University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD MEETING TO BE HELD ON THURSDAY 24th NOVEMBER 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 27th October 2016** Chairman	For Approval	Enclosure 1	
5.	**Matters Arising** Chairman	For Assurance	Verbal	
6.	**Trust Board Action Matrix** Chairman	For Approval	Enclosure 2	
Patient Experience				
7.	**Patient Story** **Chief Medical and Quality Officer**	For Assurance	Enclosure 3	10
Business Items				
8.	**Chairman's Report** Chairman	For Assurance	Enclosure 4	5
9.	**Chief Executive Officer and Chief Officers Reports** Chief Executive Officer	For Assurance	Enclosure 5	5
Performance				
10.	**Integrated Quality, Performance and Finance Monthly Report** Chief Workforce & Information Officer	For Assurance	Enclosure 6	30
Regulatory, Compliance and Corporate Governance				
11.	**Health and Safety Annual Report 2015/16** Chief Operating Officer	For Approval	Enclosure 7	10
12.	**Complaints Policy** Chief Medical and Quality Officer	For Approval	Enclosure 8	10
13.	**Appointment to Board Committees** Director of Corporate Affairs	For Approval	Enclosure 9	10
14.	**Matters delegated to Board Committees** Chairman	For Assurance	Verbal	5
Feedback from Key Meetings				
15.	**Quality Governance Committee Monthly Report of 14th November 2016**	For Assurance	Enclosure 10	5

ITEM	TITLE	BOARD ACTION	PAPER	TIME
	Chair, Quality Governance Committee			
16.	**Finance and Performance Committee Monthly Report of 16th November 2016** Chair, Finance and Performance Committee	For Assurance	Enclosure 11	5
17.	**Audit Committee Meeting Report of 14th November 2016** Chair, Audit Committee	For Assurance	Enclosure 12	5
18.	**Any Other Business**			
19.	**Questions from Members of the Public Relating to Agenda Items**			
20.	**Date of Next Meeting:** **The next meeting of the Trust Board will take place on Thursday 15th December 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 27th OCTOBER 2016 AT 10.00 A.M. IN ROOM 10009/11 OF THE CLINICAL SCIENCES BUILDING, UNIVERSITY HOSPITAL, COVENTRY

AGENDA ITEM	DISCUSSION	ACTION

HTB 16/199 **PRESENT**

Mrs B Beal, Non-Executive Director (BB)
Mr I Buckley, Vice Chair (IB)
Mr D Eltringham, Chief Operating Officer (DE)
Professor S Kumar, Non-Executive Director (SK)
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)
Mrs R Southall, Director of Corporate Affairs (RS)
Mrs P Young, Corporate Secretary (PY) – Minutes

HTB 16/200 **APOLOGIES FOR ABSENCE**

Professor A Hardy, Chief Executive Officer (AH)

HTB 16/201 **CONFIRMATION OF QUORACY**

The Chairman declared the meeting to be quorate.

HTB 16/202 **DECLARATIONS OF INTEREST**

There were no conflicts of interest declared.

HTB 16/203 **WORLD CLASS COLLEAGUE AWARD**

The Chairman was pleased to announce that Ina Holt, Ward Clark for Cedar Ward at the Hospital of St Cross has been elected to be the recipient of the third quarterly World Class Colleague Award in recognition of her role in coordinating pre-operative group and save samples for pre-transfusion testing of patients undergoing elective arthroplasty. Unfortunately, Ina was not able to receive the award in person and arrangements have been made to present the award at the Hospital of St Cross in November.

HTB 16/204 **MINUTES OF TRUST BOARD MEETING HELD ON 29th SEPTEMBER 2016**

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

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HTB 16/205 **MATTERS ARISING**

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

HTB 16/206 **TRUST BOARD ACTION MATRIX**

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

HTB 16/207 **CHAIRMAN'S REPORT**

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

There were no questions raised by other Trust Board members.

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

HTB 16/208 **CHIEF EXECUTIVE OFFICER AND CHIEF OFFICER'S REPORT**

MP reported that the Trust was pleased to receive a visit from Adam Sewell-Jones, Executive Director for Improvement at NHS Improvement (NHSI) who attended the Virginia Mason Guiding Team Meeting and had the opportunity thereafter to meet with the Kaizen Promotion Office Team.

She added that the Trust was delighted to host a visit by Professor Jane Dacre, President of the Royal College of Physicians, who praised the achievements and successes of the medical education and training provided at UHCW NHS Trust.

MP was pleased to announce that she had been awarded a Senior Founding Fellowship of the Faculty of Medical Leadership and Management in the NHS.

KM confirmed that new contracts had been issued to the 48 junior doctors that were due to commence with the Trust in December.

KM advised that a review and refresh of the Trust values and behaviours is being undertaken under the banner of Together Towards World Class (TTWC), and feedback from staff has indicated that a specific value around respect be drawn out as a core value.

In response to a query from DP regarding junior doctors contracts; KM advised acceptance of the new contract is currently being tracked. She added that new contracts will be issued to all eligible doctors through a phased approach during the next eighteen months. She further added that she was not aware of any doctors within the first cohort of 48 that had rejected the contract. In the case of any junior doctors that undertake work at the Trust but do not sign the contract this will be treated as tacit acceptance. MP assured that significant work had taken place in anticipation of the next cohort of doctors commencing in February around redesigning rotas to ensure compliance with the new contract. She reminded that a Guardian of Safe Working had been appointed who will play a key role in leading this and will report to the Trust Board on a quarterly basis to

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provide assurance to the Board.

The Trust Board **RECEIVED ASSURANCE** from the Chief Executive Officer and Chief Officer's reports.

HTB 16/209 **INTEGRATED QUALITY, PERFORMANCE AND FINANCE REPORT (IQPFR)**

KM introduced the report and reflected that Board members should be familiar with the new format. She advised that lengthy discussions had taken place at the Finance and Performance Committee earlier this month around the introduction of the Intensive Support Framework (ISF), which strengthened the current Performance Management Framework and provides greater scrutiny. The ISF is facilitated by the Corporate Delivery Group and is based on a support and improvement approach, with clear incentives in place for good performance. She added that the Finance and Performance Committee will receive an update on the progress of ISF, following each of the Quarterly Performance Reviews.

KM advised that discussion at Finance and Performance Committee also focused on medical agency spend. It was acknowledged that nationally, scrutiny around medical agency spend will be increased further with the introduction of new rules around agency staffing and a requirement for a self-certification checklist to be approved by the Trust Board in November, prior to external submission.

DP praised the ISF report received by the Finance and Performance Committee and reflected that the report demonstrated two specialties that were not achieving CIP, mandatory training or sickness targets, which was indicative of leadership issues. DP suggested that the ISF will act as a useful tool to challenge areas of poor performance.

Discussion turned to performance and DE advised that areas of challenge remain a cause for concern. The Trust reported 90.14% against the Emergency Department (ED) standard in September; although this demonstrated an improved position, it remained below the 95% national standard and the Sustainability and Transformation Fund (STF) trajectory of 92%.

DE was pleased to report that the work undertaken to reset the ED minors pathway and the new approach to triage has paid dividend in sustaining a good performance position.

Work is underway to rollout elements of the national A&E plan incorporating the SAFER model, and focusing on expected dates of discharge for all patients. Underpinning this are 'red to green' days, whereby value adding activities are encouraged for all patients to reduce length of stay and improve patient flow through the system.

The inaugural meeting of the A&E Delivery Board was held the preceding week, at which a Coventry and Warwickshire approach was agreed for the rollout of SAFER and 'red to green' to ensure consistent deployment across the footprint. This is being led by DE and support will continue to be provided by the Emergency Care Improvement Programme (ECIP).

There are five core elements to the national plan and the Trust is currently

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reporting amber against the requirements, which is a reflection of the current performance position. Work is underway to proceed with the winter plan; however, he cautioned that this was heavily reliant upon the support of partners, including the introduction a discharge to assess model that Commissioners have been charged with introducing in November. He added that positive steps have been taken to move this forward and that the work should result in additional capacity to support pathway two in the form of short-term residential care provision in November and long-term care provision to support pathway three in December, for patients to go to whilst a long-term package of care is being determined. He was confident that this would provide a greater degree of flow through the system.

IB observed that on a recent Board Walkround, there were patients that were medically fit for discharge but who were waiting a package of care and queried the merits of utilising valuable nurse time to explore options to facilitate discharge. DE assured that the Trust had a dedicated Integrated Discharge Team, that provides expertise and is responsible for liaising with external services to progress discharge and any issues are escalated to the Operations Team. He added that the issue is one of lack of capacity within the current social care infrastructure and introduction of a discharge to assess model will help to address this.

Discussion ensued and it was acknowledged that the nationally recognised cost for patient bed days was circa £250 per day, which increases significantly for critical care beds.

DE acknowledged that whilst the discharge to assess model will support improved patient flow; Commissioners will be constrained by the assets available that must meet the relevant quality standards, and are cognisant of the fact that sustainable flow through this model is key to ensuring flow through the organisation.

DP observed that a common theme running through the three published Sustainability and Transformation Plans (STP) related to the lack of social care provision and expressed concern that STP's will focus on health needs.

EMS reflected that the average length of stay (LoS) had increased by 10% but conversely the delayed transfers of care (DToC) had reduced and queried the driver for this and what measures were being undertaken to address the issue. DE acknowledged this but cautioned that this represented a crude measure of both elective and non-elective LoS. He assured that many tactics had been deployed to drive down non-elective LoS including senior review, expected date of discharge and reducing the number of diagnostic tests. In terms of elective LoS, the Corporate Delivery Group is undertaking a productivity analysis piece of work, which will be reported to Chief Officers later this month. He added that a peak in LoS is representative of the beginning of the winter effect. MP concurred, adding that there has been an increase in the number of medical admissions relating to patients over the age of 75. Specialities such as Acute Medicine and Gerontology play a significant role in managing these admissions and it is well publicised that these are hard to recruit areas nationally and this would also impact on the LoS. She reminded members that the Trust has changed it's model to review 'outlier' patients, substituting the Locum Team and integrating this function within the roles of existing medical staff, which has seen a demonstrable reduction in the number of outlier patients, which supported a shorter LoS.

DM cautioned against taking the monthly LoS figure in isolation and advised that a

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12 month overview would better demonstrate themes and trends. DP observed that the target LoS is one factor that is used to set the budget and not achieving this results in overspending and loss of income due to lack of bed availability. DM acknowledged this and added that more work was to be done to ring-fence elective capacity, in order to drive flow through the system.

IB queried whether it was possible to determine the agency costs associated with DTOC and LoS. MP advised that the care contact time app is a multi-professional tool which measures the time spent with patients, and it is planned to roll this out to the Groups within the coming months. This will help to identify causative factors and inform positive change.

Discussion turned to referral to treatment (RTT) targets and DE advised that the position remains static, despite focused effort to eradicate the backlog. He advised that the Finance and Performance Committee received a detailed update in relation to the work that is underway to ensure that the Patient Access Policy is applied to maintain the integrity of the RTT waiting list, with patients being booked in true chronological order. He added that the Operations Team were receiving the support of a national RTT expert to review the RTT position and were in the process of creating a RTT recovery plan that represented a challenging, but realistic recovery position, rather than using a mathematical formula that does not triangulate with performance, and sought the support of the Board for this approach. This is expected to be completed by 31st October and he assured that both Commissioners and NHSI have been receptive to this. He added that the review of the RTT position has revealed a number of areas that require improvement, which are being acted upon including nominating a clinical lead to strengthen the governance around this.

BS acknowledged that the Finance and Performance Committee welcomed the direction of travel and the robust approach being taken to ensure ownership and accountability, which is being driven by the Deputy Chief Medical Officer, who has been identified as the clinical lead. She expressed her support for a revised realistic trajectory.

MP advised that the Single Oversight Framework published by NHSI places providers in one of four segments between (1) no concerns to (4) major or complex concerns resulting in special measures. NHSI have indicated that UHCW is in segment (3) owing to the financial and RTT position.

Discussion turned to finance and DM proceeded to provide an overview of the month 6 financial position, confirming that the Trust was on plan but this assumes full receipt of the STF of £17.2m. However, the Trust was reporting £1.075m off plan month 4 – 6 relating to non-achievement of ED and RTT trajectories. The Trust intends to appeal the ED aspect in view of the increased number of A&E attendances against plan and is awaiting guidance from the regulator in this regard.

Contract income is forecast at £6.5m adverse to plan driven by under-performance against activity, risks and penalties. He cautioned that the Trust required £10m of savings, in order to achieve the plan.

The Trust is forecasting £29.6m spend on agency against target of £26.6m as at month 6. Positive inroads have been made to reduce agency spend but

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specialties that carry hard to recruit to posts continue to present a challenge.

The Trust has identified £25.3m of potential cost improvement programme (CIP) savings: below the required target by £0.2m.

In response to a query from the Chairman; KM assured that significant work to influence and encourage medical locums to transfer to NHS contracts had yielded some success.

The Chairman queried whether sufficient steps were being taken to encourage long-term medical locums supporting hard to fill posts to take up substantive positions. MP acknowledged this and emphasised that all endeavours were being taken in this regard including roadshows, recruitment open days etc.

EMS conveyed concern that the turnaround time for managing complaints had deteriorated and urged that providing high quality patient experience was essential and delays could result in an increase in litigation claims for the Trust. He queried whether there was a capacity issue in the system; MP acknowledged the position and advised that August had seen an unprecedented number of complaints received, with a particular increase relating to three Groups; General Surgery, Women's and Children and ED, mainly linked to cancellation of appointments, communication and delay in receiving reports. This was further compounded by staff sickness absence and delays in response from the Groups during the summer period. She assured that a robust escalation process was in place whereby delays are escalated at day 10 or day 15 and intervention then takes place. She added that the number of responses that meet the satisfaction of the complainant and therefore, do not require a further response has improved dramatically, which indicates that the complaint is being properly dealt with. Furthermore, templates have been designed, in order that responses to generic complaints can be managed more effectively.

BB assured that she had recently met with the Complaints Team, and was satisfied with the remedial mitigation plan to rectify and resolve the issue and was assured that there was no backlog to managing complaints. The Complaints Team are looking to provide NED's with an opportunity to walk through a complaint to understand the patient experience better through observing facilitated fishbowl conversations with the complainant at the centre of the dialogue. Furthermore, the Complaints Team are providing an update to the Board at a Board Seminar in January.

EMS observed that it would be helpful for the Quality Governance Committee to receive more detail around the origin of complaints and in particular to understand any trends or themes to pinpoint the driver for this increase and what action is being taken to address this. Additionally, it would be helpful to understand any capacity issues in the system, which are affecting the turnaround time. The Chairman concurred that the Quality Governance Committee explore this further.

The Trust Board **CONFIRMED** their understanding of the contents of the IQPFR, and **SUPPORTED** the associated actions taken.

HTB 16/210 **INFECTION PREVENTION AND CONTROL QUARTER 2 REPORT**

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MR introduced the report to provide assurance to the Board around the work that has been undertaken in relation to the infection prevention and control agenda for quarter 2, 2016-17 and proceeded to provide an overview of performance against national and locally set targets.

He highlighted that UHCW was currently performing just below the trajectory for C. Difficile, which was notable against the national position. As had previously been reported to the Board, one case of MRSA bacteraemia was declared in July 2016 and following investigation with external reviewers, this was found to be unavoidable and no lapses in care were identified.

Innovative work with hand hygiene measurement '5 Moments' continues and has led to measuring performance on 2,026 hand hygiene opportunities across 64 areas, with a trust-wide hand hygiene level of 57% MR emphasised that this was in line with international and national findings and confirmed that the data is being used to target areas failing to elicit hand hygiene.

UHCW continues to monitor the ongoing issues with the heater cooler units that are suspected of transmitting M. Chimera to patients following cardiac valve surgery. MR reminded the Board that this is an international issue and the Trust is following the guidance produced by the National Task & Finish Group. The latest set of water samples revealed no growth and a stringent plan for surveillance and action, as required, is in place.

Latest cleaning audits have demonstrated reduced scores and the Trust is working with ISS to ensure that rapid improvement is made as part of a four week plan to achieve an agreed standard of cleaning. Progress against the plan will be closely monitored by the Operational Cleaning Group. The Chairman added that the matter will also be raised at the next Board to Board with Project Co, due to be held at the beginning of November.

It was noted that the Quality Governance Committee receive routine updates in relation to cleaning compliance within the annual work programme.

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

HTB 16/211 **SAFEGUARDING VULNERABLE ADULTS AND CHILDREN'S Q2 REPORT**

MR introduced the report and highlighted that The Trust continues to work collaboratively with partner agencies, in order to ensure statutory safeguarding arrangements are met within both children and adult services.

A number of audits have been undertaken within the last quarter, which demonstrated variance in results. The repeat audits in respect of both Female Genital Mutilation (FGM) and information sharing and domestic violence questioning during pregnancy have seen an improvement in compliance.

The audited records evidence clear documentation from Midwives informing the Health Visiting Service when a mother has undergone female genital mutilation in 86% of cases, compared to 27% in the previous audit carried out in June 2016.

Compliance in relation to routine domestic violence and abuse questioning during

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the antenatal period has increased from 41% to 54% this quarter. This is very positive but more work is required to raise awareness of the importance of questioning. During the month of November the Safeguarding Team will be facilitating a Domestic Violence Awareness Campaign within the Trust.

Training continues throughout the Trust for both safeguarding adults and children. Compliance continues to increase and stands at 91.68% for level 2 child protection training and 78% for level 3. MR reminded members that level 3 training requires multi-agency input, face to face training. A recent unannounced visit by the Care Quality Commission indicated that level 3 compliance extends to phlebotomy and clinic staff; however, further clarity has been sought in this regard as this is inconsistent with level 3 training requirements at other provider trusts.

MR praised the work of Dr Karen McLachlan, Consultant Paediatrician for the significant work undertaken in relation to child safeguarding that has resulted in the improved management of paediatric patients attending the ED.

It was noted that significance progress had been made to improve safeguarding children since the original OFSTED review of the Local Authority. A further review is scheduled to take place in early November and the outcome of that review will be shared with the Quality Governance Committee later in November.

BB commended the report and drew attention to the work undertaken in respect of domestic violence and queried what support was available to male victims of domestic violence. MR advised that midwives receive training to look carefully at family dynamics during antenatal appointments and detect any warning signs of abuse. MR added that with regard to staff; he was confident that support was available through the Occupational Health Department.

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

HTB 16/212 **MORTALITY PERFORMANCE Q2 REPORT**

MP introduced the report to provide an overview of Trust-level mortality data and performance for the time period October 2015 to September 2016,

She advised that the completion rate for primary mortality reviews between October 2015 and September 2016 was 85.58%. Between October 2015 and September 2016 there have been four confirmed NCEPOD E graded deaths.

The Trust reviews the care of every patient over the age of 18 who dies whilst in its hospitals; 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”. High completion rates for primary mortality reviews highlight excellent engagement with clinical staff with the mortality review process. 89.97% of completed primary reviews between October 2015 and September 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 191 identified opportunities

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for learning from deaths between October 2015 and September 2016, 21.8% of which have been re-graded to NCEPOD A following multidisciplinary review.

The Trust HSMR value for the latest available 12 months of data (July 2015 – June 2016) is 104.30. This is within the 'expected' mortality range.

Over the previous 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 to 34.26%, which is in line with national levels.

BB commended the report.

The Trust Board **NOTED** the report and **RECEIVED ASSURANCE** from the Trust's mortality performance for October 2015 – September 2016.

HTB 16/213 **WE CARE PATIENT EXPERIENCE Q2 REPORT**

MP introduced the report and reflected on the earlier discussions around complaints management and whilst the response rate for managing complaints had deteriorated in August; largely due to the increased volume of complaints received, she assured that the overall age profile of the workload is in a much healthier position than previously.

The oldest complaint is 81 working days, compared to 200 working days reported at the time of the 2015 Care Quality Commission inspection. The ability to meet the 25 Working Day Standard has been registered as a risk on the local Quality Department Risk Register, with appropriate controls put in place to mitigate risk.

Focused attention has been on ensuring quality is not compromised through this challenging time; demonstrated by the reduction in the number of complaints being returned for further Local Resolution. The number of investigations opened by the Parliamentary Health and Service Ombudsman (PHSO) has also remained low and the three complaints reviewed by the PHSO in this quarter were not upheld.

PALS are now able to monitor and report on performance against the five working day response standard. Performance in Q2 was 91% against a target of ≥90% demonstrating a 14% improvement on Q1 position. Work continues to improve processes and the service has launched a satisfaction questionnaire with users to gather feedback for improvement.

Privacy and Dignity, Cleanliness, and Kindness and Compassion were the top three performing key performance indicators (KPIs) on Trust's bespoke impressions survey system. The lowest three performing KPIs were Doing Things on Time, Food and Drink, and Parking.

The Quality Governance Committee had a detailed discussion around the Friends and Family Test and innovations in place to consistently increase the response rate.

As part of the TTWC World Class Experience work streams, Brilliant Basics

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training has been offered to 310 front-facing staff providing the opportunity to learn about seven core behaviours which should exist within every interaction between members of staff and patients or visitors.

The Chairman commended the report and suggested clear outputs from the issues raised during the Board walkrounds following each visit be demonstrated in the form of an action plan included within quarterly 'We Care' report to board going forward. PY assured that the Quality Department had advised that they had made provision for this to be included within the next report.

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

HTB 16/214 **BOARD ASSURANCE FRAMEWORK Q2 REPORT**

RS presented the quarter 2 update against the Board Assurance Framework (BAF) 2016/17. She advised that there are no new risks proposed for inclusion on the BAF and no recommendations for reduction or increase in risk scores. Furthermore the new Interventional Radiology risk that was accepted for inclusion on the BAF at the Trust Board in July has been included as risk 10.

Good progress continues to be made against all risks and actions have been added where appropriate. Tables have also been added at the end of the report demonstrating which actions have been deescalated from the BAF and new risks added during the year, by way of an audit trail.

The Risk Committee continues to review the Corporate Risk Register and to recommend risks for consideration as BAF risks as appropriate.

The Trust Board **NOTED** the content of the Q2 report and **APPROVED** the Board Assurance Framework.

HTB 16/215 **MANDATORY TRAINING REPORT**

KM presented the report, which was intended to provide a summary position to the Board as a whole, given that the area is discussed in a number of different forums.

KM drew attention to table 1 on page 2 of the report and sought to dispel myths around the time required to undertake mandatory training and assured that there was sufficient capacity within the system for staff to adhere to their responsibility to maintain compliance; particularly now that the access to undertake training via e-learning had improved. She added that the original compliance standard of 90% has been stretched to 95% and was yielding positive results.

She advised that an area of concern was the ability to release staff to attend training due to operational pressures. She assured that there was sufficient capacity in the system to support operational release, in order to meet compliance. In order to improve operational release of staff in line with rostering approaches, a pilot project is currently underway to trial different approaches to the delivery of training.

An improvement plan to increase resuscitation training compliance is currently in

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place and includes a reassessment of competency alignment for Advanced Life Support within the ED, reviewing the data capture of courses delivering relevant Paediatric Life Support compliance and delivery of bespoke Intermediate Life Support training sessions through December 2016.

It is proposed that the Finance and Performance Committee continue to receive compliance information around mandatory training but with a revised focus on compliance within each specialty group rather than a topic basis.

In addition, it is proposed that Quality Governance Committee (QGC) receive a quarterly report on compliance levels across training topics areas focused on quality impact areas and risks. **KM**

EMS commended the report and supported the proposal for a quarterly report to QGC.

DP observed that the target for compliance should be set at 100% for mandatory training and sought to understand the consequences for staff that do not meet compliance. KM acknowledged this and added that some topics would be considered more mandatory than others in a health care setting e.g. hand hygiene, resuscitation training etc. There are processes already in place whereby bank staff are only engaged if they can evidence compliance. Additionally, Groups are challenged around mandatory training compliance and there are plans to link this with incremental progression under Agenda for Change.

In response to a query from DP regarding litigation claims relating to patient incidents that involve staff that are not compliant; KM acknowledged this as being a potential issue and confirmed that an analysis of claims was being undertaken and will be challenged back to the Groups at performance reviews.

In response to a query from BB regarding the inclusion of complaints training within the mandatory training profile. MP advised that significant work has been undertaken to reduce the number of topics from 35 to a manageable number and focused on ‘true’ core mandatory training subjects. She assured that management of complaints is delivered as part of the ‘brilliant basics’ training described earlier.

IB suggested that consideration be given to adding value that is meaningful to staff to encourage mandatory training compliance such as making it a prerequisite for being nominated for a World Class Colleague or Outstanding Service and Care Award (OSCA).

The Trust Board **NOTED**:

- Improved compliance levels from 2014 to 2016, with an overall 9.68% improvement;
- On-going compliance challenges and structured work underway to improve compliance;
- Appropriate governance processes are in place to monitor amendments to training requirements and to oversee overall compliance levels within specialty groups and departments;

and

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- **APPROVED** the proposal to amend governance reporting arrangements in regards to the Finance and Performance Committee and Quality Governance Committee

HTB 16/216 **TOGETHER TOWARDS WORLD CLASS PROGRAMME UPDATE**

KM introduced the report and advised that following a recent change in Chief Officer portfolios; Service Improvement as a TTWC work stream now reports to KM. As such a review of the five work streams, of which four report to KM, will be undertaken in order that these are shared appropriately across the Chief Officer portfolios.

She reflected upon the earlier discussions around the refresh of the existing organisational values and behaviour framework. A multi-professional task and finish group will focus on the development of proposals for change, alongside the development of organisational development interventions to support the embedding of the values in practice.

The Chairman requested that the existing arrangements within the Booking Centre be reviewed to ensure that there is sufficient capacity within the system to progress enquiries efficiently and effectively. **DE/MP**

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

HTB 16/217 **CARE QUALITY COMMISSION REGISTRATION REPORT**

MR advised that as part of the CQC registration, UHCW is required to comply with the fundamental standards and regulations set by law. A review of the CQC registration has demonstrated that the Trust remains compliant with regulations 12 (Statement of Purpose) and 7 (Registered Manager).

Within the Statement of Purpose that is submitted to the CQC, the Trust is required to notify them of any changes in 'Registered Manager' details. The current nominated Registered Manager is the Chief Nursing Officer who will shortly be leaving the Trust and the Chief Medical Officer will assume this responsibility in the intervening period until the Interim Chief Nursing Officer assumes the role on 28th November 2016.

The Trust Board:-

- **NOTED** the change in Registered Manager to the Chief Medical Officer on an interim basis;
- **APPROVED** the addition of Management of Supply of Blood and Blood derived products as a regulated activity for Hospital of St Cross; and
- **APPROVED** the addition of 'Urgent Care Services' as a service type for Hospital of St Cross.

HTB 16/218 **TIMETABLE OF BOARD, BOARD COMMITTEE AND BOARD SEMINARS**

RS presented the proposed Timetable of Board, Board Committee and Board Seminars for 2017 for approval and highlighted the topics already referred by the

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Board that have been scheduled within the Board Seminar Programme for 2017.

KM observed that, because of the scope and challenge of scheduling the Board and Committees, this results in a meeting taking place on most weeks of the year and as such, it may present a challenge in terms of annual leave commitments. The Chairman acknowledged this and advised that this was debated by the Committee Chairs recently and it was agreed on merit to spread the meetings as provided in the schedule.

In response to a query from PY; the Chairman confirmed that the Trust Board meeting and extraordinary meeting of the Trust Board to approve the annual accounts will remain as scheduled on separate dates.

In response to a query from PY regarding standardising the scheduling of committees in August; EMS confirmed that he was content hold a Quality Governance Committee in August. BS, BB and SK supported this.

The Trust Board **NOTED** and **APPROVED** the Timetable of Board and Committee Meetings and Schedule of Board Seminars for the 2017, subject to including a date for the Quality Governance Committee to be held in August and **NOTED** the list of Board Seminar topics scheduled for 2017.

HTB 16/219 **APPOINTMENT OF UHCW TRUSTEE TO CHARITY**

Pursuant to the Articles of Association of the Charity, UHCW is entitled to nominate four individuals to become Trustees of the Charity. Professor Mark Radford is one such nominee and given his imminent departure from the Trust, it is necessary for a further nomination to be made to ensure that the full complement of UHCW Trustees is in place.

It was proposed that Linda Abolins, Deputy Chief Nursing Officer be appointed as a trustee. The Trust is entitled to appoint any member of staff as a Trustee and it is not necessary for this to be a member of the Trust Board.

The Trust Board **APPROVED** the appointment of Linda Abolins as a Trustee of the UHCW Charity.

HTB 16/220 **MATTERS DELEGATED TO BOARD COMMITTEES**

The were no matters formally delegated to Board Committees.

HTB 16/221 **QUALITY GOVERNANCE COMMITTEE MEETING REPORTS OF 17th OCTOBER 2016**

EMS presented the report and highlighted the that the Committee received the first annual self-declaration of non-cancer specialised services report, prior to external submission to the national Quality Surveillance Team (QST). It was agreed that going forward the Patient Safety Committee will scrutinise the self-declaration submissions, with any exception reporting to QGC for assurance purposes, prior to external submission.

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

AGENDA ITEM	DISCUSSION	ACTION

HTB 16/222 **FINANCE AND PERFORMANCE COMMITTEE MEETING REPORT OF 19th OCTOBER 2016**

IB presented the report and highlighted the Committee noted that the way the Government funds apprenticeships will be changing in 2017 with the introduction of an apprenticeship levy. Work is underway to understand the impact of this to the Trust. KM added that a levy of £1.5m will be available to the organisation predicated on a substantial increase in the use of apprentices from the current position of 284 to 550. Discussions will commence with each management team in regards to the impact of the apprenticeship reforms, and to encourage workforce developments that can be supported through the deployment of apprenticeship schemes.

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

HTB 16/223 **ANY OTHER BUSINESS**

KM reported that given Profesor Radford's early departure from the Trust, the Remuneration Committee formally approved the appointment of Nina Fraser to the position of Interim Chief Nursing Officer commencing on 28th November 2016 for a period of six months. During this time arrangements will be underway to appoint to the position substantively.

The Chairman extended gratitude on behalf of the Trust Board to the significant contribution made by MR during his time at UHCW and wished him well in his new national role.

HTB 16/224 **QUESTIONS FROM MEMBERS OF THE PUBLIC**

In response to a question from a member of the public in relation to the current financial challenges and agency staff expenditure and the feasibility to explore cooperative working with other local providers; MP advised that discussions are underway to explore an opportunity for developing a peripatetic pool of ANP's and junior doctors.

In relation to a question from a member of the public relating to the cost of managing type II diabetes and actions that are being taken to prevent obesity within the organisation; MP advised that there have been a number of initiatives including the development of a Community Diabetic Service with a preventative approach and furthermore ground breaking research between UHCW and Warwick Medical School has provided the essential step towards supporting the fight against diabetes and obesity.

The Chairman acknowledged that work had been done to improve the variety of food available to patients, visitors and staff within the hospital and confirmed that healthy options meals were offered as part of this. However, as a PFI hospital the Trust has limited influence over the food that is provided.

