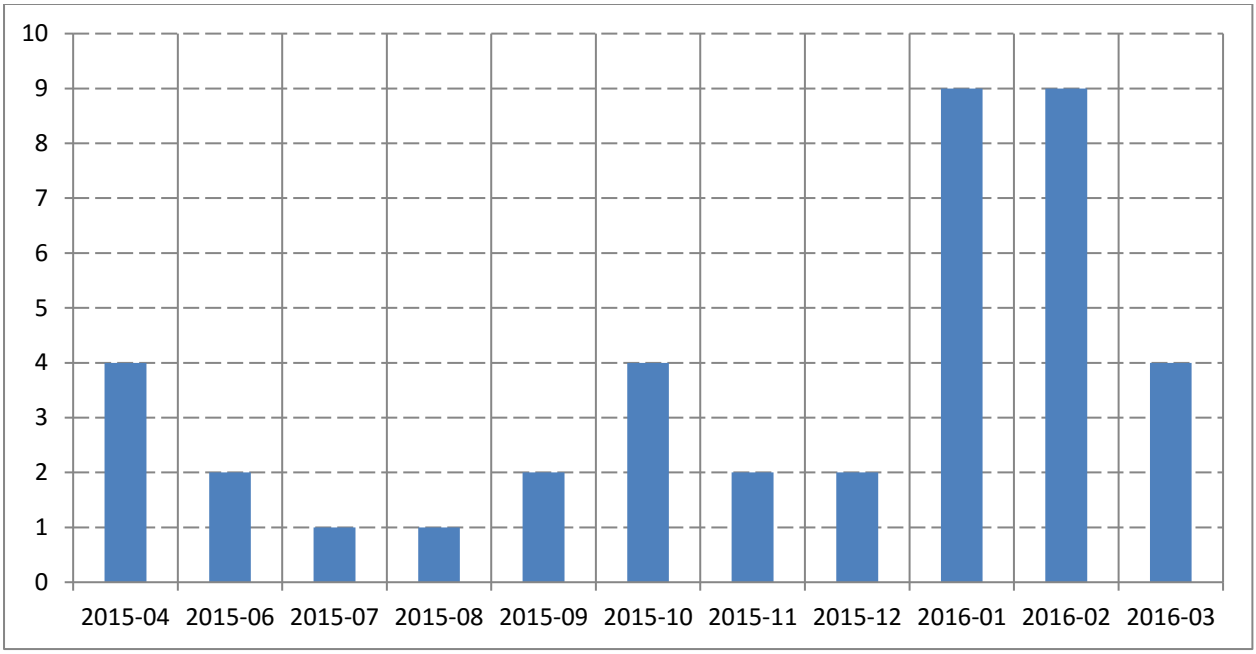
*N.B. An error in the data upload of the number of referrals for "Support for patients in the last days of life" which slightly affected the data collection for months of September 2015 – February 2016 was rectified for March data onwards; correct numbers of patients **seen** for "Support for patients in the last days of life" here:*
Sept = 76 Oct = 73 Nov = 73 Dec = 65 Jan = 71 Feb = 91
Of note these data are greater than the numbers of E-referrals for the reason that the team continue to see patients referred with a longer prognosis until the time they die (but do not generate another E-referral)

-
- Support for **family/carers of patients** in last days of life



E-referrals to the UHCW Palliative Care Team from 1st April 2015 – 31st March 2016 for

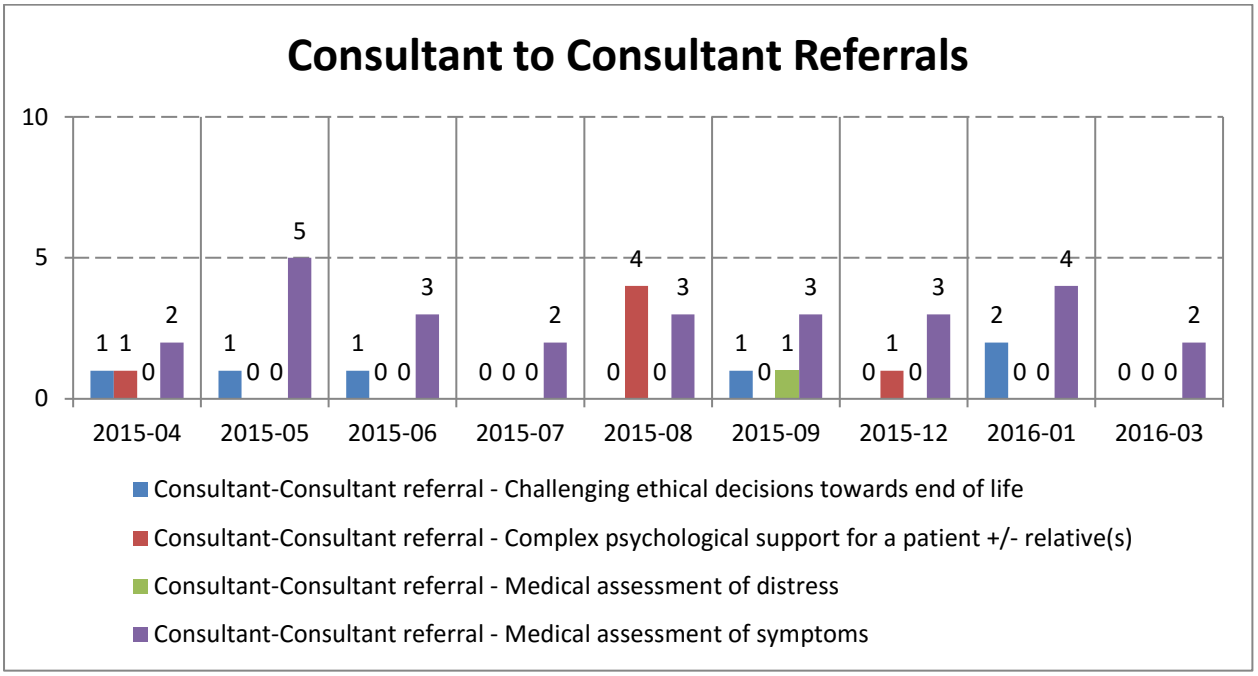
- **Rapid discharge** for patient in **last days of life**



E-referrals to the UHCW Palliative Care Team from 1st April 2015 – 31st March 2016 for

Consultant-Consultant referrals for:–

- Challenging **ethical** decisions towards end of life
- **Complex psychological** support for a patient +/- relative(s)
- Medical assessment of **distress**
- Medical assessment of **symptoms**



Enclosure 1

Coventry and Warwickshire Improvement Plan to Meet the Foundations for Good End of Life Care

This Plan is being developed at the request of Warwickshire's Health and Wellbeing Board. It describes the developments that will be taken forward across Coventry and Warwickshire to ensure that the foundations for good End of Life Care are embedded across all local services. It has been drawn up by a small group of health and social care professionals .Once it is agreed delivery of the plan will be supported through the Warwickshire Cares Better Together Programme Board, but the Warwickshire H&WBB Executive Team will be responsible for implementation and they will be held to account for this through the County Council's scrutiny committee.

The Improvement Plan is intended to lead to more effective and co-ordinated End Of Life Care across Coventry and Warwickshire. Each CCG, working with social care and other commissioning colleagues, are required to work with all local service providers (including GPs, hospitals, community services, hospices, ambulance service, pharmacies, care homes and domiciliary services) in delivering the plan.

The Improvement Plan is being developed in response to the recently published national framework for End of Life Care "Ambitions for Palliative and End of Life Care" (http://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/A-Presentation-of-the-Ambitions-for-Palliative-and-End-of-Life-Care1.pdf). The national framework was drawn up by a wide coalition of national groups and reflects the views of patients, carers and the public as well as professional bodies.

The plan builds on local developments, many of which are described on the CASTLE (Care and Support Towards Life's End) website: http://www.c-a-s-t-l-e.org.uk/useful-links.aspx and have been developed by the multidisciplinary CASTLE group.

The 'Foundations' shown in this plan and their associated outputs and outcomes are taken from the national framework. The planned action was subject to public and professional consultation and over 30 separate responses were received. In addition the plan was discussed in professional forums, by Trust End of Life Care committees and by SWCCG Patient and Public Participation Group. The Improvement Plan reflects feedback from these individuals and groups.

Glossary

CASTLE group
The CASTLE group represents clinical providers of Palliative and End of Life Care across Coventry and Warwickshire. More details can be found on the CASTLE website: http://www.c-a-s-t-l-e.org.uk/about-us.aspx

CCG (Clinical Commissioning Group)
All GP practices belong to a CCG and the groups include other health professionals, such as nurses. CCGs are responsible for commissioning a wide range of services and have a duty to involve their patients, carers and the public in decisions about the services they commission. There are three local CCGs: South Warwickshire CCG, Coventry and Rugby CCG and Warwickshire North CCG

CCG EoLC Executive Lead (End of Life Care Lead)
This is the officer identified by the CCG as having lead responsibility for EoLC. Where the CCG also has a GP EoLC lead (a clinical role) the CCG officer is expected to work with the GP lead in implementing the action plan.

EPaCCS (Electronic Palliative Care Coordination System)
EPaCCs is a secure web-based electronic clinical system which enables professionals to keep up-to-date about the care of their patients who are approaching the end of life. In Coventry and Warwickshire this will be called the CASTLE Register. The register will be available to relevant staff who have undergone training working across the settings of hospital, community, hospice and the ambulance service. Information will improve the coordination of care for an individual between different care settings and organisations and will facilitate better communication between in-hours and the out-of-hours period. For further information see CASTLE website: http://www.c-a-s-t-l-e.org.uk/planning-ahead/castle-register-the-coventry-and-warwickshire-epaccs-(electronic-palliative-care-coordination-system).aspx

H&WBB (Health and Wellbeing Board)
The H&WBB provides a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. Health and wellbeing board members need to work together to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined-up way. There is a Warwickshire H&WBB which works with local partners including the South Warwickshire, Coventry and Rugby and Warwickshire North CCGs and the Coventry H&WBB works with partners, including the Coventry and Rugby CCG.

Warwickshire H&WBB Executive Team (H&WBB Executive Team)
The Executive Team drive the strategic direction, agenda and delivery for the H&WBB. It includes Chief Officer level representation from: our five district and borough councils; Coventry and Rugby, South Warwickshire and Warwickshire North CCGs; our health providers (Coventry and Warwickshire Partnership Trust, South Warwickshire Foundation Trust, George Elliot Hospital, University Hospitals Coventry and Warwickshire; Police and Warwickshire County Council.

LA (Local Authority)
Local authorities have a wide range of functions including providing information, advice and support for the local population and are responsible for ensuring people have access to a range of services to meet their health and wellbeing needs. Different responsibilities sit with different 'tiers' of local government for example Coventry City Council and Warwickshire County Council are responsible for assessing social care needs and for providing or commissioning services to meet these needs. District and Borough Councils in Warwickshire and Coventry City Council have responsibility, amongst many other things, for assessing and meeting the local populations housing needs. Local authorities thus need to work together and with local health service commissioners and providers to ensure that population health, wellbeing and social care needs are met.

LETB (Local Education and Training Board)
LETBs are responsible for the training and education of NHS and other healthcare staff, both clinical and non-clinical, within their area. Their responsibilities include holding and allocating funding for the provision of education and training and securing effective partnerships with clinicians, local authorities, health and well-being boards, universities and other providers of education and research and providing a forum for developing the whole healthcare workforce.

Social Care EoLC Leads
Social care departments are asked to identify a commissioning lead and a lead who can provide advice in relation to the social care services provided (for example social workers and other staff, care homes and domiciliary services)

SPICT (Supportive and Palliative Care Indicators Tool)
The SPICT is a guide to identifying people at risk of dying within the next 12 months. It is the recommended tool to support local health and social care professionals to identify individuals who would benefit from a supportive and palliative approach to their care. For further information see the CASTLE website: http://www.c-a-s-t-l-e.org.uk/planning-ahead/coventry-and-warwickshire-spict.aspx

Warwickshire Cares Better Together Programme Board (WCBT Programme Board)
The WCBT Board is responsible for delivering the better together programme, which is our local interpretation of the national Better Care Fund. The focus of the programme is to support the local health and social care systems to plan, commission and deliver integrated health and social care services, whilst developing local solutions to meet nationally dictated conditions such as 7 day working and joint assessment and care planning. Locally the programme is directed towards the frail and elderly population.

