University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Declaration of Compliance against the NHS Provider Licence**
Author	**Geoff Stokes, Director of Corporate Affairs**
Responsible Director	**Andy Hardy, Chief Executive Officer**
Date	**31 May 2018**

1. Purpose

To seek Trust Board approval to submit a declaration of compliance against the relevant conditions of the NHS Provider Licence in line with the requirements of NHS Improvement (NHSI).

2. Background and Links to Previous Papers

The NHS Provider Licence was introduced in 2013 as part of the Foundation Trust Regime and replaced the former authorisation process. Whilst NHS Trusts are exempt from holding a Provider Licence, the Secretary of State requires NHSI to ensure that Trust's comply with the conditions set out in the licence that are relevant to NHS Trusts. The requirement links to the NHSI Single Oversight Framework and the Well Led framework and is a new requirement for this year. Providers will then be selected at random to provide evidence to support a declaration of compliance.

3. Executive Summary

NHSI have requested that providers carry out a self-assessment process of their compliance condition G6 and FT4 of the licence by 31st May and 29th June 2018 respectively. NHSI have not set out a single approach that must be adopted by organisations but have issued guidance which states that Trust Boards must assure themselves that the Trust complies with the requirements set out within each of the conditions before a declaration of compliance can be made.

The relevant licence conditions comprise the following:

Condition	Requirement
G6(3)	The licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of healthcare services to the NHS. Providers must certify that their Board has taken all precautions necessary to comply with the licence, NHS Act and NHS constitution.
FT4 (8)	Providers must certify compliance with required governance standards and objectives through: (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence and (b) regular review of whether these processes and systems have been implemented and of their effectiveness

3.1 Approach Taken

The Director of Corporate Affairs has considered each of the requirements and has reviewed the evidence that is available against each of these. A table of that evidence is considered relevant to each requirement is attached to this paper to aid the Trust Board's decision making around whether compliance can be declared.

The provisions of the Single Oversight Framework, which is the framework by which NHSI assess NHS Trusts have also been reviewed and are cross referenced within the appendix. The 5 themes outlined in the Single Oversight Framework are as follows:

- Quality of Care
- Finance & Use of Resources
- Operational performance
- Strategic change
- Leadership

In the view of the Director of Corporate affairs, the Trust is able to demonstrate that a robust system of corporate governance in place, which has been subject to independent assessment and on the basis of the evidence available, would recommend to the Trust Board that compliance be declared.

4. Areas of Risk

If the Trust does not have appropriate systems of governance in place, risk may not be properly identified and mitigated, which could lead to patient and staff safety incidents, failures to meet financial and performance targets, failure to comply with regulatory and statutory duties and reputation damage. The systems and processes that are in place as described in this paper are intended to mitigate this risk.

NHSI will audit selected providers to ensure the G6 self-certification is uploaded onto the Trust website.

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

The paper links to all of the Trust's annual objectives in that corporate governance and the related systems and processes are aimed at ensuring the delivery of these.

6. Governance

The Trust is obliged to comply with constitutional standards and regulatory requirements and the role of the Trust Board is to ensure that there are appropriate systems and processes in place to monitor compliance and ensure that risks are identified and acted upon.

7. Responsibility

Geoff Stokes, Director of Corporate Affairs
Andy Hardy, Chief Executive Officer

7. Recommendations.

The Board is invited to:

1. **NOTE** the requirement to make a declaration against conditions G6(3) and FT4(8) of the Provider Licence and the self-assessment process that has been undertaken
2. **CONSIDER** the robustness of the evidence that is in place against each condition and the recommendation of the Director of Corporate Affairs
3. **RAISE** any questions or concerns
4. **DETERMINE** whether compliance can be declared
5. **AUTHORISE** the Director of Corporate Affairs to complete the self-certify and publish the statement onto the Trust website

:

Licence Condition	Single Oversight Framework Reference	Evidence
G6 (3) The licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of healthcare services to the NHS.	Quality of Care Finance & Use of Resources Operational Performance	Integrated Quality & Performance Report (IQPR) submitted to the Trust Board each month which reports on all national standards and local priorities.
		Minutes evidence debate and challenge around performance issues across the spectrum of quality, operational and financial performance metrics.
		Performance Management Framework in place; Chief Officer led performance management meetings.
	Strategic Change Quality of Care	Series of scheduled reports to Trust Board around key strategic objectives e.g. mortality reporting, safer staffing, medical education, research and development
	Quality of Care	Registration with the CQC
	Finance & Use of Resources	Standing Orders, Standing Financial Instructions and Scheme of Delegation in place.
	Leadership	Trust vision and values established alongside medium and long-term objectives.
		Fit and Proper Persons assessments undertaken upon appointment to the Trust Board and annual declaration process.
		Trust Board Code of Conduct & Statement of Responsibility in place and reviewed annually which covers: -Fit & Proper Persons requirements -Duty of Candour -The Offence of False and Misleading Information -Role of the Trust Board and individual members -Role of the Trust Board Committees

		-Requirements around declarations of interest -Trust Values -Expectation of adherence to the Nolan principles.
		Clear Trust Board and Committee structure in place with dedicated work-programmes.
		Review of terms of reference and Annual Reporting process in place for Trust Board committees.
		Process of delegation from Trust Board to Board Committees and of upward escalation in place through regular Committee Chair reports.
		Process in place for assessment of Board and Committee performance.
		Non-Executive membership of all Trust Board Committees.
		Audit Committee established and comprising independent Non-Executive Directors.
		Independent Trust Board effectiveness review undertaken in 2016. Well Led review planned.
		Trust Board templates make specific reference to NHS constitutional issues to ensure that these are identified in papers.
		Raising Concerns Policy in place, Freedom to Speak Up Guardian and network of Confidential Contacts in place.
		Group Governance Framework approved and being rolled out to ensure consistency across the Clinical Groups.
	Strategic Change	Chief Finance & Strategy Officer in post with Strategy Team in support.
		CEO is the Sustainability & Transformation lead for Coventry & Warwickshire.
		Strategy Unit meeting in place
		Dedicated time for Trust Board to discuss strategic issues
FT4 (8) (a) the establishment and implementation of processes		Board Assurance Framework in place; developed by the Trust Board and reviewed by the Trust Board and Audit Committee throughout the year. Assessed by Internal Audit as 'A' rated in

and systems to identify risks and guard against their occurrence and (b) regular review of whether these processes and systems have been implemented and of their effectiveness	Quality of Care Finance & Use of Resources Operational Performance Leadership	2016/17 (and years prior).
		Head of Internal Audit Opinion around the system of internal control is one of significant assurance for 2016/17 (and prior years).
		Risk Management Committee in place chaired by the CEO and with Chief Officer attendance.
		Executive accountability for risk management (Chief Medical Officer)
		Trust Board committee terms of reference are clear around committee responsibility for risk management.
		Risk Management Strategy & Policy in Place
		Trust-wide risk register in place.
		Executive ownership of corporate risks
		Corporate Risks reviewed at Quality Governance Committee and Trust Board.
		Internal Audit review of Risk Management arrangements in 2016/18 gave conclusion of significant assurance.
		Review of Board and Committee work-programmes undertaken to ensure that all key areas of covered.
		Established process of deferral and reporting back of issues from Trust Board to Trust Board Committees to ensure that further analysis is undertaken.
		Risks are considered in Trust Board Committee sub-structure.
		Dedicated risk management team in place and training programme being rolled out across the Trust.

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**2017-2019 CQUIN Scheme for Healthy Food for NHS Staff, Visitors and Patients**
Author	**Lincoln Dawkin – Director of Estates and Facilities**
Responsible Director	**Lisa Kelly – Chief Operating Office**
Date	**31 May 2018**

1. Purpose

The purpose of this paper is to update the Trust Board on progress to date at our Trust in relation to compliance with the CQUIN target for Heathy Food for the NHS Staff, Visitors, and Patients.

2. Background and Links to Previous Papers

In an ongoing effort to improve the health of our staff, visitors, and patients, in 2016 a number of CQUIN targets were introduced to encourage healthy eating in every retail outlet within the hospital. This report provides an update on progress made to date at UHCW in terms of compliance with the initial targets and subsequent targets set since 2016.

3. Executive Summary

As described above, since 2016, the Trust has, via CQUIN targets been working hard to ensure compliance is achieved across both of our hospital sites; this report provides an update in relation to these targets and shows the ongoing commitment to maintaining these targets going forward. As all of the retail outlets at UHCW are operated under the PFI agreement via either ISS (the Trust's current soft service provider) or via the retail arm of the PFI (Gentian), the Trust has been working closely with our PFI provider to achieve the desired standard. Below is a summary of the targets set under this particular CQUIN:

- The banning of price promotions on sugary drinks and foods high in fat, sugar, and salt (HFSS)
- The banning of advertisement on NHS premises of HFSS
- The banning of HFSS from checkouts
- Heathy options must be available at any point, including those staff working night shifts.

We are pleased to confirm that both ISS, WH Smith and M&S have complied and continue to comply with the above requirements in both 2017/18 and 2018/19 and have committed to continue to comply going forward.

In addition to the above, a number of specific targets were also set in terms of charges to food and drink provision at all of our outlets:

In Year One (2017/18):

a. 70% of drinks lines stocked must be sugar free (less than 5 grams of sugar per 100ml). In addition to the usual definition of SSBs it also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml).

b. 60% of confectionery and sweets do not exceed 250 kcal.

c. At least 60% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g

In Year two (2018/19):

The same three areas will be kept but a further shift in percentages will be required

a. 80% of drinks lines stocked must be sugar free (less than 5 grams of sugar per 100ml). In addition to the usual definition of SSBs it also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml).

b. 80% of confectionery and sweets do not exceed 250 kcal.

c. At least 75% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g.

It is again pleasing to report that all of our retail providers have proactively introduced these measures in 2017/18 and have committed to achieving the 2018/19 measures for the current financial year.

In addition to this, we have also received commitment from both ISS and Gentian by signing up to the CQUIN pledge that gives the Trust comfort in terms of their ongoing assurance of compliance with the required standards.

Attached at appendix A are both the confirmation from ISS in terms of their pledge to continue to comply with the initiative going forward along with WH Smith's commitment of support for this along with the response provided by NHS England confirming compliance.

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4. Areas of Risk

The non-compliance with this CQUIN has not only a potential financial consequence to the Trust but more importantly the reduction in HFSS has a significant impact on the health of both our patients/visitors and staff.

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

Whilst not directly related to the Trust's annual objectives, this initiative will support the drive for a reduction in HFSS that will in turn improve the health of both patients, visitors and staff. This in turn supports the CQG 'good' objective.

6. Governance

The implementation of this CQUIN will be managed by the Director of Estates and Facilities with progress being reported via the CQUIN reporting structure within the Trust.

7. Responsibility

Director of Estates and Facilities via Project Co.
Chief Operating Officer.

8. Recommendations

The Board is requested to note progress to date in terms of compliance with the CQUIN along with the commitment from our service providers to continue to comply going forward.

Name and Title of Author: Lincoln Dawkin – Director of Estates and Facilities

Date: 14th May 2018

The Coventry and Rugby Hospital Company Plc
C/o University Hospitals Coventry and Warwickshire NHS Trust
FM Building
Clifford Bridge Road
Coventry
CV2 2DX

Telephone: (024) 7662 1483
Facsimile: (024) 7696 8200

University Hospitals Coventry and Warwickshire NHS Trust
FM Building
Clifford Bridge Road
Coventry
CV2 2DX

FTAO: Lincoln Dawkin

Date: 22nd March 2018

Our Reference: H-H8-UHC- 01154

Dear Lincoln,

Coventry New Hospitals Project – 2017-2019 CQUIN Scheme – Healthy Food for NHS Staff, Visitors and Patients

Further to your letter (ref: EFM5518/KH) relating the above matter, please find enclosed the response from our soft service provider relating to their retail services and catering service.

Project Co are still awaiting the formal response from Gentian to their retail service and will forward as soon as we receive it.

Yours sincerely,

Jim Valentine
PFI Representative and General Manager

Cc: Scott Humphrey

Enc.

NAME	REVIEWED	ACTIO
LD	✓	
KH	✓	✓

ISS FACILITY SERVICES

RECEIVED
15 MAR 2018

Scott Humphrey
Assistant General Manager
Coventry & Rugby Hospitals Company
F.M. Building
Clifford Bridge Road
Walsgrave
Coventry CV2 2DX
Thursday, 15 March 2018

Dear Scott

RE: University Hospitals Coventry and Warwickshire NHS Trust
2017 – 2019 CQUIN Scheme – Healthy Food for NHS Staff, Visitors and Patients.

Please find enclosed the signed copy of the document enclosed in your letter dated 8th March 2017.