In response to a question from a member of the public regarding education around obesity and links to diabetes and how these messages can be shared in the community; SK advised that diabetes and obesity was of national importance and at a local level Health and Wellbeing Boards were responsible for delivering

AGENDA ITEM	DISCUSSION	ACTION

public health messages.

HTB 16/225 **DATE OF THE NEXT MEETING**

The next Public Trust Board will be held on Thursday 24 October 2016 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
24 NOVEMBER 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	December 2016	Policy has been approved by the Audit Committee subject to comments made which have been addressed. Formal approval through staff side will now follow and the Policy will be presented to the Trust Board when that has taken place.	No
ACTIONS FROM JULY 2016 MEETING					
HTB/16/168 CARE QUALITY COMMISSION – SHAPING THE FUTURE	BB emphasised the need to understand how the NHSI Joint Oversight Framework and CQC strategy interface. MR acknowledged this and advised that arms-length bodies were taking a single lens approach and suggested this be the topic of a future Board Seminar.	MP/MR	January 2017	Scheduled on Board Seminar Schedule for January 2017	Yes

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST
ACTION MATRIX PUBLIC TRUST BOARD MEETINGS
24 NOVEMBER 2016

AGENDA ITEM 6 ENCLOSURE 2

AGENDA ITEM	ACTION	RESPONSIBLE OFFICER	COMPLETION DATE	UPDATE	REMOVAL
HTB/16/158 INTEGRATED QUALITY, PERFORMANCE AND FINANCE REPORT (IQPFR)	The Trust receives benchmarking data from Civil Eyes Research Limited. DM added that this was used to inform the annual cost improvement plan (CIP) challenges that are set for each of the clinical groups and suggested that it would be useful to have this as the topic of focus at a future Board Seminar.	DM	June 2017	Deferred from February - Scheduled on Board Seminar schedule for June 2017	Yes
ACTIONS FROM SEPTEMBER 2016 MEETING					
HTB/16/189 MEDICAL EDUCATION REPORT	BS conveyed concern in relation to the National Student Satisfaction Survey results and requested that an analysis be presented to the Quality Governance Committee for further scrutiny.	MP	November 2016	Discussed at the November 2016 QGC meeting.	Yes
HTB/16/193 AUDIT COMMITTEE MEETING REPORT: 12th SEPTEMBER 2016	Concern was expressed regarding the response rates to audits and low performance universally across NICE guidelines. It was suggested that the Quality Governance Committee, review performance against the audit strategy with particular reference to the NICE guidelines in order to receive assurance that audits are effectively delivered.	MP	November 2016	Scheduled on QGC agenda for December	No

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST
ACTION MATRIX PUBLIC TRUST BOARD MEETINGS
24 NOVEMBER 2016

AGENDA ITEM 6 ENCLOSURE 2

AGENDA ITEM	ACTION	RESPONSIBLE OFFICER	COMPLETION DATE	UPDATE	REMOVAL
HTB/16/185 (IQPFR)	KM confirmed that the results of a formal two-year post programme evaluation of the Leading Together Programme will be shared with the Trust Board at a future Board Seminar.	KM	2018	Results expected autumn 2017 and will be scheduled on a Board Seminar early 2018. In the meantime, feedback will be provided within the framework of regular TTWC reports to the Board.	No
HTB/16/189 MEDICAL EDUCATION REPORT	IB suggested that clearer key performance indicators (KPI's) would be welcomed in relation to medical student numbers, in order to monitor progress and not rely on NSS survey results in isolation. MP concurred with this and added this would also demonstrate positive feedback in respect of 100% of students obtaining their first choice placements. BS added that KPI's at both organisational and Group level would be helpful.	MP	Dec 2016	KPIs to be developed and included within the next scheduled Medical Education Report to Trust Board.	No
ACTIONS FROM OCTOBER 2016 MEETING					
HTB/16/216 TTWC Programme Update	The Chairman requested that the existing arrangements within the Booking Centre be reviewed to ensure that there is sufficient capacity within the system to progress enquiries efficiently.	DE/MP	November 2016	Update to be given at the meeting.	No

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST
ACTION MATRIX PUBLIC TRUST BOARD MEETINGS
24 NOVEMBER 2016

AGENDA ITEM 6 ENCLOSURE 2

AGENDA ITEM	ACTION	RESPONSIBLE OFFICER	COMPLETION DATE	UPDATE	REMOVAL
HTB/16/215 MANDATORY TRAINING REPORT	It is proposed that Quality Governance Committee (QGC) receive a quarterly report on compliance levels across training topics areas focused on quality impact areas and risks.	KM	November 2016	Incorporating into work-plan	No

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	Patient Story - Two cases that have been decided by the Parliamentary Health Service Ombudsmen (PHSO) and reported in October 2016
Author	PHSO Anita Kane, Associate Director of Quality
Responsible Chief Officer	Meghana Pandit, Chief Medical and Quality Officer
Date	24th November 2016

1. Purpose

The purpose is to share with the Board two summarised complaints that have published in the latest PHSO report entitled, 'Report on selected summaries of investigations by the Parliamentary and Health Service Ombudsman October to December 2015' that was published in October 2016.

2. Background and Links to Previous Papers

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

3. Narrative

In keeping with 'Together Towards World Class' and our vision of becoming a national and international leader in healthcare, the Patient Experience and nursing and midwifery teams believe that complaints and the stories within them are important to further inform the Board, and add additional patient experience information to compliment the Integrated Quality, Finance and Performance Report. Patient Stories also align with the organisations values of Compassion, Care, Openness, Partnership, Learning and Improvement.

The summarised complaints were both partially upheld by the PHSO with a recommendation that a letter of apology and an action plan were developed to ensure that similar failings do not occur.

4. Areas of Risk

If the Trust fails to learn from the findings of complaints and take necessary action then similar failings could occur, which could result in continuing poor patient experience.

5. Governance

NHS Constitution

Principle 3- The NHS aspires to the highest standards of excellence and professionalism.

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.

6. Responsibility

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

7. Recommendations

The Board is invited to **NOTE** the summarised cases and to **RAISE** any questions or concerns.

Summary 1204/December 2015

First Received into UHCW in January 2014 and re-opened for further investigation in August 2014. Received instruction from the PHSO August 2015 and PHSO decided the case in March 2016.

Trust failed to give patient prescribed medication but this did not lead to her death

The failure to prescribe the correct medication and the lack of communication regarding this, led to a reduction in Mrs T's quality of life in the last few weeks before she died. Her family were left frustrated and distressed by the inaction of the Trust.

What happened?

Mrs T's GP was treating her for a chest infection and possible urine infection. Towards the end of 2013 Mrs T's daughter, Mrs F, called for an out-of-hours doctor to see her mother as she had developed diarrhoea and felt unwell. However, instead Mrs T was taken to A&E at the Trust. The Trust carried out various tests and X-rays and admitted Mrs T while waiting for the test results. Mrs F said that during the admission her mother became more agitated and confused; she developed withdrawal symptoms and experienced cramps in her limbs. Mrs F said she discovered that during that time the Trust had not given Mrs T her daily dose of two types of medication that her GP had prescribed to her for more than ten years previously. She said that the family raised this as a concern with the medical and nursing staff on three occasions, but the Trust did not take any action. The Trust discharged Mrs T home without giving her the relevant medication. But when Mrs T got home, she had some medication which was there and Mrs F started giving it to her again. However, Mrs F said that her mother was very weak and could not walk or feed herself, and her condition deteriorated until she died ten days later. Mrs F complained to the Trust, asking why the medication was not given and why this was not discussed with the family. The Trust responded saying that one of the medicines was not given because there was a letter from the GP on its file that said Mrs T had an intolerance to a similar drug. However, the Trust acknowledged that it should have checked this with the GP. It also said that it did not know why the other medication was not given. Following further complaints and a meeting to discuss the outstanding concerns, Mrs F remained unhappy and brought the complaint to us. She said the withholding of her mother's medication contributed to the deterioration in her condition and her subsequent death ten days after discharge.

What we found

We partly upheld this complaint. The Trust did not follow the relevant guidance or established good practice when it failed to give Mrs T the correct medication. There should have been clear communication with Mrs T's family about why the Trust had not given Mrs T the relevant medication. We could not say that this contributed to Mrs T's death as she still continued to deteriorate when she returned home and started taking the medication again. However, because Mrs T experienced withdrawal symptoms from not taking the medication, we said this led to a reduction in her quality of life in the last weeks of her life. Mrs T's daughters were left frustrated and distressed by the inaction of the Trust. Even though we saw that the Trust had acknowledged these failings, we considered that it did not acknowledge the

significance of them and we felt that work was needed to make sure that the failings were not repeated.

Putting it right
The Trust produced an action plan identifying the lessons that it had learned from our investigation and explained how it would make sure that these failings would not be repeated.

Summary 1205/December 2015

First received in October 2014 and re-opened for further local resolution in December 2014. PHSO decided the case in March 2016. Poor record keeping meant Trust could not deal appropriately with complaint

Mrs A complained about the care and treatment given to her daughter, Ms P. But the Trust's lack of adequate record keeping meant that it could not support its complaint response.

What happened?
Ms P had an eleven-year history of progressive multiple sclerosis (MS). When she was admitted to A&E at the Trust, she had not been eating or drinking, she was losing weight and she was suffering from pain, particularly in her shoulder. Ms P also had three bed sores, one of which was infected and needed antibiotics. Mrs A complained to the Trust on behalf of Ms P about the care and treatment she received after being admitted to the Trust with bed sores. Mrs A complained about communication between the Trust and her family, and about a safeguarding alert that the Trust had implemented, which she felt seemed to suggest that her daughter needed protection from her and her husband. She said the Trust also delayed arranging a care plan for Ms A and the nursing care was poor. She said Ms A had become distressed and depressed due to the amount of time she spent in hospital and from the safeguarding alert that had been issued against her mother and father. Mrs A also complained that Ms A was not being turned regularly, which meant she was left in the same position for longer periods of time. Mrs A was also not happy that the Trust had accused her of repositioning Ms A when the Trust had told her not to. Mrs A said that at one point it took nurses 25 minutes to attend to Ms A when she had vomited. The Trust responded to Mrs A's concerns and said Ms A was repositioned regularly. But Mrs A remained unhappy and brought the complaint to us.

What we found
We partly upheld this complaint. The Trust's records did not provide evidence to support its view that Ms A was turned at regular and appropriate intervals. There was an absence of supporting entries on the repositioning charts and some charts were incomplete. Ms A was not turned regularly as the Trust repeatedly recorded her as being in the same position. We did not find evidence to support the Trust's claim that Mrs A had repositioned Ms A despite the Trust discussing this with her. Mrs A denied repositioning her daughter but acknowledged that she had changed her position if she had slipped or was uncomfortable. She also denied being spoken to about this by nursing staff. With regard to the safeguarding alert, the Trust explained that it had

raised it to make sure that Ms A received the best possible care from the NHS. It apologised to Mrs A if there was anything in its process that led her to believe the safeguarding alert implied criticism of her and her husband. We found the Trust's response was appropriate in this instance. The Trust also apologised for a single delay in answering a call bell, which we considered was reasonable.

Putting it right

The Trust apologised for not repositioning Ms A regularly. It also produced an action plan describing what it had learned from the failing we identified and how it would avoid a recurrence in future.

AGENDA ITEM 8 ENCLOSURE 4

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

24 NOVEMBER 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:

The key meetings and areas of interest, since the previous Board meeting were as follows:

- UHCW Board to Board meeting with Project Co
- Together Towards World Class meeting
- Consultant Interviews

STRATEGIC PRIORITIES THIS PAPER RELATES TO:

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

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	**24 November 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 each Trust Board meeting.

3. Narrative

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

- Healthcare Financial Management Association (HFMA) Board of Trustees and Strategy meeting (two-day event)
- Coventry Sustainability and Transformation Plan (STP) and winter pressures workshop
- Meeting with Neonatal Consultant Team
- Television Broadcast re: Neonatal Babies
- Quarter 2 Performance Review meetings
- Planning for 2017/18 and 2018/19: Sustainability and Transformation Plans and Operating Planning and Contracting event
- Relentless delivery and Making Change Happen event
- NHS Partnership with Virginia Mason Institute: Meeting to discuss the Compact between NHSI and the 5 participating Trusts
- STP Programme Board
- STP post-submission feedback meeting
- London Business Forum - The 1% Factor: The Power of Marginal Gains event
- Global Forum for Healthcare Innovators 2016 Chief Executive Roundtable event
- Global Comparators Conference in Los Angeles, USA
- Leading Together Evaluation Research Stakeholder Interview
- Deloitte NHS Healthcare Team Dinner
- Clinical Excellence Awards
- Academic Health Science Network (AHSN) Board Meeting
- West Midlands Health and Well-being STP Executive Group

Consultant Appointments

Since the last Trust Board meeting on 27th October the following Consultant appointments have been made:

- Kai Juen Leong – Colorectal
- Adeel Bajwa – Colorectal
- Joseph Hardwicke – Plastic Surgery

Mr David Eltringham – Chief Operating Officer

- ED and RTT performance remains challenging. I continue to spend considerable time on this and have again joined the Chief Officer performance reviews with each Group.
- Together with my colleagues from Coventry and Rugby Health Economy I attended a Development Day event for Local A&E Delivery Board members, which was facilitated by NHS England.
- I attended a meeting to discuss the Compact between NHSI and the five participating Trusts in the NHS Partnership with VMI.
- I attended a meeting of the STP Out of Hospital Design Group for the Coventry & Rugby Providers.
- Together with Chief Officer colleagues, I attended the Board to Board meeting with the PFI Company.
- I participated in a conference call with our partner organisations in Coventry & Warwickshire to discuss plans to roll out the Red to Green and SAFER initiatives across the Local Health Economy.
- I continue to undertake mid-year performance reviews and job planning conversations with the Clinical Directors.
- I participated in the Phase 2 Leadership Programme Orientation and Q&A sessions.

Mr David Moon – Chief Finance & Strategy Officer

Since the October Trust Board Meeting and, in addition to the routine corporate meetings such as COG; COG Financial Star Chamber; Strategy Group & Board Seminars, F&P, Audit Committee, VMI Trust Guiding Team and Planning Unit; I have undertaken the following commitments:

- Chaired the Sustainability and Transformation Plan Finance Meeting
- Chaired a number of Cost Improvement Plan Steering Group Meetings
- Attended the Quarterly Performance Review meetings
- Attended a number of STP Programme Board meetings including the Coventry and Warwickshire post-submission meeting
- Attended the Board to Board Meeting with Project Co
- Meeting with University of Warwick and Alliance Medical re Community Diagnostics
- Attended the Midlands Online Reporting meeting
- Attended a meeting re the Capital Plan for 2017/18
- Met with Mark Mansfield from NHS Improvement
- Attended a Meeting between Deloitte / UHCW re Electronic Patient Record (EPR)
- Chaired the Managed Theatre Consumables Steering Group meeting
- Attended the Healthcare Financial Management Association (HFMA) AGM
- Attended the PPSG Strategic Meeting
- Attended a meeting of Coventry FDs hosted by KPMG to discuss “shared control totals”
- Chaired the Strategic Partnership Board meeting with Worcester Acute Hospitals NHS Trust
- Chaired the Procurement Steering Committee
- Attended the weekly UHCW / GEH Collaborative Working Programme Group meetings
- Attended the UHCW NHS Trust and CRCCG Risk Share Meeting

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 October 2016:

- Visited wards informally, speaking to Junior Doctors, Nurses, Pharmacists and Consultant colleagues
- Made Responsible Officer submissions to GMC
- Attended Grand Round
- Attended Virginia Mason Stand Up and Report Out
- Clinical Advisory Group meetings
- Attended Acute Configuration Clinical Workshops for:
  -Maternity and Paediatrics
  -Elective and Emergency Surgery
  -Emergency Medicine
- PWC Collaboration Medical Directors Meetings/Conference Call
- Met with the Junior Doctors – Quarterly Meeting
- Inaugural speech – MSc Lecture, for the first cohort of students at Warwick Medical School
- Scoring for the Clinical Excellence Awards
- Value Stream – Sponsored Team meeting
- Met with the Neurosurgery Department
- Met with CD Diagnostics & CD Neurosciences re: Neuroradiology

Mrs Karen Martin, Chief Workforce and Information Officer

CWIO diary:

During the past month I have been in attendance at all of the regular Chief Officer meetings including Quality Governance Committee, F&P, Trust Guiding Team meeting, Risk Committee, Leadership Forum, Chief Officer Forum, as well as COG Advisory Group. I have also been in attendance at the monthly accountability meetings with the Groups and a Task and Finish Group. I have also chaired the Workforce and Engagement Committee, Transforming Workforce Supply Committee, EpR Board and the World Class Services Board.

Other work commitments during the past month have also included:-

- Invitation to attend the Audit Committee meeting
- Carried out a board walk-round with Brenda Sheils on Ward 22 ECU
- Met with the 3 newly appointed Interim Directors of ICT
- Attended St Cross Hospital to shadow a domestic as part of the “day in the life of” initiative
- Attendance at the Clinical Excellence Awards with Andy Hardy and Meghana Pandit
- Attended the West Midlands HR Directors Networking Meeting
- Attended the AUKUH HR Directors meeting in London
- Chaired the Coventry and Warwickshire STP Workforce Stream meeting held at UHCW
- Attendance at Making a Culture Change Coaching course in Burton
- Interviewed as part of the Leading Together Evaluation which is being conducted by Warwick Business School

Workforce:

- In October the Trust launched its response to the **national flu campaign**, with over 100 peer vaccinators and the Occupational Health team vaccinating 56% of eligible staff within the first month. Our target is 75% by the end of December.
- During October and November we reviewed the Trust values and behaviours, based on staff feedback (see also Communications section below). A task and finish group led by the Chief Workforce and Information Officer is considering other interventions to further embed the values at all levels of the organisation.
- The Trust took part in Coventry’s ‘One Big Thing’ to get Coventry active, and NHS Change Day on 19 October, both in support of **staff health and wellbeing**. In October we also launched a partnership with Neyber for financial wellbeing.

- NHS Improvement has issued **new reporting arrangements for expenditure on agency staff**. These come into effect during November 2016. The changes will see increased scrutiny of agency use, including Chief Executive's approval of all shifts costing over £120 per hour and NHS Improvement approval of all senior managers costing over £750 per day.
- The Trust held a training session for senior clinicians and Workforce staff on **Supporting Doctors in Difficulty,** facilitated by Capsticks. The session covered employment law and the Maintaining High Professional Standards process. The session will provide the Trust with a bigger pool of case investigators.

Equality and Diversity:

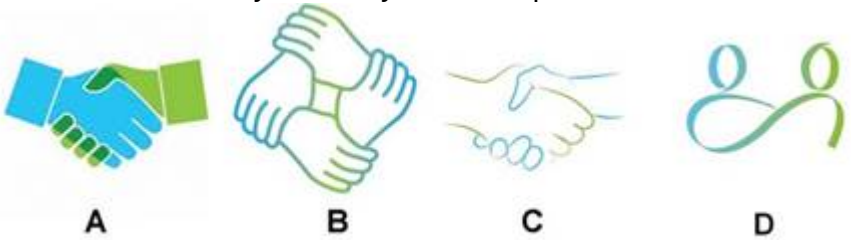
- All of the new **Changing Futures Together interns** have started their placements in a variety of roles across the Trust, ranging from security to admin work. Work has now begun on the 2017/18 programme. It is pleasing to note that four of the first year's cohort of interns have secured employment, one at the Trust.
- The first **Car Park Focus Group for Protected Characteristics** (Equality Act Assessment) has taken place. This was an opportunity for staff to identify any negative impact the new process might have on any of the Protected Characteristics groups.
- The team helped to complete the **Junior Doctors' contract Equality Impact Assessment**.

UHCW Improvement Services

- The **Patient Safety Incident Rapid Process Improvement Workshop (RPIW)** reviewed the process from a serious patient incident occurring to the start of a root cause analysis (RCA) meeting. As a result of the workshop the Trust is piloting a new approach where a Deputy Chief Medical Officer, an Associate Director of Nursing and a member of the Patient Safety Team respond immediately to any incidents, reducing the overall lead time from 54 days to 5.5 hours.
- The third session of **Lean for Leaders** took place in October, training 36 of the senior leaders in the Trust in the UHCW Improvement System. The event was supported by the Virginia Mason Institute.
- A review of the electronic directory of services has been completed towards **standardising booking in Urology**. A new triage process will go live in December.
- By the time you read this building works in support of **Theatre Rota Reconfiguration** will have begun (completion in January). This will permit more activity to move from main theatres to day surgery.

Communications:

- On November 1 a photography exhibition was launched by Neonatal as part of the **Prematurity Campaign** to celebrate patients born prematurely and the work of staff to support them and their families. The launch was led by Andy Hardy. The exhibition will raise awareness of prematurity with the coverage showcasing yet again the cutting edge care given by our women and children's service.
- We have gathered **feedback about the Trust values** introduced two years ago during the launch of TTWC and feel now is the right time for a refresh. Staff thought that the 'Learn' and 'Improve' values were too similar and suggested merging these values together to form a new value of 'Improvement.' We will be also introducing a new value of 'Respect'. Staff are being asked to vote for which symbol they want to represent the value.



- A new edition of the UHCW Improvement System newsletter came out at the end of October featuring updates on the sponsor development session that took place. It also contains details of the next set of projects taking place under the Together Towards World Class programme.

Performance and Programme Management Office (PPMO):

- The Performance team has developed reporting on the **acknowledgement of test results, handover and discharge** on the Trusts CRRS clinical system. This to support further scrutiny of clinical performance within Clinical Groups.
- Corporate Analytics key work streams include **referral to treatment time (RTT) trajectories** and the inclusion of RTT data into this year's Operational Delivery Plans. The team has implemented the **new Winter Sitrep reporting** that includes establishing several new indicators. The team is also working with the lead nurse for Quality and Safety to review the QUESTT Nursing data report and the use of Nursing data reports within the Trust.
- **Clinical Coding** colleagues started coding in their new rota of specialties, thus ensuring that each coder's knowledge and skills are developed or enhanced and a greater level of resilience across the team is provided. This will continue to improve coding processes and cover for absences.

Information and Communication Technology (ICT):

- A potentially serious **cyber security incident** (zero day malware attack) was identified, isolated and the affected service restored in less than 2 hours. This was a useful validation of the Trust's disaster recovery procedures. User awareness is essential to mitigate this risk. ICT and Communications will be further developing materials and communications to enhance this awareness.
- By the time you are reading this report, it is anticipated that the **Nugensys patient flow system** will be installed on pilot wards, with the full roll out in December. This will improve Site Operation's and each ward's view of patient flow across the Trust.
- Additional modules of the **VitalPac patient observation system** have been rolled out to ED and in support of inpatient nutrition screening across the Trust.
- The CP-IS **child protection system is now live** in Children's ED. CP-IS is a nationwide solution that connects local authority children's social care systems with those used by NHS unscheduled care settings, enabling the exchange of key child protection information.
- The **Breast Screening imaging system migration** to the Trust's Insignia Picture Archiving and Communication system (PACS) is now complete. Images can now be shared between the two systems for the benefit of our patients.
- Work has begun to implement a new gateway, filtering web and email traffic. This will improve the way users connect to the internet **reducing the risk of future cyber security threats**. Completion is expected Trust wide by March 17.

Linda Abolins – Deputy Chief Nursing Officer (Acting Chief Nursing Officer)

In addition to all regular meetings such as Chief Officers' Group, COG Finance Star Chamber, COG Advisory Group, Patient Safety Committee, Risk Committee, Quality Governance Committee, Nursing & Midwifery Committee/Forums, Serious Incident Group (SIG), Chief Inspector Hospitals Programme Board (CIHPB) and Strategy Group; I have undertaken the following activities since the last Trust Board meeting in October 2016:

- Quarterly Performance Reviews – w/c 31/10/16
- Interviewed for the post of Associate Director of Nursing – Operations & Delivery
- Met with senior nursing team at Rugby St Cross including ward walk-round – 08/11/16
- Attended the STP progress meeting at George Elliot Hospital – 09/11/16
- Facilitated visit from Milton Keynes NHS Trust to review the Healthroster Reporting Tool – 15/11/16
- Chaired the Nurse Agency Reduction Group – 22/11/16

- Chaired meeting with ID Medical in relation to overseas recruitment - 17/11/16

Attendance at AUKUH Directors of Nursing meeting
Updates were received from Ruth May, DON NHSI in relation to the nursing directorate portfolio and Janet Davies, Chief Executive and General Secretary from the Royal College of Nursing. Information was also provided about the operational productivity programme within NHSI with a focus on model hospital data scrutiny.

HSJ nomination for Care Contact Time App
UHCW has been shortlisted for a HSJ award in the *using technology to improve efficiency* category. A small team from nursing and ICT presented to the judging panel and will be in attendance at the Award Ceremony on 23rd November 2016.

Ward Manager Development
The third 2016 Time Out session was held at the end of October. The focus was on a final update and farewell from the Chief Nursing Officer, management of complaints and patient feedback, in-patient survey results and areas for improvement and focus on the Band 7 Competency Framework. The day evaluated very well, with a suggested programme of events for next year.

Operations & Delivery
- Performance is improving via the Emergency Department with 90% of patients seen within the 4 hour wait target achieved in September
- Groups are now commencing winter planning in relation to capacity and flow
- Recruitment continues to vacant posts
- Red 2 Green roll out continues across the 4th and 5th floors of the Trust
- Work continues in relation to the Nugensis Electronic Whiteboard

Education & Research
The first Acute Illness Summit 'Time to Intervene' was held on 31st October. Speakers for the summit included Dr Ron Daniels, Sepsis and Dr Roger Townsend, Acute Kidney Injury & Fluid Management. This was aimed at Registered Nurses and organised by Practice Facilitators within the R&D Team. A total of 140 delegates attended and the event evaluated very well, with requests for the event to be an annual summit.

Overseas Nurses - four Registered Nurses from Europe commenced with the Trust in October and have commenced a corporate 6 month programme of support which includes a two week induction to the Trust and Nursing in the UK, two week supernumery in practice (will continue for with monthly study/workshop) and clinical supervision. An additional 4 Registered Nurses are due attend arrive in November 2016.

A Practice Facilitator has been recruited to the post of Overseas Recruitment & Pastoral Lead on a 12 month secondment basis to support the Philippine Nurses during transition to the UK.

Nursing Associates – the collaborative application to be an initial Test Site was not accepted but the Trust have been offered the opportunity to be Fast Followers therefore revised proposal will be submitted. If successful, the programme will commence in spring 2017.

A meeting is planned with Coventry University and UHCW in relation increasing the number of children and young people pre-registration nursing students and Operating Department Practitioners on the courses and upon completion work at UHCW.

Maternity
The Maternity Unit in collaboration with GEH, SWFT and Coventry University were successful in becoming a pilot site for the EQUIP Programme. In March 2017, statutory supervision will be replaced by a new model. UHCW Maternity Service completed a bid to develop a model around restorative supervision whereby 5 pilot sites were approved across the Country; Coventry's bid

being categorised as excellent (a total of 49 organisations had submitted bids). The work is due to commence on 15th November 2016 and needs to be completed and evaluated by March 2017.

Better Births (2016) - the National Maternity Service Review will change the way that Maternity Services are delivered. A working party has been established and recommendations are currently being implemented.

Claire Fryer has been appointed Deputy Head of Midwifery and Gynaecology. Claire commenced post on 1st November 2016.

15 new registrants have been appointed across Neonates and Paediatrics and 13 across Maternity Services.

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Integrated Quality, Performance & Finance Report – Month 7 – 2016/17**
Author	**Miss Lynda Cockrill, Head of Performance and Programme Analytics**
Responsible Chief Officer	**Mrs Karen Martin, Chief Workforce and Information Officer**
Date	**24th November 2016**

1. Purpose

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

2. Narrative

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

In the Trust Board Scorecard, 27KPIs achieved the target.

Key indicators in breach are the Trusts performance against:

- the 4 hour A&E target;
- Referral to Treatment incomplete standards (including three breaches of the RTT 52 week wait standard),
- Complaints Turnaround <=25 days

Key indicators achieving the target include:

- HSMR - basket of 56 diagnosis groups
- CIP delivery
- Diagnostic Waiters – 6 weeks and over

The Trust is reporting a year to date deficit of £0.2m which is £1.4m adverse of year-to-date plan. This is due to under-performance against the Trust's STF access standards as at month 7.

The Trust is forecasting delivery of £25.5m against £25.8m of potentially identified savings. This gives a potential full delivery achievement against the Trust revised CIP target of £25.5m for 2016/17

3. Areas of Risk

As detailed in the performance trends pages.

4. Recommendations

The Board is asked to confirm their understanding of the contents of the October 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: 18th November 2016

University Hospitals Coventry and Warwickshire NHS Trust

Integrated Quality, Performance and Finance Reporting Framework

Reporting period: October 2016

Contents

Executive Summary

University Hospitals Coventry and Warwickshire NHS Trust

27 KPIs achieved the target in October

	Indicators achieved	Indicators in exception	Indicators in watching status	Total indicators
Excellence in Patient care and experience	16	16	4	36
Delivery of value for money	5	0	0	5
Employer of choice	3	1	3	7
Leading research based health care organisation	1	2	0	3
Leading training and education centre	2	0	0	2
All domains	**27**	**19**	**7**	**53**

KPI Hotspot

What's Good?

- HSMR - basket of 56 diagnosis groups
- CIP Delivery
- Diagnostic Waiters – 6 weeks and over

What's Not So Good?

- A&E 4 hour wait
- 18 week referral to treatment time
- Complaints Turnaround <=25 days

The Trust's overall performance has improved this month with 27 out of the 53 indicators being achieved. 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 continue to underperform. There have been three breaches of the RTT 52 week wait standard in September.

Improvement has been seen in the MRSA screening indicators although they remain below target. However, the MRSA decolonisation score has improved to 100% compliance from 80% in September. Complaints turnaround times remain a challenge.

Achievement of the staff sickness rate of below 4% has been sustained this month at 3.9%, which is slight decline on last month's performance. Mandatory training compliance has fallen for the fourth consecutive month and is reported at 87.28% which continues to be below the 95% target.

The Vacancy rate compared to funded establishment indicator has deteriorated this month and remains above the target of 10%. This is reflected in the agency costs against total costs which has increased from 8.23% to 8.59%.