FINAL DRAFT 1.4
Improvement Plan for Delivery of the Foundations for Palliative and End of Life Care 2016/17

Foundation	Outputs and Outcomes associated with the Foundation	Planned Action	Responsible	Date to be achieved
Personalised care planning	All individuals considered to be in the last year of life, will have an opportunity for informed discussion and planning for End of Life Care involving those important to them. Those with caring responsibilities will be identified through this process. Personal Care Plan's (PCP) will allow individuals to express their preferences for care, set personal goals, and consider appointing a Lasting Power of Attorney. It will be based on the differing physical, psychological, social and spiritual needs of individuals also reflecting their age, diagnosis, culture and religion, meeting all the requirements of the Equality Act.	1. Each local system (Coventry and Rugby, Warwickshire North and South Warwickshire) will develop a plan to support implementation of the SPICT tool. This should include training for relevant staff groups (GPs, community nurses, hospital staff and other professionals) depending on the focus of the implementation plan (ie which groups of staff are to be trained first). The training will ensure that staff have the necessary knowledge and competence to use the SPICT in their daily practice and are aware of the importance of identifying those with caring responsibilities. 2. Each CCG will develop a plan detailing how it will support General Practice in improving the effectiveness of practice EoLC (CASTLE/EPaCCs) register meetings.	CCG EoLC Executive Lead CCG EoLC Executive Lead	December 2016 December 2016
Shared Records	The PCP will be available to the individual, their carer and all services involved in care delivery. Locally this means sharing access to the CASTLE register (also known as EPaCCs). Where records are shared individuals are more likely to have well	3. A robust and clinically safe implementation plan for EPaCCs will be developed through the EPaCCs implementation group. The plan will include appropriate education and training for all relevant staff groups and will secure full collaboration from all providers across Coventry and	CASTLE Register (EPaCCS) Implementation Group	September 2016

	coordinated care and are more likely to have their EoLC preferences met.	Warwickshire. CCGs and other key stakeholders will then be invited to endorse (or agree amendment to) this plan, prior to implementation.	CCG EoLC Executive Lead	July 2016
		4. Each CCG will identify a GP lead for EPaCCs and will clarify how the CASTLE register implementation group will link into the CCG's governance structures.	CCG EoLC Executive Lead	December 2016
	In addition to sharing EoLC registers, local targets will be set for the roll-out of systems for sharing digital clinical records; across health and social care providers in all sectors.	5. Each local system will clarify how IT systems and future developments will accommodate the need for shared clinical records, including shared records for EoLC. This should be part of the 'digital road map' work currently being undertaken.	CCG EoLC Executive Lead and CCG IT lead (working with other system IT leads)	December 2016
Evidence and information	Service providers will participate in an agreed range of national initiatives to collect robust anonymous data, to support quality improvement. As a consequence more comparable information will be available about local services and about the individuals who are accessing the services (and by default information about who are not accessing services) This will inform commissioners efforts to ensure equity of access	6. The national dataset for palliative care will be implemented in line with the national timetable. In addition to this there are a range of voluntary national audits and surveys that need to be considered with a view to local organisations contributing data. Following review of their membership and ToR the CASTLE group will be asked to assess the potential for these national data collection tools to improve local services. In light of this assessment the group will recommend to CCGs and partner agencies, which	CCG EoLC Executive Lead	September 2016

	to support for all population groups	additional national data collection opportunities should be adopted locally.	CCG EoLC Executive Lead Social Care Lead	
	Local health and social care commissioners and providers will sensitively collect and use a wide range of information, including seeking feedback from service users.	7. The need for any additional data or information will be reviewed after accounting for the impact of action 6 and appropriate arrangements will be put in place to address this accordingly.	CCG EoLC Executive Lead	December 2016
	The participation of local services in national/regional research will be agreed.	8. There is an existing mechanism for local service providers to contribute to national clinical trials. However there are additional research projects where the participation of local services could bring benefit. The CASTLE group will be asked to review the current arrangements and make recommendations to CCGs.	CCG EoLC Executive Lead	December 2016
Involving and supporting carers	'The offer' for families, friends and carers will be defined and will incorporate good pre-bereavement and bereavement care. The carer will be acknowledged as part of the caring team, as appropriate. It is recognised that on occasion children and young people have caring responsibilities and specific bereavement care needs. Outcomes for carers should include increased health and wellbeing, reduced isolation and involvement in planning their loved	9. Carers now meet eligibility criteria for assessment and support if they have needs arising from providing care to another adult, which poses a risk to their own health or wellbeing. This includes support to: • carry out their caring responsibilities; • maintain a habitable environment; • develop and maintain relationships; Health and Social Care colleagues will agree what information needs to be	Social Care Leads and CCG EoLC Executive Lead	September 2016

	one's care.	provided or action taken when a carer is identified on the CASTLE (EPaCCs) register.		
	All population groups should experience improved access to bereavement support depending on their specific needs.	10. Each CCG will specify how they will review what bereavement care is provided to their population and how they will assess equity of access to this care. The findings of this review will be shared with patients, carers and the wider public in order that they can help define the future pre-bereavement and bereavement support required (in the context of the resources available)	Social Care Leads and CCG EoLC Executive Lead	December 2016
	Arrangements for bereavement support for suicide will be reviewed.	11. Each Public Health department will be asked to address how bereavement support is provided in cases of suicide, through their Suicide Prevention Strategies and to share this information with CCG and EoLC colleagues.	Public Health Suicide Prevention lead	September 2016
Education and training	Every professional will be competent to deliver of good EoLC. Local commissioners and providers will seek the support of LETBs using existing training opportunities and developing new training programmes, based on a training needs analysis.	12. The core system-wide training to be provided to different staff groups will be defined by the CASTLE group. The CCGs and Social Care will then consider how they will undertake a training needs analysis and then commission this training, working with Health Education England and training providers, as appropriate. This work needs to link into wider workforce development planning processes, and link to quality monitoring processes (for eg. in monitoring indicators of the competence of domiciliary and other	CCG EoLC Executive Lead and Social Care Leads	September 2016

		care providers) .		
24/7 Access	Every patient will have access to 24/7 services responsive to their needs; this is a system-wide expectation. Patients and their carers should receive more timely access to services, symptoms should be better controlled and unwarranted hospital admissions should be avoided.	13. CCGs will, working with their partners, review 24/7 access and develop a plan to address any shortfalls. The approach and format of this plan will be consistent with the wider strategic approaches being adopted by CCGs. The plan will be expected to demonstrate the extent to which there is equity of provision on a 24/7 basis and the extent to which the provision meets demand. The plan should include access to: • community nursing • medication • specialist palliative care • equipment • carer support • access to non-acute beds Access arrangements should reflect timely access to funding via social care or continuing healthcare budgets as appropriate.	CCG EoLC Executive Lead	December 2016
Co-design of services	Commissioners and providers will involve those with personal or professional experience of EoLC to inform plans. All health and social care systems will involve people who have personal experience of death, dying and bereavement, such that the views of service users and their families inform all developments.	14. All providers and commissioners will provide evidence that the local population, professionals and other stakeholders have been involved in planning processes. The plans submitted through this Improvement Plan will need to evidence how views were sought and how many different people contributed to the plans. The format and content of the plans may	CCG EoLC Executive Lead and Social Care Leads	December 2016

	Through this process services should be more reflective of service users' needs and be more easily accessed.	vary depending on the wider co-design processes being adopted by the respective CCGs.		
Leadership	CCGs/LAs/H&WBBs will create the circumstances necessary for action to improve EoLC. They will further develop plans to support cross-organisational leadership, collaborative commissioning, including promoting the use of Personal Budgets.	15. EoLC will be the focus of a system-wide leadership development programme. This will involve working with the H&WBB Executive Team with participation from Trust Chief Executives and CCG Accountable Officers.	Kings Fund (as currently commissioned)	September 2016
		16. There should be consideration of the need for an annual EoLC forum, enabling all relevant partners to share emerging plans and identify opportunities for system-wide working.	Warwickshire Cares Better Together Programme Board	December 2016
		17. CCGs and social care colleagues should agree how they will progress plans for increased personalisation, which may include the roll-out of personal health budgets if considered appropriate. This will be reported to the Warwickshire Health and Wellbeing Board Executive Team.	CCG EoLC Executive lead/Social Care leads (KH to clarify)	September 2016
	The role of programmes to promote public discussion of dying, death and bereavement (eg compassionate communities) will be considered for local implementation. This would increase the capacity within the local community to support	18. The Coventry and the Warwickshire Public Health Departments should be asked to consider how implementation of 'public health approaches to EoLC (eg Compassionate Communities)' might be incorporated into local community engagement programmes, with a report back to the WCBT	Public Health Departments	September 2016

	individuals and families who are dealing with EoL. For example support might be available thorough volunteers and providers of other services (such as housing) would be encouraged to support those receiving EoLC.	Programme Board.		
	Commissioners and providers will ensure that clinical leadership for EoLC is at the heart of individual provider organisations.	19. All organisations will confirm to the WCBT Programme Board that they have an executive lead and a named clinical lead for EoLC. Trusts will also be asked to identify a lay board member to lead on EoLC. These individuals will be accountable for the plans and processes related to EoLC within their organisation	Warwickshire Cares Better Together Programme Board	June 2016

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Quality Strategy (2016 – 2021)**
Author	**Jenny Gardiner, Director of Quality**
Responsible Chief Officer	**Meghana Pandit, Chief Medical and Quality Officer**
Date	**28 July 2016**

1. Purpose

The Quality Strategy requires update and refresh.

This new Quality Strategy (2016-2021) builds on the existing foundations set out in previous versions. It describes the quality improvement framework at UHCW and how this will enable the Trust achieves its vision to become a national and international leader in healthcare and deliver the highest quality of care to our patients, relatives and carers.

2. Background and Links to Previous Papers

The Quality Strategy is a five year strategy, aligned to the Trust Clinical Strategy, UHCW Improvement System, and Trust vision, mission, values and objectives.

The first Quality Strategy was approved by Trust Board in 2012 and a subsequent refresh carried out in 2013. Unlike previous iterations, the third Quality Strategy is much broader and considers quality in totality across the organisation, rather than simply describing quality within the context of the Quality Department.

3. Executive Summary

The Quality Strategy articulates the key aims and objectives that will drive the delivery of Quality at UHCW over the next five years – 2016 to 2021. It provides a clear and measurable approach to maintaining and achieving *world class quality,* and takes account of key national quality drivers.

It is a Trustwide strategy that includes a foreword from the CEO, and describes the relevance of its aims and objectives at all levels of the Trust, and to all groups of staff to ensure that everyone understands their own contribution to delivering excellent patient care and experience.

The Quality Strategy aims to:

- Avoid preventable harm through Patient Safety
- Improve Patient Outcomes through Clinical Effectiveness
- Improve Patient Experience

These aims will be delivered by a series of underpinning objectives. Quality metrics and baseline positions have been agreed with relevant leads across the organisation.

Progress against these metrics will be monitored and reported through Quality Governance Committee following approval.

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

The Quality Strategy objectives support the Trust strategic objectives in relation to Achieving Excellent Patient Care and Experience, and the annual corporate objective in relation to Improving Patient Outcomes for Mortality, Infection Control and Hospital Cleanliness.

Risks against achievement of Quality objectives will be tracked, monitored and reported to QGC.

5. Governance

- The Trust Board sets UHCW's quality priorities through the approval of this Quality Strategy. In doing so it agrees and communicates what quality means to UHCW and promotes a culture of quality improvement throughout UHCW. Trust Board holds all the organisation to account for ensuring that the patient is at the centre of care that we deliver.

- The Quality Governance Committee, reporting to the Trust Board, provides assurance there are appropriate systems in place to monitor the implementation of the Quality Strategy and achievement of its objectives.

6. Responsibility

- All Board members, clinical leaders and senior managers have the responsibility for leading, promoting and understanding the objectives of the Quality Strategy and the wider quality agenda.

- The Chief Medical & Quality Officer (CMQO) and Chief Nursing Officer (CNO) are jointly accountable to Trust Board for delivery of the quality agenda and the overall quality of care being delivered by the organisation, across all service lines.

- The Quality Department, led by the Director of Quality, supports the implementation of this Strategy and achievement of its objectives, by working with all stakeholders to ensure there are robust systems and processes in place to develop, implement and monitor quality.

7. Recommendations

The Board is invited to **APPROVE the Quality Strategy.**

Jenny Gardiner, Director of Quality
15/07/16

University Hospitals Coventry and Warwickshire NHS Trust

Quality Strategy	
e-Library ID Reference No:	**GOV-STRAT- XXX**
Newly developed Trust-wide CBRs will be allocated an eLibrary reference number following submission of e-form for registering on e-Library. Reviewed Trust-wide CBRs must retain the original eLibrary reference id number.	
Version:	
Date Approved by Corporate Business Records Committee (CBRC):	XX
Date Approved by Trust Board *(if Applicable)*	XX
Review Date:	XX
Title of originator/author:	Director of Quality Associate Directors of Quality • Patient Safety • Effectiveness and Compliance • Patient Experience
Title of Relevant Director:	Chief Medical and Quality Officer
Target audience:	All UHCW staff and External Stakeholders
If printed, copied or otherwise transferred from eLibrary, Trust-wide Corporate Business Records will be considered 'uncontrolled copies'. Staff must always consult the most up to date PDF version which is registered on e-Library.	