Yours sincerely

Andrew Naylor
Head of Compliance

NAME	ACTION	INFO	B/F	DATE
GM	✓			16/03/18
SFE	✓			16/03/18
HFE / EQUIP				
PA				
OA				

ISS Facility Services
Healthcare
ISS House
Genesis Business Park
Albert Drive
Woking
Surrey
GU21 5RW

Telephone: 0845 057 6300
Fax: 0871 429 6300

www.uk.issworld.com
info@uk.issworld.com

Service Provider to University Hospitals Coventry & Warwickshire NHS Trust

Firstly, we confirm that we have maintained the four changes that were required in the 2016/17 CQUIN in both 2017/18 & 2018/19

a. **The banning of price promotions on sugary drinks and foods high in fat, sugar or salt (HFSS)**

The following are common definitions and examples of price promotions;
1. Discounted price: providing the same quantity of a product for a reduced price (pence off deal);
2. Multi-buy discounting: for example buy one get one free;
3. Free item provided with a purchase (whereby the free item cannot be a product classified as HFSS);
4. Price pack or bonus pack deal (for example 50% for free); and
5. Meal deals (In 2016/17 this only applied to drinks sold in meal deals. In 2017/18 onwards no HFSS products will be able to be sold through meal deals).

b. **The banning of advertisements on NHS premises of sugary drinks and foods high in fat, sugar or salt (HFSS)**

The following are common definitions and examples of advertisements:
1. Checkout counter dividers
2. Floor graphics
3. End of aisle signage
4. Posters and banners

c. **The banning of sugary drinks and foods high in fat, sugar or salt (HFSS) from checkouts;**

The following are common definitions and examples of checkouts;
1. Points of purchase including checkouts and self-checkouts
2. Areas immediately behind the checkout

d.) Ensuring that healthy options are available at any point including for those staff working night shifts. We will share best practice examples and will work nationally with food suppliers throughout the next year to help develop a set of solutions to tackle this issue.

Secondly, we confirm that we are committed to introducing three new changes to food and drink provision:

In Year One (2017/18):

a. 70% of drinks lines stocked must be sugar free (less than 5 grams of sugar per 100ml). In addition to the usual definition of SSBs it also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml).

b. 60% of confectionery and sweets do not exceed 250 kcal.

c. At least 60% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g

In Year two (2018/19):

The same three areas will be kept but a further shift in percentages will be required

a. 80% of drinks lines stocked must be sugar free (less than 5 grams of sugar per 100ml). In addition to the usual definition of SSBs it also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml).

b. 80% of confectionery and sweets do not exceed 250 kcal.

c. At least 75% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g.

Signed on Behalf of Service Provider

JSS

Signed on Behalf of UHCW NHS Trust.

.....

NHS
University Hospitals
Coventry and Warwickshire
NHS Trust

Lincoln Dawkin
Director of Estates & Facilities
University Hospital
Clifford Bridge Road
Walsgrave
Coventry
CV2 2DX

Tel: 024 76968342
Fax: 024 76968494
www.uhcw.nhs.uk

1st March 2018

Jim Valentine
PFI Representative
The Coventry and Rugby Hospital Company PLC
FM Building
University Hospital
Clifford Bridge Road
Coventry
CV2 2DW

Our Ref: EFM5518/KH

Dear Jim

University Hospitals Coventry and Warwickshire NHS Trust
2017 – 2019 CQUIN Scheme – Healthy Food for NHS Staff, Visitors and Patients

We are required to detail progress regarding the implementation of the CQUIN requirements in accordance with the attached document.

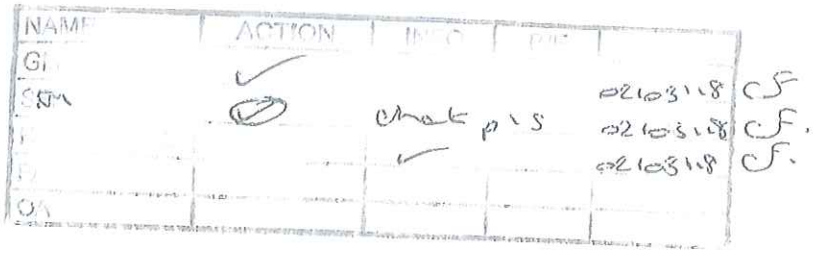
To conform with the obligations, I would be grateful if you could arrange for the Trust service providers (ie: ISS and Gentian) to commit to implementation and maintenance of the changes by signing the attached document and returning it to me by 13th April 2018 at the latest.

Your co-operation in this matter is greatly appreciated.

Yours sincerely

Lincoln Dawkin
Director of Estates and Facilities

CC: Project Office



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University Hospitals Coventry and Warwickshire NHS Trust
FM Building
Clifford Bridge Road
Coventry
CV2 2DX

FTAO: Lincoln Dawkin

Date: 3rd April 2018

Our Reference: H-H8-UHC-01166

Dear Lincoln,

Coventry New Hospitals Project – 2017-2019 CQUIN Scheme – Healthy Food for NHS Staff, Visitors and Patients

Further to your letter (ref; EFM5518/KH) relating to the above matter, please find enclosed the response from Gentian, our consortium partner for your review and acceptance.

I trust this answers your request fully but if you require any further information please let me know.

Yours sincerely,

Jim Valentine
PFI Representative and General Manager

Cc: Scott Humphrey

Enc.

→ CQUIN.

NAME	REVIEWED	ACTIONED
LD	✓	
KH	✓	✓

Claire Farthing

From: Bell, Andrew <andrewbell@gentianpartnerships.com>
Sent: 29 March 2018 12:50
To: Claire Farthing
Cc: Jim Valentine; Scott Humphrey
Subject: Fwd: FW: 2017-2019 CQUIN Scheme - Healthy Food for NHS Staff, Visitors and Patients (Ref: E-E2-CC-0054)
Attachments: 2018 NHS Retailer Letter - WHSmith.pdf; WHS CQUIN 2018 Plan (2)-signed.pdf

Hi Claire,

Please see below and attached from WH Smith in response to the letter regarding CQUIN.

Best regards

Andrew Bell
Business Development Director
Gentian Management Services Ltd
2 Stephen Street
London W1T 1AN

Company Number: 04122623

Tel: (Direct): 02074620734
Mobile: 07584 702426
Email: andrewbell@gentianpartnerships.com
Website: www.gentianpartnerships.com

---------- Forwarded message ----------
From: **Roberts, David** <David.Roberts@whsmith.co.uk>
Date: 29 March 2018 at 12:22
Subject: FW: 2017-2019 CQUIN Scheme - Healthy Food for NHS Staff, Visitors and Patients (Ref: E-E2-CC-0054)
To: "Bell, Andrew" <andrewbell@gentianpartnerships.com>

Hi Andrew,

Please see our response / sign off from NHS England re CQUIN. This should provide the Trust with every assurance required. If you could please forward onto them that would be appreciated.

Regards

David Roberts

NAME	ACTION	INFO	B/F	DATE
GM	✓			29/03/18
SFM	✓			29/03/18
HFM & EQUIP				
PA				
OA				

NHS England

Strategy Group
NHS England
Skipton House
80 London Road
London
SE1 6LH

March 2018

Dear Ian,

I am writing on behalf of NHS England to express my thanks for the progress made by WHSmith over the last 2 years to improve the nutrition of food and drink sold in NHS hospitals, and to confirm our position on your compliance with the 2017/18 CQUIN standards based on the plans you have shared with us.

Improving the range and quality of healthy options in food and drink outlets on NHS premises is an ambition we share. The engagement from our commercial partners in this endeavour is crucial and NHS England values our ongoing partnership and appreciates the progress you have made. We recognise the considerable changes which have been made by WHSmith during the last 2 years of the CQUIN scheme. This has included removing price promotions on unhealthy products, refocusing staff targets to promote healthier snacking and supporting the programme to reduce the sales of sugar sweetened beverages.

Based on the plans you have shared with us and on the understanding that these plans have been implemented in all stores, NHS England consider WHSmith to be compliant with all six of the 2017/18 CQUIN criteria that apply to retail outlets. This achievement reflects your ongoing commitment to this agenda and the significant changes that WHSmith has made during 2017/18.

For 2017/18 criteria we will honour the previous agreement made with WHSmith to retain 12 lines of bagged sweets and block chocolate that are price marked by the suppliers in order to stock lower portion bags in stores. We have also made agreement that the 'pick n mix' units and Coca-Cola branded drinks chillers will be phased out of WHSmith hospital stores during 2018.

I can confirm that in 2017/18 no exemptions have been provided to any retailer regarding meal deals, and that from 2018/19 no further exemptions will be granted to any retailer in order to maintain a fair standard.

Trusts and CCGs can check compliance on a local store level as the basis for local CQUIN negotiation and payment. Your ten point plan is also attached to this letter which can act as supporting evidence for Trusts to demonstrate to local commissioners how CQUIN has been implemented in WHSmith stores.

We recognise that to plan for significant change businesses need assurance about the longer term plan. NHS England is committed to improve the nutrition of food and drink sold on NHS sites. During

the first six months of 2018/19 we will work with our commercial partners to set our long term strategy beyond the 2018/19 CQUIN, and as part of this we will look to engage in senior level dialogue with you and our other commercial partners.

We look forward to continuing to work with you to improve the nutrition of food and drink available to NHS staff, visitors and patients.

Your sincerely,

S. A. Bampfylde

Simon Bampfylde

NHS Healthy Workforce Programme Manager

R. P. Newton

Rob Newton

NHS Food and Drink CQUIN Lead

WH Smith
Travel Limited

Victoria House
37-63 Southampton Row
Bloomsbury Square
London
WC1B 4DA

Telephone 01793 616161
Facsimile 01793 562265
March 2018

Dear Trust,

In March 2017 we fully implemented the first healthier eating CQUIN in your hospital to support both yourselves and NHS England in improving healthier retailing standards across our hospital estate. Since then, we have been in regular discussion with the CQUIN strategy team to work through the new guidelines set out for CQUIN 2. Whilst in some cases we have seen an impact to sales since implementation, we are still committed in continuing to support last year's CQUIN requirements across our stores and below outlines how we intend to show our compliance to this year's further requirements for the CQUIN in 2018.

As per last year we have replicated our strategy and have agreed an implementation plan with NHS England, which is outlined below. This will give you the assurance you need over store compliance and allows WHSmith to provide a standardised approach across our entire Hospital estate. This 10 point plan will provide the evidence you need to demonstrate to your local commissioner how CQUIN has been implemented in your store and that the WHSMITH is now fully CQUIN compliant:

- All CQUIN requirements for the 2017 CQUIN remain in situ and our compliance from last year remains in place (As per last year's letter)

WH Smith plan for CQUIN compliance in 2018/19:

1. All CQUIN requirements for the 2016/17 CQUIN remain in situ and our compliance from last year remains in place (As per last year's letter)

2. Adhere to the 60% compliance of facings for products under 250kcal (based on centrally created planograms) in store across sweet confectionary areas; this will be looked at from a total space in store for all sweet confectionary space. We will provide a % for each store in our estate. Due to the vast number of planograms we have in our estate we will be fully auditable for any store through NHS England centrally and example planograms of a small, medium and large store have been given to NHS England to show our compliance.

3. Adhere to the 60% compliance of facings for products under 400kcal or less and containing no more than 5g sat fat per 100g (based on centrally created planograms) in store across sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads , this will be looked at from a total space in store for all sandwich space. We will provide a % for each store in our estate. Due to the vast number of planograms we have in our estate we will be fully auditable for any store through NHS England centrally and example planograms of a small, medium and large store have been given to NHS England to show our compliance.

4. Continue to support the voluntary agreement on sugar sweetened beverages where WHSMITH remains committed to achieving the 90/10 sales mix, this will supersede any CQUIN criteria and satisfy our adherence in this area.

5. The meal deal will now only contain sandwiches and main meals that are under 400 kcal and less than 5g of sat fat per 100g. On top of this we will remove all snacking components of the meal deal which do now fall within green or amber traffic lights across fat, sugar and salt. This will vastly reduce the offering within our meal deal, however we have worked tirelessly to produce a range to satisfy staff and patient shoppers, this new range of sandwiches will launch as part of our going live with CQUIN 17/18 at the back end of March 2018.

6. In all of our stores where we have a Q-System, from the end of March 2018, this will no longer contain any products high in fat, sugar or salt, unless those products are excluded by NHS England, such as portion controlled dried fruit and unsalted nuts.

7. Price marked packs will still be ranged in our stores, however we will continue to limit this range to 12 lines across block chocolate and bagged sweets and chocolate. The non- price marked version is a higher weight and has more calories in the bag and as a result we will continue selling the lower portion bag size.

8. WHST cannot alter a branded supplier decision to place on pack promotions on a high fat, sugar or salt line and as a result these packs will be in situ in our stores throughout the year, however we will not price promote these lines in accordance with CQUIN criteria.

9. A number of our hospital sites contain 'pick n mix' units (circa 30 sites); whilst these will not be removed in time for the launch of the 2018 CQUIN we will have removed all of these units by mid May 2018.

10. A small number of hospital sites (6 sites) have a Coca-Cola branded chiller in situ, as above these chillers are being worked through in order to be replaced and should be all replaced by Sept 2018.

Yours sincerely,

Spencer Sheen

WHSmith Travel Business Development Director

Simon Bampflyde

NHS Healthy Workforce Programme Manager

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**NHS Staff Attitude and Opinion Survey Results**
Author	**Michelle Brookhouse, Associate Director of Workforce**
Responsible Director	**Karen Martin, Chief Workforce and Information Officer**
Date	**31 May 2018**

1. Purpose

This report provides an overview of the NHS National Staff Survey 2017 within University Hospitals Coventry & Warwickshire NHS Trust, outlining how the survey was conducted, response rates, results and next steps.

2. Background and Links to Previous Papers

The NHS National Staff Survey is undertaken annually by all Trusts nationwide, and in 2017 ran between October and December. The 2017 NHS Staff Survey involved 309 NHS organisations in England with almost 1.1 million staff being invited to participate using an online or paper questionnaire. Responses were received from 487,227 NHS staff which equates to a national response rate of 45%; an increase from 44% in 2016. Full-time and part-time staff who were directly employed by an NHS organisation on 1st September 2017 were eligible to participate.

We invited all staff at UHCW staff to participate in the 2017 Survey (8,863 including ISS/RoE staff).