The Trust is reporting a year to date deficit of £0.2m which is £1.4m adverse of year-to-date plan. This is due to under-performance against the Trust's STF access standards as at month 7. 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 October 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	18	22	⇩	23	42	42	CNO	
MRSA Bacteremia - Trust Acquired - Cumulative	1	1	⇨	0	0	1	CNO	
Serious Incidents - Number	6	19	⇩	15	15	15	CMO	
Never Events - Cumulative	2.0	2.0	⇨	0	0	2	CMO	
Same Sex Accommodation Breaches	0	0	⇨	0	0	0	CNO	
HSMR - Basket of 56 Diagnosis Groups	95.9	86.7	⇧	RR	RR	RR	CMO	
Harm Free Care	96.9%	95.7%	⇩	95%	95%	95%	CNO	
Patient Experience								
Friends & Family Test Inpatient Recommenders	89.9%	90.3%	⇧	95%	95%	95%	CMO	
Friends & Family Test A&E Recommenders	85.5%	80.1%	⇩	87%	87%	87%	CMO	
Complaints per 1000 Occupied Bed Days	1.76	1.47	⇧	0.99	0.99	0.99	CMO	
Complaints Turnaround <= 25 Days (1 month in arrears)	41%	40%	⇩	90%	90%	90%	CMO	
Theatres								
Theatre Lists Started within 15 mins of Start Time	34.3%	44.1%	⇧	75%	75%	75%	CMO	
Surgical Safety Checklist - WHO	100.00%	100.00%	⇨	100%	100%	100%	CMO	
Emergency Care and Patient Flow								
A&E 4 Hour Wait	90.1%	85.3%	⇩	95%	95%	95%	COO	
12 Hour Trolley Waits in A&E	0	0	⇨	0	0	0	COO	
Ambulance Turnaround within 30 minutes	85.7%	82.2%	⇩	100%	100%	100%	COO	
Delayed Transfers as a Percentage of Admissions	8.1%	7.1%	⇧	3.5%	3.5%	3.5%	COO	
30 Day Emergency Readmissions (1 month in arrears)	8.2%	8.1%	⇧	8.68%	8.68%	8.68%	COO	
Number of Medical Outliers - Average per Day	54.7	55.7	⇩	50	50	50	COO	
Length of Stay - Average	7.6	7.1	⇧	5.96	5.96	5.96	COO	
Bed Occupancy Rate - KH03 (3 months in arrears)	98.9%	97.9%	⇧	93%	93%	93%	COO	
Elective Care								
Last Minute Non-clinical Cancelled Operations - Elective	1.0%	1.3%	⇩	0.8%	0.8%	0.8%	COO	
Breaches of the 28 Day Readmission Guarantee	12	14	⇩	0	0	76	COO	
18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears)	87.99%	87.97%	⇩	92%	92%	92%	COO	
RTT 52 Week Waits Incomplete (1 month in arrears)	1	3	⇩	0	0	0	COO	
Referral to Treatment Incomplete - Backlog Size (1 month in arrears)	3385	3466	⇩	2204	2204	2204	COO	
Diagnostic Waiters - 6 Weeks and Over	0.18%	0.05%	⇧	1%	1%	1%	COO	

Trust Scorecard

Reporting Month October 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)	92.04%	95.91%	⇧	93%	93%	93%	COO	
Cancer 2 Week Wait Breast Symptom (1 month in arrears)	98.2%	100.0%	⇧	93%	93%	93%	COO	
Cancer 31 Day Diagnosis to Treatment (1 month in arrears)	99.55%	98.33%	⇩	96%	96%	96%	COO	
Cancer 31 Day Subsequent Surgery Standard (1 month in arrears)	98.0%	94.1%	⇩	94%	94%	94%	COO	
Cancer 31 Day Subsequent Drug Standard (1 month in arrears)	100.0%	100.0%	⇨	98%	98%	98%	COO	
Cancer 31 Day Subsequent Radiotherapy Standard (1 month in arrears)	96.3%	95.0%	⇩	94%	94%	94%	COO	
Cancer 62 Day Urgent Referral to Treatment (1 month in arrears)	85.88%	86.06%	⇧	85%	85%	85%	COO	
Cancer 62 Day Screening Standard (1 month in arrears)	90.7%	95.1%	⇧	90%	90%	90%	COO	
Cancer 104 Day Waits - TDA Measure (1 month in arrears)	4.0	1.5	⇧	0	0	0	COO	
Deliver value for money								
Liquidity Days	-22.3	-16.7	⇧	-23.8	-23.8	-21	CFSO	
Capital Services Capacity	2.0	2.0	⇨	1.7	1.6	2	CFSO	
Income & Expenditure Margin	2	2	⇨	1.8	1.3	3	CFSO	
Forecast Income & Expenditure Compared to Plan - £'000	1100	1100	⇨	1100	1100	1100	CFSO	
CIP Delivery - £'000	13201	16047	⇧	14184	25512	25512	CFSO	
Agency expenditure as a % of pay bill	8.23%	8.59%	⇩	TBC	TBC	TBC	CWIO	
Employer of choice								
Personal Development Review - Non-Medical	84.05%	83.80%	⇩	90%	90%	90%	CWIO	
Personal Development Review - Medical	79.47%	82.12%	⇧	90%	90%	90%	CWIO	
Mandatory Training Compliance	87.68%	87.28%	⇩	95%	95%	95%	CWIO	
Sickness Rate	3.57%	3.90%	⇩	4%	4%	4%	CWIO	
Staff Turnover Rate	8.79%	8.74%	⇧	10%	10%	10%	CWIO	
Vacancy Rate Compared to Funded Establishment	13.42%	13.95%	⇩	10%	10%	10%	CWIO	
Staff Survey - Recommending as a Place of Work (Quarterly)	78.69%	69.74%	⇩	46.59%	46.59%	46.59%	CWIO	
Leading research based health care organisation								
Patients Recruited into NIHR Portfolio - Cumulative (2 months in arrears)	1485	1853	⇧	1669	4006	4006	CMO	
Commercial Income Invoiced £000s - Cumulative (1 month in arrears)	413	462	⇧	600	1200	1200	CMO	
Peer Reviewed Publications - Calendar Year Cumulative (3 months in arrears)	54	69	⇧	82	197	197	CMO	
Leading training and education centre								
No of Specialties at HEWM Level 3 and 4	0	0	⇨	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	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Cancer 62 Day Urgent Referral to Treatment (1 month in arrears)	85%	81.28%	76.64%	82.53%	80.60%	85.64%	77.50%	80.41%	85.07%	85.57%	85.88%	86.06%	
Personal Devlopment Review - Medical	90%	71.24%	74.21%	73.90%	76.47%	75.55%	75.05%	72.71%	71.81%	75.72%	76.01%	79.47%	82.12%
Liquidity Days	-23.8	-26.3	-26.9	-23.3	-23.5	-18.2	-21.6	-21.1	-21	-23.9	-23.3	-22.3	-16.7

- The 62 day urgent referral to treatment cancer target continues to improve and the quarter target has also been met. However, as a result of the underperformance earlier in the year, the year to date target has not yet been achieved.
- The improvement in Medical appraisal rates has continued with Care of the Elderly (100%), Women and Childrens (93.48%) and Clinical Diagnostics (96.15%) groups achieving the target this month.
- The liquidity days position has shown a steady improvement against the plan over the last three months.

Deteriorating

(green/amber indicators worsening)

(3 months consecutive deterioration)

Measure	Target	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Personal Development Review - Non-Medical	90%	85.50%	87.48%	88.04%	87.70%	88.43%	88.40%	87.94%	87.73%	87.71%	86.34%	84.05%	83.80%
Mandatory Training Compliance	95%	85.24%	85.95%	86.10%	87.45%	87.82%	88.41%	88.39%	88.63%	88.60%	88.30%	87.68%	87.28%

- The non-medical appraisal rates have deteriorated for the seventh consecutive month to 83.8% this month. The Trauma and Orthopaedic group has the highest rate of compliance at 93.37%, however, the Specialist Medicine and Ophthalmology group have appraised 69.34% of non-medical staff. Groups have been tasked with improving this position during the recent quarterly performance reviews.
- Mandatory training compliance has continued to deteriorate this month. All groups remain in amber with the exception of the Care of the Elderly group which achieved over the 95% target. Further information is provided later in this report.

Deteriorating

(red indicators worsening)

(3 months consecutive deterioration)

Measure	Target	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Complaints Turnaround <= 25 Days (1 month in arrears)	90%	85%	85%	89%	89%	85%	98%	88%	77%	72%	41%	40%	

- September's poor turnaround time is a direct effect of August's influx as these complaints will have been due at this time together with a high number of new complaints arriving into the Trust. The capacity of both the clinical teams and the Complaints service to complete the response was diminished.

Failed Year End Target

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

- A second never event was reported in September 2016.
- A Trust acquired MRSA bacteraemia was reported in August 2016.

Trust Heatmap

University Hospitals Coventry and Warwickshire NHS Trust

Measure	Cardiac & Respiratory	Renal and Acute	Emergency	Neuro sciences	Oncology & Haematology	Surgery	Trauma & Orthopaedics	Women & Children	Specialist Medicine and Ophthal.	Theatres and Anaesthetics	Care of the Elderly	Clinical Diagnostics - Imaging	Hospital of St Cross	Clinical Support Services	Clinical Diagnostics - Pathology	Trust	Trust Target
Reporting Period:																**October 2016**	
Group Level Indicators																	
Excellence in patient care and experience																	
Clostridium Difficile - Trust Acquired - Cumulative	4	3		4	0	3	1	0	1	0	4		2			22	23
MRSA Bacteremia - Trust Acquired - Cumulative	0	0		1	0	0	0	0	0	0	0		0			1	0
Never Events - Cumulative	0.0	0.0	0.0	1.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0		0.0			2.0	0
HSMR - Basket of 56 Diagnosis Groups	85.0	80.9		65.7	49.9	58.7	0.0	0.0	136.8		90.7					86.7	100
Harm Free Care	95.2%	93.4%	100.0%	99.1%	93.6%	96.4%	93.7%	100.0%	97.1%	91.3%	94.4%		93.5%			95.7%	95%
Friends & Family Test Inpatient Recommenders	92.2%	85.5%	90.2%	88.5%	96.0%	86.0%	97.9%	96.6%	89.2%	90.0%	90.7%					90.3%	95%
Friends & Family Test A&E Recommenders			78.9%						74.7%							80.1%	87%
Complaints per 1000 Occupied Bed Days	0.36	0.72	11.26	1.70	2.21	1.84	1.27	1.29	1.93	0.99	0.60		0.00			1.47	0.99
Complaints Turnaround <= 25 Days (1 month in arrears)	50%	100%	0%	56%	100%	54%	17%	60%	33%	100%	0%	0%	100%	100%	100%	40%	90%
Theatre Lists Started within 15 mins of Start Time	56.3%	57.1%		31.9%		37.6%	55.7%	71.1%	36.5%	47.1%						44.1%	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)	7.2%	7.3%		8.1%	2.2%	8.3%	5.6%	7.8%	8.6%	3.7%	12.1%					8.1%	8.68%
Number of Medical Outliers - Average per Day	11	24		N/A	N/A	2	N/A	N/A	9		10		N/A			56	50
Last Minute Non-clinical Cancelled Operations - Elective	0.4%	0.0%		5.6%	0.4%	1.8%	2.0%	1.5%	0.7%	0.0%						1.3%	0.8%
Breaches of the 28 Day Readmission Guarantee	0	N/A		2	0	11	1	0	0	N/A						14	0
18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears)	93.64%	96.04%		93.14%	98.86%	83.63%	83.49%	90.77%	90.10%	93.07%	98.51%					87.97%	92%
RTT 52 Week Waits Incomplete (1 month in arrears)	0.0	0.0		1.0	N/A	2.0	0.0	0.0	0.0	N/A	0.0					3.0	0
Referral to Treatment Incomplete - Backlog Size (1 month in arrears)	135	9		179	5	1484	686	193	723	51	1					3466	2204
Diagnostic Waiters - 6 Weeks and Over	0.35%			0.00%		0.34%						0.01%				0.05%	1%
Cancer 2 Week Wait GP Referral to OP Appointment (1 month in	97.14%			100.00%	100.00%	94.91%	100.00%	97.89%	98.25%							95.91%	93%
Cancer 31 Day Diagnosis to Treatment (1 month in arrears)	100.00%			100.00%	100.00%	97.35%		100.00%	100.00%							98.33%	96%
Cancer 31 Day Subsequent Surgery Standard (1 month in arrears)	100.0%			100.0%	N/A	91.4%		100.0%	100.0%							94.1%	94%
Cancer 31 Day Subsequent Drug Standard (1 month in arrears)	100.0%			N/A	100.0%	100.0%		100.0%	N/A							100.0%	98%
Cancer 31 Day Subsequent Radiotherapy - Group (1 month in arrears)	100.00%			100.00%	91.67%	94.85%		100.00%	87.50%							94.96%	94%
Cancer 62 Day Urgent Referral to Treatment (1 month in arrears)	75.00%			N/A	100.00%	84.48%		100.00%	96.00%							86.06%	85%
Cancer 62 Day Screening Standard (1 month in arrears)						94.9%		100.0%								95.1%	90%

Trust Heatmap

University Hospitals Coventry and Warwickshire NHS Trust

Measure	Cardiac & Respiratory	Renal and Acute	Emergency	Neuro sciences	Oncology & Haematology	Surgery	Trauma & Orthopaedics	Women & Children	Specialist Medicine and Ophthal.	Theatres and Anaesthetics	Care of the Elderly	Clinical Diagnostics - Imaging	Hospital of St Cross	Clinical Support Services	Clinical Diagnostics - Pathology	Trust	Trust Target
Reporting Period:															October 2016		
Group Level Indicators																	
Deliver value for money																	
Agency expenditure as a % of pay bill	9.55%	19.61%	12.35%	19.98%	9.01%	9.67%	2.86%	1.61%	9.31%	4.16%	26.68%	9.29%	5.06%	0.64%	12.18%	8.59%	
Employer of choice																	
Personal Development Review - Non-Medical	75.28%	89.43%	74.68%	76.32%	81.44%	84.80%	93.37%	87.88%	69.34%	87.75%	91.02%	86.15%	93.06%	88.73%	72.56%	83.80%	90%
Personal Development Review - Medical	63.16%	88.24%	59.38%	83.78%	61.29%	85.00%	85.00%	93.48%	80.33%	84.71%	100.00%	96.15%			89.47%	82.12%	90%
Mandatory Training Compliance	90.36%	92.25%	90.79%	88.22%	91.29%	93.31%	88.61%	93.59%	92.27%	94.02%	95.95%	92.68%	94.70%	94.89%	85.60%	87.28%	95%
Sickness Rate	4.28%	4.60%	5.04%	2.70%	2.80%	4.06%	3.26%	3.58%	4.37%	5.38%	3.51%	3.72%	3.72%	3.68%	4.38%	3.90%	4%
Staff Turnover Rate	5.76%	4.99%	6.84%	8.39%	5.51%	8.24%	6.51%	7.91%	15.62%	4.50%	8.21%	11.15%	11.66%	11.03%	14.34%	8.74%	10%
Vacancy Rate Compared to Funded Establishment	17.90%	13.57%	14.77%	22.78%	15.89%	16.02%	17.85%	14.71%	11.90%	8.97%	33.24%	7.55%	21.25%	2.23%	13.50%	13.95%	10%
Staff Survey - Recommending as a Place of Work (Quarterly)	N/A	N/A	68.75%	N/A	N/A	N/A	N/A	N/A	62.12%	87.23%	82.00%	67.31%	75.51%	73.19%	50.00%	69.74%	46.59%
Leading research based health care organisation																	
Patients Recruited into NIHR Portfolio - Cumulative (2 months in arrears)	34	116		35	178	477	197	589	31	122	0		0	0		1853	1669
Peer Reviewed Publications - Calendar Year Cumulative (3 months in	6	1	0	0	1	8	0	2	31	2	1	3	2	1	6	69	82
Leading training and education centre																	
No of Specialties at HEWM Level 3 and 4	0	0	0	0	0	0	0	0	0	0	0	0			0	0	0
Job Evaluation Survey Tool Score - JEST (1 month in arrears)	3.5	3.4	4.0	3.5	4.0	3.3	3.8	3.8	3.7	3.9	3.5	3.5			4.5	3.6	3.5

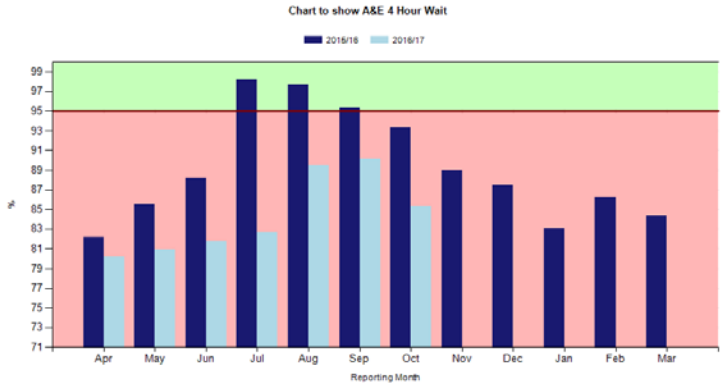
The assessment framework introduced last quarter has been applied following the second Quarterly Performance Reviews of 2016/17 which took place in early November. Groups have once again been classified in line with the criteria as remaining under standard performance management, being recommended for step down from monthly reviews or being recommended for the intensive support framework. The placement of the groups for the forthcoming quarter is shown in Table 1.

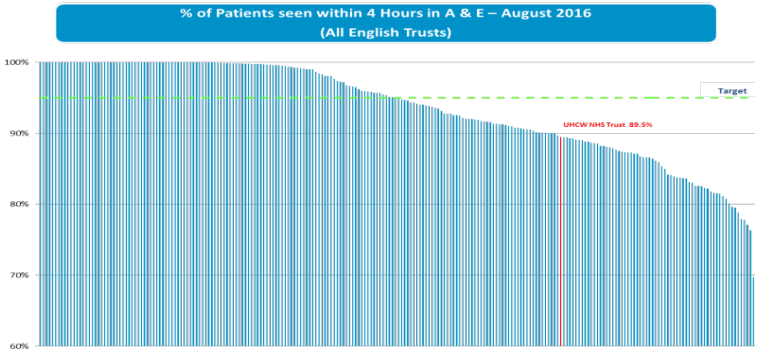
Table 1

Standard Performance Management	Recommended for step down	Recommended for Intensive Support Framework
Cardiac and Respiratory	Oncology & Haematology	Emergency Department
Neurosciences	Hospital of St Cross	Specialist Medicine & Ophthalmology
Surgery	Clinical Support Services	Renal and Acute Medicine
Trauma & Orthopaedics		
Women & Children		
Theatres & Anaesthetics		
Care of the Elderly		
Clinical Diagnostics		

Group summary of performance – A&E and associated metrics

University Hospitals Coventry and Warwickshire NHS Trust





The Trust's performance against the 95%, 4 Hour A&E standard has deteriorated through October to post a final position of 85.3%. We continue to take measures to protect the 'minors pathway' and will also look to improve performance against the non-admitted patient group attending ED. Early morning and weekend discharges remain our biggest challenge to improving flow and establishing capacity and we continue to work with the groups to address this. The Trust has undertaken mapping to match staffing to demand in ED and this has shown a deficit in manpower which has been highlighted through a Business Case to redress this imbalance.

The Trust continues to pursue further improvement both internally and with partners including working with ECIP to improve ambulance triage/handover, and implementing SAFER and Red to Green Days, as well as a focus on improving ambulatory pathways. Simultaneously the Trust has engaged an external independent adviser to review emergency pathways and procedures across ED and Acute Medicine.

The system's A&E Recovery Board continues to address the issue of capacity external to the hospital to move patient's who are awaiting external provision to more appropriate care settings. This would generate capacity within the hospital which presently accounts for around a 12% bed occupancy rate over all, of which around 8% of patients are in formal delay.

Patient Flow metrics

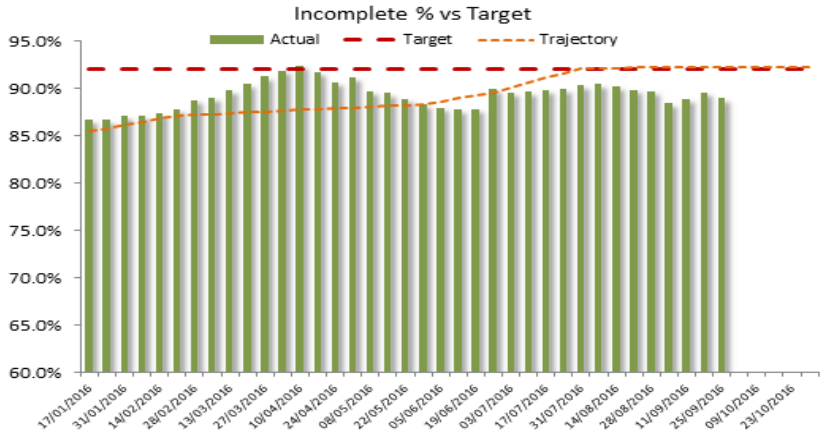
Measure	Target	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Number of Medical Outliers - Average per Day	50	58	53	73	85	67	65	58	65	67	54	61	55	56
Diagnostic Waiters - 6 Weeks and Over	1%	0.07%	0.07%	0.20%	0.57%	0.57%	0.59%	0.79%	0.47%	0.17%	0.16%	0.17%	0.18%	0.05%
Last Minute Non-clinical Cancelled Operations - Elective	0.8%	0.9%	0.9%	0.8%	2.0%	1.1%	0.7%	1.2%	1.3%	1.7%	1.6%	1.1%	1.0%	1.3%
Length of Stay - Average	6.0	6.5	6.7	7.6	6.9	7.4	7.1	7.3	7.2	7.2	7.3	6.9	7.6	7.1

Last minute non-clinical cancelled operation rates have risen since last month. Groups with the highest levels of such cancellations for October were Neurosciences (5.6%), Trauma and Orthopaedics (2.0%), Surgery (1.8%) and Women & Children (1.5%). Bed availability on the wards continues to be the main reason for these cancellations.

The percent of diagnostic waiters over 6 weeks KPI has improved further this month and is performing well against its target, having the lowest percentage of breaches, five patients, since July 2015. The total number of waiters has exceeded 10,000 again in September. Of note, there has been an increase in referrals to cardiology diagnostic outpatient in October.

Group summary of performance – Referral To Treatment

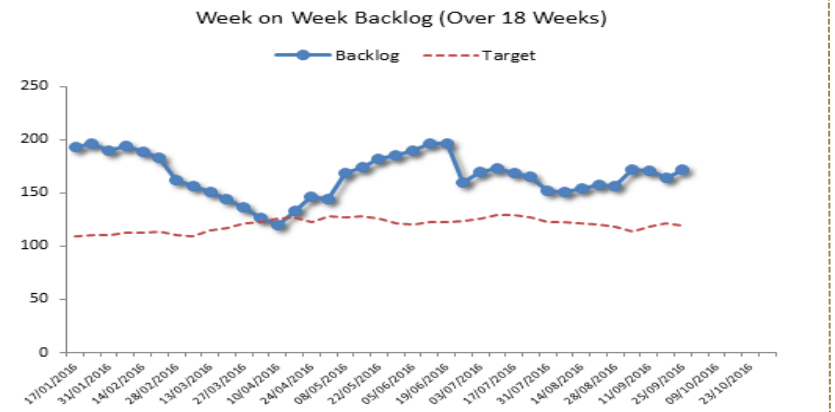
University Hospitals Coventry and Warwickshire NHS Trust



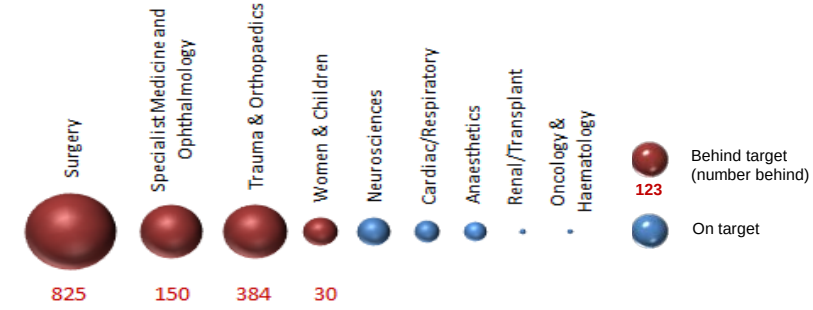
RTT Incomplete 87.97% | 18 WEEKS | (Last month 87.99%) Target 92%

6 out of 10 groups achieved the incomplete target

Underperforming groups
- Trauma & Orthopaedics (83.5%)
- Surgery (83.6%)
- Specialist Medicine and Ophthalmology (90.1%)
- Women and Children (90.8%)



Group proportion of the total backlog



Performance for the delivery against the RTT incomplete target remained similar to last month, with the Trust reporting 87.97% against the 92% target in September. The Trust did not meet the monthly target of 92.5% against the NHSI improvement trajectory that was submitted earlier in the year.

The backlog has grown to a total of 3466 patients this month with the Surgery group having the largest proportion of the Trust's total. Trauma and Orthopaedics and Ophthalmology continue to be significantly challenged.

The Trust continues to work through the detailed recovery programme by specialty which ensures that:
- Patients are booked in true clinical and chronological order
- Detailed recovery plans are agreed by each team
- Externally delivered training is being deployed to Clinical and administration staff across all areas
- Clinical review process is in place for all 52 week breaches

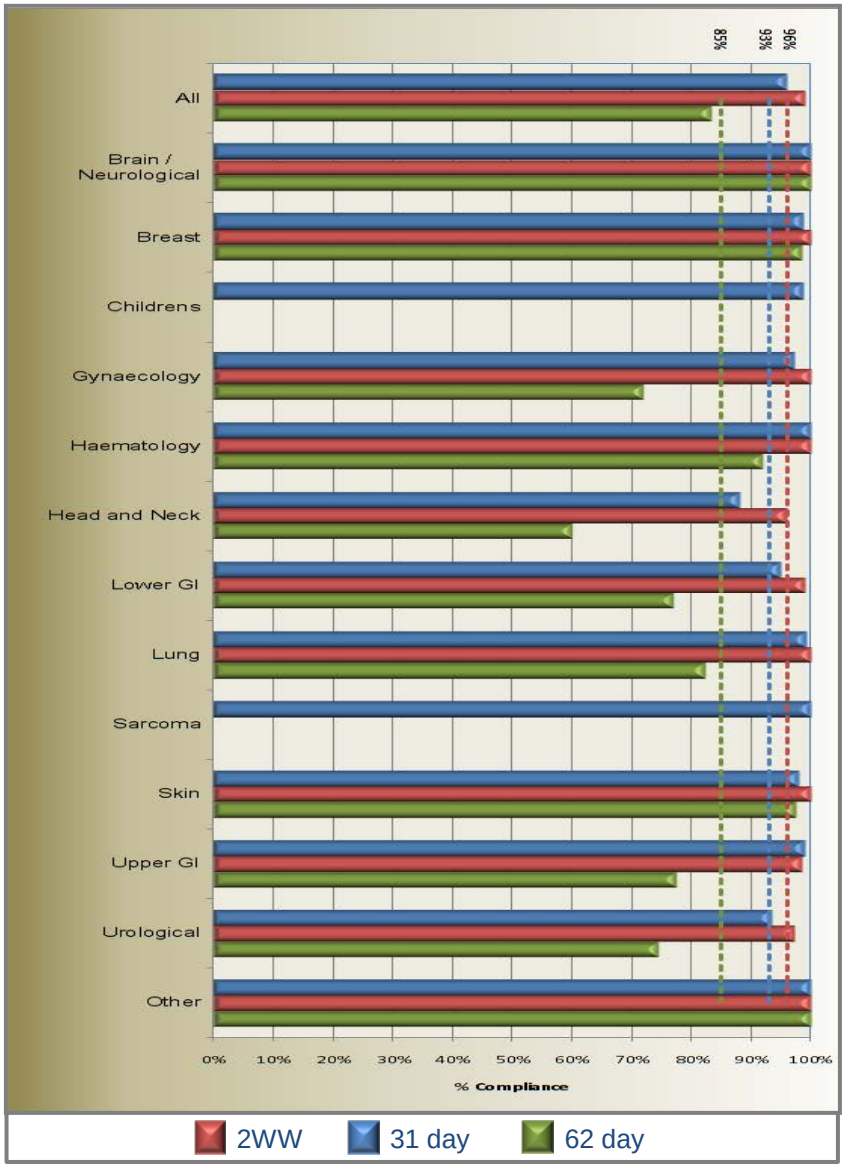
52 Weeks

The Trust has reported two plastic surgery and one neurosurgery 52 week incomplete pathway breaches in September.

Performance Summary

University Hospitals Coventry and Warwickshire NHS Trust

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



105 days and over target not met

1.5 breaches (3 patients) of the 105 days and over target have occurred in September.

1 breaches (2 patients) of the target were in urology. The remaining 0.5 breach (1 patient) occurred in skin.

In September 2016, the Trust achieved all 8 of the national cancer standards.

The Trust delivered 95.9% for Two Week Wait for suspected cancer against a 93% target following its non achievement in August.

The 62 Day Cancer Waiting Times Standard was achieved again in September with 86.1% of patients treated against the 85% standard. The Trust achieved the target for the quarter with 85.8%, however the year to date target has not yet been achieved as a result of underperformance earlier in the year.

Standard:	Jul-16	Aug-16	Sep-16	Qtr2	YTD	DoH Tolerance
TWW suspected cancer	97.7%	92.00%	95.9%	95.1%	95.8%	93%
TWW breast symptomatic	98.6%	98%	100.0%	98.7%	99.0%	93%
31 day - 1st treatment	99.5%	99.50%	98.3%	99.2%	99.0%	96 %
31 day - subsequent treatment -surgery	95.7%	98.00%	94.1%	96.0%	96.3%	94%
31 day - subsequent treatment -chemo	100.0%	100%	100.0%	100.0%	100.0%	98%
31 day - subsequent treatment - radio	92.4%	96.30%	95.0%	94.7%	95.5%	94%
31 day - subsequent treatment - other	100.0%	100%	100.0%	100.0%	100.0%	No tolerance set
31 day - rare cancers	100.0%	100%	100.0%	100.0%	100.0%	No tolerance set
62 day - 1st treatment	85.6%	85.90%	86.1%	85.8%	83.3%	85%
62 day - national screening programme	87.5%	90.70%	95.1%	91.7%	93.4%	90%
62 day - consultant upgrade	94.6%	97%	85.0%	93.5%	93.5%	CCG tolerance = 85%
62 day - treated on or after day 100+	3.5	4.0	3.0	10.5	21.0	0
62 day - treated on or after day 105+	3.5	4.0	1.5	9.0	16.5	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 deteriorated this month. However, improvement has been seen in the MRSA screening indicators although they remain below target. MRSA decolonisation score has improved to 100% compliance from 80% in September.