This Trust-wide CBR has been developed / reviewed in accordance with the Trust approved ***'Development & Management of Trust-wide Corporate Business Records Procedure (Clinical and Non-clinical strategies, policies and procedures)'***	Version XX

Summary of Trust-wide CBR: *(Brief summary of the Trust-wide Corporate Business Record)*	The Quality Strategy sets out the key quality priorities that will continually drive improvements to ensure UHCW achieves its strategic objectives and become a national and international leader in healthcare.
Purpose of Trust-wide CBR: *(Purpose of the Corporate Business Record)*	To inform staff, patients and stakeholders how improvements to Quality will be realised at UHCW.
Trust-wide CBR to be read in conjunction with: *(State overarching/underpinning Trust approved CBRs)*	UHCW Clinical Strategy
Relevance: *(State one of the following: Governance, Human Resource, Finance, Clinical, ICT, Health & Safety, Operational)*	Governance
Superseded Trust-wide CBRs (if applicable): *(Should this CBR completely override a previously approved Trust-wide CBR, please state full title and eLibrary reference number and the CBR will be removed from eLibrary)*	Quality Strategy XXX

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Responsible Director's Name & Title:	Meghana Pandit, Chief Medical and Quality Officer
Department/Specialty:	Quality

Version	Title of Trust Committee/Forum/Body/Group consulted during the development stages of this Trust-wide CBR	Date
XX	Chief Officers Group	XX
XX	Quality Governance Committee	XX
XX	Trust Board	XX

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FOREWORD BY PROFESSOR ANDREW HARDY, CEO

We are committed to working with patients, their families and carers to improve the care we deliver to our patients.

As Chief Executive Officer at University Hospitals Coventry and Warwickshire NHS Trust (UHCW), I feel privileged to lead an organisation with a skilled, passionate and dedicated workforce. These important contributions are greatly valued; our staff work tirelessly to improve patient care year-on-year, often in difficult circumstances.

In 2012, the Trust's first three year Quality Strategy was launched to provide a framework for quality within the Trust. As we review our progress over the last three years it provides us with the opportunity to reflect on our current position and future direction.

There have been many changes at local and national level that impact on our practice. Despite this, our staff continue to adapt by introducing innovations and new ways of working demonstrating commitment to health service provision whilst being aware of changing needs and expectations of our patients, their families and carers.

This new Quality Strategy (2016-2021) builds on our existing foundations, and sets out our vision to become a national and international leader in healthcare and deliver the highest quality of care to our patients, relatives and carers. The Strategy defines the Quality objectives that will be implemented and achieved by us over the next five years. It describes the expectations I hold as the Trust Accountable Officer and I fully endorse its core principles; care that is safe, clinically effective, that provides the best possible experience for patients. These three dimensions are the foundation for our Trust Quality Strategy and provide a framework in which we will drive and achieve quality improvement at UHCW.

We will utilise three interrelated and interconnecting quality improvement methodologies, collectively known as the 'UHCW Improvement System', to focus our energy and attention on over the next five years:

- **Rapid Process Improvement**

  A process of continuous improvement that seeks to identify and eliminate waste and inefficiencies in healthcare processes, making it possible for Trust staff to deliver the highest quality, safest patient care with zero defects. A five

year programme to introduce lean methodology commenced in October 2015. As part of this work we have identified three value streams which include improving ophthalmology outpatient service, incident reporting and investigation, and theatre management.

- **Sign up to Safety Programme**

  The Trust is signed up to the national 'Sign up to Safety' programme aimed at reducing avoidable harm to patients by half. As part of the Trust's Sign up to Safety campaign, we were successful in obtaining funding from NHSLA to implement a Human Factors programme for three of our high volume / high risk specialties (Theatres, Orthopaedics & Emergency Department). We are in the process of training staff in Human Factors methodology to cascade this throughout the Trust to encourage a safety culture.

- **Together Towards World Class**

  Together Towards World Class (TTWC) was launched on NHS Change Day, 3rd March 2014 as an organisational development blueprint to achieve UHCW's aspiration to become a national and international leader in healthcare. The TTWC programme is underpinned by the Trust's values and behavioural framework which are at the very heart of how we do things at UHCW. It identifies five key areas of focus: World Class Experience, Services, Conversations, Leadership and People.

Our Quality Strategy aligns to the Trust's strategic and corporate objectives. It is underpinned by the Fundamental Standards of Care (2014), and has been shaped by the recommendations of the 'Francis Report – the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry' (February 2013).

The implementation of our Quality Strategy will help us achieve our aim to consistently get things right for our patients, their families and carers across every ward and service, every day. The progress we make will be aligned to work plans with key milestones and deliverables, and will be reported through assurances to Trust Committees that will track progress. We will identify opportunities for improvement, but also highlight where we have achieved excellence, by celebrating success and good practice across the organisation and within our Quality Account and Annual Reports.

This will not happen without the continued efforts of our staff, who we know from experience, have ensured that we embark on the next stage of our journey from solid foundations. The Quality Strategy recognises the essential contribution and commitment of all multi-professional staff groups in our journey and their feedback has been taken into consideration in the development of this strategy.

Over the next five years we will continue to focus on the essential elements of care ensuring no effort is spared to improve standards and outcomes, whilst remaining committed to providing a positive patient experience for all, in everything that we do.

Professor Andrew Hardy
Chief Executive Officer

1.0 SCOPE

The Quality Strategy articulates the path for University Hospitals Coventry and Warwickshire NHS Trust (UHCW) to attain 'world class' status in provision of the highest quality of care to its patients. It is informed by the Trust Clinical Strategy and may be read by; our patients, the public and all staff and stakeholders employed by or working closely with UHCW.

UHCW is on a journey to become a national and international leader in healthcare. There are a number of building blocks that support this ambition; these are articulated within the Trust vision, mission, values and objectives which are illustrated within the strate

Figure
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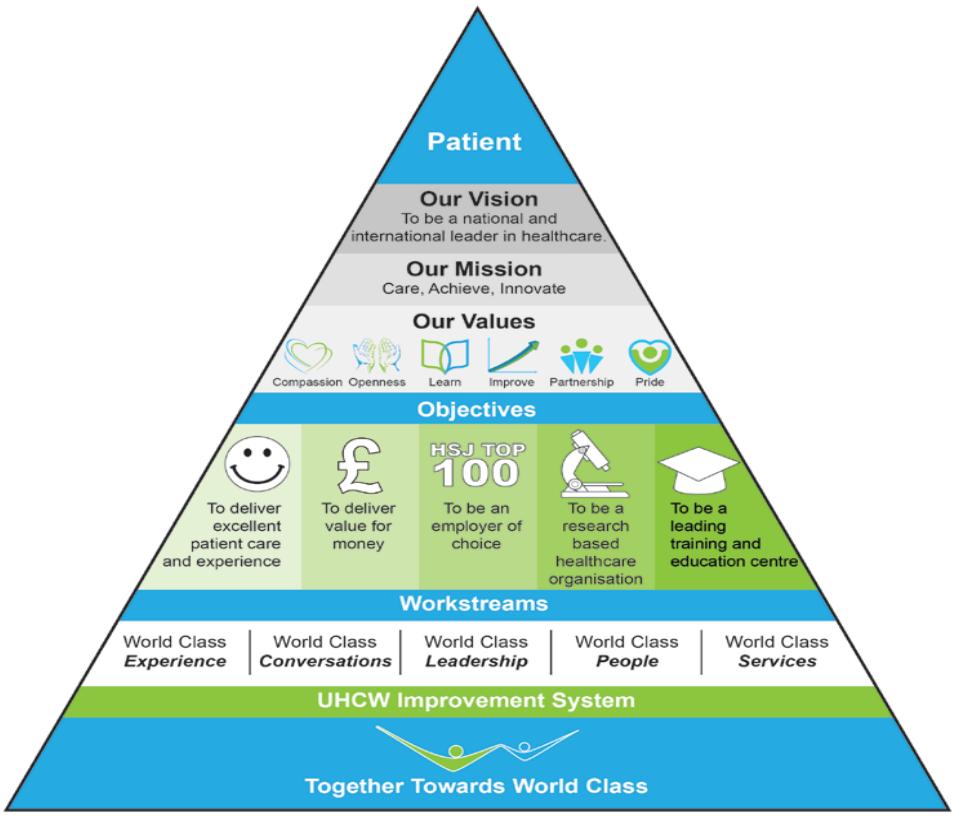


Patient Safety	Clinical Effectiveness	Patient Experience
To reduce avoidable infections	To provide care in line with national and local evidence based guidance	To improve the way we communicate with our patients and carers
To improve performance in pressure ulcer management & falls prevention	To identify areas for improvement through a continuous programme of clinical audit	To improve the patient environment
To increase learning to prevent future harm and avoidable deaths	To reduce HSMR to below 100	To embed the Trust values at the centre of patient care
To improve the management of the deteriorating patient	To interpret and deliver national regulations and standards of care	To improve the way we listen
To improve the management of Medicines		

These building blocks which underpin achievement of our vision are directly relevant to the things that matter the most to our patients namely; safety, outcomes and experience. These three dimensions provide a framework in which we will drive and achieve quality improvement at UHCW.

The Quality Strategy cannot be delivered in isolation of other Trust strategies (such as Finance, Information and Technology, Workforce), and quality improvement methodologies which collectively make up the UHCW Improvement System; Together Towards World Class, Rapid Process Improvement and Sign Up to Safety Programmes. All are interconnected and interdependent in realising our vision of being World Class. It is in the context of this strategic framework that the Quality Strategy has been developed.

2.0 INTRODUCTION

2.1 Context

The overall aim of the Quality Strategy is to set out the key objectives that will drive the delivery of Quality at UHCW over the next five years – 2016 to 2021.

There are a number of national, regional and local drivers that continue to inform this Strategy. *Equity and Excellence: Liberating the NHS* (DH 2010) (1) set out a vision for an NHS focussed on improving quality and achieving world class outcomes. The NHS Constitution (2) sets out patients' rights to high quality services based on good access, information, cleanliness, safety and national best practice and makes pledges to patients that quality standards will be upheld throughout the NHS. NHS Improvement and the Care Quality Commission (CQC) place quality at the heart of their regulatory regimes; CQUIN schemes and NICE Guidance are now well established and annual Quality Accounts provide an overview of the quality of the services we provide to our patients and clearly outline our quality priorities for the forthcoming year.

A single definition of quality was first set out in *High Quality Care for all* (DH 2008) (3); care that is effective, safe and provides as positive an experience as possible. This definition still holds in 2016. The three dimensions provide the basis for quality; all three must be present in order to provide a high quality service.

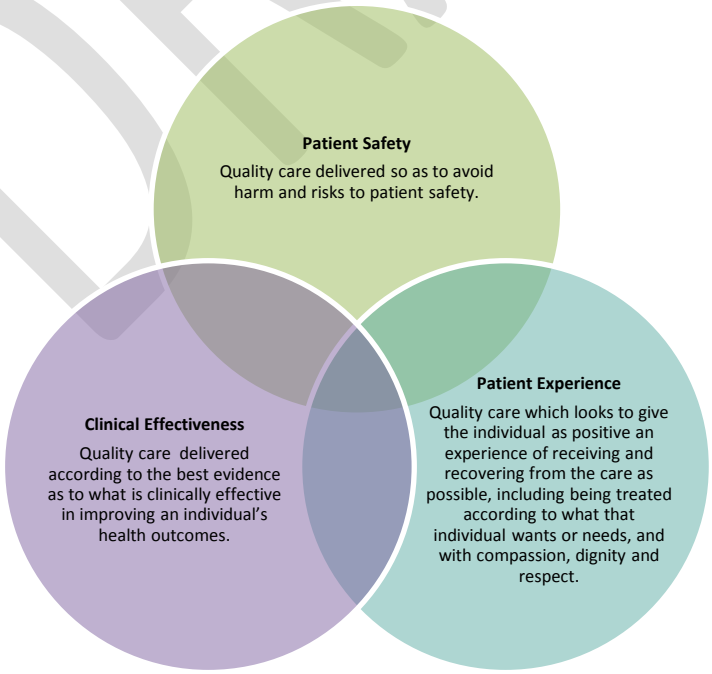


Figure 2: Dimensions of Quality

These dimensions of quality have subsequently become an organising principle, enshrined in legislation through the Health and Social Care Act 2012 (4) and the Health and Social Care (Safety and Quality) Act 2015 (5), and remain at the heart of the NHS Outcomes Framework 2016 to 2017 (6).