Our survey ran for 8 weeks commencing 4 October and was administered by our provider, Quality Health. We opted for a mixed mode delivery of the survey with paper surveys for band 4 and below working in clinical roles and ISS ROE staff (recognising the limited access to electronic devices for these cohorts of staff. All other staff received an online link via email. A small Survey Task Group was established and the communication campaign “Have your say!” was used. Weekly league tables were published to encourage an increase in response rates.

3. Survey Results

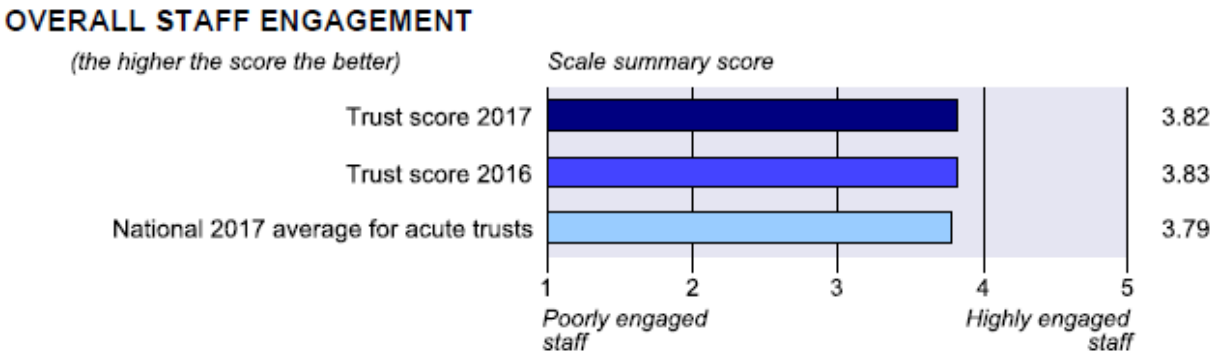
Overall our results show small improvements or no significant change in majority of the key findings this year. Key results are highlighted below.

3.1 Response Rates

Our response rate remained static this year at 41% (3,189 staff) and remains below the national average for acute trusts which also remained static at 44%. This was the second year we have invited all staff to participate in the survey. However, some staff do not believe the survey provides sufficient anonymity, despite assurances, and therefore choose not to complete the survey, which has a negative impact on our response rate.

3.2 Engagement Score

The survey provides an overall staff engagement score. Possible scores range from 1 (poorly engaged with their work, their team and their trust) to 5 (highly engaged).



The engagement score is calculated using the results of Key Findings 1, 4 and 7, which relate to:

- staff members' perceived ability to contribute to improvements at work;
- their willingness to recommend the trust as a place to work or receive treatment; and
- the extent to which they feel motivated and engaged at work

Our score of 3.82 has decreased slightly from 3.83 in 2016; however, we are above the national average for acute trusts (3.79).

We are one of 5 NHS Trusts working in partnership with Virginia Mason Institute based in Seattle, USA. Their improvement tools and methodologies are designed to improve patient care and develop a culture where staff are empowered to make a difference and therefore increase engagement. The following table provides benchmarking information on the engagement score for these organisations:

	2016	2017
Nationally	3.81	↓ 3.79
University Hospitals Coventry & Warwickshire NHS Trust	**3.83**	↓ **3.82**
Barking, Havering and Redbridge University Hospital NHS Trust	3.83	↓ 3.78
Surrey and Sussex Healthcare NHS Trust	3.97	↓ 3.96
The Leeds Teaching Hospitals NHS Trust	3.82	↑ 3.85
The Shrewsbury & Telford Hospital NHS Trust	3.75	↓ 3.73

In 2016 we were the only VMI Trust with an engagement score to deteriorate from the previous year. In 2017 four organisations have seen deterioration but, positively, we have seen the lowest negative difference (alongside Surrey and Sussex). Nationally the

trend has been for the engagement score to deteriorate. We recognise there is further work to do in this area.

During May/June this year we will be administering the Cultural Assessment Tool (CAT) survey across the organisation as part of our work with VMI. All five VMI trusts will participate. This survey was initially run in 2016 as a benchmarking exercise with plans to re-run it in 2018 and 2020. The CAT survey measures the following components of culture:

- Vision and Values
- Goals and Performance
- Team Working
- Support and Compassion
- Learning and Innovation
- Collective Leadership

The results of this survey will provide us with additional feedback and benchmarking of our culture and our journey so far.

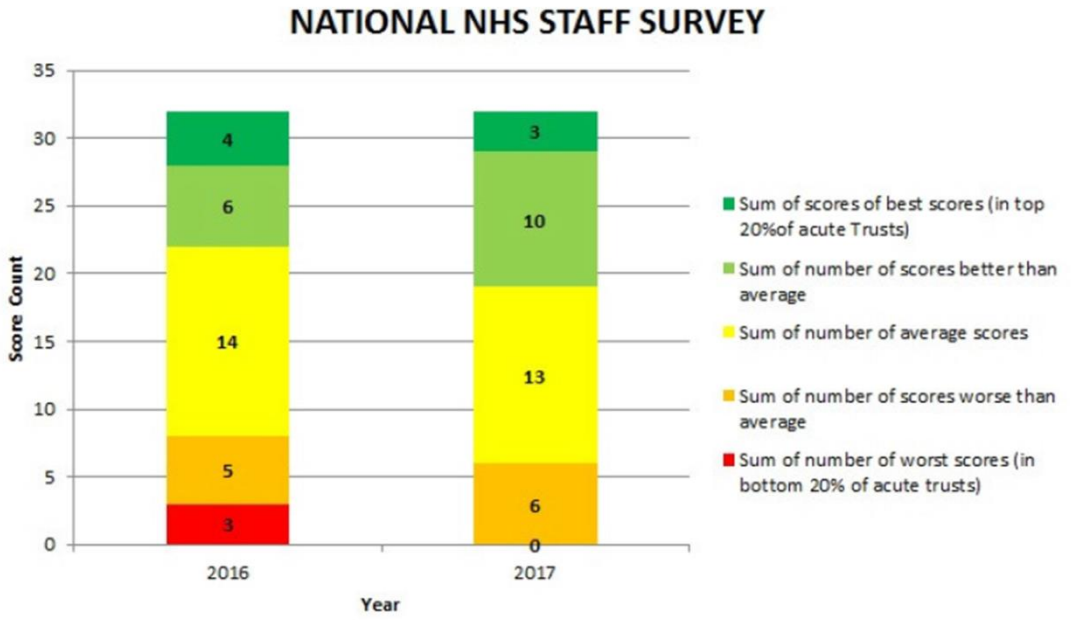
As well as the CAT survey, we are utilising the VMI Culture Transformation Continuum self-assessment tool as a way of understanding where we are culturally, where we want to be and how we move along this continuum.

Triangulating all areas of feedback and measurement from the various tools and surveys we are accessing will be important during 2018/19 to ensure we fully understand our position in our cultural journey and make the best decisions for our focused actions to achieve the outcomes we are seeking.

3.3 UHCW Comparison with all Acute Trusts

Appendix 1 provides a comparison of our results by key finding against all acute trusts.

The following graph provides a summary of our comparative scores with all acute trusts – it is pleasing to note that we do not feature in the bottom 20% of acute trusts this year.



We do, however, feature in the top 20% of acute trusts for three of the key findings:

1. KF11 Percentage appraised in the last 12 months
2. KF29 Percentage of staff reporting errors, near misses or incidents witnessed in the last month
3. KF30 Fairness and effectiveness of procedures for reporting errors, near misses and incidents

Focused work during 2017 included the introduction of our appraisal cycle between April and September and a RPIW relating to incident reporting and patient safety– both of these areas feature in our top 5 ranking areas and in the top 20% of acute trusts.

3.4 Statistically Significant Results

The following 8 key findings show the movement from 2016 results is classified as statistically significant (4 positively, 4 negatively). This compares to 4 key finding areas in 2016 (1 positively, 3 negatively). The remaining 24 key findings show no statistically significant change over 2016.

Statistically significant positive change	Statistically significant negative change
KF11- % appraised in last 12 months	KF17 - % feeling unwell due to work related stress in last 12 months
KF6 - % reporting good communication between senior management and staff	KF3 - % agreeing that their role makes a difference to patients/service users
KF22 - % experiencing physical violence from patients, relatives or the public in last 12 months	KF1 – Staff recommendation of the organisation as a place to work or receive treatment
KF30 – Fairness and effectiveness of procedures for reporting errors, near misses and incidents	KF2 – Staff satisfaction with the quality of work and care they are able to deliver

As previously noted, targeted work over the previous year around appraisal (KF11) and patient safety/incident reporting (KF30) have had an impact on how staff have responded to the survey. During the summer and early autumn of 2017 we held large events, hosted by the CEO, to update staff on our journey through TTWC and UHCW*i*. This was continued with roadshows across the organisation supported by Chief Officers, the Kaizan Promotion Team and the Organisational Development Team (including night visits to some areas). This may have had a positive impact on the number of staff reporting good communication between senior management and staff (KF6). A task group was established last year to look at the management of violence and aggression towards staff, resulting in additional training interventions being piloted, so a reduction in staff experiencing violence (KF30) demonstrates the benefits of our new approaches.

It is recommended where we have areas of statistically significant negative change that they are considered for organisational focus and improvement during the next twelve months.

3.5 Staff Friends and Family Test

In Quarters 1, 2 and 4 Staff Friends and Family Test (SFFT) results are generated through our local SFFT surveys, whilst in Quarter 3 results are generated through the NHS National Staff Survey. The SFFT measures staff recommendation of the organisation as a place to work or be treated. Our results for 2017/18 are reported below:

2017/18 Results - "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation"

Period	Recommender	Non-recommender	Unsure
Qtr 1	89%	4%	6%
Qtr 2	90%	3%	8%
Qtr 3	72%	8%	20%
Qtr 4	85%	3%	12%

2017/18 Results – "I would recommend my organisation as a place to work"

Period	Recommender	Non-recommender	Unsure
Qtr 1	69%	13%	17%
Qtr 2	68%	13%	19%
Qtr 3	61%	15%	24%
Qtr 4	67%	14%	19%

In Quarter 3 (October – December 2017) 72% of respondents said they would recommend the Trust as a place to receive treatment. Whilst this is a decrease over Q1, Q2 and Q4 we remain above the national average for acute trusts of 71% recommending their Trust.

61% of survey respondents said they would recommend the Trust as a place to work. Again this shows a decrease over Q1, Q2 and Q4 we compare as average with acute trusts.

It should be noted that our response rates generated via our local SFFT are less than the national survey and we are working on improving this in 2018/19.

Clearly there is further work to do to improve our Staff FFT results and how staff feel about our organisation and this forms part of our overall programme to increase staff engagement.

3.6 AUKUH Trusts Comparison

In addition to the standard comparator group of other Acute Trusts (which excludes specialist Trusts and those defined as community and Acute Trusts), comparisons have also been completed for all 45 members of the Associate of UK University Hospitals (AUKUH). This comparator could be viewed as providing a more comparable peer group given the nature and complexity of University Hospitals Trusts. This comparator data indicates that: for 4 of the 32 key finding areas the Trust was ranked in the Top Quartile of AUKUH Trusts, and was ranked 17th overall in terms of net quartile scores. We also fall within range for our Engagement Score compared to AUKUH Trusts (lower quartile 3.76 – upper quartile 3.90).

3.7 Verbatim Comments

As part of completing the staff survey staff are given the opportunity to provide free text feedback. We received over 400 comments which we have attempted to theme (74 of these were providing a positive view of the organisation and staff experience and the rest were of a negative nature). The following themes emerged:

- Staff shortages and use of bank/agency
- Wellbeing (including stress)
- Management and senior leadership
- Recognition, support and pay
- Hours, Workload, Shifts and Leave
- Parking
- Values and behaviour
- Communication
- Bullying, fairness, equity, blame culture

We will use these in conjunction with feedback from the Listening Events we hold to help inform our action plans in response to the results of the survey.

4.0 Next Steps & Responding to the results

It is essential that we ensure staff see feedback from the survey in order to demonstrate that we listen to their views and, importantly, are acting on them. To date we have fed back the initial results to staff (December 2017) and the full results (March 2018) via our usual communication channels. See Appendix 2 for an example.

During April and early May we held a series of listening events (You said, what next…) where we used a variety of interactive exercises to engage staff to expand on the responses given to the staff survey and to enable them to suggest ways in which we could improve their experience in certain areas. As previously mentioned, we agreed to focus our corporate interventions around the areas that had shown statistically significant negative change, to understand more about the recommender question and to try and identify how we can improve communication. We used the activities to ask the following questions:

- Why would/wouldn't you recommend your friends/family to work here?
- What prevents you/helps you to deliver the quality of care that you want to deliver
- How do you/don't you feel supported at work?
- How do staff feel that they are/aren't able to make a positive difference
- Why do you think people feel stressed at work? How can we improve this?
- How would you like to be communicated with?

Our Change Makers have also been involved in holding mini listening events in their areas and will be feeding in their results.

We are working with our Staff Side and our Head of Equalities in regards to the question of feeling supported at work; in particular to address the issues of bullying that is raised within some of our feedback. We have recently produced a revised leaflet and poster "Raising Concerns and Finding Support" as a guide for staff.

We are currently in the process of analysing feedback. Our intention is to use all our intelligence from staff feedback to develop our action plan and will involve staff representation in agreeing this.

In addition to our corporate focus and actions, each group has been looking at the results for their areas and are identifying key themes that they will focus on locally. Our HR Business partners are supporting this process. Each group is approaching this differently; as an example these are the areas from the survey identified by two of our groups to work on:

Surgery:
I am able to make improvements happen in my area of work
How satisfied are you with the recognition you get for good work
Communication between senior management and staff is effective

Theatres/Anaesthetics:
The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?
Communication between senior managers and staff is effective
Senior managers here try to involve staff in important decisions
Senior managers act on staff feedback.
There are enough staff at this organisation for me to do my job properly

Groups are due to feedback on this work by the end of May.