20 KPIs achieved the target in October

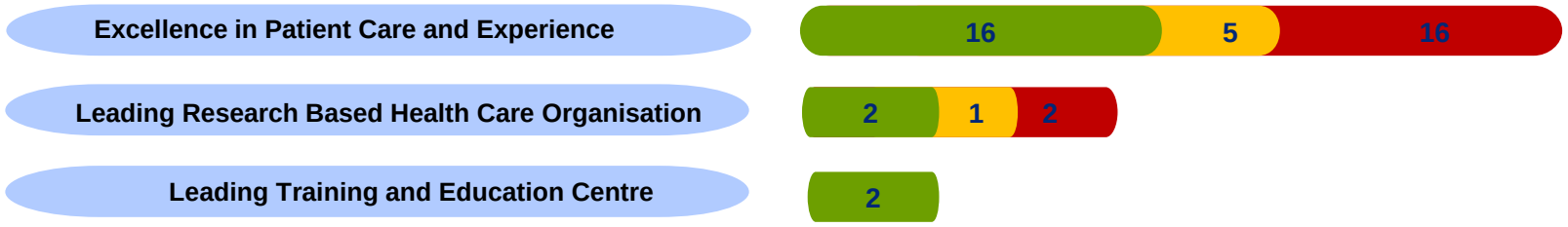
Quality & Safety Scorecard	Indicators achieved	Indicators in exception	Indicators in watching status	Total indicators
Excellence in Patient care and experience	16	16	5	37
Leading research based health care organisation	2	2	1	5
Leading training and education centre	2	0	0	2
All domains	**20**	**18**	**6**	**44**

There has been an increase the number of serious incidents reported this month, with an associated increase in falls per 1000 occupied bed days resulting in serious harm.

A medication error involving an overdose of insulin was reported in October. The patient was managed appropriately post incident with no long lasting effects. Immediate actions were taken and investigations completed. The signed off report is expected by the end of November.

Complaints turnaround remain a challenge for the Trust through September with a reported performance of 40%. Further detail is included in the performance trend section of this report.

The number of patients recruited into the NIHR portfolio continues to rise with 1853 patients against a target of 1669 at the end of August.



Trust Scorecard – Quality and Governance Performance Committee

Reporting Month October 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	18	22	↓	23	42	42	CNO	
MRSA Bacteremia - Trust Acquired - Cumulative	1	1	→	0	0	1	CNO	
MRSA Decolonisation Score	80.0%	100.0%	↑	95%	95%	95%	CNO	
MRSA - Elective Screening	87.9%	90.5%	↑	95%	95%	95%	CNO	
MRSA - High Risk Emergency Screening	79.2%	83.8%	↑	90%	90%	90%	CNO	
Serious Incidents - Number	6	19	↓	15	15	15	CMO	
Serious Incidents - Overdue	10	10	→	0	0	0	CMO	
Medication Errors Causing Serious Harm	0	1	↓	0	0	0	CMO	
Reported Harmful Patient Safety Incidents (1 month in arrears)	25.6%	33.7%	↓	24.94%	24.94%	24.94%	CMO	
CAS Alerts - Overdue	1	0	↑	0	0	0	CMO	
NCE POD Categorised E Deaths - Cumulative (3 months in arrears)	0	0	→	4	10	10	CMO	
Never Events - Cumulative	2.0	2.0	→	0	0	2	CMO	
Same Sex Accommodation Breaches	0	0	→	0	0	0	CNO	
HSMR - Basket of 56 Diagnosis Groups	95.9	86.7	↑	RR	RR	RR	CMO	
SHMI - Quarterly (6 months in arrears)	107.80	107.80	→	RR	RR	RR	CMO	
Harm Free Care	96.9%	95.7%	↓	95%	95%	95%	CNO	
Pressure Ulcers Grade 3 and 4 - Trust Associated (1 month in arrears)	0	1	↓	0	0	5	CNO	
Falls per 1000 Occupied Bed Days Resulting in Serious Harm	0.03	0.23	↓	0.04	0.04	0.04	CNO	
Eligible Patients Having VTE Risk Assessment (1 month in arrears)	97.2%	97.0%	↓	95%	95%	95%	CNO	
C-UTI	100.0%	99.8%	↓	99%	99%	99%	CNO	
Transfer of Patients at Night (UH to Rugby)	22	21	↑	0	0	0	COO	
Patient Experience								
Friends & Family Test Inpatient Recommenders	89.9%	90.3%	↑	95%	95%	95%	CMO	
Friends & Family Test Inpatient Coverage	23.4%	26.8%	↑	35%	35%	35%	CMO	
Friends & Family Test A&E Recommenders	85.5%	80.1%	↓	87%	87%	87%	CMO	
Friends & Family Test A&E Coverage	14.0%	13.5%	↓	20%	20%	20%	CMO	
Maternity FFT No of Touchpoints Achieving a 15% Response Rate	4	4	→	4	4	4	CMO	
Number of Registered Complaints	55	48	↑	32	32	32	CMO	
Complaints per 1000 Occupied Bed Days	1.76	1.47	↑	0.99	0.99	0.99	CMO	
Complaints Turnaround <= 25 Days (1 month in arrears)	41%	40%	↓	90%	90%	90%	CMO	
Theatres								
Surgical Safety Checklist - WHO	100.00%	100.00%	→	100%	100%	100%	CMO	
National Quality Requirements								
Valid NHS Number - Inpatients (2 months in arrears)	99.3%	99.3%	→	99%	99%	99%	COO	
Valid NHS Number - A&E (2 months in arrears)	97.6%	97.6%	→	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 October 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	85.7%	82.2%	↓	100%	100%	100%	COO	
Ambulance Turnaround within 60 Minutes	99.9%	99.6%	↓	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	3	↓	0	0	0	COO	
Leading research based health care organisation								
Patients Recruited into NIHR Portfolio - Cumulative (2 months in arrears)	1485	1853	↑	1669	4006	4006	CMO	
Performance in Initiating Trials - Quarterly	57.1%	54.9%	↓	80%	80%	80%	CMO	
Performance in Delivery of Trials - Quarterly	80.0%	75.0%	↓	80%	80%	80%	CMO	
Research Critical Findings and Serious Incidents - Quarterly	1	0	↑	0	0	0	CMO	
Peer Reviewed Publications - Calendar Year Cumulative (3 months in arrears)	54	69	↑	82	197	197	CMO	
Leading training and education centre								
No of Specialties at HEWM Level 3 and 4	0	0	→	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	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
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 3 consecutive months. The three 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

Deteriorating

(red indicators worsening)

(3 months consecutive deterioration)

Measure	Target	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Complaints Turnaround <= 25 Days (1 month in arrears)	90%	85%	85%	89%	89%	85%	98%	88%	77%	72%	41%	40%	

- September's poor turnaround time is a direct effect of August's influx as these complaints will have been due at this time together with a high number of new complaints arriving into the Trust. The capacity of both the clinical teams and the Complaints service to complete the response was diminished.

Failed Year End Target

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

- A second never event was reported in September 2016.
- A Trust acquired MRSA bacteraemia was reported in August 2016.

Ward Staffing Levels - Monthly by Trust

Entry Date : October 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)	8186	7772	8009	97.8%	7971	7491	7659	96.1%	6386	5997	6455	101.1%
Health Care Support Worker (HCSW)	4338	4337	4325	99.7%	3705	3724	3716	100.3%	3028	2998	3071	101.4%
Cohort	0	694	203		0	577	160		0	482	137	
Specialist Trained Neonatal Nurse	282	275	287	101.8%	279	266	275	98.6%	299	286	300	100.3%
Registered Nurse	81	69	71	87.7%	81	74	75	92.6%	47	27	31	66.0%
Nursery Nurse (NN)	84	80	88	104.8%	80	76	79	98.8%	64	64	65	101.6%
1:1	0	435	337		0	446	313		2	421	323	16150.0%
Total (non Cohort)	12971	12968	13117	101.1%	12116	12077	12117	100.0%	9826	9793	10245	104.3%

Ward Staffing Levels - Monthly Ward Scorecard - Exceptions

Entry Month : October 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)	
10	102.8%	103.3%	116.9%	132.3%	6.3	Good fill rates across all domains
20	87.1%	118.7%	97.5%	132.8%	7.3	Drop in RN fill rate by 3% on days - high level of vacancies
21S	94.4%	88.8%	99.0%	95.1%	5.9	Sustained improvement on fill rates
30	95.9%	113.0%	96.8%	137.7%	6.3	Drop in RN fill rates on days
33 Gastro	94.4%	106.5%	100.0%	106.5%	6.3	Sustained improvement across all domains for fill rates
41	94.7%	112.9%	98.7%	116.1%	6.6	Sustained improvement with fill rates
42	88.4%	135.7%	95.1%	179.1%	5.8	Increase in ECT requirements overnight
43	95.1%	140.0%	107.6%	120.9%	6.4	RN day fill rates improved
43SDU	116.3%	39.9%	87.1%	418.2%	9.1	4 beds closed on 43 SDU due to difficulty filling RN shifts however improved from previous month
Oak Ward	97.1%	98.8%	99.0%	98.3%	6.9	Good fill rates across all domains
Total Fill rate	**96.8%**	**112.5%**	**101.2%**	**116.6%**	**8.1**	**Improvement from previous month on RN fill rate for days. CHPPD remains 8.00-8.50**

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

University Hospitals Coventry and Warwickshire NHS Trust

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 the Delivery of Value for Money section are being revised in-line with recent guidelines from NHSI. Further details on revised KPIs have been provided in the Integrated Finance Report that is submitted to Finance and Performance Committee.

27 KPIs achieved the target in October

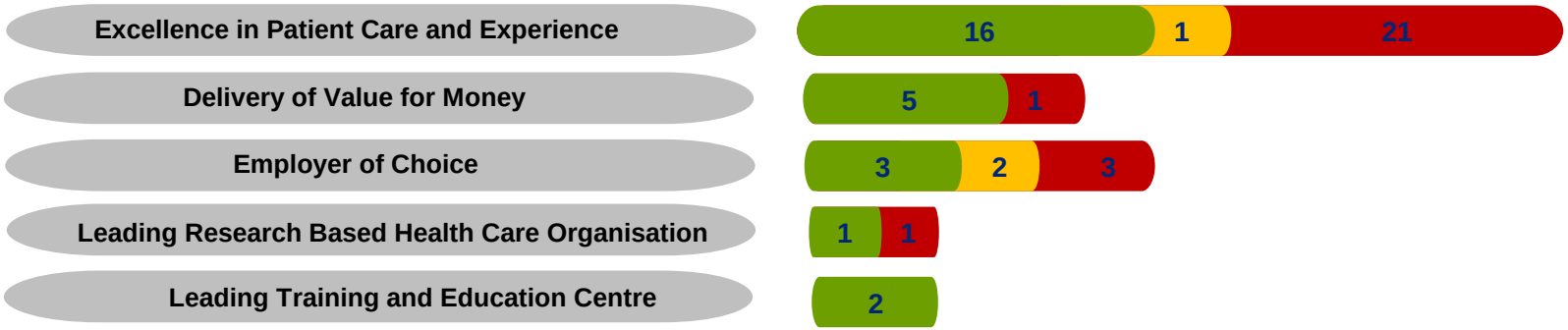
	Indicators achieved	Indicators in exception	Indicators in watching status	Total indicators
Excellence in Patient care and experience	16	21	1	38
Delivery of value for money	5	1	0	6
Employer of choice	3	2	3	8
Leading research based health care organisation	1	1	0	2
Leading training and education centre	2	0	0	2
All domains	**27**	**25**	**4**	**56**

Achievement of the staff sickness rate of below 4% has been sustained this month at 3.9%, which is slight decline on last month's performance. Mandatory training compliance has fallen for the fourth consecutive month and is reported at 87.28% which continues to be below the 95% target.

Medical and non medical PDR KPIs remain below target, although there has been improvement in medical PDR compliance for four consecutive months.

The Vacancy rate compared to funded establishment indicator has deteriorated this month and remains above the target of 10%. This is reflected in the agency costs against total costs which has increased from 8.23% to 8.59%.

Targets related to the emergency pathway (A&E waiting times and delayed transfers of care) and the elective pathway targets including RTT incomplete pathways continue to underperform. The Trust did not meet the monthly incomplete RTT target of 92.5% against the NHSI improvement trajectory that was submitted earlier in the year.



Trust Scorecard – Finance and Performance Committee

Reporting Month October 2016

University Hospitals Coventry and Warwickshire NHS Trust

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	90.1%	85.3%	↓	95%	95%	95%	COO	
12 Hour Trolley Waits in A&E	0	0	→	0	0	0	COO	
Ambulance Turnaround within 30 minutes	85.7%	82.2%	↓	100%	100%	100%	COO	
Ambulance Turnaround within 60 Minutes	99.9%	99.6%	↓	100%	100%	100%	COO	
Delayed Transfers as a Percentage of Admissions	8.1%	7.1%	↑	3.5%	3.5%	3.5%	COO	
30 Day Emergency Readmissions (1 month in arrears)	8.2%	8.1%	↑	8.68%	8.68%	8.68%	COO	
Number of Medical Outliers - Average per Day	54.7	55.7	↓	50	50	50	COO	
Length of Stay - Average	7.6	7.1	↑	5.96	5.96	5.96	COO	
Non emergency care								
Last Minute Non-clinical Cancelled Operations - Elective	1.0%	1.3%	↓	0.8%	0.8%	0.8%	COO	
Breaches of the 28 Day Readmission Guarantee	12	14	↓	0	0	76	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)	87.99%	87.97%	↓	92%	92%	92%	COO	
18 Week Referral to Treatment Time - Admitted (1 month in arrears)	71.0%	69.4%	↓	90%	90%	90%	COO	
18 Week Referral to Treatment Time - Non-admitted (1 month in arrears)	89.1%	88.7%	↓	95%	95%	95%	COO	
RTT 52 Week Waits Incomplete (1 month in arrears)	1	3	↓	0	0	0	COO	
Referral to Treatment Incomplete - Backlog Size (1 month in arrears)	3385	3466	↓	2204	2204	2204	COO	
E-referral Appointment Slot Issues – National data (1 month in arrears)	48.1%	40.2%	↑	3%	3%	3%	COO	
Diagnostic Waiters - 6 Weeks and Over	0.18%	0.05%	↑	1%	1%	1%	COO	
Bed Occupancy Rate - KH03 (3 months in arrears)	98.9%	97.9%	↑	93%	93%	93%	COO	
Cancer								
Cancer 2 Week Wait GP Referral to OP Appointment (1 month in arrears)	92.04%	95.91%	↑	93%	93%	93%	COO	
Cancer 2 Week Wait Breast Symptom (1 month in arrears)	98.2%	100.0%	↑	93%	93%	93%	COO	
Cancer 31 Day Diagnosis to Treatment (1 month in arrears)	99.55%	98.33%	↓	96%	96%	96%	COO	
Cancer 31 Day Subsequent Surgery Standard (1 month in arrears)	98.0%	94.1%	↓	94%	94%	94%	COO	
Cancer 31 Day Subsequent Drug Standard (1 month in arrears)	100.0%	100.0%	→	98%	98%	98%	COO	
Cancer 31 Day Subsequent Radiotherapy Standard (1 month in arrears)	96.3%	95.0%	↓	94%	94%	94%	COO	
Cancer 62 Day Urgent Referral to Treatment (1 month in arrears)	85.88%	86.06%	↑	85%	85%	85%	COO	
Cancer 62 Day Standard plus 31 Day Rare Cancers (1 month in arrears)	86.0%	86.2%	↑	85%	85%	85%	COO	
Cancer 62 Day Screening Standard (1 month in arrears)	90.7%	95.1%	↑	90%	90%	90%	COO	
Cancer 62 Day Consultant Upgrades (1 month in arrears)	97.2%	85.0%	↓	85%	85%	85%	CMO	
Cancer 104 Day Waits - TDA Measure (1 month in arrears)	4.0	1.5	↑	0	0	0	COO	
Theatre Productivity								
Theatre Efficiency - Main	66.6%	64.4%	↓	85%	85%	85%	COO	
Theatre Efficiency - Rugby	67.5%	62.9%	↓	85%	85%	85%	COO	
Theatre Efficiency - Day Surgery	54.8%	57.6%	↑	70%	70%	70%	COO	
Theatre Utilisation - Main	82.2%	80.0%	↓	85%	85%	85%	COO	
Theatre Utilisation - Rugby	76.0%	72.5%	↓	85%	85%	85%	COO	
Theatre Utilisation - Day Surgery	65.6%	70.1%	↑	70%	70%	70%	COO	
Surgical Safety Checklist - WHO	100.00%	100.00%	→	100%	100%	100%	CMO	
Theatre Lists Started within 15 mins of Start Time	34.3%	44.1%	↑	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 October 2016

University Hospitals Coventry and Warwickshire NHS Trust

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	-22.3	-16.7	↑	-23.8	-23.8	-21	CFSO	
Capital Services Capacity	2.0	2.0	→	1.7	1.6	2	CFSO	
Income & Expenditure Margin	2	2	→	1.8	1.3	3	CFSO	
Forecast Income & Expenditure Compared to Plan - £'000	1100	1100	→	1100	1100	1100	CFSO	
YTD Income & Expenditure Compared to Plan Trust - £'000	-841	-262	↑	1143	1100	1100	CFSO	
CIP Delivery - £'000	13201	16047	↑	14184	25512	25512	CFSO	
Agency expenditure as a % of pay bill	8.23%	8.59%	↓	TBC	TBC	TBC	CWIO	
Employer of choice								
Personal Development Review - Non-Medical	84.05%	83.80%	↓	90%	90%	90%	CWIO	
Personal Development Review - Medical	79.47%	82.12%	↑	90%	90%	90%	CWIO	
Mandatory Training Compliance	87.68%	87.28%	↓	95%	95%	95%	CWIO	
Sickness Rate	3.57%	3.90%	↓	4%	4%	4%	CWIO	
Staff Turnover Rate	8.79%	8.74%	↑	10%	10%	10%	CWIO	
Vacancy Rate Compared to Funded Establishment	13.42%	13.95%	↓	10%	10%	10%	CWIO	
Staff Survey - Recommending as a Place of Work (Quarterly)	78.69%	69.74%	↓	46.59%	46.59%	46.59%	CWIO	
Enrolled on Leading Together Programme - All	153	177	↑	200	300	300	CWIO	
Leading research based health care organisation								
Submitted Research Grant Applications - Quarterly - Cumulative	40	68	↑	40.33	124	124	CMO	
Commercial Income Invoiced £000s - Cumulative (1 month in arrears)	413	462	↑	600	1200	1200	CMO	
Leading training and education centre								
No of Specialties at HEWM Level 3 and 4	0	0	→	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

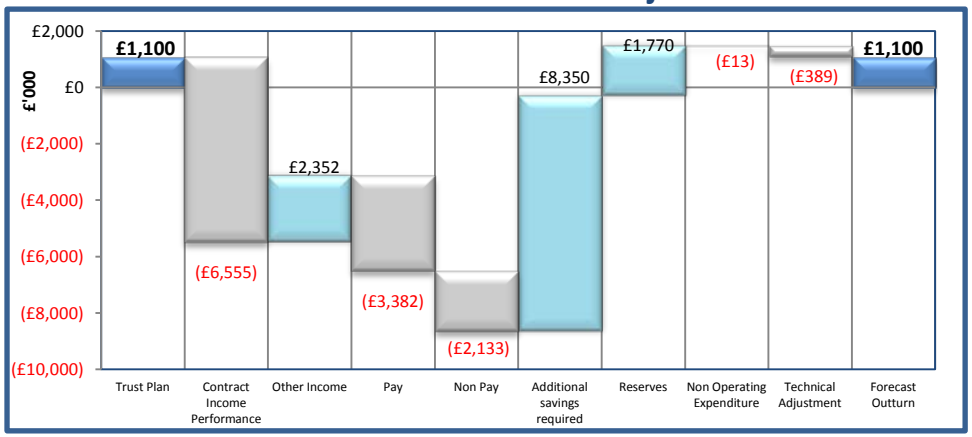
DoT
↑ Improving
→ No change
↓ Falling

Finance | Headlines October 2017

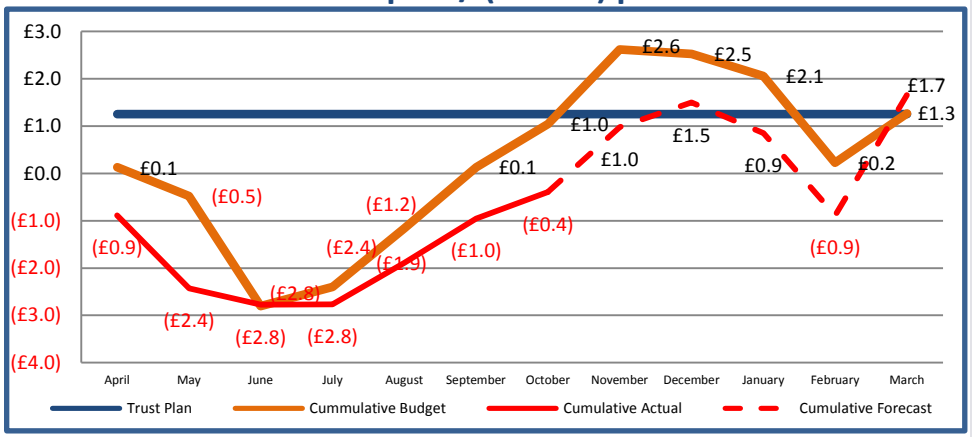
University Hospitals Coventry and Warwickshire NHS Trust

The Trust reports a £1.1m surplus forecast control total which is in-line with plan as at month 7. This assumes full receipt of the STP funding of £17.2m. The Trust is reporting a £1.4m deficit year-to-date against a planned year-to-date surplus of £1.1m. This is a deterioration of £0.3m in actual position from previous month. The slippage includes the year-to-date under achievement of the STP trajectory of £1.4m.

Trust Position Post Technical Adjustment



Net Surplus / (Deficit) position



Updates on Control Total

Other movements within the control total is largely impacted by under delivery on contract income (1.3% adverse to plan); pay and non-pay overspends (1.1% adverse to plan). To achieve the planned net surplus, the Trust needs to achieve additional savings of £8.4m.

Updates on Net Surplus/(Deficit) position

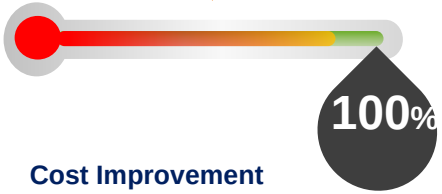
The net surplus position reports a favourable outturn position of £0.4m against plan a plan of £1.3m. Year-to-date position is £1.4m adverse to plan of £0.1m surplus. This gives a net deficit of £0.4m as at month 7. This is driven by the non achievement of STF funding year to date.

CONTACT & ACITIVITY INCOME

1.3 % under-performance

Contract income from activities reports an adverse variance of £4.1m YTD and £6.6m on outturn .

Under-performance on income is largely driven by shortfall in Elective, Daycase, Emergency, and outpatient procedures.



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

The Trust has identified £25.8m of potential savings: above the required target by £0.3m

FRP

Trust has a revised FRP target of £12.1m.

£8.1m of the Target has been delivered as at month 7. This gives a shortfall of £4.6m.

Capital

As at Month 7, the Trust is forecasting a £41.6m capital expenditure against a revised plan of £46m.

£18.6m AGENCY SPEND

£18.6m actual spend on agency spend year to date against NHSI profile of £16.8m

The Trust is forecasting £30.1m spend on agency against target of £26.6m as at month 7.

SOCI – Statement of Comprehensive Income

Reporting Month October 2016

University Hospitals Coventry and Warwickshire NHS Trust

7 months ended 31st October 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	509,444	502,889	(6,555)	(1.3%)	299,293	295,192	(4,101)	(1.4%)
Other income from activities	24,369	23,955	23,918	(37)	(0.2%)	13,959	12,511	(1,448)	(10.4%)
Other Operating Income	75,105	75,997	78,386	2,389	3.1%	44,732	46,101	1,369	3.1%
Total Income	**607,330**	**609,396**	**605,193**	**(4,203)**	**(0.7%)**	**357,984**	**353,804**	**(4,180)**	**(1.2%)**
Pay costs	(356,672)	(358,013)	(361,395)	(3,382)	(0.9%)	(209,941)	(208,119)	1,822	0.9%
Other operating expenses	(197,423)	(202,552)	(204,685)	(2,133)	(1.1%)	(119,390)	(119,559)	(169)	(0.1%)
CIP gap to target delivery			0	0					
FRP gap to target delivery			0	0					
Additional savings required			8,350	8,350					
Reserves	(6,199)	(1,977)	(207)	1,770	89.5%	(1,076)	0	1,076	100.0%
Total Operating Expenses	**(560,294)**	**(562,542)**	**(557,937)**	**4,605**	0.8%	**(330,407)**	**(327,678)**	**2,729**	**0.8%**
EBITDA	**47,036**	**46,854**	**47,256**	**402**	**0.9%**	**27,577**	**26,126**	**(1,451)**	**(5.3%)**
Profit / loss on asset disposals	0	182	218	36		173	218	45	
Depreciation	(20,894)	(20,894)	(20,894)	0		(12,187)	(12,169)	18	
Interest Receivable	115	115	77	(38)		67	54	(13)	
Interest Charges	(465)	(465)	(465)	0		(248)	(266)	(18)	
Financing Costs	(22,278)	(22,278)	(22,278)	0		(13,033)	(13,022)	11	
Unwinding Discount	(34)	(34)	(35)	(1)		(34)	(35)	(1)	
PDC Dividend	(2,214)	(2,214)	(2,214)	0		(1,295)	(1,292)	3	
Impairments	0	0	(10)	(10)		0	(10)	(10)	
Net Surplus/(Deficit)	**1,266**	**1,266**	**1,655**	**389**	**30.7%**	**1,020**	**(396)**	**(1,416)**	**(138.8%)**
EBITDA %	7.7%	7.7%	7.8%			7.7%	7.4%		
Net Surplus %	0.2%	0.2%	0.3%			0.3%	(0.1%)		
Technical Adjustments:									
Donated/Government grant assets adjustment	(166)	(166)	(565)	(399)	(240.4%)	123	124	1	0.8%
Impairments	0	0	10	10		0	10	10	
Trust Position Post Technical Adjustment	**1,100**	**1,100**	**1,100**	**0**	**0.0%**	**1,143**	**(262)**	**(1,405)**	**(122.9%)**

The Trust reports a £1.1m forecast control total surplus against a £1.1m plan in Month 7.

The control total position assumes the full receipt of the STF of £17.2m. Contract income is forecast at £6.6m adverse to plan driven by under-performance against activity plans, risks and penalties. The variance is due to under-performance on Elective, Daycase, Emergency and Outpatient procedures. Close monitoring on activity income continues to take place to ensure planned activities are achieved in future months.

Forecast operating expenditure is £4.6m favourable to budget. Overall Group expenditure forecasts £5.5m adverse to budget; largely driven by over-spends on Medical costs, Specialing and other Non-pay pressures. The position highlights a gap to target of £8.4m on outturn.

The Trust is reporting a year to date deficit of £0.2m which is £1.4m adverse of year-to-date plan. This is due to under-performance against the Trust's STF access standards as at month 7.

SOFP – Statement of Financial Position

Reporting Month October 2016

University Hospitals Coventry and Warwickshire NHS Trust

7 months ended 31st October 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	379,528	(4,457)	349,198	345,326	(3,872)
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	26,288	349	36,525	39,763	3,238
Total non-current assets	**423,241**	**419,133**	**(4,108)**	**399,040**	**398,406**	**(634)**
Current assets						
Inventories	13,274	13,274	0	13,274	13,246	(28)
Trade and other receivables	29,308	29,796	488	48,867	43,580	(5,287)
Cash and cash equivalents	2,760	2,760	0	2,748	10,678	7,930
	45,342	**45,830**	**488**	**64,889**	**67,504**	**2,615**
Non-current assets held for sale	0	0	0	0	0	0
Total current assets	**45,342**	**45,830**	**488**	**64,889**	**67,504**	**2,615**
Total assets	**468,583**	**464,963**	**(3,620)**	**463,929**	**465,910**	**1,981**
Current liabilities						
Trade and other payables	(59,767)	(56,034)	3,733	(80,997)	(83,547)	(2,550)
Borrowings	(5,860)	(5,860)	0	(4,427)	(4,428)	(1)
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	(878)	(3,100)	(2,222)
Net current assets/(liabilities)	**(24,253)**	**(20,032)**	**4,221**	**(23,902)**	**(26,060)**	**(2,158)**
Total assets less current liabilities	**398,988**	**399,101**	**113**	**375,138**	**372,346**	**(2,792)**
Non-current liabilities:						
Trade and other payables						
Borrowings	(261,175)	(260,424)	751	(260,286)	(260,315)	(29)
DH Interim Revenue Support loan	(17,053)	(17,528)	(475)	(12,479)	(12,479)	0
DH Capital loan	(20,192)	(20,192)	0	(10,515)	(10,515)	0
Provisions	(2,260)	(2,260)	0	(2,356)	(2,358)	(2)
Total assets employed	**98,308**	**98,697**	**389**	**89,502**	**86,679**	**(2,823)**
Financed by taxpayers' equity:						
Public dividend capital	60,741	60,741	0	60,741	59,330	(1,411)
Retained earnings	(14,330)	(13,941)	389	(14,580)	(15,992)	(1,412)
Revaluation reserve	51,897	51,897	0	43,341	43,341	0
Total Taxpayers' Equity	**98,308**	**98,697**	**389**	**89,502**	**86,679**	**(2,823)**

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 variance on outturn is largely driven by a £4.5m reduction in Property, plant and equipment against plan as a result of constraints on national capital funding. As a result of the reduction in the Trust capital programme, it is expected that a reduction in the Trust's payables balance will occur and as a result trade and other payables assumes a reduction of £3.7m.
- Significant variances year-to-date is mainly due to the increase in cash and cash equivalents of £7.9m driven by the reduction in trade and other receivables of £5.3m. The reduction in current trade and other receivables is due to an improved receivables position from the original plan.
- Other contributing factors to the year-to-date movement is an increase in current provisions by £2.2m as a result of newly assessed in year contractual provisions and change in the usage profile of prior year provisions.