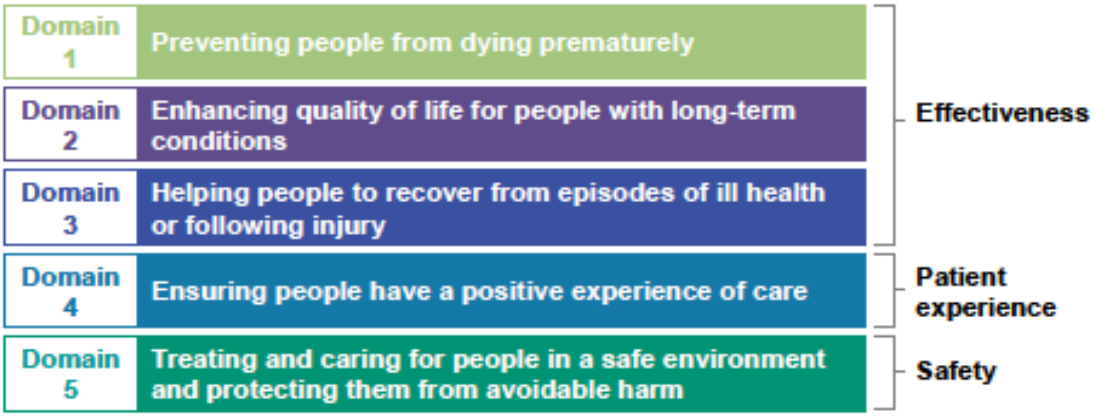


Figure 3. Domains of the NHS Outcomes Framework

The importance and relevance of effectiveness, patient experience and safety have further been reinforced through such national reports as the Francis Inquiry Report (2013) (7), Berwick (2013) (8) and Keogh (2013) (9).

Quality is central to achieving the NHSE Five Year Forward View – a vision for the future of the health system (2015) (10) , which describes a "Triple Aim" of improving population health; providing the highest possible quality and excellent experience; and getting value from all our services (efficiency), based on the Institute for Healthcare Improvement (IHI) methodology. This means providing services that are safe, effective, accessible, affordable and sustainable - reducing harm, variation and waste.

Recent NHS reforms have a central tenet based on putting patients first, and improving quality through a focus on outcomes rather than being process driven. Our second iteration of the Quality Strategy encapsulates this ambition and seeks to provide a Trust-wide framework for quality improvement through improved patient outcomes.

2.2 Why do we need a strategy?

Whilst it is accepted that 'quality' is everyone's responsibility, providing a clear and measurable approach to maintaining and achieving *world class quality* ensures that everyone understands their own contribution to delivering excellent patient care and experience – a determined focus sustained.

It is important that we understand the drivers for having a strategy that seeks to improve the quality of the healthcare that we provide to both the individual patient and to groups of individual patients within pathways of care. Understanding the drivers helps us to ensure our strategy is targeted to those aspects of providing quality services that make the biggest positive impact to the individual patient experience and outcome, and thus for groups of patients. The drivers for our Quality Strategy are detailed below:

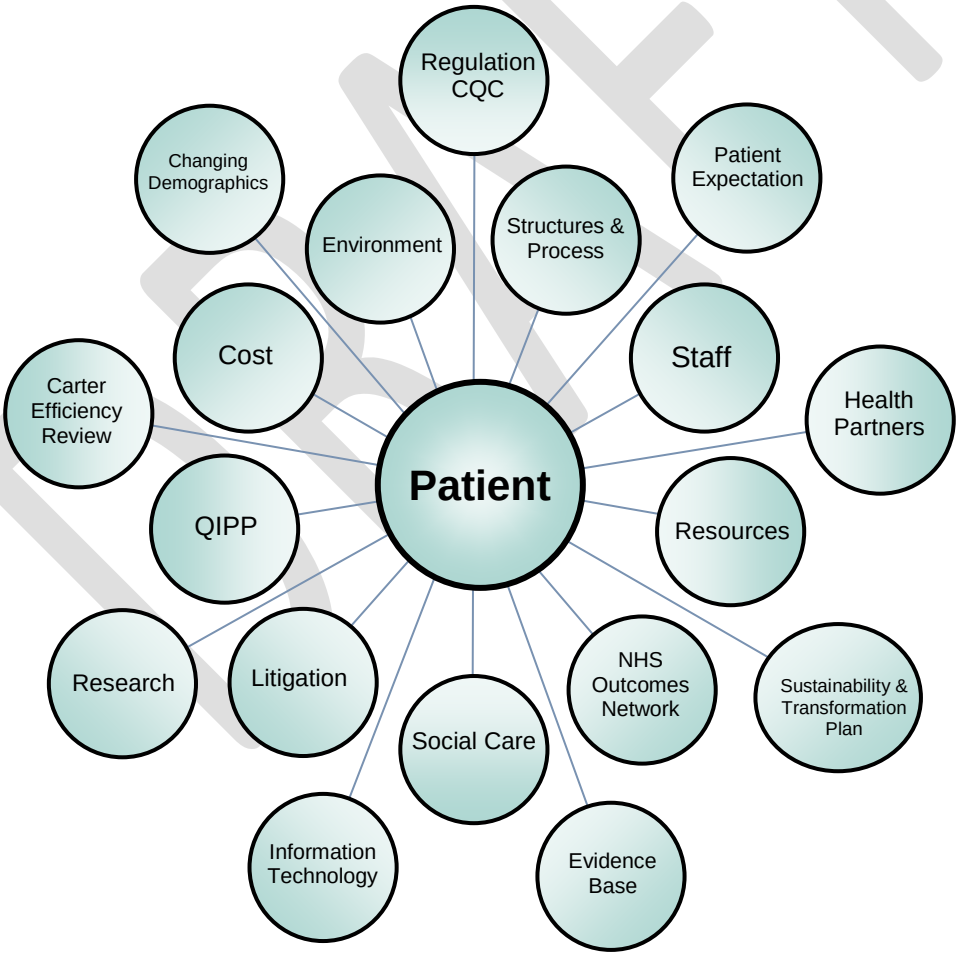


Figure 4: Drivers for Quality at UHCW

All the above drivers influence the quality of care we provide to our patients.

2.3 Our Stakeholders

Understanding the drivers for this Strategy enables us to identify the many stakeholders who are affected by our ambition to deliver world class services and have the power to influence the success of this Strategy.

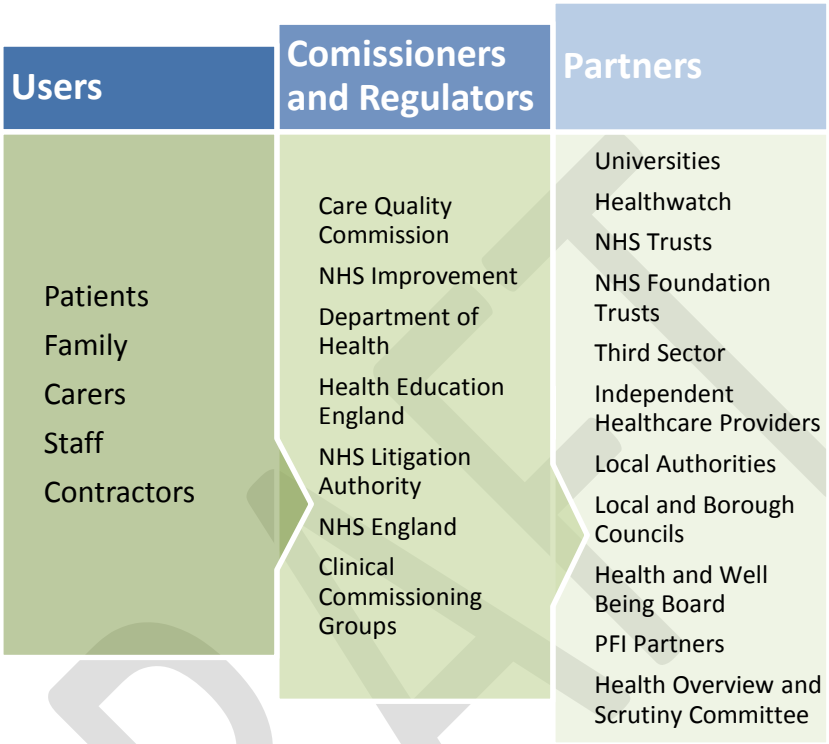


Figure 5: Stakeholders for delivering Quality at UHCW

3.0 STATEMENT OF INTENT

The Quality Strategy outlines the priorities for UHCW in addressing all three dimensions of quality to enable it to achieve its overall vision, mission and objectives. The Strategy describes;

- The context of delivering quality at UHCW
- The aims and objectives that will deliver world class quality at UHCW.
- What will be measured to demonstrate achievement
- The challenges to delivery and how we will work to overcome them
- How we will monitor achievement and sustain this
- Our road map to achievement

The Quality Strategy applies to all staff at UHCW. All staff have a professional duty

for the quality of care being delivered by our organisation, and for encouraging openness and transparency in their interactions with patients and the public and with all stakeholders and regulatory bodies.

4.0 DEFINITIONS

4.1 Quality

As defined by NHS England (2016) (11), **quality** encompasses three equally important parts:

- Care that is **clinically effective** – not just in the eyes of the clinicians but in the eyes of the patients themselves,
- Care that is **safe** and,
- Care that provides as positive an **experience** for patients as possible.

4.2 Patient Safety

As defined by the World Health Organisation (2016) (12), **patient safety** is the prevention of errors and adverse effects to **patients** associated with health care.

4.3 Effectiveness

As defined by Promoting Clinical Effectiveness: a framework for action in and through the NHS (1996) (13) effectiveness is the extent to which specific clinical interventions do what they are intended to do.

4.4 Patient Experience

The sum of all interactions, shaped by an organisation's culture, that influence patient perceptions across the continuum of care. The Beryl Institute (2016) (14).

5.0 DUTIES / RESPONSIBILITIES

Ensuring that patients receive high quality care relies on a complex set of interconnected roles, responsibilities and relationships between professionals. Delivering a quality service is the responsibility of all professional groups at UHCW.

The Quality Department working in collaboration with the Chief Officers and healthcare professionals from all disciplines is committed to supporting the Trust in this.

The Trust Board is responsible for overseeing the implementation of the Quality Strategy. It agrees and communicates what quality means to UHCW and drives a culture of quality improvement throughout UHCW. In turn, it holds all in the organisation to account for ensuring that the patient is at the centre of care that we deliver.

Trust Board encourages and promotes innovation in quality, recognising the importance of quality and continuous improvement to achieving our strategic objectives and realising our vision. As an effective high performing organisation we uphold the following principles:

- All Board members, clinical leaders and senior managers have the responsibility for leading, promoting and understanding the objectives of the Quality Strategy and the wider quality agenda. They ensure that any service changes are assessed for the impact on quality and that change is managed appropriately to safeguard the continued delivery of safe and effective care to patients.

- The Trust Board sets UHCW's quality priorities through the approval of this Quality Strategy, as per the diagram below. It monitors delivery of quality at every meeting, having oversight of the quality of care in specialties.

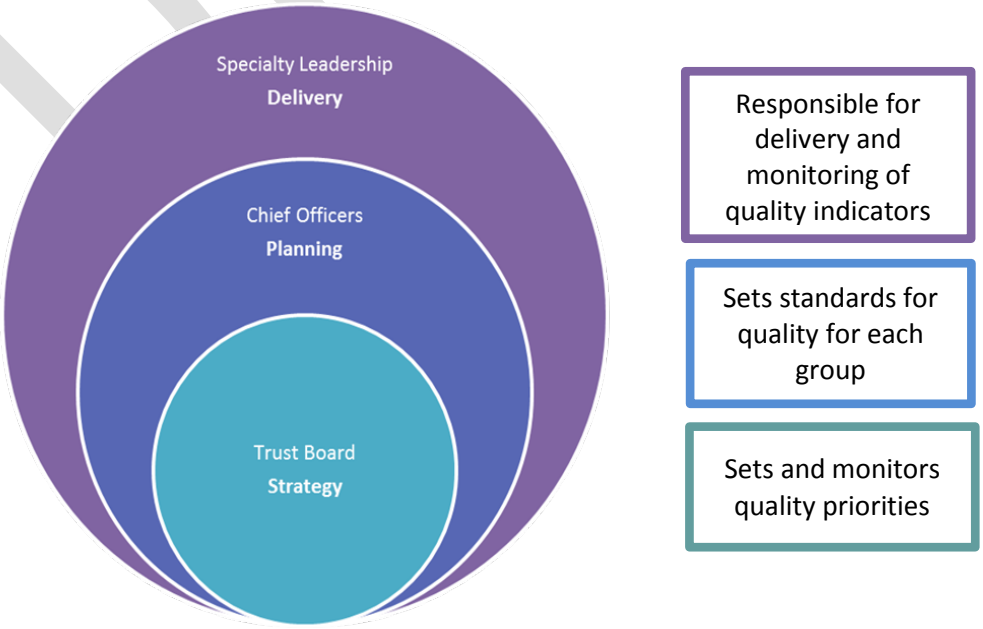


Figure 6: Strategy, planning and delivery at UHCW

- The Trust Board is supported by a number of sub-committees that monitor the progress of delivering and improving quality, and escalate appropriately.