Below we have agreed the following deadlines to ensure we make progress in a timely manner – both at corporate and group level.

What	By when
Complete collation and theming of feedback	11 May
Formalise action plan to address key themes	31 May
Feedback to staff…you said, we will…	1 June
HRBPs supporting groups to identify themes and develop local action plans	31 May
Monitor action plan and showcase work with staff	From June
Develop quarterly reports combining feedback from all surveys to feed into actions plans	July (for Q1)
Prepare for 2018 NHS National Staff Survey	July

Progress will be monitored through our Workforce and Wellbeing Committee, a sub-committee of the Strategic Workforce Committee.

4. Areas of Risk

The NHS Staff Survey provides an opportunity for organisations to survey their staff in a consistent and systematic manner. This makes it possible to build up a picture of staff experience, to compare and monitor change over time and to identify variations between different staff groups. Obtaining feedback from staff, and taking account of their views and priorities, is vital for driving real service improvements both here at UHCW and nationally across the NHS.

The results may be accessed and utilised by a range of individuals. For example, individuals considering us as an employer may look at the results in order to assess our suitability as a future employer.

Whilst the results are primarily intended for use by organisations to help review and improve staff experience in order that staff can provide better patient care, the Care Quality Commission will use the results from the survey to monitor ongoing compliance with essential standards of quality and safety. The survey will also support accountability of the Secretary of State for Health to Parliament for delivery of the NHS Constitution.

It is essential to continue to provide targeted focus on improving staff engagement levels in order to increase and maintain momentum on our journey of culture transformation. Failure to do this will impact on our strategic objective to become a model employer.

The development of our Organisational Development Strategy, focused staff engagement work and the continued expansion of understanding and use of our UHCW Improvement

System are all enablers to increased engagement of staff and a transformed culture. All of which will have a positive impact on future staff survey results.

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

Improving our staff survey results demonstrates better engagement of our staff and a better experience of working at UHCW, all of which contribute to meeting our strategic objective of being a Model Employer.

6. Governance

National Staff Survey results have now been published and are in the public domain.

7. Responsibility

The Chief Workforce and Information Officer will retain oversight for coordination of the National Staff Survey and reporting of progress against the results through to Chief Officers Group (the results and agreement of focus have already been received by Chief Officers Group and presented at Chief Officers Forum).

8. Recommendations

The Board are asked to NOTE:

(a) Overall our results show small improvements or no significant change in majority of the key findings this year compared to our 2016 results. Our Staff FFT and engagement levels remain above the national average for Acute Trusts, with 3 of our key findings being in the top 20% of acute trusts.

(b) There are 8 key finding areas where the movement from 2016 – 2017 is classified as statistically significant; with a negative deterioration in four areas.

(c) Work has already commenced to engage staff and develop action plans to address the key outcomes from the survey.

Michelle Brookhouse
Associate Director of Workforce

May 2017

APPENDIX 1

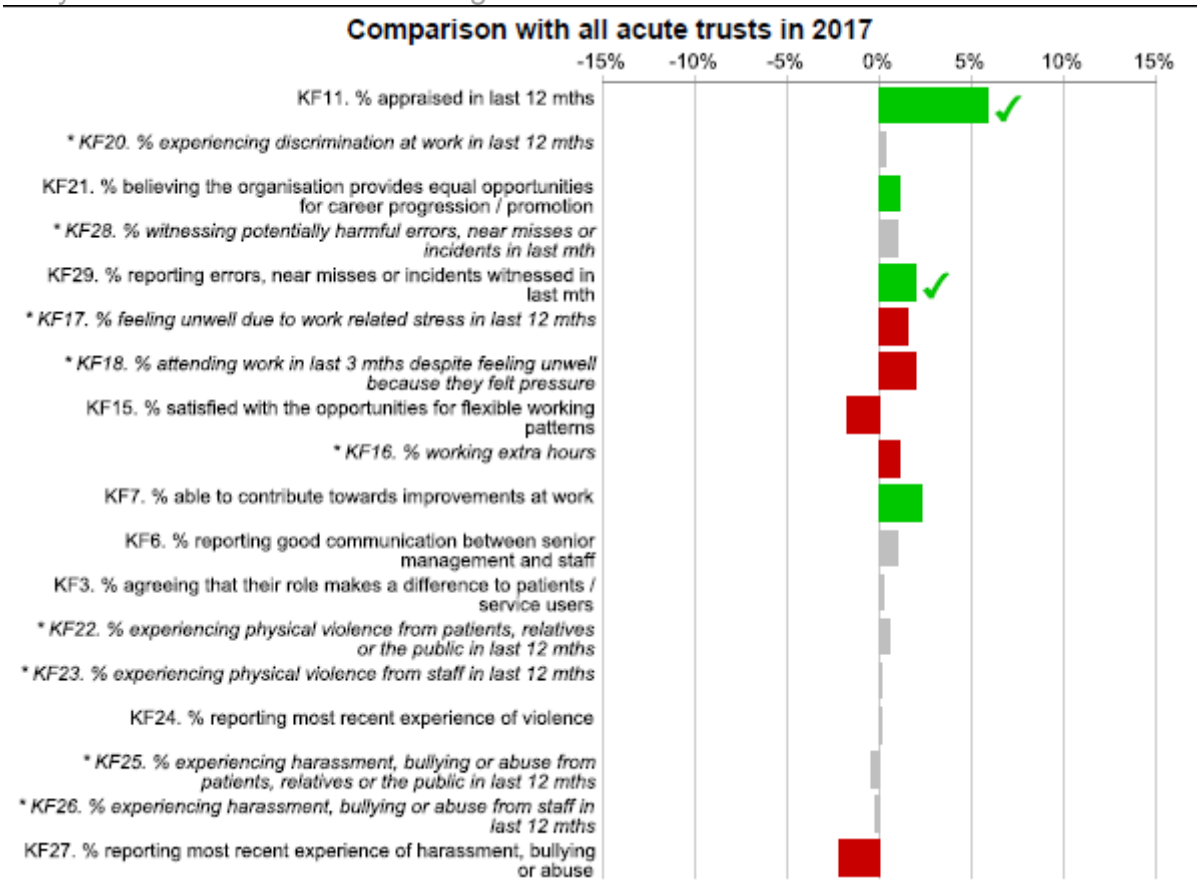
Comparison of Key Findings for UHCW with all Acute Trusts

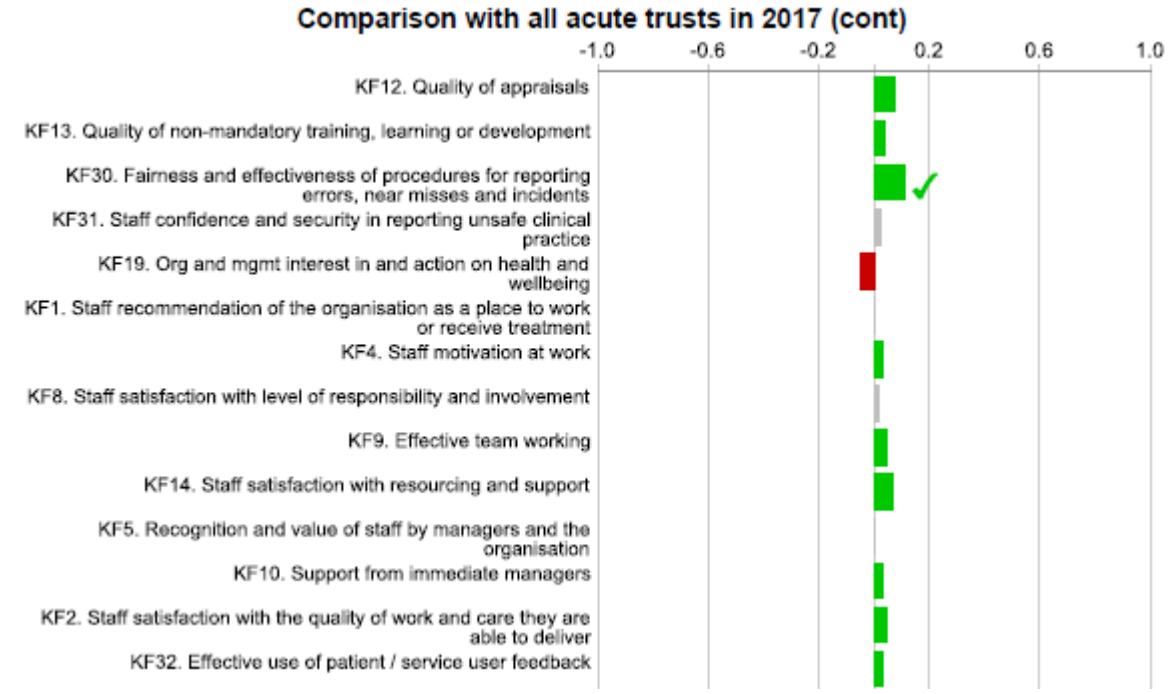
KEY:

Green = positive finding, e.g. better than average. If a √ is shown the score is in the top 20% of acute trusts

Red = Negative finding, i.e. worse than average. If a ! is shown the score is in the worst 20% of acute trusts.

Grey indicates the score is average.





National Staff Survey 2017 (Initial Results)

Together Towards World Class

HAVE YOUR SAY!
NHS Staff Survey 2017

3,189 of you…

Felt more POSITIVE about:

- ✓My role makes a difference to patients
- ✓My manager values my work and gives me feedback
- ✓Senior managers try to involve me in important decisions and act on feedback
- ✓Treating me fairly if I am involved in an error, near miss or incident
- ✓Giving me feedback about changes in response to reported errors, near misses and incidents
- ✓Feeling secure in raising concerns and confidence they would be addressed
- ✓Reducing my experience of violence and aggression
- ✓Reducing my experience of bullying, harassment , abuse and discrimination
- ✓My appraisal helps to set clear objectives, improve how I do my job and makes me feel valued

Still feel there is MORE TO DO to:

- Reduce work related stress
- Improve reporting of incidents of violence and aggression
- Support you to be able to report cases of bullying
- Help you deliver the care you aspire to

You have seen improvements in 46 and no change in 22 of the 87 questions from the 2016 Survey

NHS
University Hospitals Coventry and Warwickshire
NHS Trust

Putting Patients First Empowering Staff

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	UHCW Improvement System (UHCW*i*)
Author	Neil Griffin, Kaizen Promotion Office Lead
Responsible Director	Karen Martin, Chief Workforce & Information Officer
Date	31 May 2018

1. Purpose

As we continue our partnership with Virginia Mason Institute (VMI) we need to celebrate our successes with using the UHCW Improvement System (UHCW*i*) in our Hospitals and beyond, and share the learning from this journey of transformation.

The UHCW Improvement System has 3 simple but powerful messages so staff can understand the culture of the Improvement System and link it to the Patient First strategy triangle:

The method is based on using lean tools to continuously improve services but more than this the partnership is about implementing a management system that will support a long term cultural transformation. This is now the second report for Trust Board and others on the progress and outcomes from the implementation of UHCW*i*. The method is about lean processes with the elimination of waste and duplication however some elements will be revisited to continue to help spread the awareness and understanding of the UHCW*i.*

2. Background and Links to Previous Papers

The January report to Board explained the background, structure and method to the partnership between UHCW NHS Trust and VMI. The other Trusts in the partnership are Leeds, Shrewsbury and Telford, Barking Havering & Redbridge and Surrey & Sussex.

The reports via TTWC board and presentations at board seminars have summarised the impact of UHCW*i* methodology and how the management system is being embedded into the Trust, featuring an update on education, spread of learning and use of tools in specific processes/environments to improve patient experience.

3. Executive Summary

Governance for Programme

Transformation Guiding Board (TGB)
The five Trust Chief Executives meet together with NHSI and VMI representatives and these monthly Transformation Guiding Board meetings continue to be used to steer, develop and maximize the value of the partnership. Learning is shared between the Trusts and each meeting has a thematic discussion based on how the programme is developing across the Trusts.

Trust Guiding Team (TGT)
The TGT is where the Chief Officers meet monthly with representatives from the Kaizen Promotion Office (members of our own staff trained in the method by VMI) and a Sensei from Virginia Mason Institute to locally monitor progress in embedding UHCW Improvement System as the way we run our hospitals. The TGT monitors the Trust level, Executive led Value Streams alongside the training and spread of the method to all levels of leadership in the Trust.

The training and spread of the Improvement System is undertaken by the Kaizen Promotion Office which comprises of 5 staff who have all been directly trained and certified by VMI in Advanced Lean Training, at the last report 3 of these staff were certified to run Rapid Process Improvement Workshops (RPIWs) and the other 2 staff were going through the assessment process. Lisa Warden has now been certified to act as both a Team Lead and a Workshop Lead in an RPIW and Lee Sutcliffe will be certified to the same level by the end of May.

Value Streams
The Trust Level Value Streams all have high level metrics to track improvement and RPIWs (Rapid Process Improvement Workshops) are run focusing on a part of a process to eliminate waste and add value measured from a patient perspective. These metrics are routinely monitored through the Trust Guiding Team and also reported at the Transformation Guiding Board. The Trust has now held 15 RPIW weeks – these are improvement events where the staff who do the work are given the time and support to identify and test ways to improve the processes. As part of our commitment to Patient First, 5 of these weeks have now included a Patient Partner, these patient representatives work alongside the staff to identify and test ideas and ensure the ideas add value from a patient perspective.