Efficiency Delivery Programme – CIP & FRP

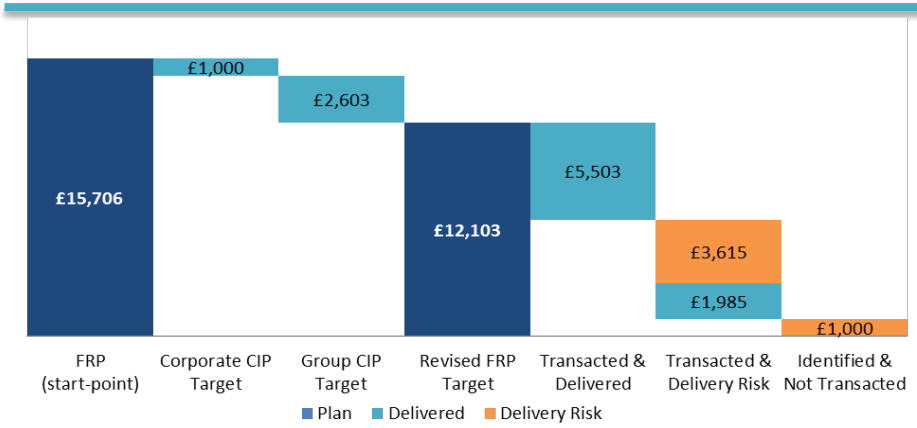
Reporting Month October 2016

University Hospitals Coventry and Warwickshire NHS Trust

Finance Summary

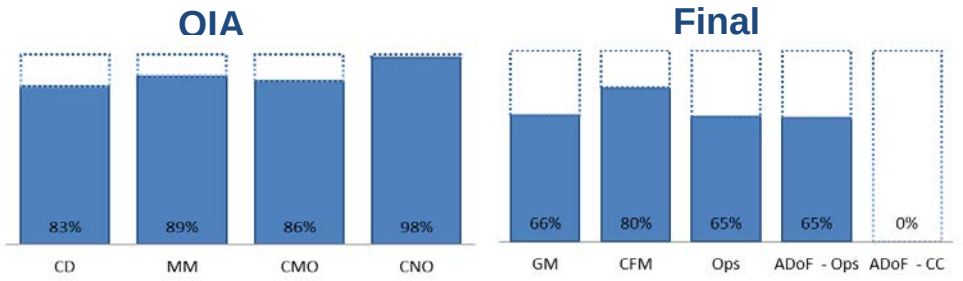
Overview

- **The Trust is forecasting delivery of £25.5m against £25.8m of potentially identified savings.** This gives a potential full delivery achievement against the Trust revised CIP target of £25.5m for 2016/17.
- To achieve the £1.1m surplus; the Trust is required to deliver a £25.5m internal CIP for 2016/17. £19.3m is expected to be achieved by cost reduction and/or income from new services from clinical and core groups whilst £6.2m is expected to be delivered from increased productivity, and continued improvement to counting and charging.
- Groups have documented 412 schemes worth £25.8m (101%) against a target of £25.5m with an over-identified value of £0.3m as at Month 7.
- The Trust is reporting a £16.0m delivery against a target of £14.2m giving a 113% year-to-date delivery position as at Month 7.



The **Financial Recovery Programme** of £12.1m is additional to the Trust CIP plan. £7.5m delivered against plan as at month 7.

- Of the £4.6m outstanding, £3.6m relates to Agency Premium reduction scheme with delivery risk associated as indicated on the chart above. £1m relates to outliers.



All schemes are required to be assessed for quality impact assessment (QIA) and signed-off for operational and financial approval.

Each scheme, at **QIA** require clinical approval from individual Group's Clinical Director (CD) and Modern Matron (MM); and the Trust's Chief Nursing Officer (CNO) and Chief Medical Officer (CMO). As at M7, 86% of the documented 412 schemes have been fully assessed by both CD and MM; of these 86% have been assessed and signed-off by CMO and 98% by CNO.

At **Operational and Finance sign-off stage**, schemes require Chief Operating Officer (DCOO/COO) and Associate Directors of Finance (ADoF – Ops/CC). There are 90 schemes awaiting final sign-off and 133 of these schemes have been fully signed off, as such classed as being "fully implemented". These are schemes that have fully been assessed for QIA.

Workforce Information | Headlines October 2016

University Hospitals Coventry and Warwickshire NHS Trust

Staff in Post | *Variation from Workforce Plan*

	31st October 2016	TDA Plan	Variation from Plan	Last Month's Variation from Plan	ISS
WTE	6,820.63	6850.00	-29.37	-21.50	552.40
WTE including ISS	7,373.03				
Headcount	7773				711
Headcount including ISS	8484				

*The above figures do not include 1396 bank only staff (Zero contracted hours).

The Trust's staff in post is 29.37 WTE behind the workforce plan of 6850 WTE. The Trust's monthly staff in post has deceased by 5.85 WTE from September 2016 figures.

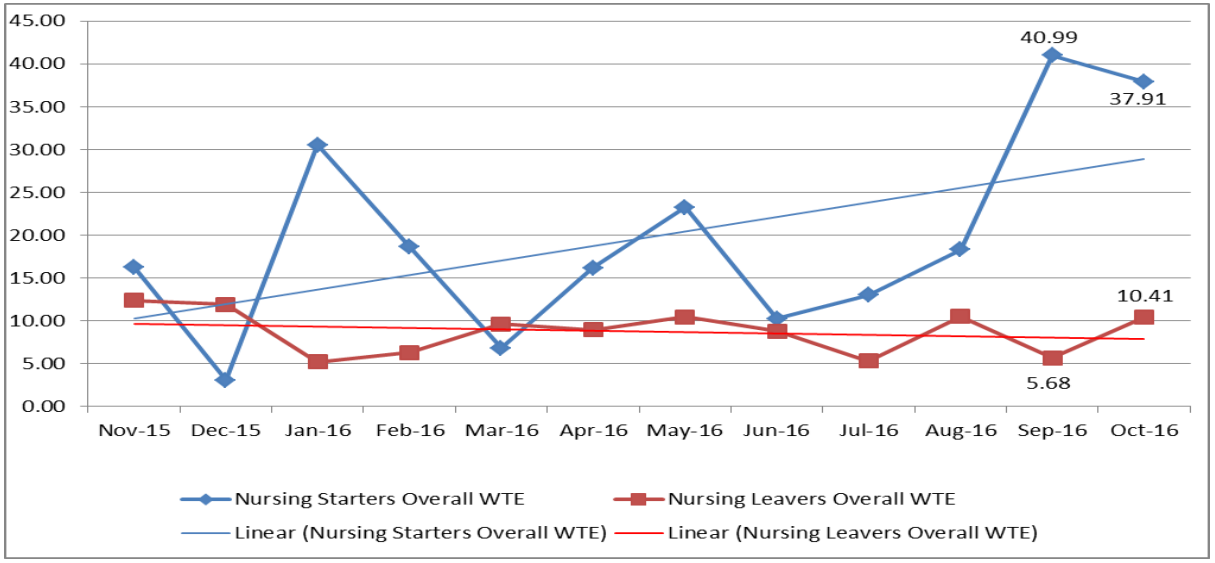
Staff Group in Post | *Monthly Variation*

Staff Group	Staff In Post WTE 30th Sep 2016	Staff In Post WTE 31st Oct 2016	Variance (WTE)	% Variance
Add Prof Scientific and Technic	228.74	227.70	-1.04	-0.46%
Additional Clinical Services	1583.09	1596.05	12.96	0.81%
Administrative and Clerical	1177.07	1174.32	-2.75	-0.23%
Allied Health Professionals	399.97	408.58	8.61	2.11%
Estates and Ancillary	5.00	5.00	0.00	0.00%
Healthcare Scientists	318.21	322.83	4.62	1.43%
Medical and Dental	956.68	926.31	-30.37	-3.28%
Nursing and Midwifery Registered	2112.99	2114.11	1.12	0.05%
Students	44.73	45.73	1.00	2.19%
Totals	**6826.48**	**6820.63**	**-5.85**	**0.10%**
ISS	**554.40**	**552.40**	**-2.00**	**-0.36%**

Workforce Information | Headlines October 2016

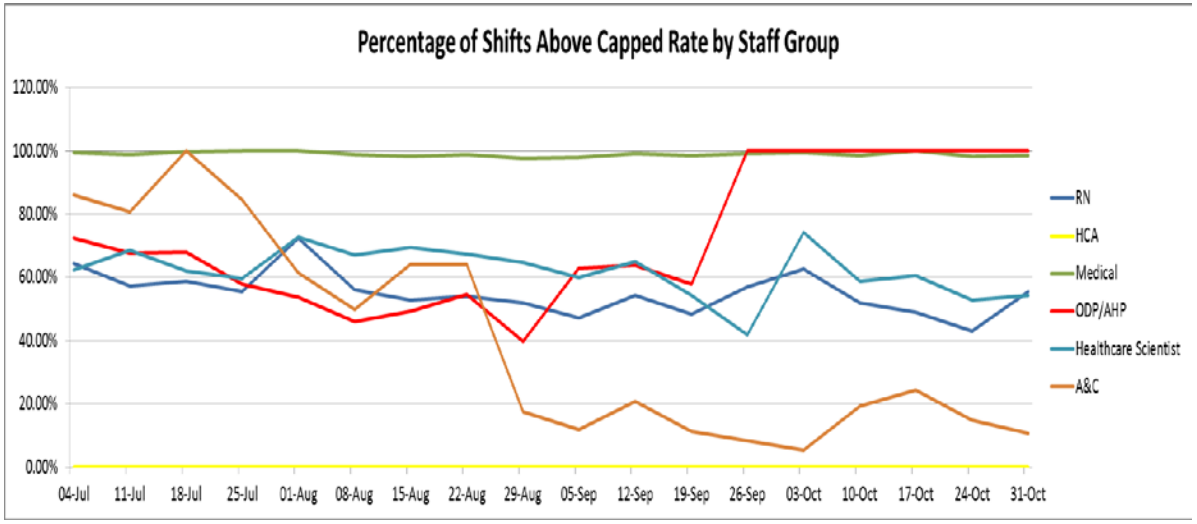
University Hospitals Coventry and Warwickshire NHS Trust

Starters & Leavers | *Nursing*



- The starters results for this October highlight that 20 Newly Qualified Nurses have commenced in post compared to 25 last month.
- New starters for Nursing totalled 37.91 WTE in October. The overall vacancy gap has therefore reduced by 27.5 WTE.
- The forecast new starters for Nursing next month is 19 (Source – Resourcing Dept).

NHSI Rate Caps | *Percentage of Shifts Booked Over Cap*

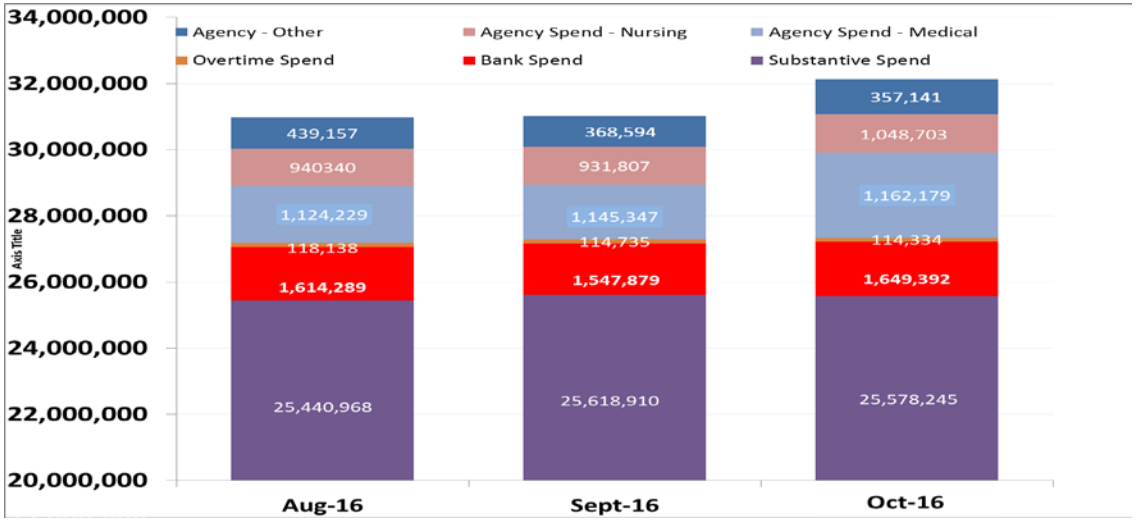


- 98% of Medical Agency shifts remain above cap. This is due to the specialist skills required when booking agency workers and not being able to secure these skills at a reduced rate.
- Nursing shifts over cap have fluctuated during September and October but, have now began to positively reduce by the end of the October.
- Other staff groups have seen a positive reduction in usage.

Workforce Information | Headlines October 2016

University Hospitals Coventry and Warwickshire NHS Trust

Pay Costs | *Provided by Finance*

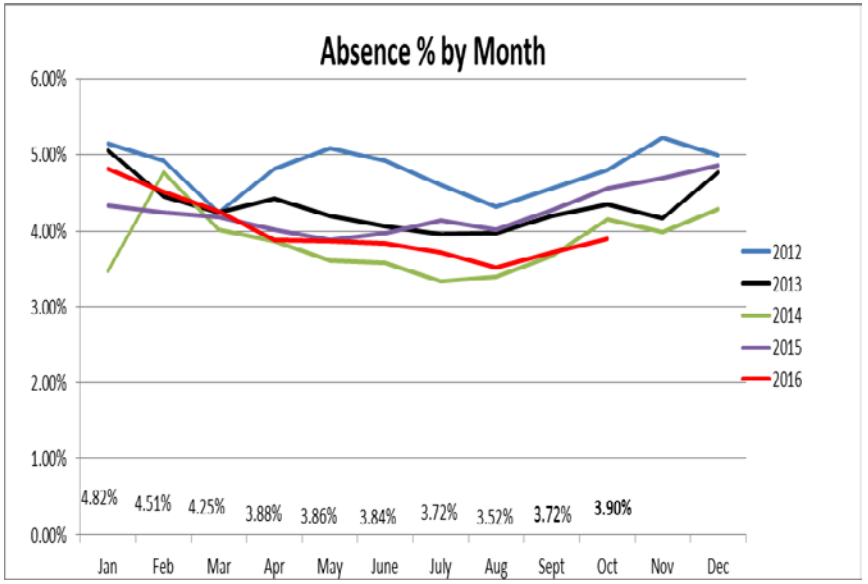


- Temporary costs equate to 14.48% of the Trusts total pay bill (£29,909,992), this is a increase of 0.66% from Sept 2016.
- Agency costs against total costs increased from 8.23% to 8.59%
- There was an overall increase in total agency spend with spend increasing by £123k against September 2016. Agency spend by Medical staff have increased by £17k with Nursing Spend increasing and other agency spend decreasing by £11.5k.
- Bank and overtime usage increased by £223k and is 8.59% of the total spend.
- The substantive pay bill has decreased by £40k from September to October.
- The overall pay bill for October 2016 is £182k above the September 2016 pay bill due to the increase in bank spend, agency spend Medical & Nursing.

Absence | *Specialty Group*

Specialty Group	% Abs Rate (WTE)
Cardiac & Respiratory	4.28%
Care of the Elderly	3.51%
Clinical Support Services Specialty Group	3.68%
Core Functions	2.74%
Emergency Department Specialty Group	5.04%
Hospital of St Cross	3.72%
Imaging	3.72%
Neurosciences Specialty Group	2.70%
Oncology and Haematology	2.80%
Pathology Network Cov & Warwicks	4.38%
Renal Specialty Group	4.60%
Specialist Medicine & Ophthalmology	4.37%
Surgery Specialty Group	4.06%
Theatres and Anaesthetics Specialty Group	5.38%
Trauma & Orthopaedics Specialty Group	3.26%
Women & Children Specialty Group	3.58%
Trust Totals	3.90%

Absence | *Month*

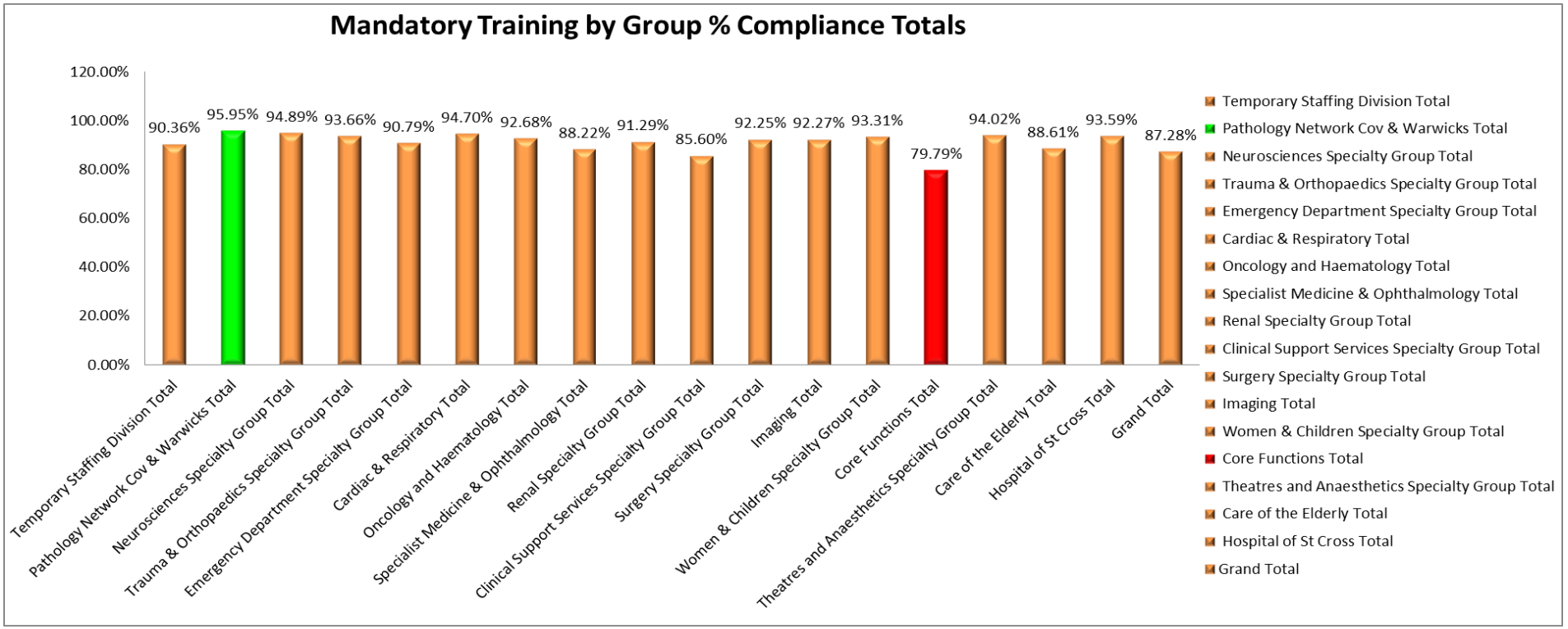


- The Trust has achieved sickness absence rates below the 4% target for the seventh consecutive month.
- Seven specialty groups remain above the 4% target, Emergency Department, Cardiac & Respiratory, Theatres and Anaesthetics, Pathology Network Cov & Warwicks, Renal Specialty Group, Surgery Specialty Group, and Specialist Medicine & Ophthalmology. St Cross has now moved to target.

Workforce Information | Headlines October 2016

University Hospitals Coventry and Warwickshire NHS Trust

Mandatory Training | *Topics*



- Mandatory Training compliance is currently 87.28%, a small decrease of 0.4 % against September.
- Three topics are above 95% (Hand Hygiene Non Clinical, Equality and Diversity & Thromboprophylaxis Initial), eight topics are amber status between 85% and 95% and twelve topics below 85%.
- Two topics are below 60% Immediate Life Support (ILS) – Annual at 52.50 % and Advanced Life Support – 4 Yearly at 59.09%.
- 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 61.98 % in October.
- Immediate Life Support (52.50%) is recorded against the Cardiac and Respiratory group and only two departments ECG and Cardiac Rehab.

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	Health and Safety Annual Report 2015/16
Author	David Lord, Health & Safety Manager
Responsible Chief Officer	David Eltringham – Chief Operating Officer
Date	24 November 2016

1. Purpose

The report is provided primarily for assurance given the overall responsibility of the Trust Board for Health & Safety in the organisation and the potential individual and corporate consequences of health and safety breaches.

2. Background and Links to Previous Papers

The Health and Safety team produce an annual health and safety report that summarises health and safety performance, key issues and achievements within the Trust during the reporting period. It is presented to the Trust Board in accordance with corporate governance and risk management requirements.

3. Narrative

Some of the key issues of note within the report are:

Health and Safety Training:
A review of health and safety training provision has been carried out. Training modules are under development aligning to the trust health and safety management structure.

Reporting of Injuries, Disease and Dangerous Occurrences Reports (RIDDOR) Reports to the Health and Safety Executive:
The Health and Safety Executive followed up six reportable incidents. The Trust cooperated fully with the Inspectors and none resulted in enforcement action.

In response to a Coroners enquiry, a compliance review was carried out and patient falls (previously thought to be exempt from reporting under regulation 14), were identified as reportable under RIDDOR, if specific criteria were met. To address this anomaly a revised RIDDOR reporting procedure was implemented and communicated to managers. A series of face to face training sessions were delivered to managers, supplemented by information packs. A historical review of patient falls was carried out and those identified to be reportable have been notified to the Health and Safety Executive. The revised investigation and reporting procedure is being monitored by a senior management group to scrutinise compliance and provide assurance.

Fire Safety:
A remediation plan has been developed to rectify identified deficiencies in the fire compartment walls. High levels of controls are in place to mitigate the risk, which have been developed in conjunction with the fire and rescue service.

Fire Safety Training:
This continues to be well attended with compliance improving to 85% from 80% last year

Security Management:
The number of physical assaults rose to 244, up from 188 for the previous year. Patient medical factors continue to account for the largest number of reported conflict management incidents. Staff have received additional training aimed at recognising and managing patient factor incidents.

Reporting Arrangements:
Whilst not directly referenced within the report, the current Committee reporting arrangements have been reviewed and it is proposed that the Health & Safety Committee reports directly to the Quality Governance Committee going forwards. The Committee will be chaired by David Eltringham, Chief Operating Officer.

4. Areas of Risk

If the Trust does not put into place adequate measures to comply with relevant Health & Safety legislation then harm might occur which could result in avoidable harm, statutory and regulatory failings, reputation damage and at worst case prosecution.

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

The report links to BAF risk (9) and to our strategic objective to deliver excellent patient care and experience.

6. Governance

The Trust is required to comply with all relevant health & safety legislation and with CQC regulations in this regard. This report is provided as a source of assurance to the Trust Board around compliance and actions that are being taken to ensure that this is continuous.

7. Responsibility

David Eltringham, Chief Operating Officer
Lincoln Dawkin, Director of Estates & Facilities
David Lord, Health & Safety Manager

7. Recommendations

The Board is invited to**:**

1. **NOTE** the content of the report and raise any questions or concerns.
2. **NOTE** the revised reporting arrangements for the Health & Safety Committee
3. **APPROVE** the 2016/17 Annual Report.

University Hospitals Coventry and Warwickshire NHS Trust

Risk Management
(Non Clinical Health and Safety, Fire and Security)

Annual Report

2015/16

David Lord
Health and Safety Manager
Date: August 2016
Version 1

Contents **Page**

1.0 INTRODUCTION

This report summarises the activities of the Trust Health, Safety, Security and Fire Committee (HSC) as part of the Trust's on-going commitment to Health and Safety, for the period 1st April 2015 to 31st March 2016.

The report highlights some of the work of the HSC in regard to non-clinical risk management and further progress that has been made in regard to embedding safety and risk across the Trust by the non-clinical health and safety team.

Some of the key issues that the Committee have discussed are:

- A review of Conflict Resolution training
- A review of Health and Safety training provision
- RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013)
- Safe use of Xylene and air borne monitoring in Cytology/Pathology
- Noise levels in Bowel Cancer Screening Unit, St Cross
- Policies approved include;

  Health and Safety Policy

  Latex Management Policy

  Occupational Stress Policy

  CCTV Policy

  Baby Abduction Procedure

  Fire Safety Policy and Procedures

2.0 RISK MANAGEMENT AND GOVERNANCE

The HSC business plan continues to see better alignment of reporting, and sharing of information around health and safety performance between the Trust and the Project Co. partners. A transition of the non-clinical risk team was agreed and the new Health and Safety Team now comprises of a Health and Safety Manager and a Health and Safety Advisor with 0.4 WTE Admin Specialist support. The new Health and Safety team were transferred from the Quality Governance Department to the Estates and Facilities Department in November 2015.

3.0 HEALTH AND SAFETY TRAINING

3.1 Mandatory Training

The induction training programme is managed via the Learning and Development team. Face to face delivery of health and safety awareness on the induction programme was re-introduced in January 2016.

The e-Learning programme for the three yearly update appears to be running well with the compliance numbers increasing month on month, see Figure 1. Compliance is currently running at about 92% of staff up to date with their health and safety awareness training.

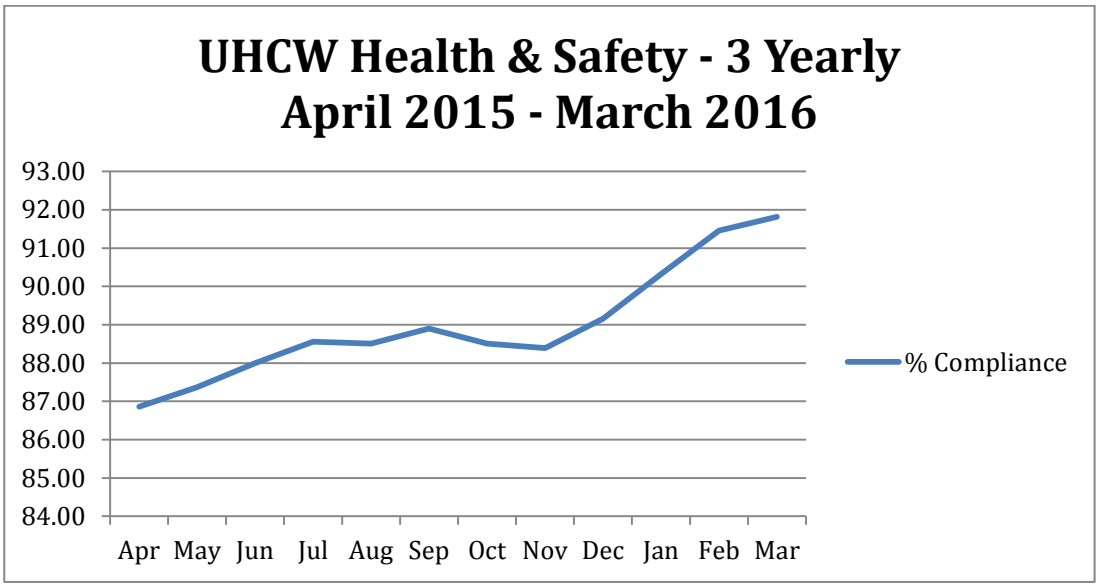


Figure 1 Graph showing Mandatory Training Compliance over Past 12 Months

3.2 Statutory Training Provision

The Awaken e-Learning system for Display Screen Equipment (DSE) training and risk assessment was launched in August 2014. There is a rolling programme of introduction throughout the Trust. Areas are enrolled to the system once they have the appropriate support system in place. i.e. a local DSE assessor. A total of 668 staff have completed their on-line training and self-assessment. Further departments will be enrolled during 2016/17.

3.3 Training Needs Analysis

There is a legal responsibility under the Health and Safety at Work Act 1974, and the Management of Health and Safety at Works Regulations 1992 to develop a robust

health and safety management system. Undertaking *"suitable and sufficient"* risk assessments is a key requirement in achieving this.

A modular approach to Risk Management training has been proposed and will be developed and implemented during 2016/17. The proposed training for staff groups is outlined in Figure 2 below.

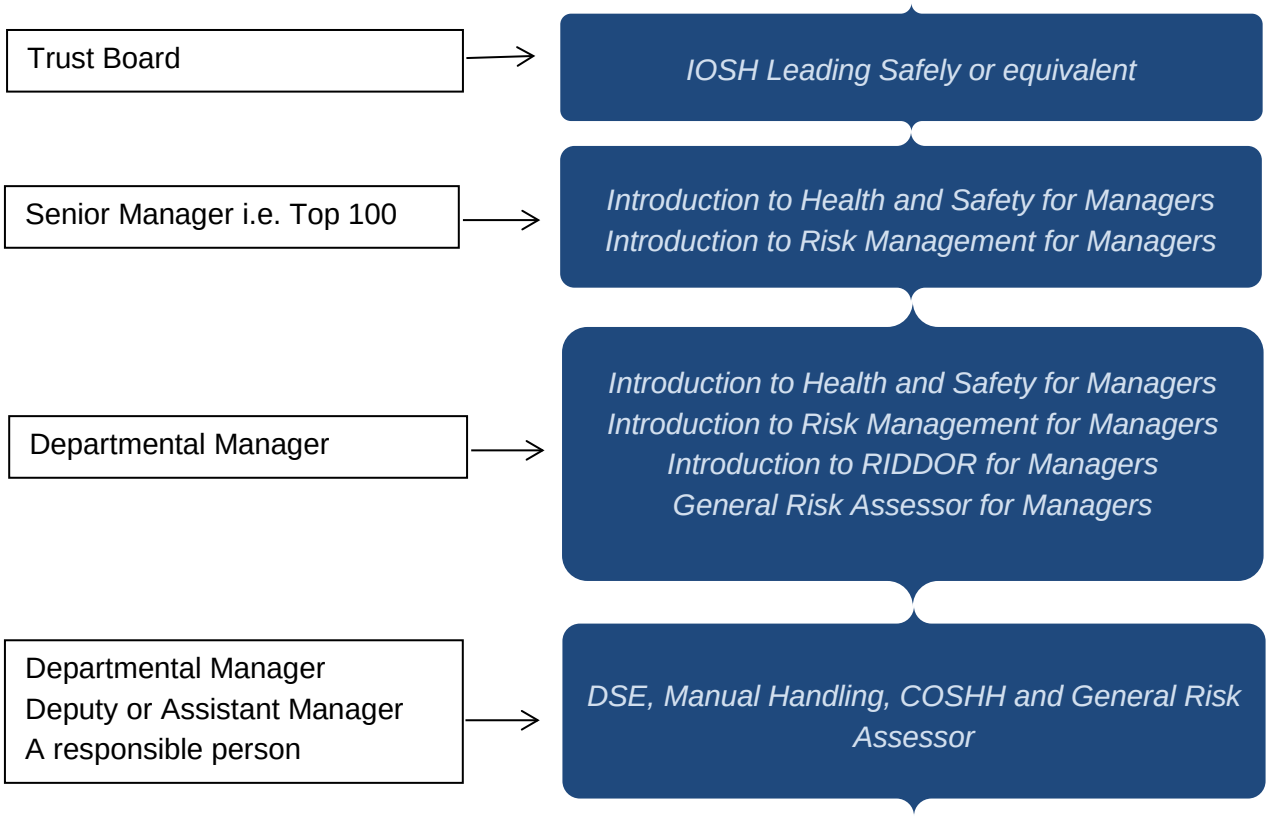
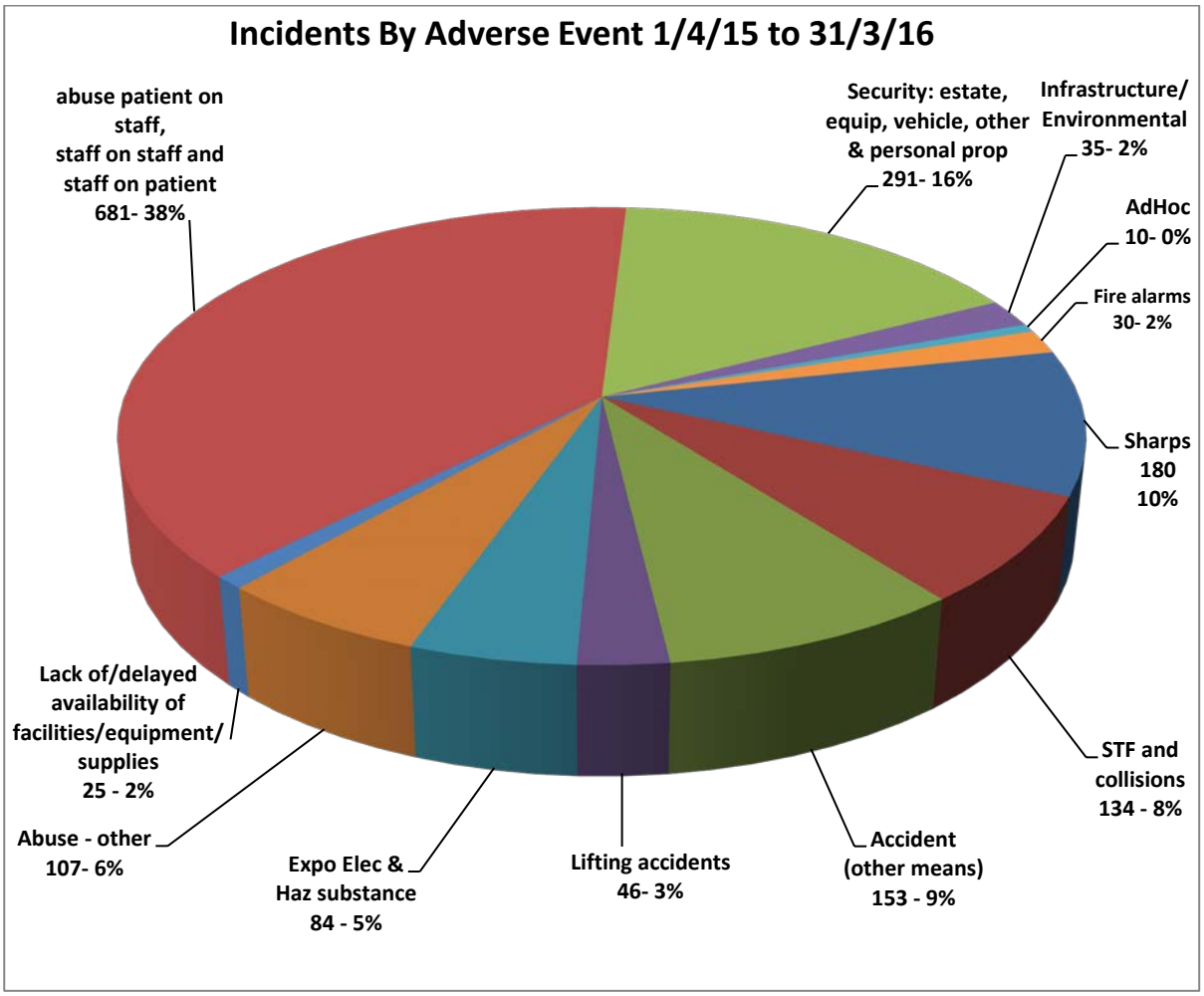


Figure 2 Initial training proposal is not exclusive to each Group but indicative of the minimum requirement.