- The Quality Governance Committee, reporting to the Trust Board, seeks assurance that specialties and services have appropriate systems in place to develop and monitor the implementation of the Quality Strategy.

- The Chief Medical & Quality Officer (CMQO) and Chief Nursing Officer (CNO) are jointly accountable to Trust Board for delivery of the quality agenda and the overall quality of care being delivered by the organisation, across all service lines.

- The CMQO is the Responsible Officer (RO) for all aspects of Medical Revalidation and the professional lead for doctors. The CMQO holds the Executive portfolio for the Quality Department, Research & Medical Education, and Medicines Management, and is responsible for development and delivery of the Clinical Strategy and the underpinning Quality Strategy.

- The Chief Nursing Officer (CNO) is the professional lead for nurses, midwives, scientists and allied health professionals; responsible for overseeing care standards and quality improvements in relation to safeguarding, infection control and nursing revalidation. The CNO is the nominated individual (NI) with accountability at Trust Board for maintaining Trust registration with the Care Quality Commission (CQC). The CQC is responsible for ensuring all NHS providers demonstrate that they meet the Fundamental Standards of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (15).

- The Quality Department, led by the Director of Quality, supports the implementation of this Strategy and achievement of its objectives, by working with all stakeholders to ensure there are robust systems and processes in place to develop, implement and monitor quality.

- Clinical leaders have a key responsibility for ensuring effective clinical and quality governance and that the culture in the organisation supports the Trust

values and behaviours amongst their staff. They also need to be aware of and promote awareness of the 'Fundamental Standards of Care'.

- Healthcare professionals working in multidisciplinary teams play a critical role in securing high quality care and excellent outcomes for patients by regularly participating in clinical and quality governance activities; continuously measuring and monitoring indicators on the quality of care they are providing; identifying areas for improvement using data from a range of quality metrics and other sources of intelligence. At a minimum, they must ensure that the services they provide meet the CQC's 'Fundamental Standards of Care'.

- Front-line professionals, both clinical and managerial, who deal directly with patients, carers and the public are responsible for their own professional conduct and competence and for the quality of the care that they provide.

- All UHCW staff are responsible for ensuring that the quality of care and safety of patients is paramount in their interactions with patients and that they carry out their duties of care in accordance with this Strategy, the policies and procedures of the organisation and their professional obligations.

6.0 DELIVERING QUALITY

6.1 Achieving Quality

The system architecture to deliver high quality care at UHCW needs to be focused on ensuring that the three dimensions of quality are integrated with performance management across the whole Trust and across a range of indicators.

Three aims have been identified that will be delivered by a series of objectives. Our aims are to:

- Avoid preventable harm through Patient Safety
- Improve Patient Outcomes through Clinical Effectiveness
- Improve through Patient Experience

Through consultation we have identified our key objectives for achieving and delivering these aims relating to excellent patient care and experience over the next five years. The objectives are summarised below:

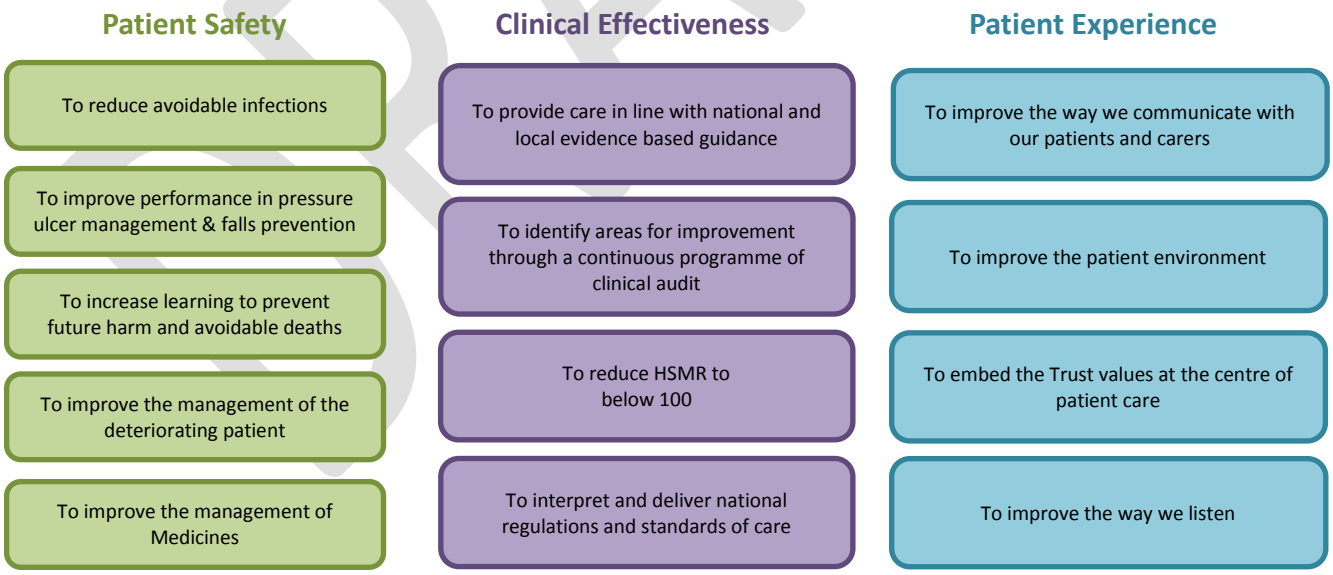


Figure 7: Objectives to deliver Quality at UHCW

To be able to demonstrate achievement of the objectives measures of success have been identified.

6.2 Achieving Patient Safety

Aim: To avoid preventable harm through Patient Safety

We aspire to provide world-class healthcare for the local populations of Coventry and Warwickshire in an environment where safety is at the heart of everything we do.

We will achieve this objective through delivery of our Clinical Strategy and Sign up to Safety Campaign, combined with targeted aspects of safety and mistake-proofing, based on a variety of data sources such as patient and staff feedback, incident reporting and investigation, complaints investigation and legal claims.

To achieve our aim we have identified five objectives. We will measure our progress against each of these objectives to demonstrate our achievements.

Objective 1: **To reduce avoidable infections**

We aim to utilise the most effective evidence-based infection prevention and control measures, working with our partners to deliver the highest standards of cleaning and decontamination.

We will continue to analyse all incidences of infection through a robust root cause analysis process so that we can learn from these cases but we will also proactively seek to learn from high-performing Trusts, wards and departments, both internally and externally.

As measured by:

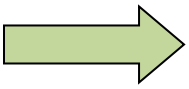
- Maintain 0 hospital-acquired MRSA bacteraemia year on year (currently 0)
- < National C Difficile ceiling (maintain or improve position against other Trusts) to be in top 3 by 2018 (currently in top 5)
- Year on year improvement against baseline for WHO 5 moments for hand hygiene aiming for 60% in 2018 (currently 55%)
- Year on year improvement against compliance with day to

day central line management aiming for 50% in 2018 (currently 23%)
- Maintain 100% compliance with insertion of lines practice to 2018 (currently 100%).

Objective 2: **To improve performance in pressure ulcer management and falls prevention**

We aim to deliver a reduction in the number and the severity of harm of avoidable hospital-acquired pressure ulcers and falls. We will continually seek out the best available strategies to reduce the risk of patients coming to avoidable harm whilst in our care and we will work collaboratively with our stakeholders and partners to drive best practice across the local health region.

As measured by:



- >98% harm free care for hospital-acquired (known as "new harms") on the Safety Thermometer by 2017 (currently 98%)
- 50% reduction in avoidable hospital-acquired grade 2 and above pressure ulcers by 2018, with the further ambition of achieving zero avoidable hospital-acquired grade 2 and above pressure ulcers by 2020 (currently 123)
- Reduction in the total number of falls in hospital by 50% by 2018/19 (currently 6.12 falls/1000 bed days)
- Reduction in the number of falls in hospital with serious harm (moderate or above) by 50% by 2018/19 (currently 0.12 falls/1000 bed days)

Objective 3: To increase learning to prevent future harm and avoidable deaths

We aim to learn from local and national sources of patient safety information and disseminate and embed this widely through:

- Safety alerts
- Safety newsletters
- Individual feedback
- Human Factors training
- Mortality review
- Improved safety data and information

- Always events

We will continue to review all serious incidents at our weekly Significant Incident Group to ensure that rigorous investigations and action plans are implemented and shared.

As measured by:

- 10% reduction in number of serious incidents (excluding pressure ulcers and falls) by 2018 (currently 52)
- Maintain NCEPOD E deaths below 10 by 2017 (currently 6)
- By 2019, 90% of actions arising from RCAs are embedded in practice (currently 49%)
- 5% increase in patient safety incident reporting by 2017/18 (currently 13,787 incidents)

Objective 4: **To improve the management of the deteriorating patient**

We will raise awareness of sepsis by a continuous programme of training and awareness for our clinical staff so that they are equipped to identify susceptible patients. We will maintain our VitalPac clinical observations / monitoring system with the most up to date developments to facilitate improved detection of deteriorating patients so that they can receive prompt intervention by specialist staff. We will develop our electronic handover tool to improve consistency and accuracy of communication and information between all multidisciplinary team members.

As measured by:

- Reduction in the number of serious incidents each year relating to suboptimal care of the deteriorating patient to <3 by 2018 (currently 9)
- >90% of patients who meet the criteria of the local protocol for sepsis screening should be screened for sepsis by 2018 (currently 55%)
- 95% of observations completed within 30 minutes of when due by 2017 (currently 85%)
- Maintain 99% completeness of recorded observations by the end of 2016 (currently 99%)
- Observations to be undertaken by qualified practitioners

only in 90% of wards by the end of 2016 (currently <10%, 3 wards)

Objective 5: **To improve the management of Medicines**

We will provide training and skills for clinical staff to drive up standards and create a culture of safety first around medicines management at all levels. We will maintain a programme of medication safety walkarounds across the Trust to identify both good and poor practices from which we can learn.

We will encourage further reporting and learning from medication incidents through the work of the Medication Safety Officer.

As measured by:

- 20% increase in medication incident reporting (using incident data) by 2021 (currently 1746 (2015/16))
- 5% reduction in number of preventable omitted doses of medication by 2021 (currently 52%)

6.3 Achieving Effectiveness

Aim: To improve Patient Outcomes through Clinical Effectiveness

We want to provide effective evidence based care across all our services that ranks us as world class in the delivery of healthcare that achieves the best outcomes for patients. The care that we provide will reflect clinically effective practice that complies with regulatory and statutory frameworks. We recognise that this is an ambitious journey but we believe it is achievable with the right clinical engagement and standardisation of Trust processes within an environment of learning.

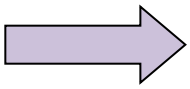
To achieve our aim we have identified four objectives. We will measure our progress against each of these objectives to demonstrate our achievements.

Objective 1: **To provide care in line with national and local evidence based guidance**

We believe that strong systems and processes are important to support our clinical staff in delivering effective evidence based care. Evidence based clinical guidelines that are relevant to the care of patients will be current and available to all staff. They

will provide the guidance for staff to ensure that patients receive care that promotes the best possible individual outcome through informed decisions.

As measured by:



- <4% yearly average expired guidelines by 2017 (currently 4.75%)
- 90% compliance with NICE Guidance by 2017 (currently 61.8%)
- 5 additional care bundles introduced to support improvements and consistencies in care by 2017 (currently 0)

Objective 2: **To identify areas for improvement through a continuous programme of clinical audit**

It is important to us that patients know whether their service is doing well. To help us in this we have a well embedded clinical audit programme that enables us to find out if the care that we provide is in line with national and local standards. Where there is evidence to suggest that improvements are required we take action to address any shortfall. Clinical audit activity helps us to not only improve patient outcomes but also make our services more effective. In the future we want to be better able to demonstrate the benefits that these service changes bring to individual patient care and the efficiency of our Trust.