The Trust continues to have 5 Value Streams each with an Executive Sponsor. There have been many ideas tested from the RPIWs in each value stream, below features an updated summary of outcomes:

Value Stream #1 Opthalmology Outpatients – Executive Sponsor Nina Fraser
Ophthalmology is one of the busiest outpatient specialties in the Trust so has a significant impact on our patients. This Value Stream has not had a further RPIW since the January Report but there are discussions around the best focus for a fourth RPIW in the near future. The metrics for the overall value stream continue to be re-measured on a quarterly basis, and these will guide us to decide the area of focus for the next RPIW

Value Steam #2 Patient Safety Incident Reporting – Executive Sponsor Nina Fraser
This Value Stream has completed 4 RPIWs and is very much a flagship of the improvement work for UHCW. This Value Stream has been purely focused on Delivering Safer Care for our patients. The outcomes for this Value Stream are now being shared nationally and staff from other Trusts have attended open days to learn from the implementation of the RPIWs in this value stream. The plan for this Value Stream is to continue to build on this great work with Kaizen Events (shorter improvement events than RPIWs but maintaining the same principles) and to sustain the improvements by monitoring adherence to the standard work developed.

Value Stream #3 Theatres – Executive Sponsor Meghana Pandit
This Value Stream has completed 4 RPIWs and due to the size of scope the plan for this Value Stream is to complete at least a further 2 RPIWs. This Value Stream has been around patients attending for inpatient elective surgery including the processes up to and during theatre. Whilst sustaining the improvements documented in the previous report, there have been further improvements following the RPIW held in January:

Improvements

- **97% reduction** in the number of fast track instrument cleaning requests for elective surgery.
- **64% improvement** in trays not having broken or missing items when they are opened – this reduces delays in starting surgery

Value Stream #4 Discharge – Executive Sponsor Karen Martin
This Value Stream has now completed 2 RPIWs and is about to complete a 3rd. Focusing on Acute Medicine patient discharge, this Value Stream has looked at how we eliminate waste in the discharge process from one of our wards to develop learning that could be spread to other wards. The RPIW in planning will focus on access to CT scans as part of patient discharge. The team involved in the value stream has continued to sustain the improvements from the 1st RPIW. The use of the production board to track problems has continued this is enabling better visibility of patients, prompting earlier actions so that the patient is ready for

discharge earlier in the day. Since the January report there has been a 2nd RPIW that has produced additional improvements in this value stream:

Improvements

- Lead time for obtaining blood results has **improved by 8 hours** meaning results are available for morning board round.
- **Elimination of walking** for Ward 3 Phlebotomist to obtain trolley thereby increasing productivity.
- **Visual control** added to blood request to signify those patients who need their blood test as part of their discharge

Value Stream #5 Pre-Operative Pathway – Executive Sponsor Andy Hardy

This Value Stream focuses on preparing Orthopaedic patients for admission for surgery, looking at the pre-operative pathway following the identification of the need for an operation. This Value Stream has completed 2 RPIWs:

Improvements

- **Testing a new triage pathway** to stop some patients needing a full pre op assessment so **reducing visits.**
- **Reduce duplication** of patient documentation between paper and IT systems.
- Pre op appointment being held closer to date of operation to **reduce patient cancellations.**

Education and Engagement

A part of the method we continue to test ways to engage with staff from awareness to formal training and coaching in the Improvement System.

Over 1,500 staff have received differing levels of training in UHCW*i*, from basic 5S (a lean tool to make the workplace safer and more organised) up to Lean for Leaders and Advanced Lean Training.

Lean for Leaders

Lean for Leaders is a 5 month programme, which is designed to prepare leaders to lead in new ways, becoming problem framers and empowering staff to make improvements to their services. Staff are taught how to embed UHCWi methodology in to their service. Importantly, the programme provides teaching and coaching to leaders to enable them to observe and measure their services from a patient perspective. Leaders develop skills to lead change effectively by developing standard work for daily management, create visual displays to show the status of the department, organize and convene daily staff huddles, perform root cause analyses and promote daily kaizen (improvement), engaging their team in ideas generation and testing using the Plan-Do-Study-Act (PDSA) method.

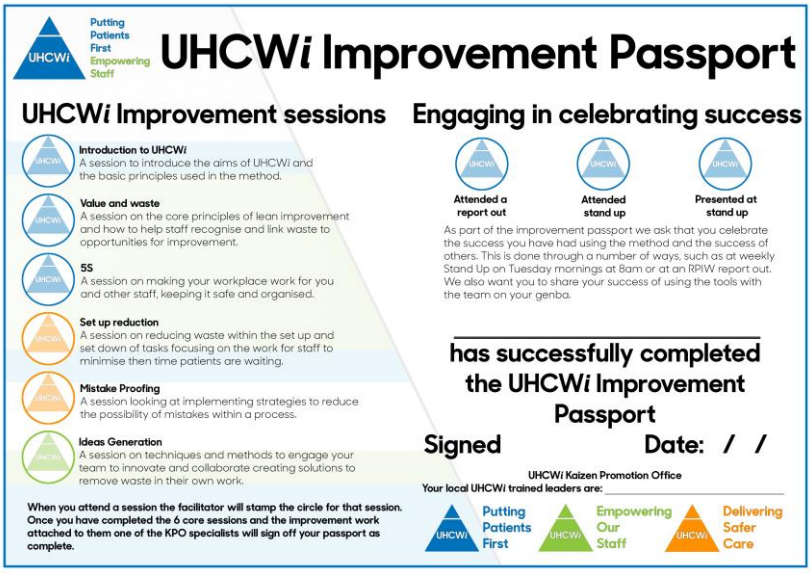
As more Lean for Leaders complete the course, production boards are becoming more visible across the Trust and senior leaders are being encouraged to undertake genba rounding (visit the area to understand the daily status, ideas for improvement and support the removal of barriers to embed the daily management method). To date 148 staff have been trained (either completed or completing the course) these are from a variety of levels within the organization from Executive to Band 4. There are a further 100 staff booked for the next cohort of training.

Leadership Training - Leading Together Masterclass

We continue to offer a mandatory Masterclass as part of the Trust's Leading Together Leadership Programme. 409 staff have attended the UHCW*i* Masterclass.

Passport Sessions

As part of process of continuous improvement and aim to spread across our whole Trust we wanted to reach all levels of staff and to build an army of problem solvers not necessarily just focusing on leadership roles. We have developed a programme of short education sessions called Improvement Passport sessions. These are offered to all staff and are 'bite-sized' introductions to the tools and methods as part of UHCW Improvement System. The staff member can attend individual sessions to build up to a completed Improvement Passport.



Putting Patients First
Empowering Staff

UHCW*i* Improvement Passport

UHCW*i* Improvement sessions

Introduction to UHCWi
A session to introduce the aims of UHCWi and the basic principles used in the method.

Value and waste
A session on the core principles of lean improvement and how to help staff recognise and link waste to opportunities for improvement.

5S
A session on making your workplace work for you and other staff, keeping it safe and organised.

Set up reduction
A session on reducing waste within the set up and set down of tasks focusing on the work for staff to minimise then time patients are waiting.

Mistake Proofing
A session looking at implementing strategies to reduce the possibility of mistakes within a process.

Ideas Generation
A session on techniques and methods to engage your team to innovate and collaborate creating solutions to remove waste in their own work.

When you attend a session the facilitator will stamp the circle for that session. Once you have completed the 6 core sessions and the improvement work attached to them one of the KPO specialists will sign off your passport as complete.

Engaging in celebrating success

Attended a report out | **Attended stand up** | **Presented at stand up**

As part of the improvement passport we ask that you celebrate the success you have had using the method and the success of others. This is done through a number of ways, such as at weekly Stand Up on Tuesday mornings at 8am or at an RPIW report out. We also want you to share your success of using the tools with the team on your genba.

_____ has successfully completed the UHCW*i* Improvement Passport

Signed **Date: / /**

UHCW*i* Kaizen Promotion Office
Your local UHCWi trained leaders are: _____

Putting Patients First | Empowering Our Staff | Delivering Safer Care

We have begun to introduce our new staff to the method and tools as part of the registered nurse preceptorship programme and on specialty training days. In total 392 staff have started their Improvement passport, with 704 attendances at the sessions overall.

As part of the passport we encourage staff to share their own learning following the sessions.

Stand up

Stand up now takes place every Tuesday at 8am as business as usual. This event is held publicly in front of the UHCWi screens in the main hospital entrance on the UH site. It is led by the Chief Officers and is used as a forum to maintain focus and accountability on the ideas being tested following a RPIW. Staff designated as leads on the improvement weeks present their progress, celebrate successes and highlight barriers to the Chief Officers, who offer their support. It is also used to show the progress of Lean for leaders participants who present on their learning during their training. Stand Up now takes place once a month in the main Outpatient area at the Hospital of St Cross so the Improvement Work can be openly discussed on both sites.

Communication and Media

NHS Improvement have commissioned a series of short films that captures the benefits staff have experienced from the Lean for Leaders training. These films will be available from May on the Trust website and will also be shown on the UHCWi screens in main hospital entrance.

At the end of each Rapid Process Improvement Week we continue to have a Report Out where the staff involved in the week share the improvements they have identified and tested, Report Outs are normally held in the Lecture Theatre with an open invite to all staff, they are also filmed and made available for all staff to view as part of sharing the improvement method.

External Visits/Visitors to the Trust related to UHCW*i*

Visit by Jeremy Hunt, Secretary of State for Health and Social Care, 1st March 2018

Jeremy Hunt visited UH on 1st March 2018. The event was focused on patient safety. Presentations were given by Professor Meghana Pandit on the UHCWi work and other improvements by the Trust. Jeremy Hunt spoke about the importance of patient safety and the work being done nationally to improve it and Professor Mike Durkin, Senior Advisor on Patient Safety Policy and Leadership at Institute of Global Health Innovation spoke about how we need to work across professions to provide the safest care possible. Mr Hunt has since tweeted about his visit, praising the Trust. He was also filmed speaking to Elaine Clarke, ADN, about the work of the Patient Safety Response Team which was an outcome from an RPIW in the patient safety Value Stream.

UHCW Improvement System Open Day, 9th March

We hosted an Open Day where we invited representatives from other Trusts and NHSI. Professor Pandit opened the day and Emma Fish (Kaizen Promotion Office) described our improvement journey. Throughout the day staff reflected on their learning and use of the Improvement tools that they had learned by attending Lean for Leaders and participating in RPIWs. One of the patient partners who was part of an RPIW also presented on his experience of being involved in the work. The day also provided the opportunity to showcase improvements in clinical areas in addition to outlining our education programme and the structure of our RPIW planning, including the tools we produce prior to an improvement week

Patient Safety Open Day, 15th May 2018

The Patient Safety Team hosted a 2nd sharing and learning event for Trusts nationally to learn about the work they have done following the 4 RPIWs. The team collaborated with the Kaizen Promotion Office to describe the improvement method and journey, sharing their outcomes and learning. The Patient Safety Team also offered those that attended the opportunity to learn about the system changes that have taken place, seeing how Datix is now used and to understand the role of the Patient Safety Response and how they have implemented a learning team approach to serious incident investigation.

4. Recommendations

The Board is invited to **note** the progress of the implementation of UHCW*i*.

Neil Griffin, Kaizen Promotion Office Lead
Date**: May 2018**

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	Research & Development Annual Report 2017-18
Author	Prof Chris Imray, Director of Research & Development (R&D); Ceri Jones, Head of R&D
Responsible Chief Officer	Prof Meghana Pandit Chief Medical Officer, Deputy Chief Executive Officer
Date	31st May 2018

1. Purpose

This report provides the Trust Board with a review of progress made during 2017-18 and assurance on delivery against the Research & Development Strategy during this period.

2. Background and Links to Previous Papers

- Research and Development are integral components of providing world-class services, which is a key work stream in our Together Towards World Class programme.
- Research & Development report 3 times a year to the Trust Board
- This report summarises activity and successes for the 2017-18 financial year.

Evidence suggests that patients have better outcomes at research-active hospitals, regardless of whether they took part in the research studies availalbe. The facts that research contributes to the quality of care provided to our patients and that taking part in commercial drug trials saves money have been presented to the Board in previous papers.

It is now becoming accepted that well-led healthcare organisations support patients to join cutting-edge research projects and clinical trials. One of the latest publications demonstrated a statistically significant association between clinical trials activity and both improved CQC ratings and lower Summary Hospital-level Mortality Indicator scores[1]. As such, for future assessments, the CQC will provide NHS organisations with the opportunity to showcase research as part of their assessment by the CQC to enable them to demonstrate their commitment to high quality patient care.

[1] https://www.researchgate.net/publication/323110563_The_correlation_between_National_Health_Service_trusts%27_clinical_trial_activity_and_both_mortality_rates_and_care_quality_commission_ratings_a_retrospective_cross-sectional_study

3. Executive Summary

2017-18 was another strong year for the team, with improvements in national performance metrics, Research Capability Funding income and achieving National Institute for Health Research (NIHR) Clinical Research Facility status.

The development of our Clinical Research Facility and move towards doing earlier phase research necessitates a proactive governance approach, and much progress has been made in developing systems and training to enable us to safely deliver such projects this year.

An evidence based approach to workforce configuration and developed competency and training packages have enabled us to maximise opportunities for our patients to take part in research.

Our Tissue Bank has expanded its commercial reach and is also delivering the 100,000 Genome service, a recent audit of which has demonstrated that all oncology patients eligible are being offered the opportunity to take part.

Our Trial Management Unit is a unique service offering that enables us to develop and deliver pilot studies to generate data to support larger grant applications and our success in terms of grant applications is above that of many national funding streams, with £2million secured from the NIHR this year.