4.0 GENERAL INCIDENT REPORT

4.1 All Non-Clinical Incidents

There were a total of 1767 (1517 in previous year) non-clinical incidents in the reporting period (including RIDDOR). The pie chart below provides a breakdown of the incidents. The increase (250 incidents) may be due to the work carried out by the Health and Safety Team, in conjunction with the Quality Patient Safety Team. During the audits and inspections the need to report incidents has been highlighted.



Data collated 05/05/16

Figure 3 Incidents by Adverse Events - Clustered

Figure 3 shows a breakdown of the types of incidents reported in the past year. The bulk of the reported incidents relate to security and violence, whilst Sharps, Slips/Trips/Falls and Accident others, also appear to be significant. Although only 8% of incidents were related to Slips/Trips/Falls, they usually account for the most serious injuries sustained, frequently resulting in fractures.

4.2 Table of Top 5 Adverse Events

Figures 4 and 5 show a summary of the top 5 incidents as well as those by type. Abuse of staff and patients remains the commonest incident reported.

2014/15		2015/16		Trend
Abuse-Staff by patients	544	Abuse- Of staff and patients	681	⬆
Needle stick injury	165	Security – of estate, personal property, equipment	291	⬆
Slips, Trips and Falls	139	Needle stick injury	180	⬆
Accident caused by some other means	116	Accident caused by some other means	153	⬆
Abuse – other	93	Slips, Trips and Falls	134	⬇

Figure 4 Table of Top 5 Adverse Events

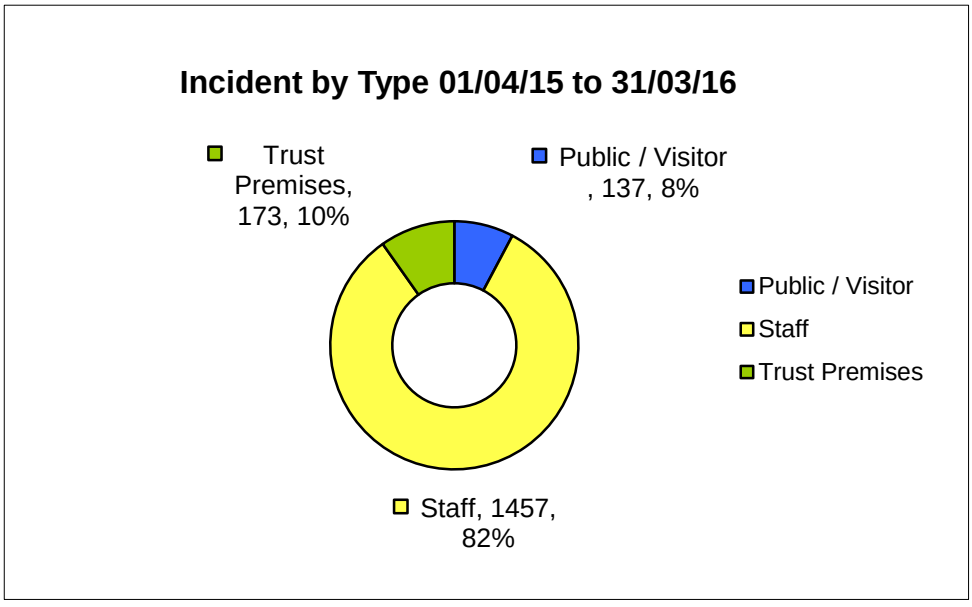


Figure 5 Chart showing Incidents by Type

5.0 RIDDOR

The Trust is required to report to the Health and Safety Executive (HSE) a specific range of work related events under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013).

All RIDDOR incidents are reported by the Health and Safety Team and all RIDDOR reportable incidents are discussed at the HSC to ensure lessons are learned and recurrence prevented.

Following last year's significant downward trend, with only 36 RIDDOR reportable incidents, the number of RIDDORs reported this year have returned to a number more consistent with the past few years (average 52p.a.)

Methods to improve the understanding of RIDDOR and the timely reporting of RIDDOR incidents have been explored. Flowcharts have been developed to aid managers decide if an incident is a RIDDOR reportable event and a reporting procedure drafted.

5.1 RIDDOR Reportable Incidents

Figures 6 and 7 show the breakdown for these incidents. Figure 6 indicates the RIDDOR reporting category.

Category	2013/14	2014/15	2015/16	Trend
Over 7 day Injury (since 6/4/12)	20	20	29	⬆
Specified Injury	13	12	9	⬇
Dangerous Occurrence	22	4	7	⬆
Fatality	0	0	1	⬆
Occupational Disease	-	-	3	⬆
Total	55	36	**49**	⬆

Figure 6 RIDDOR incidents by category

Type of Person Affected

	2013/14	2014/15	2015/16	Trend
Staff	46	31	42	⬆
Patients	1	2	5	⬆
Public	4	3	2	⬇
Other	4	0	0	↔

Figure 7 RIDDOR Incidents By Person Affected

5.2 Type and Learning from RIDDOR incident

Injuries from Slips, Trips and Falls (STF) accounted for 39% (19) of RIDDOR reports, usually due to a specified injury. Ten of the STF victims sustained a fracture.

Manual handling related incidents (16% of incidents) resulted in 8 staff injuries requiring staff to take more than 7 days off sick from work.

The three cases of occupational disease, confirmed by the Occupational Health Physician included;

- Dermatitis due to excessive hand washing
- Dermatitis due to an allergic reaction to Gojo soap (out of date soap used)
- Asthma due to an allergic response to Chloramines (Tristel)

Learning outcomes from incident follow up aim to prevent further incidents and may apply locally or Trust wide. For example:

- There will be trials of new green needle safety devices.
- ISS to review their stock management system and checked every unit of Gojo soap in use, withdrawing several out of date units.
- Changes to Pathology SOP so that difficult or unusual gram stains have clinical verification.
- Patient Falls Care Plan to be commenced on all patients admitted with a fall at high risk.

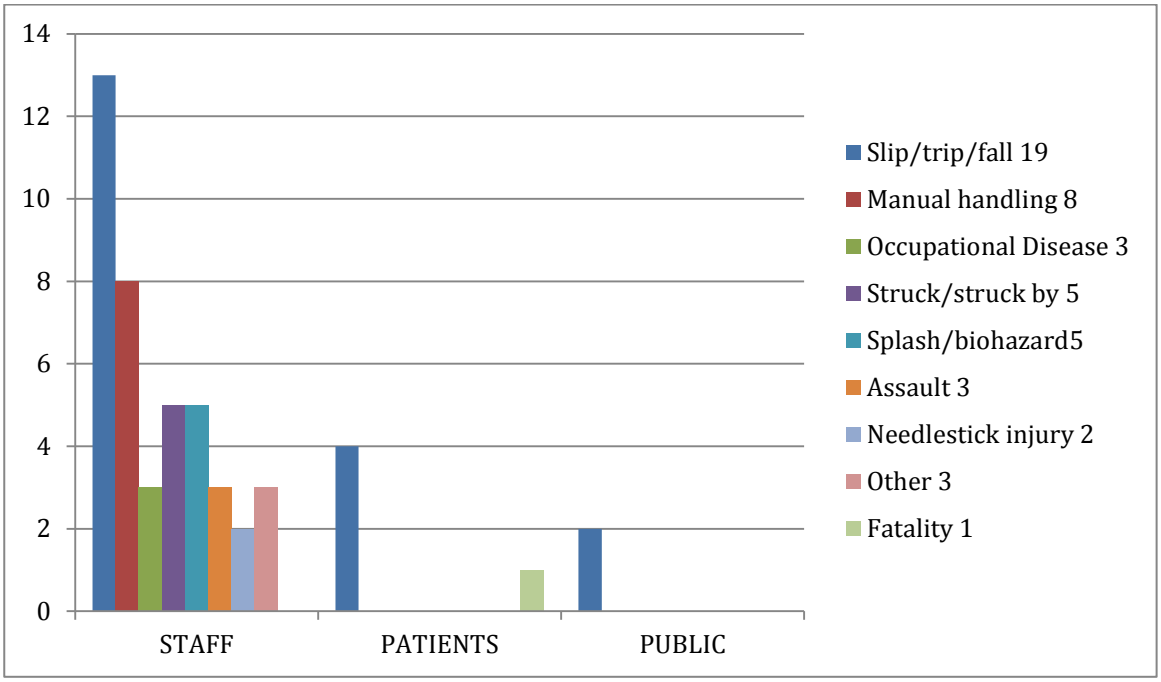


Figure 8 Bar chart showing type of RIDDOR by Person Affected 2015/16

5.3 Contact with the HSE

The HSE contacted the Health and Safety Team to follow up 6 RIDDOR reports. The HSE initially telephoned the team to discuss the reports and then followed this up with emails requesting further information. The HSE were satisfied with the information provided on incident investigations and the management of individuals affected and did not carry out any compliance visits.

6.0 AUDITS AND RISK ASSESSMENT

6.1 Health and Safety Inspection Checklist

A programme of inspection/audits was introduced in 2012 varying its focus on departments each year. Satellite sites will be included annually to improve contact and assistance to departments that may sometimes feel isolated from the main organisation. Due to a temporary reduction of staff when the previous Health and Safety Manager left, a slightly reduced number of departments were audited and inspected. A total of 33 departments were audited and 7 inspections were carried out.

Whilst a targeted approach was taken, all departments are required to review their Inspection Checklists on a regular basis.

The inspection included interviews with the staff, review of the checklist, audit of the local risk assessments and a walkabout survey. Managers received feedback on the positive aspects of their completed checklist and advice on what action, if any, was needed. The checklist enables managers to both assure themselves, their groups/speciality and the Trust Board that they are compliant with the Trust's Policies and Procedures in regard to Health and Safety.

Due to a few recent legal cases (not involving the Trust) 3 extra questions were added regarding recording patients hoist sling sizes, the inspection of steps/kick-stools and Dermatitis.

Health and Safety Audit Checklist Progress and Summary

	Action	Result
Apr 2015	Checklist issued to all wards at St Cross and the renal units at Whitnash and George Eliot Hospitals.	All wards (100%) at St Cross returned their completed checklists. Managers received feedback on the positive aspects of their completed checklist and advice on what action, if any, was needed.
Apr 2015 – Mar 2016	Checklist issued to 47 departments at University Hospital. One unplanned audit/inspection carried out.	A total of 22 (47%) departments completed & returned their checklists. Managers received feedback on the positive aspects of their completed checklist and advice on what action, if any, was needed.
Apr-Oct 2015	Checklists issued and appointments made with 4 satellite sites. An appointment was made to review the Stratford Renal Unit which Fresenius manages on behalf of the Trust.	All (100%) departments returned completed checklists. Five sites were visited and inspected. Managers received feedback on the positive aspects of their completed checklist and advice on what action, if any, was needed.
Summary	The response rate for St Cross and the Satellite sites was 100%. At University Hospital only 47% of departments completed and returned a checklist. The returned checklists were very positive and showed that the majority of departments were reasonably compliant.	

	For example, 97% stated they had risk assessments for slips/trips, a 5% increase since last year. 100% stated they had risk assessments for needlestick injuries an increase of 7.5% from last year. 100% of staff had completed a Trust Induction and a local safety induction. The checklists also indicated there continues to be a lack of DSE assessments, although this has improved from 37% completed up to 51%. This year the inspections did not reveal any discrepancies that required follow up inspections. It was good to see the remedial actions recommended following last year's inspections had been undertaken and the general standards within the workplace and for sharing health and safety information had improved.
2016/17 Action Plan	Using a targeted approach has worked well, particularly for the inspections of the Satellite sites. It is envisaged that a number of sites and departments will be visited as part of the familiarisation plan for the new Health and Safety Manager.

Figure 9 Summary of Audits Undertaken

Departments Inspected 2015/16

Community Diabetes Specialist Nurses, Newfield House Coventry	Lucy Deane Renal Unit, George Eliot Hospital
Stratford Renal Unit	COPD Service, Paybody CoCHC
Community Heart Failure Service, Paybody CoCHC	Whitnash Renal Unit
Estates and Facilities Department UHCW	

Figure 10 Departments inspected

7.0 FIRE SAFETY MANAGEMENT

7.1 Remediation Plan

A Remediation Plan was developed to address deficiencies in the fire compartment walls that were identified as part of routine maintenance work. Phase 1 of the plan has been implemented and work is on-going. The Trust has been working closely with the Fire Service and high levels of controls and risk mitigation have been put in place to reduce the risk of a fire incident developing, including a revised fire evacuation strategy and staff training.

Table-top exercises for the hospital Fire Response Team and the first on-call managers were held on the 2nd and 3rd of September 2015 and these were followed by a live evacuation exercise which was held on the 13th October 2015.

7.2 Fire Service Attendance

The Fire Service attended a total of 46 fire alarm activations across both Trust sites during the year. This is once again a significant improvement on the previous reporting year (59).

The table below shows a breakdown of these figures with last year's totals shown in brackets.

Fire Alarm Activations 2015/16	University Hospital	St Cross
Fire	1 (1)	0 (0)
Cooking Fumes / Burnt Toast	5 (9)	1 (2)
Electrical / Overheating Appliance	4 (8)	1 (2)
Fire Panel / Equipment Fault	4 (8)	4 (3)
System procedures not complied with	1 (2)	4 (0)
Smell of Burning	5 (11)	3 (4)
Accidentally broke fire alarm glass	0 (2)	0 (0)
Malicious use of the alarm system	0 (1)	0 (0)
Environmental	4 (8)	0 (1)
Dust	1 (6)	0 (1)
Steam	1 (3)	1 (1)
Smoking	0 (2)	0 (0)
Plant / Equipment	1 (2)	0 (0)
Unknown	3 (5)	2 (2)
Total	30 (68)	16 (16)

One fire occurred at the University Hospital on the 20th February 2016 at approx. 22.45hrs. A small fire was started by a patient in a four bedded area on Ward 1. The fire was extinguished quickly by staff. There was slight damage to furniture which caused a strong smell of burning throughout the area. As a result of this, all patients in the general vicinity of the area were evacuated to another ward. This was a precautionary evacuation, not because any patients were at risk but mainly due to smoke and ash particles contaminating the clinical area. The bay where the fire occurred was subsequently terminally cleaned and all patients returned to the ward the following morning. Staff in the vicinity responded correctly and efficiently.

The hospital fire procedure worked as it is designed to do and the hospitals Fire Response Team led by the Hospital Bleep Holder responded and took control and

gave direction. The Fire Service attended but the fire was out on their arrival. No significant disruption was caused to the services provided by the Trust as a result of this fire.

7.3 Fire Risk Assessments

All fire risk assessments continue to be updated and reviewed by the Trust Fire Safety Manager. The review process is continuous.

All fire risk assessments at the University Hospital have had to be reviewed to reflect the issues caused by the shortfalls found in the structural fire protection at the University Hospital.

It is stressed once again that in accordance with the Regulatory Reform (Fire Safety) Order 2005 that the Trust is only responsible for carrying out fire risk assessments in areas under which it has direct management control. Areas such as plant rooms, electrical cupboards, service ducts, service risers, above false ceilings, and other areas which fall under the control of ISS, Vinci and Project Co are risk assessed by those respective organisations.

The performance and compliance of contracted partners is monitored and assurances sought via the Consortium Fire Safety Group, under the control of Project Co.

7.4 Fire Safety Training for Staff

The mandatory staff fire training programme continues at both hospital sites, to ensure that the Trust continues to meet its statutory obligations. A fire training programme is produced annually by the Fire Safety Manager.

Attendance at fire lectures during 2015/16 continues to be good with approximately 85% of Trust staff attending. This is an increase from the last report (80%)

The Trust Fire Safety Manager continues to be actively involved with the Mandatory Training Committee and works closely with other committee members to improve the effectiveness of all staff training throughout the Trust.

7.5 Off Site Premises

The Trust Fire Safety Manager continues to provide advice and technical fire safety guidance to, and regularly visits, staff at the following ‘off site’ premises:

- Whitnash Renal
- Stratford Renal
- City of Coventry Health Centre
- Newfield House
- Watch Close
- Clay Lane Renal

7.6 Fire Safety Website

The Fire Safety website is regularly updated and it continues to be a valuable resource for staff to find information about general fire safety matters and Trust specific fire safety information. It also contains details of dates and times of the staff fire lecture programmes.

8.0 SECURITY MANAGEMENT

The Trust Security Manager (TSM) continues to promote & develop partnership working with the Police and local managers through formal and informal channels e.g. one to one, team and group meeting and the monitoring of incidents and trends in order to follow up and identify the key underlying causes leading to incidents of violence, aggression and harassment. The overarching aim of this approach is to raise staff awareness of the Trust's prioritisation of and approach to this issue ultimately reducing the level of severity and the numbers of this type of incident.

This year has seen a focus on auditing of security procedures and the ISS security team compliance. Due to ongoing concerns, an action plan was developed and agreed which was monitored at focused fortnightly meetings.

The Crime and Incident Reduction Group (CIRG) has been successful in bringing together the TSM, ISS security, Prison service and the Police to discuss Security issues at each site. The clinical input at these meetings dropped off causing concern and was raised at the Trust Health, Safety, Security & Fire committee resulting in the Chair contacting matrons to gain support.

Due to the re-role at HMP Rye Hill to an all sex offender prison it has been necessary to review the risk assessments and protocols when offenders visit the Trust for treatment. New appointment procedures were introduced in November 2015 to mitigate risks identified when offenders visit site. To avoid confusion HMP Onley follow the same procedure.

Our contacts with the Police and the local community continue to play an important part in security management at the Trust. Our partnership work has allowed us to plan in advance and intervene in incidents at an early stage which has stopped reoccurence of problem situations.

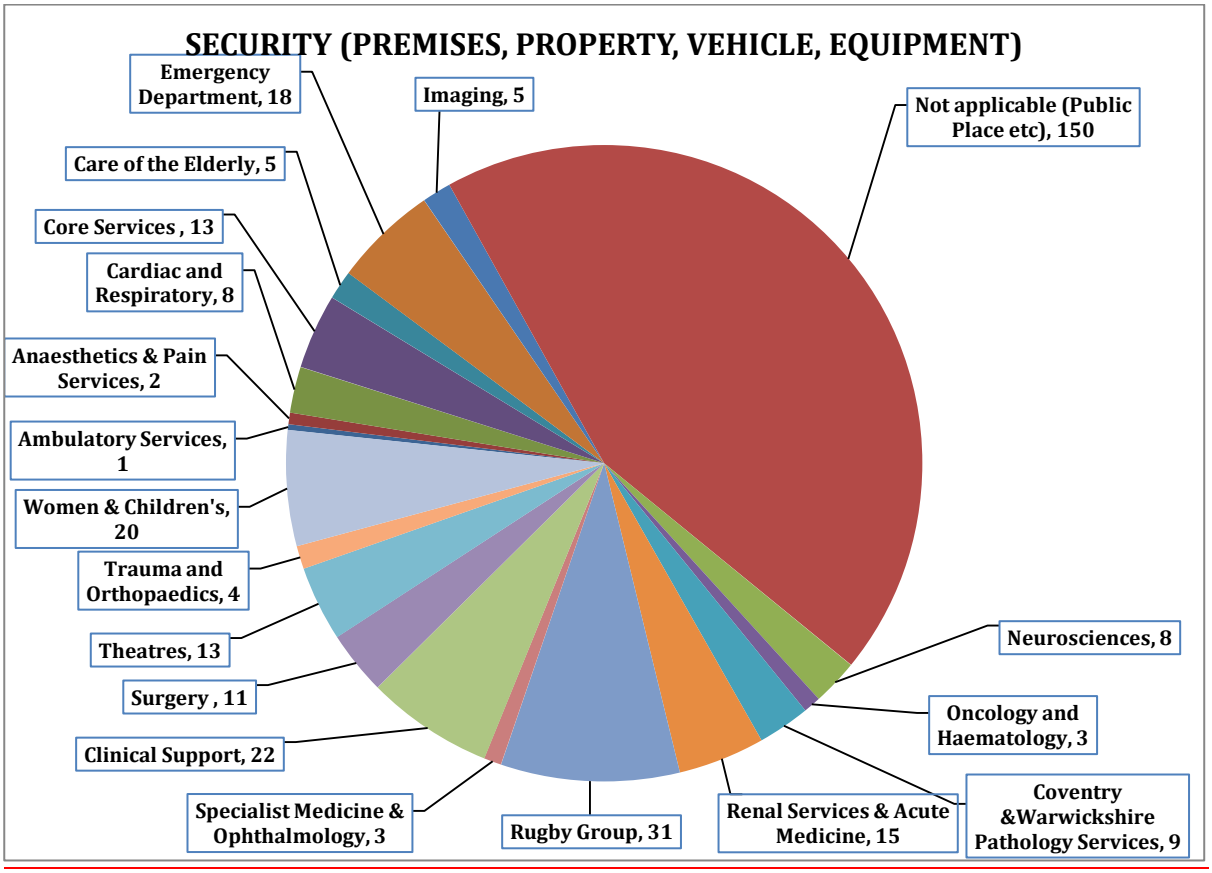
Security awareness of staff continues to be one of the key objectives for the TSM.

8.1 Access Control

The TSM continues to audit and review Access controls throughout the Trust. The procedural changes have ensured that only authorised staff has access to departments in the building and the issue of access is now regulated closely. This should help to allow only authorised personnel access to Trust property and generally strengthen security measures in its buildings. The Trust rely on our Hard and Soft service providers to maintain robust procedures for contractors who visit site.

8.2 Security Advice

The TSM and the Police Hospital Liaison officers have met with Matrons and Ward Managers from across the Trust and completed walk round reviews of security in their departments/wards. Advice has been given where security failings have been identified. The police have also run events at the hospital like ‘Cuppa with a Coppa’ and set up a stall in the mall to offer advice to staff and visitors to reassure that security incidents across the Trust are taken seriously.



8.3 Rugby St Cross

Considerable improvements have been made in security measures at the Hospital of St Cross Rugby and the TSM continues to foster strong relationships with Business Improvement District (BID), Warwickshire Police and the ISS security team. Improvements include a revised patrolling schedule and monitoring of lone workers.

8.4 Security, Lone Working and Violence and Aggression Risk Assessments

When security related incidents are reported on DATIX the TSM reminds mangers to review the local risk assessments and offers advice when requested. The local risk assessments have been completed by departments to review controls and put an action plan in place where deficiencies are found.

NHS Protect have agreed a framework agreement with Reliance for the provision and monitoring of lone worker devices. All managers with lone workers are requested to complete the appropriate risk assessment to identify their specific needs.

8.5 Incidents

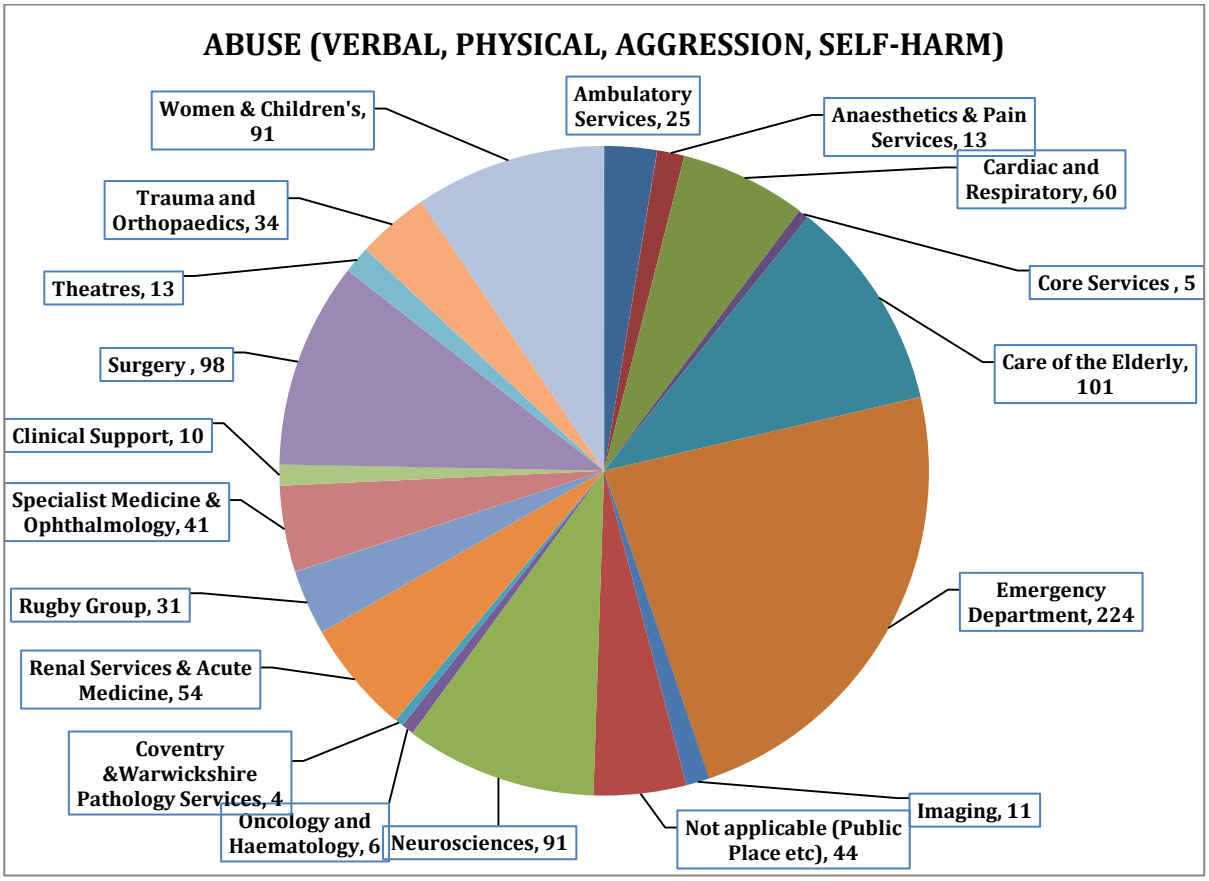
A large proportion of incidents of physical assault result from the clinical condition of the patient. These invariably result in staff being offered support and guidance on sanctions available to them. However, in the majority of instances staff refuse to take the matter forward as they appreciate that the actions of the patient were as a result of the patient's clinical condition.

The majority of the physical assaults were due to an existing clinical condition such as Dementia, Head Injury etc.

Number of assaults	Assaults Involving Medical Factors	Assaults NOT Involving Medical Factors	Declared sanctions
2015/2016 244	**188**	**56**	**20**
2014/2015 188	**156**	**32**	**14**
2013/2014 156	**136**	**20**	**5**
2012/2013 163	**140**	**23**	**9**

UHCW NHS Trust has care of its staff as a core value. Numbers of violent incidences against staff is increasing both nationally and locally. Due to this we have reviewed our procedures when managing non-clinical violent/abusive incidents and have trained staff accordingly. The Criminal Justice & Immigration Act (CJIA) gives powers of eviction to NHS staff when dealing with nuisance persons on NHS sites. The Clinical Site Managers have undergone training as an authorised person to assess the eviction of nuisance persons on NHS premises. The ISS security officers have been trained to evict nuisance persons while understanding the boundaries of section 119/120 of the Criminal Justice & Immigration Act (CJIA).

Below is a summary of the total number of abuse (verbal, physical, aggression, self-harm) by group for 2015/16:



Incidents by Speciality Group and Stage of care

	SECURITY	ABUSE
Ambulatory Services	1	25
Anaesthetics & Pain Services	2	13
Cardiac and Respiratory	8	60
Core Services	13	5
Care of the Elderly	5	101
Emergency Department	18	224
Imaging	5	11
Not applicable (Public Place etc)	150	44
Neurosciences	8	91
Oncology and Haematology	3	6
Coventry &Warwickshire Pathology Services	9	4
Renal Services & Acute Medicine	15	54
Rugby Group	31	31
Specialist Medicine & Ophthalmology	3	41

Clinical Support	22	10
Surgery	11	98
Theatres	13	13
Trauma and Orthopaedics	4	34
Women & Children's	20	91
Totals:	341	956

8.6 Trust Self-assessment Against NHS Protect Standards for Providers

NHS Security arrangements are now set out in the NHS Standard Contract and as part of this the Trust submit a self-review against certain standards as below:

Strategic Governance. This section sets out the standards in relation to the organisation's strategic governance arrangements. The aim is to ensure that anti-crime measures are embedded at all levels across the organisation.