As measured by:

- 90% completion of annual clinical audit programme by 2019 (currently 45%)
- 100% of action plans implemented in following audit year 2018 (currently 15%)
- 25% of local clinical audits achieve measurable benefits by 2019 (currently 0% baseline as 'benefits' is to be defined)
- Self-assessment against HQIP clinical audit matrix scores 100% 'firm progress in development' as a minimum by 2018 (currently 50%)

Objective 3: **To reduce HSMR to below 100**

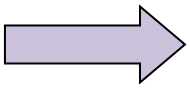
Understanding the care processes that have led to a patient death is complex. We have a well-established and robust process that considers the care of each patient

over the age of 18 that dies in our hospitals. These reviews are complex when considering patients with complex conditions and co-morbidities. However, the reviews are important as they help us understand where less than satisfactory care may have been provided and not achieving the best outcome for the patient. With this understanding we can put in place changes to improve the care that we provide.

Monitoring our risk adjusted mortality rate is another way of understanding whether our care is impacting on the number of deaths in our hospitals. Patients with different profiles and illness have a different risk of mortality. To help understand these differences, we use a risk adjusted ratio that incorporates the characteristics of each patient and their illness. A risk adjusted mortality above 100 means more patients have died that expected; one below 100 means fewer than expected have died.

We believe our mortality rate is an important indicator of the quality of care that we provide and that it can be improved to be consistently under 100.

As measured by:



- HSMR continually less than 100 by 2017 (currently 103.26)
- Ranking in the 10% of Trusts with the lowest mortality rate by 2018 (currently in the worst 25% performing trusts)

Objective 4: **To interpret and deliver national regulations and standards of care**

We are measured against national regulations and standards of care that are considered to be best practice. It is important to us that we are able to demonstrate that the care we provide meets those standards so that:

- patients and their families are confident in the care that we give
- staff are confident in the care that they give
- future staff are confident that we are an employer of choice

We will work with external assessment organisations, such as the CQC, to demonstrate that the care and experience that patients receive, meet and exceed expectations.

As measured by:

- Achieving a minimum 'Good' CQC inspection rating by 2019 (currently 'requires improvement')
- 100% eligible doctor revalidation by 2018 (currently 80%)
- Junior doctors experience and training meets Health Education West Midlands (HEWM) standards by 2017 (currently 2 specialties assessed as level 3 and 4 status by HEWM)
- Student nurse feedback captured (currently 0 mechanisms in place)
- 100% nurse revalidation by 2019 (currently 0%).

6.4 Achieving Patient Experience

Aim: To improve the Patient Experience

We want to ensure that our patients, their families and carers have a positive experience either as an inpatient or outpatient at UHCW. We want to learn and improve using their comments, concerns, complaints and feedback on the services we provide and ensure that robust mechanisms are in place to achieve this. Our service needs to expand to provide easier access to our PALS and patient information services and provide our staff with the skills they need to enhance the patient experience.

To achieve our aim we have identified four objectives. We will measure our progress against each of these objectives to demonstrate our achievements.

Objective 1: To improve the way we communicate with our patients and carers

We believe that effective communication with our patients and their carers is fundamental to high quality healthcare. The Trust will use feedback from service users and their families to improve communication both internally and externally. The Trust will deliver training to support this aim.

As measured by:

- A Score of 'Better' as compared to other Trusts taking part

in the Annual National in-patient Survey for Questions around Information Giving and Involvement in decision making by 2020 (currently 2015/16 'worse')

- 'Looking After You' Boards and 'Welcome' posters in use across 100% of all applicable clinical areas by 2017 (currently in all adult and paediatric inpatient areas)
- Increase in Friends and Family Test recommender rate to ≥95% by 2021 (currently 2015/16 89%)
- 100% of inpatient wards have outcome data published on UHCW website by 2018 (currently 0% as new project)

Objective 2: To improve the patient environment

We aim to improve the quality of the patient's care environment as this has an impact on recovery and well-being. Improvements will be made to infrastructure, nutrition and cleanliness.

As measured by:

- ≥ 90% of respondents leaving a 'mainly good' Impression on the quality of food and drink by 2021 (currently 2015/16 87%)
- Achieve ≥ 90% on the Matron's ICNA audits by 2021 (currently 85%)
- Consistently achieving above the national average across all 6 PLACE domains from 2017 (currently above national average, achieving 6/6)

Objective 3: To embed the Trust values at the centre of patient care

We will continue to promote and share the Trust values though a variety of work streams. All staff will be reminded of these values and encouraged to reflect on these in their everyday patient centred practice.

As measured by:

- Customer care training linked to UHCW Values and Behaviours is available in differing formats by 2018 to all staff (0% new course)
- All nominated leaders have undertaken the Leading Together programme by 2019 (currently Top 100 hospital

leaders have undertaken the course)
- All appraisals are values based by April 2017 (0% starting April 2016)

Objective 4: To improve the way we listen

We will gather and interrogate feedback from service users and their carers in order to learn and understand their experiences at UHCW. This information will be seen as an opportunity to improve the Patient Experience. We will encourage local teams through the publication of Experience Intelligence Reports to use staff and patient feedback to put listening into action.

As measured by:

- ≥90% of PALS contacts have their enquiry locally resolved or referred in 5 working days by 2018 (no current baseline - new indicator)
- ≤10% of complaints are returned for further local resolution by 2019 (currently 2015/16 – 15.8%)
- 75% representation of all Groups at Complaint/PALS Training by 2020 (0% - new indicator)

6.5 Challenges To Delivery

We recognise that this strategy is ambitious and is to be accomplished against the backdrop of a large acute teaching organisation across two sites, serving the expanding and diverse population of Coventry and Warwickshire as well as patients that access our tertiary services. The pressures to deliver safe care and meet national and local targets threatens the achievement of all of our Quality objectives but cannot be allowed to divert us from striving to be the best.

We will work in the following ways to overcome the challenges to deliver this Strategy. They have been structured based on the McKinsey 7 S model from '*In Search Of Excellence: Lessons from America's Best-Run Companies(2004)'* which identifies seven interrelated elements

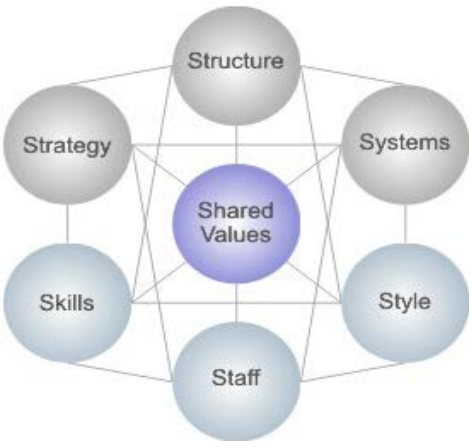


Figure 8: Mckinsey 7 S values based model

that are mutually reinforcing and need to be aligned to enable a complex organisation such as UHCW to deliver its strategic vision for quality.

SHARED VALUES

Challenge: The Trust has commenced its journey through the Together Towards World Class Programme that has six values at its heart. We recognise that this is a long term Strategy and that our values still have some way to go before they are embedded in all that we do.

In response we will:

- work in an open and transparent way with our stakeholders to ensure services delivered by UHCW strive to demonstrate world class care
- commit to greater levels of engagement and involvement with our stakeholders
- work closely with our partners to align quality of care delivered to meet the needs of our local population
- actively seek to learn from other organisations' best practice models for spreading organisational learning
- report incidents and near misses so that we can learn from them

STRATEGY

Challenge: As the Trust continues on its journey towards world class, it has many competing priorities for delivery. Driving towards excellence in quality will require alignment of strategies and focus on achieving demonstrable improvement comparable with the best.

In response we will:

- manage the risks associated with meeting any requirements in our ambition to deliver excellent patient care and experience, and ensure corrective actions are identified and prioritised
- actively seek to benchmark ourselves and work with partners providing world class services to drive clinical standards of care (through participation in the Global Comparators Network and Association of UK University

Hospitals)

- implement the UHCW Improvement System as a management method which seeks to continually improve through the identification and elimination of waste and inefficiency in the many processes that are part of the healthcare experience, making it possible for Trust staff to deliver the highest quality and safest patient care with zero defects
- monitor mortality and surgical morbidity to reduce future harm
- use CEBIS (Clinical Evidence Based Information Specialists) and our Library and Knowledge services to help promote and facilitate access to and use of information and information resources with a clear focus on evidence based patient care, and improving the patient experience

STRUCTURE

Challenge: With so many competing priorities there is a requirement to keep focused and understand the steps and timelines to achieve our aspirations.

In response we will:

- underpin this strategy with a delivery plan, with progress reported annually (Appendix 1)
- support the Trust's organisational structure by working together to deliver joined up care across groups and corporate departments within the framework of performance, quality and formal committee meetings
- publish an annual Quality Account, which will identify annual priorities across the three dimensions of quality, to illustrate our commitment to providing high quality services and being an open and transparent organisation

SYSTEMS

Challenge: The Quality agenda is broad and complex. It poses challenges regarding efficient and accurate collection and analysis of relevant performance monitoring and benchmarking data.

In response we will:

- adopt a range of quality improvement techniques and approaches to promote effective use of clinicians' time and for the use of data
- ensure that due consideration is given to quality implications of future plans and programmes by monitoring their impact on quality and taking subsequent action as necessary to ensure quality is maintained through quality impact assessments (QIA)
- develop, monitor, evaluate and triangulate key performance indicators and stretch targets to raise the quality bar through the Trust via the performance assurance framework
- ensure the Board Assurance Framework and the Risk Register are monitored closely to provide assurance and guarantee controls are in place

STAFF

Challenge: There are challenges around creating the right culture to encourage, engage and empower staff to continuously strive to achieve their aspirations.

In response we will:

- ensure that effective leadership arrangements and behaviours are in place to support staff in their day to day delivery of quality care
- ensure that staff feel engaged and empowered to continuously drive and achieve quality in their specialties, services, departments and teams
- develop compacts which will outline the mutual responsibilities of UHCW, its clinicians and leadership
- undertake a programme of getting the basics right enquiry visits and quality workarounds in patient facing areas

SKILLS

Challenge: There are competing priorities between delivering excellent day to day high quality care and providing our staff with the skills to deliver the best models of care.

In response we will:

- ensure staff have the competencies to provide evidence based treatment and care
- in partnership with other institutions (notably the University of Warwick and Coventry University), seek to further strengthen education, research, and innovation programmes which are already active at a nationally-competitive level
- drive to achieve quality through setting clear objectives in appraisals and personal development plans

STYLE

Challenge: We acknowledge that communication of this Strategy and engagement with its ambition will be a challenge, but this is critical if we are to realise and deliver our objectives.

In response we will:

- communicate our achievements in an open and engaging way that reaches all our stakeholders
- measure and report performance in an open and engaging way to hold staff to account for the care delivered
- actively promote this strategy with staff and stakeholders.

7.0 DISSEMINATION AND IMPLEMENTATION

7.1 This strategy will be available on e-Library after consultation at Chief Officers Group (COG) and Quality Governance Committee (QGC), and formal approval by Trust Board and Corporate Business Records Committee. It will be widely disseminated to all staff via local / departmental and corporate meetings. It will be also be available via the UHCW website www.uhcw.nhs.uk. Implementation will be led by the Quality Department and monitored by the Quality Governance Committee.

8.0 TRAINING

8.1 We recognise the importance of providing our staff with the continuing education, training and professional development to deliver our ambitions. The framework for education, training and professional development provision in the Trust will be driven

and shaped by local and national initiatives, embracing innovative new ways of working wherever possible to ensure our staff can deliver world class care.

9.0 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

9.1 Monitoring Table

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual department responsible for the monitoring	Frequency of the monitoring activity	Group / committee which will receive the findings / monitoring report	Group / committee / individual responsible for ensuring that the actions are completed
Implementation of the Quality Strategy	Review	Quality	Annual	Quality Governance Committee	Quality Governance Committee
	Quality Department Annual Report	Quality	Annual	Quality Governance Committee	Director of Quality
	Quality Account	Quality	Annual	Quality Governance Committee	Chief Executive Officer

10.0 STAFF COMPLIANCE STATEMENT

All staff must comply with this Trust-wide Corporate Business Record and failure to do so may be considered a disciplinary matter leading to action being taken under the Trust-s Disciplinary Procedure. Actions which constitute breach of confidence, fraud, misuse of NHS resources or illegal activity will be treated as serious misconduct and may result in dismissal from employment and may in addition lead to other legal action against the individual/s concerned.

A copy of the Trust's Disciplinary Procedure is available from e-Library.