Our Human Metabolism Research Unit (HMRU) has had its busiest year on record.

Research activity at UHCW NHS Trust is supported by the dedicated R&D staff who work tirelessly to make research happen. However, all of this work is driven or supported by our colleagues throughout the Trust, particularly those in supporting departments, principally radiology, pathology, pharmacy, library and knowledge services and PPMO without whom this success would not be possible.

3.1 This report sets out the work undertaken during 2017-18 and the delivery in our 4 strategic research areas (detail provided in Appendix 1):

3.1.1 Increase high quality research activity that impacts across the organisation

- Research Performance – recruitment, set-up and delivery
- Research Portfolio Development – grants development and submitted

3.1.2 Provide quality management and support for research

- Research Governance – quality
- Research Clinical Delivery Team - activity

3.1.3 Provide high quality facilities for clinical research and healthcare innovations capable of responding to change on demand and evolving the collaborative environment

- Trial Management Unit

- NIHR Clinical Research Facility
- Tissue Bank & 100,000 Genome Project
- Human Metabolic Research Unit

3.1.4 Raise the profile of Research
Communications / Awards / Events / Esteem measures

4 Areas of Risk

4.1 Research should be regarded as 'core business'

We believe that the culture continues to change to become more research supportive. That said, we still find that clinical pressures can lead to challenges, such as the inability to release staff to do research (even if their time is fully funded) as securing back-fill can be problematic, or difficulty securing agreement to support specific projects.

4.2 Academic Leadership:

In our last Annual Report to the Trust Board, we identified that a lack of research leadership as a key risk. Specifically, we still need more clinical academics of sufficient quality to be able to attract significant NIHR funding and lead the research culture at UHCW.

However, since then, a number of positive developments are in train, specifically:

- Dr Harpal Randeva has been appointed as Director of the Human Metabolic Research Unit (HMRU), to generate additional commercial links and provide much-needed high profile clinical academic engagement (see Section 3.1.3 HMRU).
- We have secured agreement from a number of our collaborators to develop joint academic posts, including:
  - Coventry University: a joint Professor in Clinical Nursing (Prof Jane Coad, commencing May 2018), plus a joint Senior Research Fellow (to be advertised 2018/19). A joint Chair in Cardiology is in development.
  - Oxford University: a joint Senior Fellow in Transplantation (Mr James Hunter).
  - Birmingham City University: a joint Research Assistant to complement existing research work in frailty (to be advertised shortly).

Additionally, the NIHR Clinical Research Facility funding has enabled us to expand our research base by funding 50% of 2 research fellow posts in the HMRU and Biomedical Research Unit (BRU).

Very positively, at the Trust Board Seminar focussing on Research in February, the Executive team and Warwick Medical School agreed to develop an application for an NIHR Biomedical Research Centre. Such a model will connect world-leading researchers based at both organisations with a joint vision to drive forward the translation of scientific breakthroughs into cutting edge treatments and care for patients. A successful application requires a large numbers of high impact research publications and evidence of world class impact between our organisations. As such, this joint ambition will involve significant joint investment into research leaders and facilities. R&D are working with a project team from Warwick Medical School to progress this initiative.

We are maintaining our vibrant programme (INCA - Interdisciplinary Non-medic Clinical Academic (INCA) Research Programme to identify and develop the non-Medic research leaders of the future, but it will be some years before these staff are leading their own grant applications. Our first 'Spring School' for aspiring researchers at PhD and post Masters level is arranged for May 2018. The appointment of Prof Jane Coad and a new Associate Director of Nursing for Research and Education in 2018/19 provides opportunity to review and refresh this strategy.

4.3 Research Performance and Income:
Our performance had been on an upward trajectory for the last year or so, but we still need to perform consistently. We have won a regional award (section 3.4) for the implementation of IT solutions to better performance manage and are starting to see improvements. Recruitment performance is intrinsically linked to income and we are focussing our activities in this area.

Commercial income remains significantly behind target. This is a concern as this income offers full cost recovery and additional capacity building to 'top-up' funding received from the NIHR. We are working to address this, as demonstrated by an increase in commercial trials opened (sections 3.1.1, Performance, and 3.1.2, Clinical Delivery).

We have a heavy reliance on Research Capability Funding (RCF) to fund R&D activity, at time of writing, our NIHR RCF allocation for 2018/19 has yet to be announced, but is predicted to decline by £412K in 2018/19 (down from £1.14 million to c. £740K). We need to invest in academic leaders to reverse this trend.

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

A Increase the level of participation in research
This is demonstrated by a number of indicators including an increased numbers of specialities supported to do research and the number of patients recruited exceeding target.

B Meet national performance objectives
Our performance against our 2 national targets ('Initiation' and 'Delivery') are detailed in section 3.1.1. Whilst significant progress has been made this year ('Initiation' increasing from 56% to 78% and 'Delivery' increasing from 57% to 75%), we need to hit the 80% target during 2018-19.

C Achieve the Financial Plan.
Our cost improvement solutions are income based; we endeavour to increase income from external sources, particularly commercial research. We exceeded our CIP target in 2017-18.

6. Governance
All R,D&I activity is covered by the UK Policy Framework for Health and Social Care Research. Key legislation is the UK Statutory Instrument Number 1031 that implements the Medicines for Human Use (Clinical Trials) Directive 2004 and subsequent amendments, assurance is received via the Research

Governance and Human Tissue Committee and thence to the Patient Safety Committee.

7. Responsibility

Professor Meghana Pandit, Chief Medical Officer
Professor Chris Imray, Director of Research and Development.
Ceri Jones, Head of Research and Development.

8. Recommendations

The Board is invited to **note**:

1. the work that has been achieved around the research and development agenda

and **support:**

2. the future developments suggested

Name and Title of Authors:

Professor Chris Imray, Director of Research and Development.
Ceri Jones, Head of R&D
Nic Aldridge, R&D Nurse Lead
Deborah Griggs, research Portfolio Development Manager
Sean James, Arden Tissue Bank Manager, Genomics Ambassador.
John Hattersley, Head of HMRU
Tracy Gazeley, NIHR CRF Manager
Katie Bruce, Trial Manager
Natassia Garton, R&D Business Manager
Isabella Petrie, Research Governance Manager
The Research and Development Team

Date: 8th May 2018

APPENDIX 1: 2017-18 delivery by Strategic Research Area
3.1.1 Increase high quality research activity
Area: Research Performance

Background:
In support of the Trusts' strategic aim to be a research based healthcare organisation R&D report performance against a number of metrics at Trust and national level. These include the NIHR Performance in Initiation and Delivery metrics.

Current position:
This year, we exceeded our patient recruitment target, recruiting 4,583 patients, 108% of target.

While commercial income remains behind target, an increasing number of new studies commenced in 2017/2018 (25 commercial trials opened compared to 15 during 2016/17). To provide a more sustainable commercial research environment, our commercial strategy was launched in September 2017.

National Benchmarks – Performance in Initiating and Delivery:

	Q4 UHCW	**Target**
Performance in Initiating	**78%**	80%
Performance in Delivery	**73%**	80%

Performance in Initiation: There has been a significant increase in the number of studies meeting the 70 day target in the last quarter. At the end of 2016/17, the percentage of studies meeting the target was only 56%. We are now extremely close to meeting this target for the first time. We are confident we are reporting accurate data and are striving towards increasing this metric by proactive performance monitoring and improving relationships with external sponsors to improve efficiency of set-up activities.

Performance in Delivery: This indicator changed during 2017, so that only studies which have closed in the past 12 months are now to be reported. We have noticed a significant increase in the number of studies meeting the recruitment target. This has been due to more realistic targets being set along with a thorough feasibility being completed by all teams. For the last quarter of 2017/18, 8 out of 11 studies met the target. The other three studies were complex trials with tight eligibility criteria and recruitment was challenging nationally as well as locally.

Local Benchmark – Publications 234 publications (79% of target achieved); we are seeking to revitalise reporting of publications with staff and will review the provision of Knowledge Services publication data in 2018/19.

SUMMARY:
We have seen a marked increase in national benchmarks this year and we are working to increase commercial activity further as we seek to exceed both our Trust and national benchmarks and increase capacity to support further research.

3.1.1 Increase high quality research activity
Area: Research Portfolio Development

Background:

The Portfolio Development team supports and facilitates grant application and helps promote an active research culture. Our grant submissions target for 2017/18 was 128. Priority is given to NIHR proposals where the Trust benefits from Research Capability Funding (RCF). Our goal is to maintain RCF at £1 million per annum.

Current position

Progress against targets: During 2017/18, 123 grants were submitted (96% of target). Twenty six grants have been funded to date (21%). We are still awaiting the outcome for 29 grant applications but will hear whether these have been funded within the next few months.

Comparative data: Over the last 3 financial years (2015/16 to 2017/18), 393 grants have been submitted and 97 funded – a success rate of 25%. This compares favourably with national success rates published by funders, e.g. NIHR Research for Patient Benefit (15%), NIHR Health Technology Assessment (24%) and the Medical Research Council (23%).

Risks/Mitigation: We continue to prioritise our resources to support NIHR applications where the Trust is the lead organisation. Of grants submitted in 2017/18, 42% were to NIHR programmes (30% in 2016/17). We are also diversifying our research portfolio to other funders, including the research councils (11% of grants submitted compared to 6% in 2016/17) and charities (22%; 32% in 2016/17). RCF allocation exceeded £1mill for the first time in 2016/17 and this was maintained for 2017/18. The RCF allocation for 2018/19 has yet to be announced (expected May 2018) but, as predicted in last year's report, this is likely to be below £800k. RCF is anticipated to recover for 2019/20, based on grant income from recent large NIHR grant awards. RCF is under review by the Department of Health and any change in the formula will impact on our RCF income in future years.

Other: A number of successful NIHR grants have been secured in 2017/18, including: StartReacts (EME; £980k) and Artisan (HTA; £1.1mill), both in Orthopaedics. Three other NIHR proposals have been shortlisted with very good reviewer feedback (total value £2.97mill) and we expect to hear the outcome of these by July. Investment was also secured from the MRC for the Tommy's Reproductive Health Biobank (£1.15mill). Work is underway to scope a MRC Confidence in Concept bid jointly with University of Warwick. If successful, this will pump-prime promising early translational projects which will feed into the NIHR Coventry and Warwickshire Clinical Research Facility and underpin a future application to host an NIHR Biomedical Research Centre.

SUMMARY:

Although the number of grant submissions was slightly below the annual target, the quality of those is reflected by a strong success rate and high value NIHR and MRC awards. Trust R&D investment in Orthopaedics and Reproductive Health has leveraged significant external funding for research studies and infrastructure in these areas.

3.1.2 Provide quality management and support for research
Area: Research Governance

Background:

Research Governance enables us to safeguard our patients taking part in research, protect our researchers by providing a clear framework within which to work, enhance the ethical and scientific quality of what we do, mitigate risk, monitor practice and promote good practice by ensuring lessons are learned.

Current position:

This year the Governance Unit has:

- Introduced an effective quality management system to ensure a defined, communicated and implemented quality control and risk management system.
- Updated all our Standard Operating Procedures (SOPs) in line with the UK Policy Framework for Health & Social Care Research, European Medicines Agency, MHRA and the addendum to GCP.
- Put governance requirements in place for the Trust's first sole-sponsored and fully trial managed phase 1 trial, including a suite of new SOP's to meet governance requirements for Phase 1 trials, in line with the MHRA Phase 1 Accreditation scheme.
- Worked closely with Pharmacy and Lead Research Nurse to provide robust corrective and preventative actions (CAPA) for incidents reported to the Research Governance & Human Tissue (RG&HT) Committee.
- Continued to provide support for research teams learning lessons from incidents, internal reviews and monitoring visits.
- Introduced laboratory staff training for research champions in UHCW laboratories to have an understanding of clinical research by undertaking GCP training with a laboratory perspective to ensure all research samples are processed in accordance with GCP, as per MHRA requirements.
- Supported daily safety huddles within our research teams, implemented by our Lead Research Nurse.
- Implemented a risk assessment monitoring and review cycle to a) ensure all hazards are covered by our risk assessments and b) identify if the controls implemented following a risk assessment are effective.

Critical findings and serious breaches:

Our target of zero breaches and critical findings was not met, as we had one serious breach in December 2017 following two incidents where patients were not treated as per the protocol in the same trial. The issues leading to this have been identified and resolved.

Risk based monitoring is ongoing in order to maintain the overall improvement in the quality of data and research practice.

SUMMARY:

The Research Governance Unit continues to adapt its processes in line with research developments, this year, the implementation of the CRF has required the development of additional processes to ensure that we can safely support earlier phase projects.

3.1.2 Provide quality management and support for research
Area: Research Clinical Delivery Team

Background:

The Clinical Delivery team support and facilitate patient recruitment into trials. The team are responsible for the safety of patients when participating in research and continue to develop and maintain a research culture at UHCW, striving for better outcomes and quality of life for all patients at UHCW.

Current position:

2017/18 we exceeded our patient recruitment target, offering more patients across more specialities opportunities to participate in research and access new treatments along with shaping healthcare treatments for the future, 4,583 participants, 108% of target. This was achieved across 28 specialities and delivered by our new workforce model: Nurses, Midwives, Assistant Research Practitioners, Clinical Trial Co-ordinators and a Clinical Data / Administrative team. Our staff continue to participate in safety huddles within departments where we have research participants present.