Inform and Involve. This section sets out the requirements in relation to raising awareness of crime risks against the NHS and working with NHS staff, stakeholders and the public to highlight the risks and consequences of crime against the NHS.

Prevent and Deter. This section sets out the requirements in relation to discouraging individuals who may be tempted to commit crimes against the NHS and ensuring that opportunities for crime to occur are minimised.

Hold to Account. This section sets out the requirements in relation to detecting and investigating crime, prosecuting those who have committed crimes and seeking redress.

UHCW NHS Trust self-assessment table (No standards are scored as Red)

	Self-assessed overall score	Number of standards in section	Number of standards assessed Green	Number of standards assessed Amber
Strategic Governance	Green	5	4	1
Inform and Involve	Amber	7	2	5
Prevent and Deter	Amber	15	7	8
Hold to Account	Amber	4	1	3

In April 2015 the Trust were audited by NHS Protect against the Prevent and Deter element of the standards with a positive report.

8.7 SIRS

NHS Protect have introduced the Security Incident Reporting System (SIRS) to capture data on all security incidents from NHS Trusts nationally. UHCW NHS Trust has upgraded to a version of DATIX which is compatible with the SIRS system for upload of incidents which will result in valuable information being shared nationally to inform NHS Protect security strategy.

8.8 Conclusion

The protection of patients, staff and visitors will enable the continuation of our core activity, that is, the treatment and care of our patients to be conducted in a safe environment, free from worry or concern over the damaging effect that crime or the threat of violence gives. It will create an atmosphere of care and foster a better - motivated workforce. Additionally, the protection of assets, either corporate or personal will enable resources to be focused into patient care, rather than be diverted in the direct and consequential costs of losses incurred by criminal activity.

Security management activity has been intense over the last year, and it is not expected to be any less this year. The result is that the role of the LSMS has become even more embedded in the organisation, enabling more support and advice offered to staff when unfortunately incidents do occur.

9 SUMMARY

The Trust continues to work towards improving standards for Health, Safety, Fire and Security Risk Management.

Incident reporting is showing an upward trend indicating an open culture in staff confidence of reporting and helping in identifying areas for improvement. Although the number of RIDDOR reports increased there is still a concern about the lack of understanding regarding RIDDOR reportable incidents.

There has been a lack of Health and Safety training for managers and staff during the last year.

10 RECOMMENDATIONS

The Trust should consider reviewing:

- Methods to improve the understanding of RIDDOR and the timely reporting of RIDDOR incidents.
- The health and safety training needs of managers and staff.

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Complaints Policy**
Author	**Andrew Wilkins, Head of Patient Relations**
Responsible Chief Officer	**Professor Meghana Pandit, Chief Medical Officer and Quality Officer/Deputy CEO**
Date	**24 November 2016**

1. Purpose

To present the Complaints Policy to the Trust Board for approval.

2. Background and Links to Previous Papers

The revised Complaints Policy has been presented and consulted upon through the Patient Experience and Engagement Committee and through Quality Governance Committee and is recommended to the Trust Board for approval.

3. Narrative

In keeping with 'Together Towards World Class' and our vision of becoming a national and international leader in healthcare, the Complaints Policy enables the Trust to demonstrate commitment to delivering excellent patient care and experience. It ensures that patient feedback is encouraged and utilized to facilitate learning and to achieve positive change.

4. Areas of Risk

If the Trust does not manage complaints appropriately and take necessary corrective action then patients may have a continuing poor experience, lessons will not be learned and the Trust will not meet its statutory and regulatory requirements, which could result in regulatory intervention and consequent reputation damage. The Policy and mechanisms that are in place to deal with complaints and the associated learning are intended to mitigate against this.

5. Governance

This policy meets the requirements prescribed by the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and Parliamentary and Health Service Ombudsman best practice guidance.

6. Responsibility

Professor Meghana Pandit; Chief Medical Officer and Quality Officer/ Deputy CEO
Jenny Gardiner, Director of Quality
Anita Kane, Associate Director of Quality

8. Recommendations

The Trust Board is asked to **APPROVE** the Complaints Policy.

University Hospitals Coventry and Warwickshire NHS Trust

Complaints Policy	
eLibrary ID Reference No:	**GOV-POL-003-07**
Version:	7.0
Date Approved by Trust Board:	N/A
Date Approved by Corporate Business Records Committee (CBRC): *(to be applied by CBR Officer following CBRC approval)*	
Review Date: *(a 3 year review date will be applied unless stated otherwise)*	
Title of Author:	Head of Patient Relations
Title of Clinical Director: *(if applicable)*	N/A
Title of Chief Officer:	Chief Medical Officer
Target Audience:	All Staff

If printed, copied or otherwise transferred from eLibrary, Trust-wide Corporate Business Records will be considered 'uncontrolled copies'. Staff must always consult the most up to date PDF version which is registered on eLibrary.

As a controlled Trust-wide CBR, this record should not be saved onto local or network drives but should always be accessed from eLibrary.

Summary of Trust-wide CBR: *(Brief summary of the Trust-wide Corporate Business Record)*	The Trust's approach to, and processes for, receiving and responding to complaints from patients or their representatives about the treatment, care or service provided.
Purpose of Trust-wide CBR: *(Purpose of the Corporate Business Record)*	To ensure that; - patients and representatives feel supported in raising their concerns; - concerns are appropriately investigated and responded to; and - We learn from complaints and improve the service we provide.
Trust-wide CBR to be read in conjunction with: *(List overarching/underpinning strategies, policies and procedures)*	Patient Advice and Liaison Service Operational Policy
Relevance: *(State one of the following: Governance, Human Resource, Finance, Clinical, ICT, Health & Safety, Operational)*	Governance
Superseded Trust-wide CBRs (if applicable): *(Should this CBR completely override a previously approved Trust-wide CBR, please refer to eLibrary and state full title and eLibrary reference number and the CBR will be removed from eLibrary)*	Complaints policy V6

Author's Name, Title and email address: *(must not be the same as reviewer)*	Andrew Wilkins – Head of Patient Relations andrew.wilkins@uhcw.nhs.uk
Reviewer's Name, Title & email address: *(must not be the same as author)*	Anita Kane – Associate Director of Quality anita.kane@uhcw.nhs.uk
Group Manager's Name, Title & email address: *(if appropriate)*	Jenny Gardiner – Director of Quality
Title of Group/Department/Specialty:	Quality and Patient Safety / Patient Experience

Version	Consultation Committees/Meetings/Forums etc *List **all** Trust Committees/Forums/Bodies/Groups where this version of the CBR has been consulted on during the development/review stages.*	Date
	(This table must be complete or the CBR will be returned to the author)	

Table of Contents

1.0 SCOPE

1.1 This policy applies to complaints made by or made on behalf of a patient relating to the Trust's services, including any satellite or contracted services.

1.2 The policy applies to concerns that cannot reasonably be resolved at the point of contact or with the assistance of the Patient Advice and Liaison Service (PALS) and where the patient or their representative wants their complaint to be formally investigated.

1.3 The policy does not apply to internal disputes, whether that be between staff or services and it does not apply to inter-organisational disputes.

2.0 INTRODUCTION

2.1 The Trust is committed to providing excellent patient care and experience and patient feedback is seen as a valuable tool for understanding how well we are delivering on that commitment as well as being a key way of identifying opportunities for improvement.

2.2 The Trust will treat complaints seriously and ensure that complaints raised by patients, relatives and carers are properly investigated in an unbiased, non-judgmental, transparent, timely and appropriate manner.

2.3 Effective complaint management helps maintain organisational integrity and promotes confidence in our services within the communities that we serve.

2.4 Through individual investigations and complaint data analysis, the management of complaints contributes to the Trust's risk management system.

2.5 The policy ensures that complaints are managed in accordance with the requirements of the Local Authority Social Care and National Health Service Complaints [England] Regulations (2009), the NHS Constitution and it reflects the recommendations from the Francis report (2013) and Clwyd Hart review (2013) as well as Parliamentary and Health Service Ombudsman guidance.

3.0 STATEMENT OF INTENT

The Complaints Policy has several distinct and important objectives:

- To provide a service accessible to all.
- To operate a patient centred complaints policy, tailoring our communication and approach to meet the needs of the patient or their representative.
- To manage complaints in a speedy and efficient manner, being mindful and sympathetic to the circumstances.
- To use complaints as a means of improving services.
- To maintain a balance between treating staff fairly and maintaining proper accountability for their actions.

- To avoid unnecessarily protracted correspondence.
- To provide co-ordinated handling of those complaints which cross health and social care organisations, providing the complainant with a single response.

4.0 DEFINITIONS

4.1 Trust services: All aspects of treatment, care and services.

4.2 Contracted services: Services provided by a company to a patient or for the direct benefit of a patient on behalf of the Trust.

4.3 Interested other party: A person in a position to hold a genuine interest in the patient's needs, such as a relative, friend, carer, or advocate.

4.4 Complainant: A patient raising a complaint or someone authorised to raise a complaint on their behalf.

4.5 Complaint: a complaint can be defined as any expression of dissatisfaction that requires a response or action.

Complaints should be responded to in the most appropriate manner; the use of the word complaint does not necessarily mean that the matter should be registered and investigated through the complaints process; it may be that the issue can be immediately or quickly resolved avoiding the need to instigate the complaints process. Further information and guidance is provided at paragraph 6.2.

5.0 DUTIES / RESPONSIBILITIES

5.1 Trust Board

The Trust Board is required to receive assurance that the Trust's management of complaints is fit for purpose, ensuring that feedback is received, appropriate investigations are carried out and learning and improvements result where failings are identified.

5.2 Chief Executive Officer

The Chief Executive Officer has overall responsibility for the quality of care delivered and therefore for ensuring that complaints are appropriately managed. Specifically, the Chief Executive Officer has responsibility for ensuring complaints are managed in accordance with national legislation to ensure that patients or their representatives views are heard and appropriately acted upon.

The Chief Executive Officer will also review, approve and sign all final responses to complaints. In the absence of the Chief Executive Officer, complaints will be reviewed and final responses signed by persons with delegated authority.

5.3 Chief Medical Officer

The Chief Medical Officer has executive accountability and provides assurance to the Board through overseeing the management of the complaints process on behalf of the Chief Executive Officer. The Chief Medical Officer is therefore responsible for ensuring that effective complaint management systems are in place and that complaints are used as mechanism to continually improve the quality of the treatment, care and service we provide.

5.3 Chief Medical Officer

Chief Officers are responsible for ensuring complaints in their areas of responsibility are responded to and that learning is implemented.

5.4 Patient Experience and Engagement Committee

The Committee is to monitor the Trust's management of complaints and through the use of complaints data and intelligence it will seek assurance that positive changes are taking place across the Trust to improve the overall patient experience.

5.5 Director of Quality

The Director of Quality is responsible for overseeing the performance and effectiveness of complaint management within the Trust on behalf of the Chief Medical Officer.

5.6 Associate Director of Quality (Patient Experience)

The Associate Director of Quality (Patient Experience) is responsible for the strategic and operational performance of the Complaints Department, ensuring the necessary processes and procedures are in place and complied with and that complaints are managed in accordance with legislative requirements and relevant guidance.

5.7 Head of Patient Relations

The Head of Patient Relations has responsibility for leading the Complaints Department and ensuring it meets its statutory and local targets, that it functions in accordance with this policy and associated policies and that it delivers efficient, effective and patient centred complaint management.

5.8 Associate Director of Nursing for Professional Standards and Patient Experience

The Lead Nurse for Patient Experience will support the training of Nursing Staff on the local management of dissatisfaction and in assisting with the investigation of formal complaints. They will provide ad-hoc assistance to the PALS and Complaints Department to help facilitate the effective investigation and resolution of complaints and they will work with the Complaints Department to ensure learning is disseminated across the organisation.

5.9 Lead Consultant for Patient Experience

The Lead Consultant for Patient Experience will support the training of medical staff on the local management of dissatisfaction and in assisting with the investigation of formal complaints. They will provide ad-hoc assistance to the PALS and Complaints Department to help facilitate the effective investigation and resolution of complaints and they will work with the Complaints Department to ensure learning is effectively disseminated across the organisation.

5.10 Clinical Directors

Group Clinical Directors are responsible for overseeing the effective management of complaints within their Group. They must promote and lead an open and compassionate culture that supports and values feedback and ensure that staff follow this policy in their handling and overall management of complaints. They must develop and maintain a culture of learning and improvement and to ensure learning and improvements result from those complaints where failings have been identified.

5.11 Specialty Group Managers

Must ensure that:

- Support is provided to staff involved with complaints.
- They are familiar with policies and associated procedures for managing concerns and complaints.
- Statements are of sufficient quality and are provided within the timescales set out in the Complaint Management Plan.
- Escalation emails are appropriately actioned.
- Final responses are reviewed and approved by themselves or the most appropriate person and that any actions or improvements agreed are implemented.
- Any service improvements or learning outcomes that have arisen as a result of the investigation are identified within the response.
- Ensuring Specialty Group Colleagues comply with requests for availability for meetings within the required timeframes.
- Ensuring that complaints are shared and used as learning tools at Quality Improvement and Patient Safety Meetings.
- Risk grading complaints at the conclusion of the investigation.

5.12 Line Managers, Modern Matrons, Ward Managers and Heads of Department

Must ensure that staff within their areas of responsibility are:

- Supported when involved with complaints.
- Familiar with policies and associated procedures for handling concerns and complaints.
- Aware that concerns and complaints should be resolved locally where possible and that they know of the availability and how to refer to the PALS

for support.

- Are informed about what action they would need to take if a patient or representative wished to make a formal complaint.

  Aware of their responsibility to comply with any reasonable request made by the complaints department during the investigation of a complaint.

5.13 All staff

It is the responsibility of all Trust staff to make all reasonable attempts to resolve dissatisfaction wherever it may arise. Should staff be involved in the investigation of complaints under the Complaints Process, they are required to engage with and meet the requirements of that process, such as providing quality statements within agreed timeframes and making themselves available to meet with complainants to assist the resolution of the complaint.

5.14 Patient Advice and Liaison Service (PALS)

The PALS provide advice and support to patients and/or their representatives to help resolve complaints or enquiries quickly and informally. Should the PALS receive a complaint that they consider would be more appropriately responded to through the Complaints Process, they must offer to refer this to the Complaints Department. The PALS offer advice and support to patients or their representatives in having their complaint considered under the Complaints Policy.

5.15 Complaints Department

The complaints department is responsible for:

- Ensuring the Complaints Process is easily accessible and that there are no barriers to making a complaint.
- Ensuring that all staff are aware of their responsibilities under the Complaints Process and that the necessary training is available for them to competently fulfil their responsibilities.
- Triaging new complaints to assess, amongst other things, whether consent is required, whether the complaint is within prescribed time limits to be registered as a formal complaint and whether there is any other investigation already taking place (such as a Patient Safety Investigation).
- Risk assessing complaints received and escalating complaints graded blue or above to the Head of Patient Relations.
- Acknowledging complaints within 3 working days of receipt and ensuring we fully understand the issues being raised in the complaint.
- Identifying and issuing complaints to relevant staff and ensuring the investigation is progressed in accordance with the Complaint Management Plan.
- Ensuring the patient or representative is kept reasonably updated throughout the life of their complaint.
- Ensuring the outcomes of investigations are communicated to the patient or relative in a clear and compassionate way.
- Arranging and facilitating meetings with complainants.
- Maintaining accurate and up-to-date electronic records.
- Monitoring and reporting on actions resulting from complaint investigations.

- Reporting on the performance of the Complaints Department and the Trust's management of complaints via a variety of means, such as quarterly and annual reports, presentations to the Patient Experience and Engagement Committee and through monthly meetings with a member of Trust Board.
- Meet the reporting requirements of the Health and Social Care Information Centre.
- Producing and disseminating intelligence throughout the Trust to help facilitate Trust wide improvements.
- Liaise with the Patient Safety Team to ensure that complaints involving a Patient Safety Investigation are appropriately managed so that they remain patient centred.
- Ensure appropriate liaison and compliance with the requests of the Parliamentary Health and Service Ombudsman.
- Responding to freedom of information requests.
- Managing enquiries received from Members of Parliament that are of a complaint nature.
- Working with outside voluntary, advocacy and community groups in order to publicise and seek feedback on the Trust's complaints process.

6.0 DETAILS OF THE POLICY

6.1 Equal treatment

Patients care will not be adversely affected due to the making of a complaint. Such behaviour is contrary to professional codes of conduct and Trust Values. Any member of staff found to be treating a patient less favourably due to the making of a complaint will face disciplinary action and where applicable a referral may be made to

their professional regulator.

Patients need to be assured that they can raise concerns without fear of recrimination. If a patient, an interested party or their representative raises a concern in this regard then the member of staff made aware of this concern should seek to understand the reasoning behind it. They should take the necessary action to ensure the patient feels supported and comfortable to raise their complaint; this may include but is not limited to action such as involving the PALS or the Independent Complaints and Advocacy Service, Specialty Group Leads such as the Group Manager, Clinical Director or the Head of Patient Relations.

6.2 Local Resolution of complaints

All Trust staff are required to proactively identify dissatisfaction and to seek to resolve the dissatisfaction at a local level wherever possible, either through taking action themselves or referring the matter to a senior colleague within the service concerned. If it is not possible to resolve the dissatisfaction within one working day of the issues being raised, the dissatisfied party must be advised of their entitlement to have their issue considered under the Complaints Process. The dissatisfied party may choose to continue with local resolution or have their matter considered through the Complaints Process.

Any staff involved in the management of dissatisfaction at a local level must give consideration to whether the matter would be best handled through the complaints process. In making this assessment, consideration may be given to but is not limited to the severity of the issues raised, the level of investigation required to respond to the issues raised and whether there is potentially a wider failing that requires a formal

investigation. Should the staff consider the issues concerned require or would benefit from a formal investigation they should discuss that option with the dissatisfied party and, if they wish to pursue that option, assist them in that process.

The Patient Advice and Liaison service are also available to liaise with staff, managers and, where appropriate, other relevant organisations, to negotiate speedy solutions for patients/relatives/carers concerns.

Should the Complaints Department receive a complaint where they consider local informal resolution is a reasonable option that may best serve the interests of the patient the Complaints Department or the PALS will discuss the available options with the patient and seek their instructions on how they want their complaint to be managed.

6.3 Time limit for making a complaint

A complaint should generally be made no later than 12 months after:

• The date on which the matter which is the subject of the complaint occurred; or

• if later, the date on which the matter which is the subject of the complaint came to the notice of the patient.

The Trust reserves the right to consider any complaint received outside of this time limit if they are satisfied that the patient or their representative had good reasons for not making the complaint within the time limit and notwithstanding the delay, it is still possible to investigate the complaint effectively and fairly.

Where a decision is taken not to investigate the complaint, the reason for this decision must be communicated to the patient or their representative in writing and they must be advised of their right to approach the Parliamentary and Health Service Ombudsman.

6.4 Receipt of complaints

The Trust has the means to accept complaints orally, in writing or by email via the feedback@uhcw.nhs.uk address. This address is detailed on the Trust's website.

Where possible, it is preferable that complaints are submitted in writing as this ensures that the issues the patient wants to be investigated are clearly set out. Should a patient or representative need support in setting out their complaint they should be made aware of the support that is available such as the PALS or the Independent Complaints Advocacy Service.

In the event that a complaint is made orally, a written record of the complaint must be made and a copy of this must be provided to the complainant within 3 working days of receipt and the complainant asked to confirm we have correctly understood their complaint. Once their confirmation has been received the complaint must be registered and the formal investigation commenced. The investigation does not commence until the complainant has confirmed we have correctly understood their complaint.

6.5 Patient confidentiality

In accordance with the Caldicott guidelines, the requirement to maintain confidentiality is absolute during all aspects of the complaints process. The investigation of a complaint does not remove the need to respect a patient's confidentiality. No member of staff should divulge information about the identity or medical condition of any patient to anyone who does not have a clear entitlement and need to receive it. This also applies if the complaint involves more than once organisation, i.e another Trust or a Local Authority.

Consent if the complainant is not the patient: In many circumstances it will be an 'interested other party' such as a relative, friend or advocate who complains on behalf of a person who is or has been a patient. If this is the case, it is essential that permission is obtained from the patient for the 'interested other party' to act on their behalf.

Consent if the patient is a child: In the case of a child, the representative must be a parent, guardian or other adult who has care of the child. Where the child is in the care of a local authority or a voluntary organisation, the representative must be a person authorised by the organisation. Consent will be sought from patients aged 16 or over.

Consent if the patient is unable to act for themselves: If a patient is unable to act for themselves, the complaint can be accepted from an interested other party, such as a close relative, friend, organisation or individual suitable to represent the patient. However, where the medical records or the electronic patient records detail a next of kin, consent should be obtained from the person named before the complaint is

registered and an investigation commenced. If the recorded next of kin is unavailable or not in agreement with the complaint being registered the Head of Patient Relations must decide on how best to proceed having given regard to all the circumstances.

If the Complaints Department is satisfied that the interested party is not conducting the complaint in the best interests of the patient, they must stop their investigation and inform the interested party that the investigation has ceased.

Consent if the patient is deceased: If a patient is deceased the complaint can be accepted from an interested party, such as a close relative, friend, organisation or individual suitable to represent the patient. Where the medical records or the electronic records detail a next of kin, consent should be obtained from the person named before the complaint is registered and the investigation commenced. If the recorded next of kin is unavailable or not in agreement with the complaint being registered the Head of Patient Relations must decide on how best to proceed having given regard to all the circumstances.

It is always important in these circumstances to respect the patient's confidentiality and any known wishes expressed by the patient that information should not be disclosed to anyone else. If the Complaints Department is satisfied that the interested party is not conducting the complaint in the best interests of the patient, they must discontinue their investigation of the complaint and inform the interested party that the investigation has ceased.

Members of Parliament: The position of the MP office combined with a clear intention and expectation on behalf of the complainant / enquirer that the matter will

be raised with the Trust means that the Trust will find that consent is implied and will proceed accordingly.

6.6 Complaints grading and investigation

On receipt of a complaint, the Complaints Department will grade each registered complaint with regard to severity and potential future risk to the Trust in terms of patient safety and potential loss to the Trust (including loss of confidence or reputation of the Trust) see Appendix 1. This grading is undertaken using the same grading tool used for Clinical Adverse Events and should be denoted on the complaints database. The complaint will be re-graded by the Group Manager once the investigation has been completed.

Whilst all complaints will be fully investigated, those complaints scoring blue or red on the initial grading, must be raised with the Patient Safety Manager. The seriousness of the issues detailed will reflect the grade applied to the complaint. As a minimum, the investigation must include a review of all the issues raised in the complaint, what may have led to those, whether things could or should have been done differently and what the Trust aims to do as a result. More serious clinical complaints (i.e. those graded red or blue) will likely be subject of a serious untoward incident and as such will be investigated in line with the Procedure for Investigation and Root Cause Analysis. Wherever a complaint investigation identifies a failing or an opportunity for improvement, an Action Plan must be created setting out the actions that will be carried out to deliver the required improvements. These actions will be recorded and monitored in the Complaints Department and the Specialty Group Managers will be responsible for ensuring the actions are completed.

6.7 Complaints handling

In line with statutory requirements the complaints team will manage the complaints process by undertaking the following:

- Logging correspondence on a post log.
- Reviewing the complaint to understand the issues being raised.
- Give consideration to how the complaint will be best managed. If it is considered that the complaints processes may not be the most suitable option the Complaints Department should discuss this with the patient or representative and obtain their agreement to it being managed in some other way.
- Consider whether any immediate action is required in response to the complaint and action this accordingly.
- Identify whether consent is required to register and investigate the complaint and obtain this where necessary.
- Register the complaint by completing the necessary records.
- Risk grade the complaint using the risk grading matrix and escalate any complaints graded blue or above to the Patient Safety Manager.
- Write to the patient or representative to confirm receipt of the complaint and to explain the investigation process.
- Where complaints are received verbally, the Complaints Department must take a written record of the complaint and send this to the patient or representative within three working days of receipt to obtain their confirmation that we have correctly understood their complaint.
- Identify the relevant staff and issue the complaint to them within three working days of receipt clearly explaining what is required of them.

- Escalate complaints where staff responses remain outstanding at 10 and 15 days from receipt in accordance with the Complaint Management Plan.
- Give careful consideration to how the outcome would be best communicated to the patient giving regard to all the circumstances of the case.
- If a written response is to be provided, draft a clear and compassionate and open response sharing the findings of the investigation and any resulting actions. Where failings have been identified an apology must be given and any other remedy provided as appropriate.
- The draft response must be quality assured within the Complaints Department, the staff involved must be given the opportunity to review the draft response and it must be signed off by the relevant Specialty Leadership before being sent to the Chief Executive Officer for signing.
- The response must advise patients of their entitlement to refer their complaint to the Parliamentary and Health Service Ombudsman if they remain dissatisfied with the outcome of their complaint.
- The patient or representative should be kept reasonably updated throughout the course of the investigation.

The Trust should use all the resources available to ensure the best resolution is achieved and these staff and their expertise may need to be utilised for that reason also:

- Chief Officers
- Deputy Directors
- Clinical Directors

- Associate Directors
- Group Managers
- Modern Matrons
- Ward Managers
- Heads of Service

The Trust is committed to investigating and responding to complaints in a timely manner and within the 25 working day internal response standard. The Trust and the Complaints Department work hard to achieve this timeframe in every case, however there are occasions where this cannot be achieved; this may be due to the complexity of the complaint or the availability of clinicians, for example. Where the 25 working day timeframe is not achievable, the Complaints Department will advise the patient at the earliest possible opportunity and provide a revised timeframe. The time taken to respond to complaints must not exceed 6 months.

6.8 Local resolution

The final response issued from the Chief Executive Officer under what is termed Local Resolution should be in accordance with the Parliamentary and Health Service Ombudsman Principles for Remedy, it should:

- Detail how the complaint has been considered
- Who has been involved in the investigation process
- Reply to the specific issues raised using language that is easy to understand or defined where necessary
- Detail any action taken
- Apologise as appropriate for any shortcomings

- Detail the opportunity to come back to the Trust within 15 working days where possible if they are not satisfied with the response provided; and
- Detail the opportunity to approach the Parliamentary and Health Service Ombudsman.

6.9.1 Disciplinary action

It is recognised that some complaints may lead to disciplinary and conduct procedures being instigated. Any issues of this nature will be managed under the Trust's Disciplinary Procedure. Where this occurs, the complainant may be advised that this procedure has been instigated but no further information should be given that may compromise the disciplinary action, the reputation of the Trust or the confidentiality of the member of staff concerned.

6.9.2 Further response under local resolution

Although it is hoped that by following the above process the complaint will be resolved, it is equally recognised that complainants are not always satisfied with the explanations and any remedial action detailed and that the information provided may lead to further concerns being raised. The complaint response should provide the opportunity for the complainant to approach the Trust again with their outstanding issues. If a meeting is not indicated a further written response should, where possible, again be provided within 25 working days.

6.10 Meetings

Meetings can be offered at the point of receiving a complaint or at any point throughout the investigation of the complaint. If a number of specialties/clinicians are detailed this may be better allocated to a lead clinician or Specialty Group Lead. Any

meeting should be open and honest and look to bring about resolution of the issues. A written summary of the meeting must be provided to the complainant following the meeting for their reference and records.

6.11 Supporting staff involved in a complaint

Further information on the process for supporting staff is situated in Supporting Staff Involved in Incidents Complaints or Claims Policy.

6.12 Freedom of Information and Data Protection Issues

Any matters that may be highlighted within a complaint that refer to either a Freedom of Information request or a Data Protection Issue must be immediately referred to the Information Governance Team.

6.13 Access to Health Records

There will be occasions when a complainant asks for access to the patient's health records. Access to Health Records is subject to a separate procedure in accordance with the Health Records Act 1990. In such circumstances, the Trust's Access to Health Records Department must be notified and the complainant advised of the procedure to follow.

6.14 Independent medical opinion

In some situations, it may be helpful, depending on the circumstances, to involve an independent clinical advisor. This may be a clinician that works for the Trust who is independent of the clinical team providing the care being complained about. In some circumstances, where this is not possible, consideration will be given to obtaining independent external clinical opinion. On sourcing independent clinical advice, the

Trust will provide clear terms of reference setting out the scope and nature of the advice sought.

6.15 Parliamentary and Health Service Ombudsman (PHSO)

Although the emphasis is on resolving complaints at a local level, if the complaints process has been exhausted and the complaint remains unresolved the complainant should be advised of their option to approach the PHSO.

The Head of Patient Relations will act as the main point of contact with the PHSO and co-ordinate any request for documentation and information.

6.16 External bodies

External bodies include but are not limited to the Care Quality Commission (CQC), Commissioners, NHS England and Healthwatch. Although not involved in investigating complaints it is recognised that the above bodies may ask for summarised details of a complaint either at local resolution stage or following an investigation by the PHSO. Such requests will be managed by the Head of Patient Relations.

6.17 Publicity

The Trust has a statutory duty to provide information on the complaints process. Information is detailed on the Trust website and the Complaints Leaflet is available throughout the Trust. This details contact information for the organisations patients can contact if they require support in making their complaint.

It is important to remember that complainants may be unable to write, may not have

English as their first language, or have disabilities which make formal written complaints difficult to make. ICAS can assist with these issues or the Trust is able to source services to assist complainants who need to communicate verbally, who require interpreting or translation services, services for blind/partially sighted or deaf/impaired hearing and for those unable to put their complaint in writing.

6.18 Exclusions

The following complaints are not required to be dealt with under this procedure:

- A complaint that has been resolved satisfactorily without the need for registration.
- A complaint the subject matter of which is the same as that of a complaint that has previously been made, investigated and a final response provided under the NHS Complaint Handling Regulations, past or present.
- A complaint the subject matter of which is being, or has been investigated by the Local Commissioner under the Local Government Act 1974 or a Health Service Commissioner under the 1993 Act.
- A complaint arising out of alleged failure to comply with a request for information under the Freedom of Information Act 2000.
- A complaint relating to Private Healthcare.
- A complaint relating to employment.
- A complaint from other health providers.

6.19 Complaints received from Independent Complaints Advocacy Service (ICAS), MPs or Councillors

Any complaint arriving via ICAS, unless stated, should be acknowledged with the patient, and where advised all correspondence should be copied to ICAS.

Any complaint made via a Member of Parliament or a Councillor that requires investigation will be managed in accordance with the normal complaints procedure. Whilst correspondence will usually take place between the complainant and the Trust, the representative should be advised when Local Resolution has been concluded and provided with a copy of the final response.

6.20 Complaints involving Independent Providers

A number of services that link into the hospital form part of the PFI contract. Should the University Hospitals Coventry and Warwickshire NHS Trust receive complaints involving these services, the provider must co-operate with the Trust's complaint procedures. Depending on the nature of the complaint they may need to be submitted to the Independent Provider anonymously or with any health care issues removed. Where appropriate UHCW will lead and respond to these complaints, drafted by the Complaints Department and signed by the Chief Executive.