11.0 EQUALITY & DIVERSITY STATEMENT

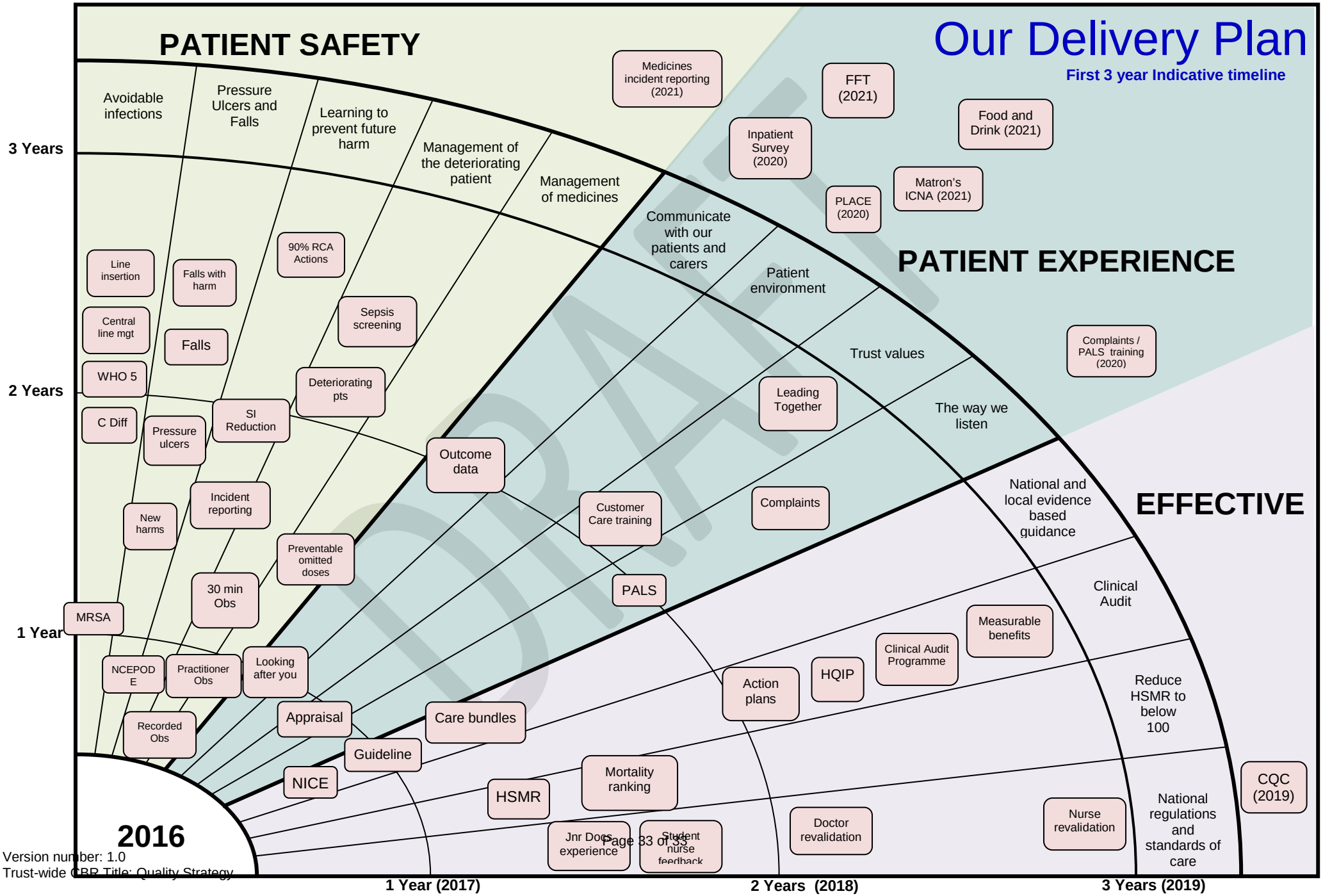
Throughout its activities, the Trust will seek to treat all people equally and fairly. This includes those seeking and using the services, employees and potential employees. No-one will receive less favourable treatment on the grounds of sex/gender (including Trans People), disability, marital status, race/colour/ethnicity/nationality, sexual orientation, age, social status, their trade union activities, religion/beliefs or caring responsibilities nor will they be disadvantaged by conditions or requirements which cannot be shown to be justifiable. All staff, whether part time, full-time, temporary, job share or volunteer; service users and partners will be treated fairly and with dignity and respect.

12.0 REFERENCES AND BIBLIOGRAPHY

12.1 Equity and Excellence in the NHS, Department of Health, 2010
12.2 NHS Constitution, Department of Health, 2012
12.3 High Quality Care for All, Department of Health, 2008
12.4 Health and Social Care Act, 2012
12.5 Health and Social Care (Safety and Quality) Act, 2015
12.6 NHS Outcomes Framework 2015 to 2016, (2014)
12.7 The Francis Inquiry, 2013: Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry
12.8 Review into the quality of care and treatment provided by 14 hospital Trusts. Prof. Bruce Keogh, 2013
12.9 Berwick Review into Patient Safety, 2013, Department of Health
12.10 NHS England Five Year Forward View – a vision for the future of the health System, 2014
12.11 NHS England, 2016, https://www.england.nhs.uk/about/
12.12 World Health Organisation-Patient Safety, http://www.who.int/patientsafety/
12.13 Promoting Clinical Effectiveness: a framework for action in and through the NHS, 1996
12.14 The Beryl Institute, http://www.theberylinstitute.org/
12.15 Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014
12.16 In Search Of Excellence: Lessons from America's Best-Run Companies, 2004

13.0 UHCW ASSOCIATED RECORDS

13.1 UHCW Clinical Strategy



Version number: 1.0
Trust-wide CBR Title: Quality Strategy

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Care Quality Commission – Shaping the future briefing**
Author	**Sue Basham, Associate Director of Quality**
Responsible Chief Officer	**Mark Radford, Chief Nursing Officer**
Date	**28 July 2016**

1. Purpose

This paper provides an update to Trust Board of the Care Quality Commission's (CQC) strategy for 2016 to 2021 and outlines changes to the inspection regime for statutory regulation.

2. Background and Links to Previous Papers

This report is related to the Registration Report presented to Trust Board April 2015 and Trust's CQC Comprehensive Inspection Report published in August 2015.

3. Narrative

In June 2016 the CQC released its five year strategy "Shaping the Future" which, incorporates four priorities for 2016 to 2021. The focus of the strategy is on a more targeted, responsive and collaborative approach to regulation.

All comprehensive inspections are complete and now provide a baseline of the quality of care in England. Going forward, the inspection framework will still ask the same questions for every service – Is it safe? Is it effective? Is it caring? Is it responsive? Is it well-led? Individual CQC report findings create a baseline and highlight areas for improvement and areas that require attention prior to a further inspection.

The strategy is based on the following four priorities:
(Ref: http://www.cqc.org.uk/content/our-strategy-2016-2021)

1 - Encourage improvement, innovation and sustainability in care – work with others to support improvement, adapt the CQC approach as new care models develop, and publish new ratings of NHS Trusts and Foundation Trust's use of resources.

2 - Deliver an intelligence-driven approach to regulation – will use information from the public and providers more effectively to target CQC resources where the risk to the quality of care provided is greatest and to check where quality is improving, and introduce a more proportionate approach to registration.

3 - Promote a single shared view of quality – will work with others to agree a consistent approach to defining and measuring quality, collecting information from providers, and delivering a single vision of high-quality care.

4 - Improve CQC's efficiency and effectiveness – work more efficiently, achieving savings each year, and improving how the CQC works with the public and providers.

The CQC's intention is to focus on the inspections or unannounced inspections where ratings require improvement or are inadequate within a core service and an update will take place to ratings accordingly. The inspections will be smaller and consist of a core service and the 'well led' domain. An inspected Trust will be expected to describe their quality against the five key questions and feed this information into an annual review, which will focus on the inspection activity for the year ahead. The CQC will also develop inspections across core service boundaries i.e. cancer and mental health in Acute Trusts. Inspection against the 'well led' domain is being strengthened by the inclusion of assessment of progress against the Workforce Race Equality Standard (WRES) report. A new rating may be issued for the efficiency and effectiveness of resources.

The CQC will triangulate and use information from outliers, external resources and current inspection reports to target areas of risk. The factors that may change the overall Trust rating are as follows:

- The findings of inspections carried out that year
- A review of leadership and governance within the organisation
- The information gathered through various sources

The new assessments on efficiency and effectiveness will be published in 2016/17 as well as assessing the existing current ratings.

4. Areas of Risk

CQC can use enforcement powers where regulations are breached.

5. Governance

Implications and progress against actions in relation to CQC inspections are monitored through the Trust's Chief Inspector of Hospitals Programme Board.

6. Responsibility

The CQC nominated named responsible person for UHCW services is Mark Radford, Chief Nursing Officer.

7. Recommendations

The Board is invited to note:

- The new approach to inspections which now concentrates on the well-led domain and areas that require improvement.

Name and Title of Author: Pam Hayer, Compliance Manager
Date**:** 30 June 2016

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Workforce Race Equality Standard (WRES) Annual Report**
Author	**Barbara Hay – Head of Diversity**
Responsible Chief Officer	**Karen Martin – Chief Information and Workforce Officer**
Date	**28 July 2016**

1. Purpose

The purpose of this report is to provide the Trust Board with the assurance that UHCW NHS Trust is compliant with the requirement of NHS England to complete and submit the WRES reporting template by 1st August 2016. This report also provides the Trust Board with an update on the progress made on the WRES Action plan 2015-16.

2. Background and Links to Previous Papers

On 31st July 2014 the NHS Equality and Diversity Council (EDC) announced that it had agreed action to ensure employees from BME backgrounds have equal access to career opportunities and receive fair treatment in the workplace. The move followed recent reports which had highlighted disparities in the number of BME people in senior leadership positions across the NHS, as well as lower levels of wellbeing amongst the BME population.

Therefore, from April 2015 all Trusts were required to submit an annual WRES report and plan. To ensure compliance, UHCW Trust Board was presented with the following:

- A paper to approve to content of the WRES reporting template 2015-16 for submission (24th September 2015).
- A paper to note and approve the WRES action plan addressing gaps and issues identified from the reporting template (17th December 2015).

3. Executive Summary

WRES 2015-16

A small working group (which includes ESR and Workforce Information Team, Staffside, Learning & Development, Workforce Business Partners and TTWC) have 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 , at the time, 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.

Key Points from 2015-16 Action Plan:

- Good progress has been made in completing the majority of actions in the agreed time frames(see appendix 1).
- The action relating to ISS staff being included in calculations has proved to be more problematic than originally thought.
- Due to ESR staff changes two of the actions have not been completed by the original target date set. Discussions have taken place with the Associate Director of Workforce - Learning & Organisational Development and the Deputy ESR & Workforce Manager to address this and the actions are now being progressed or incorporated into existing plans.

WRES 2016-17 (Appendix 2)
This year NHS England has revised the template, primarily as a result of the learning taken from last year's WRES reporting. It was identified that there was some confusion about what data was needed and how it was to be calculated.

The Deputy ESR & Workforce Manager, Organisational Development Advisor and Resourcing Manager have been instrumental in providing the information required for the WRES reporting template. However, the work involved in collating the information for the revised template has significantly increased in comparison to last year.

The key points for noting from this year's data collection are:

- There are still a small proportion of employees who have not recorded their ethnicity on ESR.
- We are unable to undertake a comparison with last year's data due to information being automatically removed (NHS Jobs removes data after 12 months) and some information required for the WRES report is not systematically recorded on ESR at present i.e. non-mandatory training.
- We have now resolved the issue of including ISS ROE staff in to our figures.
- There has been a slight increase in the number of BME staff reporting harassment, bullying or abuse from patients, relatives or the public.
- A positive decrease in the number of staff experiencing harassment, bullying or abuse from other staff.
- A notable increase in BME staff who believe the Trust provides equal opportunities for career opportunities or promotion
- A notable decrease in the number of BME staff who have experienced discrimination from Manager, Team Leader or other colleagues.

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

The WRES contributes to the Corporate Objectives in that it enables the Trust to identify how it can develop BME staff to their full potential. There is a direct link to improving staff experience, developing a flexible workforce and our recruitment ambitions around use of agency staff if we are able to widen the skills and knowledge of the workforce to respond more appropriately to the needs of our patients.

By addressing the gaps and issues affecting BME staff, it will have a positive impact on the overall workforce's ability to progress the Trust's objectives.

5. Governance

The regulators, the Care Quality Commission (CQC) will use the WRES to help assess whether NHS organisations are well-led.

Implementation of the subsequent WRES action plan will be monitored by the Workforce and Engagement Committee and any arising issues escalated to the Quality Governance Committee.

There is a requirement for the WRES report and actions to be presented and agreed by Trust Board annually.

6. Responsibility

Barbara Hay, Head of Diversity is responsible for collating/populating the WRES reporting template, leading on the development and implementation of the supporting action plan. Karen Martin, Chief Workforce and Information Officer is the responsible Chief Officer.