Opportunities taken within 2017/2018: Our new work force was shaped and developed by the collection of over 3000 hours data from across 10 teams utilising the Care Contact App (using codes adapted for research). This data enabled R&D to identify the workforce and skill mix required to ensure we have the right person for the right role and offer greatest value to our patients. From making changes and creating new roles it enabled R&D to release an increased 710 hours per month (4.8wte) from our current Nursing and Midwifery workforce, increasing patient facing time and ensuring appropriate role for task.

Within 2017/18 UHCW R&D was also awarded Clinical Research Facility status and has resulted in the creation of 3 new nursing posts working across specialities, trained and supported to be able to offer early phase clinical trials at UHCW.

Performance in delivery continues to improve moving from 57% to 73% of studies recruiting first patient within 70 days of site being approved.

We continue to develop our commercial research activity, opening more commercial studies than ever before. Our clinical teams are building a reputation for delivering high quality research, to create ‘preferred supplier’ status for future opportunities.

Looking Forward: We continue to strive to offer increased opportunities for patients to be involved in research and will be increasing our presence and capacity within the following areas in 2018-19: Colorectal Surgery, Urology, Children’s, Rheumatology and Stroke.

SUMMARY

Our key priorities are increasing opportunities for participation in high quality research at UHCW across multiple specialities, delivered by a dynamic and highly skilled clinical workforce.

3.1.3 Provide high quality facilities for clinical research and healthcare innovations capable of responding to change on demand and evolving the collaborative environment
Area: Trial Management Unit (TMU)

Background:
The Trial Management Unit (TMU) was established in August 2015 to provide in-house trial management and support to research studies developed by our staff, thereby increasing the quality. The Unit provides a unique role, enabling our staff to collect robust pilot data to enable them to apply for larger grants by assisting with planning, coordination and delivery of research trials and pilot studies against agreed milestones and targets.

Current position
The TMU continues to support a range of high-quality, Trust-sponsored projects, including multi-centre and randomised controlled trials. In 2017/18 this included:

- Delivery of Prof. Siobhan Quenby's SIMPLANT (drug) trial (Does the DPP4 inhibitor Sitagliptin increase endometrial mesenchymal cells in women with recurrent miscarriage?) to time and target. Based on the findings of the trial, work is now underway within the Investigator's team to progress towards an application for funding for a larger, multi-centre clinical trial.
- Successful application for regulatory and ethical approval of the Trust's first sponsored phase 1 drug trials, Prof. Chris Imray's D4H trial (Spectroscopic and diffusion weighted analysis of the effects of dexamethasone on high altitude cerebral oedema). The trial will be delivered by our Clinical Research Facility when it starts in the coming months.
- Supporting Prof Richard King's randomised-controlled trial to evaluate novel technology (EXACT: Evaluation of X-ray, Acetabular Guides and CT in Total Hip Replacement).
- Supporting the design and funding applications of an increasing number of early phase and experimental trials.
- Design and implementation of clinical trial quality management processes and documentation in line with regulatory requirements and Trust policies to ensure standardisation across Trust-sponsored studies. Also providing oversight for Sponsored studies managed by Warwick Clinical Trials unit (ALIFE2) to improve quality in study delivery.
- Development of a regulatory and GCP-compliant electronic data capture system in collaboration with ICT, to reduce expenditure on 3rd party systems and build capability within the Trust to provide similar systems for future studies.

The TMU team (1.8WTE) is funded by Research Capability Funding and external grants. Grant income for the TMU increased from £21.850 in 2016/17 to £45.506 in 2017/18.

SUMMARY:
The TMU continues to support the delivery of a growing, increasingly complex, portfolio of Trust-sponsored studies, with a demonstrated track record for delivering high quality research to time and target. The unit provides practical support and expertise to our staff to enhance participation in research increasing the volume and complexity of research Sponsored by UHCW. The TMU continues to be self-sustaining, attracting increasing grant funding this year.

3.1.3 Provide high quality facilities for clinical research
Area: NIHR Coventry &Warwickshire Clinical Research Facility

Background:

The Coventry and Warwickshire Clinical Research Facility (CRF) receives funding from the National Institute of Health Research (NIHR) to provide the infrastructure and support required to conduct high-quality early translational (experimental medicine) research. 2017/18 was the first year of funding.

Current position:

Establishing the Team: Prof Chris Imray is the Director of the CRF and the CRF Team sits within the organisational structure of UHCW R&D. A CRF Team of clinical and non-clinical staff has been established, with the recruitment of a CRF Delivery Manager, CRF Senior Research Nurse and two x 0.6 WTE CRF Nurses.

Performance: In 2017/18, 43 studies were conducted in the CRF, recruiting a total of 984 participants. Notable projects include:

- Development of the processes required and assessment and delivery of training needed for staff, to enable the CRF to support the Trust's first Phase I Clinical Trial (D4H: Effects of dexamethasone on high altitude cerebral oedema)
- The M40 Alliance by supporting the set-up of the Arthritis Therapy Acceleration Programme at UHCW in partnership with Birmingham and Oxford Universities.
- The scientific component of the British Army Ice Maiden expedition (via HMRU).

Governance: A CRF Study Review Group has been established which is responsible for the study adoption process, the completion of risk assessments for CRF studies and continued governance of the CRF. We have implemented the processes required to conduct phase I studies, these will be tested during 2018/19.

Patient and Public Involvement and Engagement (PPIE): The CRF PPIE Strategy has been developed, reviewed by two members of the public and ratified by the UHCW Patient Experience and Engagement Committee. The strategy has been published on the UHCW website as required under the NIHR contract.

Issues: Funding is initially provided for 2 years. We need to demonstrate significant increase in earlier phase/experimental medicine research to maintain this funding. A review of the translational pipeline has highlighted that commitment to additional infrastructure is required to ensure that the CRF is able to deliver its strategy.

SUMMARY:

Strong progress has been made in delivering the CRF strategy during the initial year of NIHR funding. The CRF Team has been established and is working collaboratively with UHCW R&D to support experimental medicine research. Governance arrangements have been developed to ensure that early phase studies conducted by the CRF meet the necessary regulations and guidelines. Moving forward, it is essential that a translational pipeline is established for CRF research themes to ensure the strategy can be delivered.

3.1.3 Provide high quality facilities for clinical research
Area: Arden Tissue Bank & 100,000 Genome Project

Background:

The Arden Tissue Bank provides ethically approved human tissues to researchers carrying out high quality research. Aspects of the Bank operate under the Trust's Post Mortem licence, no 30019 and we are inspected by the Human Tissue Authority. The team are also leading on the delivery of the 100,000 Genome project Cancer recruitment at UHCW & George Eliot Hospitals (GEH).

Current position:

Commercial applications:

Tissue Bank continue to supply consented human tissues on a cost recovery basis to one UK based commercial company for several tissue types by request, currently this includes regular supply of healthy skin, and a reduced number of healthy myometrium. We continue to develop closer commercial ties to support the long term sustainability of the Bank with two commercial companies in late stage talks for supply.

100,000 Genome Project:

The 100,000 Genome project has been open to recruitment at UHCW for cancer for 20 months, to date 405 patients have been recruited across 10 cancer types. The Genomics team and Tissue Bank have been supporting recruitment of patients to the project at GEH hospital since November 2017, to date 31 patients have been recruited. We are still reliant on good will to support the project and capacity amongst the pathology team is proving limiting for some tumour types.

Rare diseases recruitment has been open at UHCW for 20 months, to date there have been 112 patients recruited. Recruitment in rare diseases is static due to lack of capacity across the Trust within clinical staff teams to identify suitable patients. Recruitment to the project is to end in September 2018, and genomic testing is to embedded into routine clinical practice – if funding allows, this will be the focus of the Genomic Ambassador/Tissue Bank manager's role for the next two years at UHCW, GEH, South Warwick and Hereford Hospitals.

MRC Tommy's Biobank

Utilising MRC grant funding a Tommy's Biobank Manager has been appointed and is co-ordinating combining standard operating procedures, transfer and data sharing agreements across the six UK centres of fertility excellence that comprise the National Tommy's Reproductive Health Biobank - Arden Tissue Bank being one of those centres.

SUMMARY:

The 100,000 Genome project aims to change patient treatment by embedding genomic testing within care pathways, this is starting to happen in certain specialities e.g. breast surgery, but is not consistent (this is mirrored regionally/nationally).

Arden Tissue Bank is developing its commercial links to increase external income and leading on the networking of 6 Tommy's centres to collect tissues in a standardised way.

3.1.3 Provide high quality facilities for clinical research
Area: Human Metabolic Research Unit

Background:

The Human Metabolic Research Unit (HMRU) is a facility within University Hospital that investigates human energy metabolism. The initial development of the unit was funded through grants from Advantage West Midlands (Science City Initiative), with significant contributions from the University of Warwick and UHCW.

Current position:

Research:

- An increasingly diverse portfolio of multidisciplinary research.
- Excellent local collaborations (Warwick, Coventry, Birmingham and Oxford).
- Increasing national contacts (Imperial, Lancaster, Nottingham and Aberdeen).
- Developing international profile.
- Increased industrial interest.
- 2017-2018 has been the busiest since inception (occupancy up 64% from 2015-16).

Infrastructure: the problems relating to chamber integrity have been resolved; however, the HMRU has experienced several minor, but persistent environment control problems. Thanks to the diligence and hard work of the HMRU staff, a quality service has been maintained. This has high-lighted problems with the HMRUs integration in to the Trust processes (see Risk/Mitigation).

Clinical Director: Prof Harpal Randeva has been appointed as HMRU Clinical Director, this will allow a clear clinical strategic direction to be developed, open new avenues for research and increase collaborations within academia, healthcare and industry. Our Operational Committee has been re-instated, meeting monthly.

Impact: HMRU continues to engage with popular media (e.g. Ice-Maidens, Spear17, BBC etc.) towards the public health agenda; produce high-quality research publications across research disciplines; increasing number of grant applications and company sponsored studies.

Risks / Mitigation:

Clinical engagement: HMRU Clinical Director now appointed.
Nursing support: the varying and intermittent workload provides challenges. This is improving with additional Clinical Research Facility nursing staff funded as part of our CRF application.
Kitchen: HMRU remains without access to a suitable food prep, storage and cooking area. This is not stopping studies but remains a long-standing issue.

SUMMARY:

The HMRU has had and extremely busy year. It is integrated well with the NIHR Clinical Research Facility framework, and with the appointment of clinical director a long-term strategy is being developed. The HMRU continues to collaborate well with local partners and increasing links with national UK based universities; we are gaining wider exposure to international collaborators.

3.1.4 Raise the profile of Research and Innovation

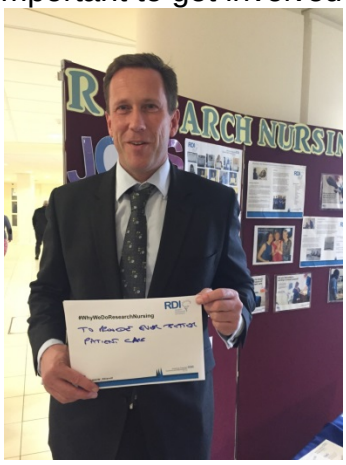
Communications / Awards / Events / Esteem measures

The R,D&I Team are very active in promoting our work and that of our researchers, we have a strong marketing ethos and run our own Twitter account. Jointly with the Communication Team, we also support applications to award-granting bodies to enable all trust staff to promote their work (regardless of whether it has a research base). Highlights are given below:

NIHR CRF

Launched April 2017

R,D&I Open Day for staff and public: showcasing our research activity, with stands and our "Research on the go!" trolley going to departments and wards, discussing with patients and staff what it is that we do and why it is important to get involved



Workforce

Redesign, training and support. HSJ Value Award nominated for 'Workforce Efficiency'.

The Summit – Our annual celebration of research, had 160 attendees, double that in 2016-17

Clinical Research Network Awards

- Winners: Natassia Garton and R&D won 'Business Intelligence Leader' award for their implementation of data systems to

support research, the BRU team (pictured) won for ‘TommysNET’, using technology for research:

- Highly Commended’: Dr Martin Weickert and NET Team for ‘Emerging Team’ and Angela Polanco (Research Midwife, pictured), for her patient involvement work:

AHSN Awards

- ‘Highly Commended’: Sean James, Arden Tissue Bank and Genomics Ambassador), for ‘Innovative Team’ in the regional Academic Health Science Network awards.

Warwick University Awards

- Our Biomedical Research Unit Team won ‘Research Team’ award in

Pharmatimes International Clinical Research Awards

- R&D won Silver in the NIHR NHS Clinical Research Site of the year category.

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Audit Committee Annual Report 2017/18**
Author	**David Poynton, Non-Executive Director and Audit Committee Chair**
Responsible Director	**David Poynton, Non-Executive Director and Audit Committee Chair**
Date	**31 May 2018**

1. Purpose

To present the Audit Committee Annual Report for assurance and approval.

2. Background and Links to Previous Papers

The Audit Committee Chair presents an Annual Report to the Trust Board in April each year; this iteration covers the Committee's activities in the financial year 2017/18.

3. Narrative

The report is submitted to provide assurance to the Trust Board that the Audit Committee is functioning in accordance with its Terms of Reference and in line with the requirements of the NHS Audit Committee Handbook. The detail is contained within the attached report and there are no specific areas of concern that need to be highlighted to the Trust Board.

4. Areas of Risk

There are no specific risks arising from the report because the Committee has been functioning in accordance with best practice and guidance. The risk arises out of the Trust failing to have an effective Audit Committee in place, in that if it does not, the overall governance of the Trust would be in jeopardy, which could lead to potential regulatory intervention and action and reputational damage.