6.21 Mixed sector complaints

Relevant regulations require the Trust to co-operate where a complaint involves another NHS Trust or another body such as the Local Authority. Those involved need to reach an agreement as to who will lead the complaint and liaise with the other organisations involved, in order to obtain their comments and provide a single, full

response to the issues raised. Permission must be sought from the complainant in advance of the sharing of the complaint with any other provider.

If a complaint is received that is solely about the services provided by another organisation the consent of the complaint must be obtained to pass their complaint to the relevant other organisation. Once consent has been obtained the Complaints Department must refer the complaint to that organisation without delay.

Joint Complaint Resolution will be required when a complaint is received which covers issue over a range of organisations. In this situation complaints will be acknowledged by the organisation that receives the complaint. If UHCW receives the complaint, the Complaints Department will contact the complainant for consent to share the complaint with the relevant organisations. Once consent is obtained the Complaints Department will then liaise with the other organisations to investigate the issues raised and to provide a single response to the issues raised.

6.22 Vexatious and habitual conduct

Most complainants conduct themselves in an appropriate manner and a reasonable allowance must be given if the complainant has faced particularly challenging circumstances. However, whilst rare, there are occasions where complainants display unreasonable conduct that may pose a risk to staff or require a disproportionate amount of resources to be used to manage their complaint.

Care must be taken to ensure that the conduct displayed is not due to a disability. If there is any reason to believe this may be the case then guidance should be sought from a relevant medical professional before instigating the management of the vexatious or habitual behaviour or the process put on hold if it has already been

commenced.

The existence of vexatious or habitual conduct does not mean that the complaint is not valid and the complaint must therefore still be investigated as fully as possible.

The Trust will use the following criteria in determining when a complainant's conduct has become vexatious / habitual. The complainant will usually display or all of the following conduct:

- **Persisting in pursuing a complaint** where the Complaints Procedure has been fully and properly implemented and exhausted, but no referral has been made to the Parliamentary Health Service Ombudsman.
- **Seeking to prolong contact** by continually raising further concerns or questions upon receipt of a response (care must be taken not to discard new issues, which are significantly different from the original issue).
- **Unwilling to accept documented evidence** as being factual or denying receipt of an adequate response in spite of correspondence specifically answering their questions, or does not accept that facts can sometimes be difficult to verify without the availability of impartial evidence.
- **Does not clearly identify the precise problem,** despite reasonable efforts of staff and where appropriate support has been offered from the PALS or an independent organisation such as ICAS.
- **Focusses on a matter to an extent which is out of proportion to its significance** and continues to focus on this point.
- **Has threatened or used actual physical violence towards staff or their families or associates.** This will, of itself, cause personal contact with the person and/or their representative to be discontinued and the issue will, thereafter, only be pursued through written correspondence.

- **Has harassed or been personally abusive or verbally aggressive** on more than one occasion towards staff dealing with their issue or their families or associates. However, staff must recognise that people may sometimes act out of character at times of stress, anxiety or illness and reasonable allowances should be made for this.
- **Has had, in the course of addressing an issue, an excessive number of contacts with the Trust**, placing unreasonable demands on staff time or resources. Judgement must be used in determining what is 'excessive' and this will be based on consideration of all the circumstances of the case.
- **Displays unreasonable demands or expectations** and fails to accept that these may be unreasonable (e.g. insists on responses to enquiries being provided more urgently than is reasonably or normally recognised practice).

6.22.1 Responsibilities

All staff are responsible for ensuring any suggestion of vexatious behaviour is clearly documented on DATIX and appropriately escalated.

The Head of Patient Relations is responsible for ensuring vexatious or habitual conduct is managed in accordance with this policy and Line Managers are responsible for ensuring that staff exposed to this behaviour receive appropriate support.

The Associate Director of Quality (patient experience) or another Associate Director of Quality on their behalf, are responsible for overseeing the management of the vexatious or habitual conduct, deciding whether to instigate the vexatious management process.

The Director of Quality must authorise the instigation of stage 2 and must decide,

having taken any necessary advice from the Legal Department, whether to instigate stage 3.

It is the responsibility of the Legal Department to advise on the application of this policy in the management of vexatious or habitual conduct and to issue the correspondence at stage 3.

The Local Security Management Specialist may be approached to provide advice and support in the management of vexatious or habitual behaviour and in the application of this policy.

6.22.2 Options for managing habitually demanding or vexatious behaviour

Stage 1

The Head of Patient Relations must be informed of any instance where an individual demonstrates habitually demanding or vexatious behaviour. The Head of Patient Relations will ensure that an appropriate record is made and the matter is escalated to an Associate Director of Quality.

Having regard to all the circumstances, the Associate Director of Quality must decide what action, if any, to take in response to the conduct. This may include advising the complainant, either verbally or in writing that their conduct is unacceptable and requesting that they modify their conduct. The Associate Director of Quality must decide who, in their judgement, is best placed to perform the communication, but it will ordinarily be the Complaint Officer concerned, the Head of Patient Relations or an Associate Director of Quality themselves.

Any communication must clearly state the elements of their behaviour that are unacceptable, clearly explain in what way we are requesting they modify their

behaviour and it must also explain what steps may be taken if the conduct continues.

Stage 2

Where, having completed stage 1, an individual continues to demonstrate habitually demanding or vexatious behaviour, the Associate Director of Quality, having consulted with the Director of Quality, may offer the complainant to enter into an agreement called a 'code of behaviour' setting out the behavioural modifications required. This must be communicated in writing from an Associate Director of Quality. Any behaviour modifications requested must be proportionate and specific to the vexatious behaviour that has been demonstrated and any agreement must be reviewed at least every three months. The modifications could include but are not limited to restricting the frequency of contact or the method of communication. This communication must explain what steps may be taken if the conduct continues.

Stage 3

If, having completed stage 2, the complainant continues to demonstrate habitually demanding or vexatious behaviour, the Director of Quality will consult with the Trust Legal Department and, having taken their advice, the Director of Quality will authorise the Legal Department to write to the individual advising that the Trust will engage in no further communication with them about the matters being complained about. If the complaint response is still outstanding at this point, the Complaints Department will continue to issue their final response in writing.

6.23 Inquests

Complaints received concerning a deceased patient can be subject to a Coroner's Inquest. Where the Complaints Department are aware that the death is, or will be, subject to an inquest they must liaise with the Legal Department to establish whether

the issues raised in the complaint will be addressed at the inquest.

Having given consideration to all the circumstances of the case, the Complaints Department and Legal Department must reach an agreement on how best to progress the complaint. The available options being to; (a) proceed to investigate and respond to the complaint as usual, (b) agree with the complainant the issues that will be responded to via the complaints process and the issues that will be left to the inquest, (c) not to progress the complaint until the inquest has taken place, at which point the complainant can decide whether to proceed with a complaint.

Once a decision has been reached, the Complaints Department must discuss the options on how to proceed with the complainant and seek their agreement to the proposed approach. Ultimately, the complainant's wishes on how to proceed will be respected and the complaint progressed accordingly.

6.24 Patient Safety Investigations

Where a complaint is received concerning a patient safety incident that has been or will be subject to a Root Cause Analysis Investigation the complainant will be advised that the issue is being investigated through that process. The Trust would encourage the complainant to consider the findings of that investigation before progressing with their complaint as this may well address the issues raised in the complaint. The complaints process would remain open to the complainant should any of the issues not be addressed through the Root Cause Analysis Investigation.

Where a complaint is received concerning a patient safety incident that has or will be subject to a Root Cause Analysis Investigation but where there are additional issues that will not be investigated through that process, those additional issues will be investigated and responded to through the Complaints Process.

6.25 Litigation

Where legal action is being taken, the Trust will, if needed, hold discussions with the relevant authority e.g. Legal Advisors, the Police or the Crown Prosecution Service to determine whether progressing the complaint might prejudice subsequent legal or judicial action. If so, the complaint will be put on hold and the complainant informed. If not, an investigation, providing there are no contra-indicators to do so, should proceed.

6.26 Remedying complaints

In line with the Parliamentary and Health Service Ombudsman's Principles for Remedy the Trust will, where possible, offer a remedy that returns the complainant to the position they would have been in had the failing not occurred. If that is not possible, the Trust will seek to provide a remedy that compensates them appropriately.

Any of the following remedies may be offered:

- An apology, explanation, and acknowledgement of responsibility.
- Remedial action, which may include reviewing or changing a decision on the service given to an individual complainant; revising published material; revising procedures to prevent the same thing happening again; training or supervising staff; or any combination of these.

6.27 Retention of complaints correspondence

Registered complaints files will be kept for 10 years in the health records storage facility. It is important that complaints correspondence must not be filed in a patient's Health Records.

A copy of a complaint file can be requested and considered under the Data Protection Act 1998.

6.28 Annual report

Annually, the Trust will prepare a report for senior management, healthcare providers and the main Commissioners which is made available externally.

As a minimum, this report will specify:

- The number of complaints received.
- The number of complaints that were upheld or partially upheld.
- The subject matter of the complaints received and any matters of general importance arising out of those complaints or the way in which they were handled.
- Any matters where action has been taken or is being taken to improve services as a consequence of those complaints.
- The number of complaints referred to the PHSO.

7.0 DISSEMINATION AND IMPLEMENTATION

7.1 The policy will be saved on the Trust's eLibrary system, where it is available to all Trust staff.

7.2 Specialty Group Leads will be made aware of its renewal and they are required to ensure that all staff within their Group are made aware of and are familiar with the new policy. This may be through promoting the policy at Modern Matron meetings, Ward Manager Meetings and on wards areas.

8.0 TRAINING

Training is available to all staff to ensure that they possess the necessary skills to manage and resolve dissatisfaction at a local level and capable of assisting with the investigation of a complaint.

Further in depth training on the management of complaints will be provided for groups of staff with a particular focus on the areas in which they work.

Ad-hoc targeted training sessions will be provided where required.

9.0 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

Monitoring compliance with this policy is performed through:

- Quality Assurance reviews
- Regular reporting to the Patient Experience and Engagement Committee
- Quarterly and annual reporting to Trust Board; and
- Monthly review of Complaint Management by a member of Trust Board

The table below outlines the Trust's monitoring arrangements for this policy/ document. The Trust reserves the right to commission additional work or change the monitoring arrangements to meet organisational needs.

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
25 working day standard	*Monthly review / reporting to PPMO*	*PPMO / Specialty Groups*	*Monthly*	*Patient Experience and Engagement Committee / QGC / Trust Board*	*Patient Experience and Engagement Committee*
Quality of Complaint Management	Number of complaints returned for Further Local Resolution	Complaints Department	Monthly	Patient Experience and Engagement Committee / Trust Board	Patient Experience and Engagement Committee
	Complaint handling satisfaction survey	Complaints Department	Monthly	Patient Experience and Engagement Committee	Patient Experience and Engagement Committee
Leaning and improvement	Monthly review	Complaints Department /	Monthly	Patient Experience	Patient Experience

		Specialty Group		and Engagement Committee	and Engagement Committee
Accessibility	Twice yearly	Lead Nurse for Patient Experience & Head of Equality and Diversity	Annually	Patient Experience and Engagement Committee	Quality Experience and Engagement Committee

10.0 STAFF COMPLIANCE STATEMENT

All staff must comply with this Trust-wide Corporate Business Record and failure to do so may be considered a disciplinary matter leading to action being taken under the Trust-s Disciplinary Procedure. Actions which constitute breach of confidence, fraud, misuse of NHS resources or illegal activity will be treated as serious misconduct and may result in dismissal from employment and may in addition lead to other legal action against the individual/s concerned.

A copy of the Trust's Disciplinary Procedure is available from eLibrary.

11.0 EQUALITY & DIVERSITY STATEMENT

Throughout its activities, the Trust will seek to treat all people equally and fairly. This includes those seeking and using the services, employees and potential employees. No-one will receive less favourable treatment on the grounds of sex/gender (including Trans People), disability, marital status, race/colour/ethnicity/nationality, sexual orientation, age, social status, their trade union activities, religion/beliefs or caring responsibilities nor will they be disadvantaged by conditions or requirements which cannot be shown to be justifiable. All staff, whether part time, full-time,

temporary, job share or volunteer; service users and partners will be treated fairly and with dignity and respect.

12.0 REFERENCES AND BIBLIOGRAPHY

Principles of good complaints handling. Parliamentary and Health Service Ombudsman 2008.

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

A Review of the NHS Hospitals Complaints System – Putting Patients Back in the Picture. October 2013. Right Honourable Ann Clwyd MP and Professor Tricia Hart.

NHS Constitution 2009

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

Parliamentary and Health Service Ombudsman's Principles for Remedy.

Leeds Teaching Hospitals NHS Trust Complaint Policy.

13.0 UHCW ASSOCIATED RECORDS

Procedure for Investigation and Root Cause Analysis

Aggregating Data and Learning from Incidents, Complaints and Claims Policy.

Being Open Policy

Supporting Staff Involved in Incidents Complaints or Claims Policy

PALS Operational Policy

14.0 APPENDICES

Appendix 1

UHCW RISK & INCIDENT GRADING MATRIX

(PLEASE REFER TO THE RISK MANAGEMENT POLICY ON E-LIBRARY FOR FURTHER DETAILS)

A reminder to all staff who grade incidents and risk – please use the following definitions to ensure that grading is standardised. ***If in doubt, contact the Safety & Risk Management Team.***

1. Likelihood Matrix from Trust Risk Management Policy

The easiest & most accurate descriptor to work from is the "***time framed***" line

Score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Broad Frequency Based	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
Time Framed	**Not expected to occur for years**	**Expected to occur at least annually**	**Expected to occur at least monthly**	**Expected to occur at least weekly**	**Expected to occur at least daily**
Probability based for projects	<0.1	0.1 to 1%	1 to 10%	10 to 50%	>50%

2. Consequence Matrix and examples of descriptors

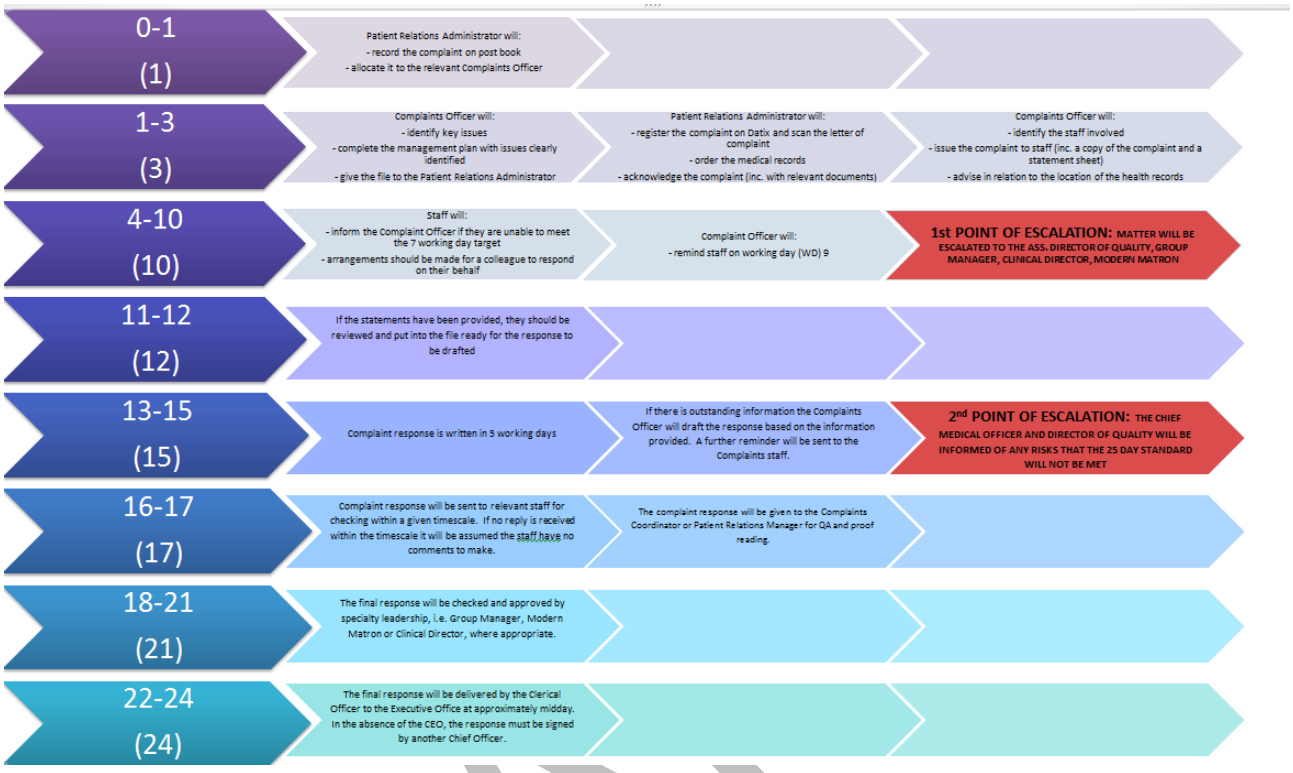
Use the "***domain***" that most closely matches the type of incident or risk that you are assessing.

	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 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	<25k Small loss Risk of claim remote	>£25k- <£500k Claim less than £10,000	>£500k-<£2.5mk Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective >£2.5k - <£5m Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	>£5m Non-delivery of key objective 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

Appendix 2



COMPLAINTS MANAGEMENT PLAN FOR ACHIEVING THE 25 WORKING DAY STANDARD

Complaints process to be followed in order to achieve the required response time of 25 working days.

Complaints Management Plan – Guidance

- Any complaints received by the Executive Office should be immediately forwarded to the Complaints Service for triage
- If when speaking to the complainant in order to establish the main issues, it is agreed that they do not want their concerns to be a formal complaint, the paperwork is passed to PALS to deal with it as a PALS enquiry
- If the complaint is complex or there are multiple staff involved, the medical records should be held centrally by the Complaints Officer and staff will be expected to access them there
- The Trust takes responsibility for the final response in instances where staff are unable to comment on the response and it is due to leave the Trust
- Final responses must be signed by another Chief Officer in the absence of the CEO to ensure that the response will meet the post deadline on that day

Appendix 3

University Hospitals Coventry and Warwickshire NHS Trust

STATEMENT SHEET FOR STAFF PROVIDING INFORMATION IN RESPONSE TO A FORMAL COMPLAINT

Name of patient:	
Hospital Number and or DOB	
Complaint ref: *(official use)*	
Date complaint received*: (official use)*	

Please give **your** full details here:

Full name:	
Designation:	
Department:	
Line Manager:	

Response

Action/Improvements taken as a consequence of this complaint (no matter how simple) need to be detailed here and whether this action needs to be monitored by the Quality and Patient Safety (QPS) Team:

This must page must be completed as it is imperative for the Trust to be able to demonstrate action/learning from complaints

Actions:

1.

2.

3.

Signature:	**Date:**	
Name (please print your name clearly):		

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Appointment of Interim Chief Nursing Officer to Trust Board Committees & Statutory Roles**
Author	**Rebecca Southall, Director of Corporate Affairs**
Responsible Chief Officer	**Andy Meehan, Chairman**
Date	**24th November 2016**

1. Purpose

To set out the proposed appointment of the Interim Chief Nursing Officer to Trust Board Committees and the appointment to statutory and regulatory roles commensurate with the portfolio.

2. Background and Links to Previous Papers

Following the departure of Professor Mark Radford, Chief Nursing Officer on 31st October 2016, Linda Abolins, Deputy Chief Nursing Officer has been formally acting up into the role of Chief Nursing Officer and has assumed the full responsibilities and accountabilities commensurate with the post, with the exception of Registered Manager for CQC, which has been held on a temporary basis by the Chief Medical Officer. An interim appointment has now been made and this paper proposes the appointment of the interim post-holder to the Committees of the Board and into statutory and regulatory roles.

3. Narrative

Nina Fraser has been appointed as Interim Chief Nursing Officer for a period of 6-months commencing 28th November 2016 and will assume the full responsibilities commensurate with the portfolio. In line with that, the Trust Board is asked to approve her appointment to the Quality Governance Committee and to note that she will also assume the role of:

- Director of Infection Prevention and Control (DIPC)
- Registered manager for the CQC
- Lead for Safeguarding Children and Adults
- Lead for NMC revalidation
- Health and Care Professional Standards Lead for Allied Health Professionals
- Lead for Nurse Education

4. Areas of Risk

There are no areas of risk as membership is compliant with best practice in corporate governance and the statutory and the proposed arrangements ensure that appropriate arrangements are in place in respect of the statutory and regulatory roles.

5. Governance

Appointing members to Board Committees is a responsibility reserved to the Trust Board as set out in the Trust's Standing Orders.

6. Responsibility

Andrew Meehan, Chairman
Rebecca Southall, Director of Corporate Affairs

7. Recommendations

The Trust Board is asked to **APRROVE** the appointment of Nina Fraser to the Quality Governance Committee and to note the statutory and regulatory roles that she will fulfill during her tenure at the Trust.

University Hospitals Coventry and Warwickshire NHS Trust

INTERIM QUALITY GOVERNANCE COMMITTEE REPORT TO BOARD
Purpose: This report has two purposes; firstly to **ASSURE** the Board that the Committees that it has formally constituted are meeting in accordance with their terms of reference; and secondly to **ADVISE** Board Members of the business transacted at the most recent meeting and to **INVITE** questions from non-committee members. The Board is asked to note the business discussed at the meeting and to raise any questions.
Committee Name: Quality Governance Committee (QGC)
Committee Meeting Date: 14th November 2016
Quorate: Yes **Apologies:** Rebecca Southall, Rita Stewart. Meghana Pandit and David Eltringham
Chair: Ed Macalister-Smith
1. Renal Transplantation Peer Review Visit Action Plan; QGC **received assurance** further to the ongoing progress against the Peer Review Action Plan. However, there was concern that the PFI arrangements are preventing the required theatre improvements, directly creating a significant impact on patient safety and experience.
2. Role & Function of the Cancer Board; governance arrangements at the level of accountable Director are clear and robust, but still remain unclear as to where the Cancer Board reports. It was also unclear for example whether the Cancer Board had considered the non-compliance in the Chemotherapy Service self assessment. It was **agreed** that this issue is escalated to the Chief Officer's Group for further discussion and clarity with an update provided to QGC in December.
3. Patient Safety Thermometer; QGC **welcomed** the positive level of harm free care with the highest target achieved in August 2016 at 97.88%. It was also **noted** that the Trust remain above the national average for all pressure ulcers and also in the number of patients receiving risk assessment and prophylaxis for VTE. Taken together, this is a major positive achievement.
4. Seven Day Services; the Committee received an update from the Seven Day Steering Group with particular focus against the five clinically led workstreams to deliver the clinical standards set by NHS England. QGC was made aware of an operation and financial risk relating to culture and resource requirements. The committee **were assured** with the measures in place to overcome these risks.
5. CQUIN Update; the Committee **noted** challenging areas during Q1 relating to the 62 day cancer indicator, virtual outpatient clinics and two elements of emergency care. The committee **received assurance** that the 62 day cancer indicator was achieved in Q2. The challenge for the delivery of virtual outpatient clinics is centred around coding and recording activity appropriately. The emergency care elements are due to be delivered by year end however this has been highlighted as behind expected delivery trajectory as it is in part dependent upon health system partnership working.
6. Emergency Preparedness Annual Report; the Committee **received assurance** that the Trust are substantially compliant with 86 of the 91 Core Standards previously submitted. A workplan has been devised moving into 2017 with particular focus to be given to Business Impact Assessment and Business Continuity, and this programme of work will be complete within the next 18-24 months.
MATTERS DELEGATED FROM TRUST BOARD
7. National Student Survey; the Committee received an analysis of the results from the National Student Satisfaction Survey from undergraduate medical students. The result demonstrated low satisfaction against two elements related to Assessment & Feedback and also Organisation & Management. The committee **were assured** with the robust systems in place to improve student satisfaction. A particular challenge was to ensure that in the absence of a large cohort of dedicated Teaching Fellows as at SWFT, then UHCW consultants needed to ensure that they delivered their planned teaching responsibilities.
8. Complaints Analysis; the Committee undertook a detailed review of the significant increase in complaints during August 2016, but no causative trends were identified. Factors contributing to the subsequent collapse of complaint response times included the influx of complaints, staff capacity due to annual leave and specific focus applied to the breached complaints caseload. Wide variation was noted within specialty groups, and it was agreed that Operation's Team will undertake a deep dive into this data and provide an update at January's meeting. The committee **were assured** with the processes put into place to improve complaints handling against the 25 working day response standard.

INTERIM COMMITTEE REPORT TO BOARD
Purpose: This report has two purposes; firstly to **assure** the Board that the committees that it has formally constituted are meeting in accordance with their terms of reference and secondly to **advise** Board Members of the business transacted at the most recent meeting and to **invite** questions from non-committee members thereon.
Committee Name: Finance and Performance Committee
Committee Meeting Date: 16th November 2016
Quoracy: Yes
Apologies: David Eltringham
Committee Chair: Ian Buckley
Report submitted by: Ian Buckley, Vice Chair
1. Workforce Information Report The Committee **received assurance** in relation to the sustained position in managing sickness absence with performance of 3.66% against a target of 4% in month 6. The Committee welcomed the slight reduction in overall agency spend in month 6 against the previous month and **acknowledged** conversely this had resulted in an increase in substantive spend in month.
2. Month 7 Finance Update The Committee **reviewed** the month 7 contract and activity position and **noted** variances to plan (£4.1m year to date and £6.6m on outturn) largely driven by a shortfall in elective, daycase, emergency and outpatient procedures. Furthermore, the Committee observed the movements within the finance control total, impacted by under delivery on contract income; pay and non-pay overspends and **noted** that in order to achieve the planned surplus position, the Trust is required to make additional savings of £8.4m. The Committee **noted** the marginal increase in agency spend in month 7 and **acknowledged** the challenges that continue in relation to medical agency spend but **recognised** the focused attention through recruitment campaigns and events to attract candidates and recruit into hard to fill posts. The Committee **received assurance** that the Trust had identified £0.3m over the £25.5m cost improvement programme (CIP) target for 2016/17 and **requested** that further rigour be added into the system to identify CIP targets for 2017/18, which will be closely monitored through the refined Annual Work Plan **approved** by the Committee at its meeting today. The Committee **agreed** that the Trust Board would receive an update in relation to the Single Oversight Framework and Planning Guidance in November.
3. Control Total 2017/18 The Committee **acknowledged** that contract negotiations were continuing with Commissioners with a view to signing up to a control total by 24th November 2016.
4. Integrated Performance Report The Committee **noted** the recent challenges to performance against the cancer two week wait standard in August and **received assurance** that performance was on track to meet the standard for September.
5. Referral to Treatment (RTT) Update The Committee were **assured** by the actions being taken to increase the rigour around RTT performance through weekly access meetings with members of each of the senior management teams and **noted** the considerable work underway to agree a revised trajectory that will support a sustainable position and ultimately delivery for patients. The Committee **requested** an update on how this is progressing in December. The Committee **acknowledged** the significant work underway, supported by the continued engagement of senior clinical leaders, to ensure that the Patient Access Policy is applied to maintain the integrity of the RTT waiting list, with patients being booked in clinical and chronological order.

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

University Hospitals Coventry and Warwickshire NHS Trust

Agenda item 17 Enclosure 12

INTERIM COMMITTEE REPORT TO BOARD

Purpose: This report has two purposes; firstly to **assure** the Board that the committees that it has formally constituted are meeting in accordance with their terms of reference and secondly to **advise** Board Members of the business transacted at the most recent meeting and to **invite** questions from non-committee members thereon.

Committee Name: Audit Committee

Committee Meeting Date: 14th November 2016

Quoracy: Yes

Apologies: David Poynton, Rebecca Southall

Chair: Barbara Beal, Non-Executive Director

Report submitted by: Barbara Beal, Non-Executive Director

1. Internal Audit Report: Recruitment Processes

The Committee **received assurance** that the implementation of the new TRAC recruitment system had sufficiently addressed the two control weaknesses identified within the original internal audit report. The comprehensive recruitment system negates the use of multiple standalone systems, allowing accurate tracking of posts and promoting a more streamlined approach to recruitment with initial data demonstrating a reduction in the time taken to shortlist candidates and completion of pre-employment checks.

2. Internal Audit Report: Financial Systems

An overall conclusion of 'significant assurance' was provided in relation to the Trust's overall key financial systems.

The Committee **received assurance** from the robust controls in place to proactively pursue creditors, **acknowledged** the challenges relating to payments for overseas patients but were **assured** that the debt collection, recovery and write-off procedures were sufficient to ensure that delay in receiving payments and loss of credit income was minimised. The Committee **noted** the acute cash issues experienced across the NHS and the impact this was having on financial sustainability**.**

3. Internal Audit Report: SafeCare Module Pilot on Healthroster

An overall conclusion of 'moderate assurance' was provided on the implementation of the SafeCare module on the Trust's e-rostering system.

The Committee welcomed the appointment of the Clinical Implementation Manager who is driving forward Trust-wide engagement and utilisation of the SafeCare module and has already yielded a positive impact on the Trust's ability to monitor compliance levels in terms of usage of the SafeCare module. Furthermore, the Committee were **assured** that the plan to roll-out across the organisation was now on track to be completed by the end of March 2017 with the intention for Internal Audit to undertake a further review in 2017/18 to assess progress.

4. External Audit Plan 2016/17

The Committee **approved** the approach to the external audit plan. As part of that, consideration will be given to the Trust's involvement, participation and governance in supporting partnership working through the Coventry and Warwickshire Sustainability and Transformation Plan (STP). The Committee **acknowledged** that the confidentiality surrounding the development of the STP has proved challenging. Once regulators have indicated, which plans they are willing to support, engagement and any formal legal consultation processes will follow, as required.

5. Anti-Fraud Progress Report

The Committee **acknowledged** the increased number of referrals in 2016/17, **noted** the new cases received and the progress made to date with the investigations and **agreed** to receive a further progress update in February.

The Committee **received** the NHS Protect circular relating to the review of NHS Protect Functions and Services and **noted** that the Anti-Fraud Specialist would be undertaking a review to determine the impact that this may have on existing services for presentation to the Committee in April.

6. NHS Protect: Quality Assurance Process

The Committee **noted** the NHS Protect circular and **acknowledged** the requirements for ensuring that proper anti-crime arrangements are in place through annual assessment of the quality assurance process

	to demonstrate compliance.
7.	**Accounting Policies** The Committee were **assured** that there were no significant accounting policy changes that will impact upon the Trust's accounts for 2016/17 but **noted** that the Department of Health Group Accounting Manual requirement in 2016/17 for NHS providers to make Injury Costs Recovery scheme bad debt provision had increased by 0.95% resulting in additional income and expenditure cost pressure of circa £80k.

The Board is asked to **NOTE** the business transacted at the meeting and to **RAISE** any questions in relation to the same.