7. Recommendations

The Board is invited to **note**:

1. Progress made against action of the WRES 2015-16 Action plan
2. Content of the WRES reporting template

And **agree/approve**

1. Approve the content of the WRES reporting template
2. Agree the actions for 2016-17 identified in the WRES reporting template
3. Agree to the submission of the WRES reporting template to NHS England and our commissioners by 1st August 2016.
4. Agree to the publishing of the content and actions of the WRES reporting template on the Trust website

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

WORKFORCE RACE EQUALITY STANDARD (WRES)
ACTION PLAN 2015-16

WRES Indicator 2 Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts					**Progress to date**
Issues identified	**Action**	**Lead(s)**	**By when**	**Expected outcome**	
• *Current method of capturing data is not fit for the purpose of the WRES data collection*	Carry out a system review to determine a more robust way of capturing data.	Nick Rees Jenna Bryan	January 2016	Able to capture relevant data for future WRES reports and also to identify issues and gaps in relation to BME and recruitment and selection	This action is completed and we will be able to run the necessary reports for the next WRES report.
• *Have identified issue with alignment of ISS data capture to the Trust's data capture*	To work with ISS to ensure that data is collected and included in calculations quarterly.	Zoe Whittaker	April 2016	ISS (ROE) staff included in our numbers to provide a true reflection of employee profile.	This has now been resolved and we are able to confidently to include the BME data from ISS ROE staff.
WRES Indicator 4 Relative likelihood of BME staff accessing non-mandatory training and CPD as compared to White staff					
Issues identified	**Action**	**Lead(s)**	**By when**	**Expected outcome**	
• *Currently no requirement to record non-mandatory training centrally.*	Carry out campaigns to encourage all staff, but particularly BME employees, to update their profile and report all training on the ESR system.	Zoe Whittaker	May 2016 (NHS Equality Week)	All relevant training recorded on ESR system to allow us to analyse and identify gaps and/or issues.	Limited progress due to staffing changes. However, through the Talent Management work stream it is expected that all employees will update their ESR profiles to include non-mandatory training (2017).
	Discuss with L&D possibility of making it compulsory for all training to be linked to PDR's and any training	Lucy Taylor	April 2016		Pilot of value based appraisals currently taking place

• *Cannot retrieve data from ESR due to technical issues*	sponsored or supported by the Trust must be entered on to ESR IBM are aware and it is a known error waiting to be resolved. Working towards finding a resolution for collecting and reporting centrally.	Zoe Whittaker	Ongoing	Statistical information which will enable us to develop plans to ensure equity of training opportunities for BME staff.	
WRES Indicator 7 KF 27. Percentage believing that trust provides equal opportunities for career progression or promotion					
Issues identified	**Action**	**Lead(s)**	**By when**	**Expected outcome**	
• *Appears that BME staff do not believe that the Trust provides equality of opportunity in regard to career progression or promotion*	It proposed that BME staff who meet the criteria, will be targeted and encouraged to take the earliest opportunity to participate on the TTWC leadership programme as positive action.	Donna Griffiths Rajni Martin	April 2016	Collate number of BME staff upskilled in leadership. Monitor progression of BME staff on leadership programme.	14 BME staff have taken part in the leadership programme to date. This represents 8.75% of the total participants. Because all team leaders/supervisors are expected to complete the programme relevant BME staff are not disadvantaged.
• *Unable to verify this statistically due to issues identified under WRES Indicator4*	New starters and leavers surveys will be introduced. The design of the survey will enable us to identify if there are any areas for concern or investigation in relation to BME staff. Surveys will be monitored locally and key issues will be escalated to Workforce and Engagement	Rachael Atkins	November 2015	Collate and use information from surveys to identify and address issues and/or themes. Escalate issues and/or themes to relevant Managers and/or Committees.	To date 173 employees have completed the starters and leavers' survey of which 31 (17.92%) were BME. Analysis of BME responses has not identified any issues for concern or escalation. Responses will continue to be monitored.

	Committee and/or Training, Education and Research Committee.				
WRES Indicator 8 Q23. In the last 12 months have you personally experienced discrimination at work from any of the following: Manager/team leader or other colleagues					
Issues identified • *Some BME staff believe that they have been discriminated against during the last 12 months.*	**Action** With the support of TTWC Changemakers, set up a BME staff network with a clear remit and reporting line. Issues will be escalated to relevant groups and corporate departments to address key themes.	**Lead(s)** Pat McGee Rachael Atkins HRBP (tbc)	**By when** (Launch) May 2016 To coincide with NHS Equality Week	**Expected outcome** Able to identify if there are significant issues around discrimination of BME staff. Support BME staff to escalate issues and/or concerns to appropriate Managers and/or Committees. Increased BME staff satisfaction identified through staff surveys.	More than 100 leaflets were produced, for the Equality Week event, offering the opportunity to set up and or be part of a BME network. However, to date here have been no inquiries. A small group of BME senior manager has been formed and will be co-ordinating and facilitating engagement events for BME staff to identify how they want their issues identified and escalated/addressed.

Workforce Race Equality Standard

REPORTING TEMPLATE (Revised 2016)

Name of organisation

University Hospitals Coventry & Warwickshire NHS Trust

Date if report: month/year

July 2016

Name and title of Board lead for the Workforce Race Equality Standard

Karen Martin, Chief Workforce and Information Officer

Name and contact details of lead manager compiling this report

Barbara Hay, Head of Diversity (barbara.hay@uhcw.nhs.uk)

Names of commissioners this report has been sent to (complete as applicable)

NHS Arden and Greater East Midlands Commissioning Support Unit, Westgate House, Market Street, Warwick CV34 4DE

Name and contact details of co-ordinating commissioner this report has been sent to (complete as applicable)

Suman Ghaiwal, Equality and Human Rights Projects Manager
E: suman.ghaiwal@ardengemcsu.nhs.uk
M: 07813 544426 **T:** 01926 353839

Unique URL link on which this Report and associated Action Plan will be found

To be added

This report has been signed off by on behalf of the Board on (insert name and date)

Report on the WRES indicators

1. Background narrative

a. Any issues of completeness of data

No significant issues, however, there is still a small proportion of employees who do not record their ethnicity. There are plans in place to work with managers to encourage their teams to update their information via self-service on the ESR system.

b. Any matters relating to reliability of comparisons with previous years

There have been some issues relating to the reliability of comparisons with last year's date. This is mainly due to the Trust investing in new and more robust systems that will enable us to collect and analyse workforce data.

HNS Jobs only retains information for a set time therefore it was not possible to look indicator 2 before this reporting period.

Data relating to non-mandatory training is not systematically recorded at this time. However, plans are in place to carry out a talent mapping exercise next year. This will enable us to look at the data relating to BME staff and any other protected characteristic group.

2. Total numbers of staff

a. Employed within this organisation at the date of the report

8436

b. Proportion of BME staff employed within this organisation at the date of the report.

22.61%

3. Self-reporting

a. The proportion of total staff who have self-reported their ethnicity

90.73%

b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity

A key development is that all new staff are now able to access ESR employees self-service on their first day of employment and are actively encouraged to complete their personal information/profile.

c. Are any steps planned during the current reporting period to improve the level of self-reporting by ethnicity

- Publicity emphasising the benefits and importance of updating ESR personal information
- Campaign to encourage staff to complete their ESR personal information
- BME events where staff will be able to complete their ESR personal information

4. Workforce data

a. What period does the organisation's workforce data refer to?

1st April 2015 to 31st March 2016

5. Workforce Race Equality Indicators

Please note that only high level summary points should be provided in the text boxes below – the detail should be contained in accompanying WRES Action Plans.

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	For each of the these four workforce indicators, compare the data for White and BME staff				
1	Percentage of staff in each of the Afc Bands 1-9 and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	**Non-clinical** White 1417.76% BME 4.29% **Clinical** White 49.95% BME 18.28%	**Non-clinical** White 19.06% BME 4.40% **Clinical** White 51.17% BME 17.28%	There has been a slight increase in the percentage of BME staff both clinical and non-clinical.	Work is underway involving recruiting staff from diverse communities/countries. This will be monitored through the WRES action plan to see if any significant increases in BME take place.
2	Relative likelihood of staff being appointed from shortlisting across all posts.	BME staff have a 13.16% of being appointed following short listing across all posts.	Previous year's data unavailable as the recruitment system NHS only retains data for one year	As we do not have the data for the previous year due to the retention period in our recruitment system.	We have archived the information this year so that it can be provided for next year's comparisons and submission
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.	**2014-16** White = 121 BME = 57 (32%)	**2013-15** White = 136 BME = 58 (29%)	There is a slight increase in the % of BME staff involved in formal disciplinary investigations. It is also a notably higher % of BME staff involved in formal disciplinary in comparison to BME staff employed. However, this only relates to 0.68% of the BME staff employed for the year 2014-16 and 0.72% for 2013-15.	The Head of Diversity will be working with the Workforce Business Partners to look more closely at these figures. It has already been identified that there were no issues in relation to discrimination matters, however, we will look further to see if there are areas for concern.
4	Relative likelihood of staff accessing non-mandatory training and CPD	n/a	n/a	At present UHCW does not record non mandatory training and CPD activities in one centralised system, with the ESR being utilised for the recording of mandatory training only and some other training on an ad-hoc basis. This therefore means it is not currently possible to extract information regarding access to non-mandatory training and CPD for BME staff.	As part of a wider piece of work around the development of education within UHCW, all core skills for staff groups will be mapped by April 2016, with ESR being utilised as a recording system for completion. Once in place this will allow us to report on accessibility for BME staff.

	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, <u>compare the outcomes of the responses for White and BME staff</u>				
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	White 27.69% BME 26.67%	White 29.78% BME 24.64%	UHCW has seen deterioration from 2014 to 2016 with the % of BME staff experiencing bullying or abuse from patients, relatives or public in the last 12 months. From 2014 to 2015 there has been an improvement with the % of white staff experiencing this.	Over 300 members of staff have had Dignity at Work training during the past 12 months. This has included front line staff and managers, enabling them to identify bullying, harassment and develop skills to challenge and/or report such behaviours. Workforce Business Partner will be leading on this area of work in future with support from the Equality and Diversity team UHCW will be working with the Hate Crime team (Coventry City Council) to develop a strategy to raise general awareness and support staff who experience abuse.
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	White 23.46% BME 20%	White 26.99% BME 28.99%	UHCW has seen a positive decrease in white and BME members of staff reporting harassment, bullying and abuse within the last 12 months.	Over 300 members of staff have had Dignity at Work training during the past 12 months. This has included front line staff and managers, enabling them to identify bullying, harassment and develop skills to challenge and/or report such behaviours. Workforce Business Partner will be leading on this area of work in future with support from the Equality and Diversity team
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.	White 91.84% BME 76.92%	White 89.88% BME 68%	There is a notable increase in the number of BME staff who believe that UHCW provides equal opportunities for career progression or promotion.	UHCW has embarked on an Organisational Development programme called "Together Towards World Class" (TTWC). As part of TTWC, a Leadership programme has been developed and implemented. BME staff that fit the criteria have been actively encouraged to participate. BME engagement events will be held over the next 12 months. These will help identify possible barriers to progression and how they can be addressed.
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other	White 4.96%	White 9.61%	UHCW has seen a positive decrease in the amount of white and BME members of staff personally experiencing discrimination at work from their	A small working group of senior BME Managers are developing a strategy to engage BME staff across UHCW in activities and/or forums which will allow them to identify issues in relation to discrimination.

	colleagues	BME 6.78%	BME 14.49%	manager/team leader/other colleagues.	It is also envisaged that the forums will be used to develop a network of staff who can support UHCW in policy development, equality impact assessments and BME staff development.
	Board representation indicator For this indicator, compare the difference for White and BME staff				
9	Percentage difference between the organisations' Board voting membership and its overall workforce.	Voting Board Members BME = 8.33% BME staff across Trust =	Voting Board Members BME = 8.33%	There is a significant difference between BME membership of the Board and the overall workforce.	The Board actively encourages individuals from all diverse backgrounds to become part of the Board as and when vacancies arise.

Note 1. All provider organisations to whom the NHS Standard Contract applies are required to conduct the NHS Staff Survey. Those organisations that do not undertake the NHS Survey are recommended to do so, or to undertake an equivalent.

Note 2: Please refer to the WRES Technical Guidance for clarification on the precise means for implementing each indicator.

5. Are there any other factors or data which should be taken into consideration in assessing progress?

Due to staff changes and shortages, progress in some areas has been impacted. Nonetheless, most actions in the plan have been completed or at least started and in developmental stage.

6. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.

Once the actioned identified in this reporting template are agreed by Trust Board they will be transferred to a separate table to but submitted.