5. Governance

It is best practice as set out in the Audit Committee Handbook for the Committee to prepare and present an annual report each year describing the work that it has done and how this has supported and contributed to the Trust's governance arrangements. This also contributes to the production of the Annual Governance Statement

6. Responsibility

The Chair of the Audit Committee is responsible for preparing the report supported by the Director of Corporate Affairs.

7. Recommendations

The Trust Board is asked to **NOTE** the work of the Audit Committee during 2017/18, to **RAISE** any questions or concerns and to **APPROVE** the Audit Committee Annual Report.

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

AUDIT COMMITTEE ANNUAL REPORT 2017/18

1. Introduction

This Annual Report summarises the activities of the Trust's Audit Committee (the Committee) for the financial year 2017/18 and sets out how it has met its terms of reference and complied with the duties delegated to it by the Board of Directors ("the Board").

The Committee is a formal committee of the Board. It follows best practice guidance as set out in the NHS Audit Committee Handbook and provides a form of independent check upon the management of the Trust.

2. Membership and Meetings

In line with best practice, the Committee comprises solely Non-Executive Directors (NEDs) thus ensuring the required degree of independence. The terms of reference provide for 4 NEDs comprising membership of the Committee.

The members of the Audit Committee within the period covered by this report were:

- David Poynton – Chair
- Barbara Beal – Vice Chair
- Ian Buckley
- Ed Macalister-Smith

During the year, the Chief Finance & Strategy Officer and the Director of Corporate Affairs were in regular attendance at Committee meetings along with the Associate Director of Finance. Representatives from the Trust's internal and external auditors and from Counter Fraud services were also in regular attendance to report on a range of risk and control issues and the financial controls and statements.

The Committee reviews its terms of reference on an annual basis. This year the members reviewed the terms of reference remotely during February and March and these were then approved by Trust Board at its March meeting.

Through its terms of reference, the Committee is responsible on behalf of the Board for independently reviewing the systems of governance, control, risk management and assurance. Its activities cover the whole of the Trust's governance agenda in line with best practice and it provides assurance to the Trust Board in relation to the efficacy of the system of internal control as a whole.

The Committee met on 6 occasions during 2017/18; 5 ordinary meetings were held with an additional extraordinary meeting taking place in May 2017, at which the Annual Accounts for 2016/17 were discussed and recommended to the Trust Board for adoption. A schedule of attendance is set out in the following table where (x) indicates attendance.

Member	April	May (Extra-ordinary)	July	September	November	February
David Poynton (Chair)	X	X	X			X
Barbara Beal			X	X	X	
Ian Buckley			X	X	X	X
Ed Macalister-Smith	X	X		X	X	

3. Governance Arrangements

There are 2 other committees of the Board over which the Audit Committee has an oversight and monitoring role; these are Quality Governance Committee (QGC) and Finance and Performance Committee (F&P). The Chairs of these Committees are members of the Audit Committee and through that linkage and the submission of Committee Annual Report to the Audit Committee, the Committee is familiar with their work. The Committee is reliant upon the work of QGC to provide assurance around the clinical governance and quality agenda and on F&P regarding matters financial and performance issues.

The Chair of the Audit Committee prepares a short summary report to the Board meeting that follows the Committee meeting to ensure timely information flow, within which, key issues are highlighted. The minutes of the Audit Committee are formally submitted to the Board once approved.

4. Work and Achievements

As is demonstrated by the table above, the Committee met in line with its schedule and achieved quoracy at each meeting. It also considered all matters that are properly under its jurisdiction within the year. A Committee work-plan was produced for the year, which drove the agenda for each meeting and ad hoc reports were requested where appropriate and necessary.

Of particular note is continued improvement in the number of outstanding actions arising out of audit reports and the introduction of a requirement for Chief Officer approval of any requests to extend deadlines for completion. The Committee has held individual managers to account during the year through requests to attend the Committee where actions have not been completed within agreed deadlines. It has also been agreed that the relevant Chief Officer will be asked to attend the meeting when there is a report with a conclusion of less than significant assurance.

4.1 Risk Management

The Committee received and discussed the Board Assurance Framework (BAF) twice during the year.

In addition, a revised format for the BAF was discussed at the February meeting and this was approved by the Committee.

The opinion of Internal Audit is that the 2017/18 BAF is of reasonable assurance that the Trust has an effective system of internal control to manage the principal risks identified by the organisation.

Good progress in relation to the risk agenda has continued to be made throughout the year with the number of historical risks on the register reducing significantly and positive action being taken with regards to the mitigation of risks.

4.2 Clinical Audit

The Committee approved the Clinical Audit work plan for the year and was satisfied that it met requirements in terms of both nationally mandated and Trust driven audits. The Committee was also given assurance via the report that appropriate arrangements for clinical governance across the Trust are in place.

4.3 Regulatory Matters

The Committee also reviewed the following:

- Register of Interests
- Register of gifts
- Losses and Special Payments
- Debt write offs
- Waivers of Standing Orders/Standing Financial Instructions
- Changes to Accounting Policies
- Arrangements for establishing an Auditor Panel
- Raising Concerns Policy
- Register of Interests Policy

4.4 Self-evaluation of the Committee

Committee members completed the Audit Committee checklist as set out within the HFMA Audit Committee handbook. The survey was carried out in accordance with the revised Audit Committee Handbook (3rd edition) and comprised 2 sections; effectiveness and processes.

The self-assessment tool, introduced during 2016/17, has continued to be completed after each meeting. The 'results' and comments are discussed at the next meeting with the aim to continue to improve performance of the Committee.

5. Independent Assurance

Internal Audit

CW Audit Services provided the Trust's internal audit function during 2017/18. During the year the Committee received progress reports from internal audit at every meeting. The Head of Internal Audit opinion for 2017/18 gives an overall opinion of significant assurance that there is a generally sound system of internal control in place.

During the year the Committee received 15 detailed assurance reports from internal audit (including 1 in draft) relating to a range of systems of internal control set out in the

2017/18 plan (detailed at appendix A). By year end, one report remained in draft and 5 assurance statements were not provided against the planned reviews due to the changed scope and nature of work undertaken.

Each report included an assurance opinion and an action plan that was approved by management and accepted by the responsible Chief Officer, other than in the case of advisory pieces of work where no formal opinion was given[1]. Agreed recommendations were then uploaded into the audit recommendation tracker system operated by internal audit, and a tracking report received at each meeting to enable the Committee to fulfil its function with regards to ensuring that agreed recommendations were followed up, and to provide assurance to the Trust Board in that regard.

There were 3 recommendations that had been deferred beyond the year end. There was one occasion where a Chief Officer was requested to attend Committee to provide assurance that outstanding recommendations were receiving action. The Committee were assured that there had been a failure in administrative processes rather than the required work not being undertaken.

It should be noted that whilst there were no reports received with a no-assurance opinion, there were 3 reports receiving moderate assurance and 3 reports received with a limited assurance period;. The detail of the reports and their assurance levels are set out at Appendix A.

Members of the Committee were offered the opportunity to meet with both internal and external audit in private and such meetings periodically took place during the year.

6. External Audit and Review of Financial Statements

The Trust's external audit function was provided by KMPG who were the Trust's auditors for 2017/18. The role of external audit is to review and report on the Trust's financial statements and to report on whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of its resources.

The Audit Plan for the 2017/18 audit of the accounts and financial statements was received at the February meeting. Progress reports and briefings on emergent issues pertinent to the Audit Committee have also been provided throughout the year. The final report and opinion for 2017/18 is not available at the time of writing this report.

7. Anti-Fraud & Security Management

By year end, there were 4 investigatory cases that remained unresolved.

All suspected frauds that were reported within the year were investigated with progress being reported within regular reports to the Committee. The Committee also received updates around security management during the year.

The Committee approved the annual work plan for 2018/19 at its meetings held in April.

[1] Information Governance and Acute Medicine Activity Review

8. Annual Report and Quality Account

The Committee received and approved the Annual Report and Annual Accounts (including the Quality Account) for 2016/17 at its extraordinary May meeting to ensure that the content was accurate and consistent with the information that the Audit Committee had been privy to over the year. The 2017/18 accounts will have been received on 25 May 2018 and will be reported upon in the next iteration of this report.

9. Conclusion

The Committee is of the view that it has taken appropriate steps to perform its duties as delegated by the Board and that it had no cause to raise any issues of significant concern with the Board arising out of its work during 2017/18.

In making this statement the Committee acknowledges the support given to it by management, in particular the Chief Financial & Strategy Officer and her team, and by internal and external audit colleagues.

David Poynton
Chair, Audit Committee
May 2018

Appendix A

Schedule of Internal Audit Reports 2017/18

Review	Status	Assurance Level
Budget Setting	Final	**Significant Assurance**
Financial Systems	Final	
Complaints	Final	
Data Quality- A&E	Final	
Data Quality- Cancer	Final	
Data Quality- RTT	Final	
ISS Payroll Controls	Final	
DBS Checks	Final	
Risk Management	Final	
Prescribing and Administering	Final	**Moderate Assurance**
Roster Management/ Safe Staffing	Final	
Agency Controls	Draft	
Salary Overpayments	Final	**Limited Assurance**
Completion of CPR Flag on CRRS	Final	
Clinical Review Processes (long waiters)	Final	
Board Assurance Framework	Not undertaken	**Not undertaken**
Information Governance Toolkit Compliance	Not undertaken	
Non-Purchase Order (NPO) Expenditure	Not undertaken	
CRM investigation of activity and income	Not undertaken	
TSS Follow Up	Not undertaken	

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Employee Relations Position Report**
Author	**Wendy Bowes, Associate Director of Workforce**
Responsible Director	**Karen Martin, Chief Workforce and Information Officer**
Date	**31 May 2018**

1. Purpose

This report provides an overview of the Trust's approach to managing Employee Relation cases and also provides an analysis of the number and type of case during the period October 2017 to April 2018, including demographics.

2. Background and Context

Robust, simple, transparent and fair processes to manage employee relation issues are critical for staff to feel engaged and confident in their employer with regards to their safety, protection, work experience and application of terms and conditions.

The Trust's Workforce Operational team is responsible for ensuring employee relation matters are managed appropriately, effectively and compassionately. The team comprises of an Associate Director of Workforce, Workforce Business Partners and Workforce Advisers. All are qualified HR practitioners and are members of the Chartered Institute of Personnel and Development. The team also includes an Employee Relations Specialist, who is a qualified solicitor.

The team utilise a range of methods to ensure that the processes are robust including:

- A Case Management Tracker, detailing all suspensions, disciplinary, grievance and performance management cases including named responsible officers, milestones and outcomes
- Monthly Case Management Reviews with attendance by the full Workforce Operational team
- A weekly "screening" process for all new non-medical staff potential cases to ensure consistency of approach and the identification of lead investigating managers and support
- Fortnightly meetings to discuss all Medical Staff Concerns, with attendance of the CMO/CWIO, Associate Director of Workforce and Deputy CMO's to ensure consistency of all new potential medical staff cases and to ensure that any investigation is conducted in accordance with Maintaining High Professional Standards (MHPS)
- A designated Board Member (Non-Executive Director) who will oversee all MHPS investigations
- Regular reporting of the number of cases, demographics and themes to the Partnership and Engagement Forum, JNCC and the Chief Officers Forum

- We provide training on performance management, case investigations and sickness absence management as part of the Leading Together Masterclasses and also deliver bespoke training at Group level

The team also works closely with staff side colleagues to ensure that all employee relation cases are managed in a timely and compassionate way. This liaison also enables any specific concerns to be raised and addressed at the earliest opportunity.

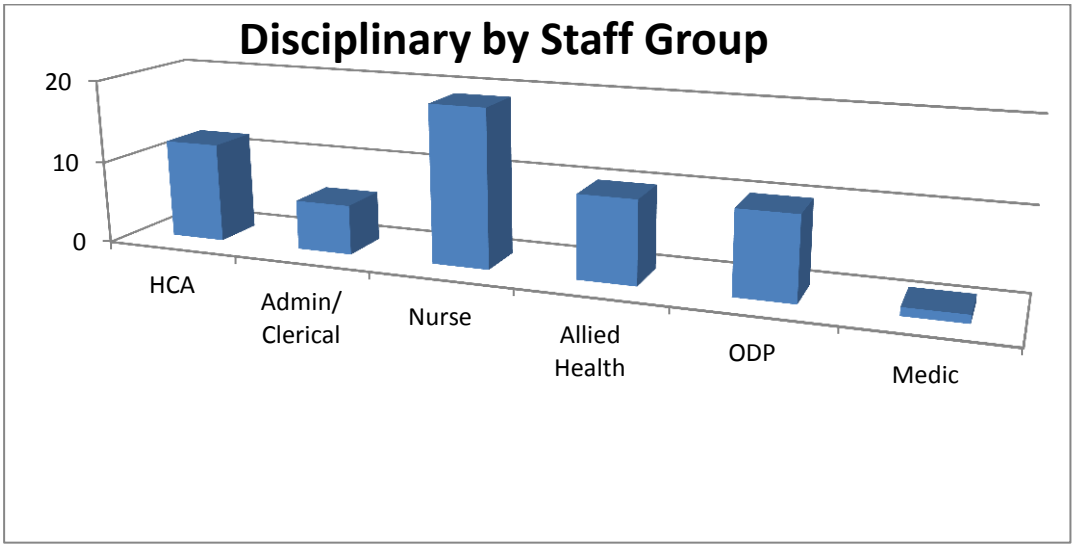
We are also in the early stages of working with staff side on a collaborative campaign around bullying with the aim of identifying any particular area of concern, known hotspots and areas of good practice, along with raising general awareness and available support.

3. Executive Summary – October 2017- April 2018

- There were 50 disciplinary investigations undertaken during this period
- 38% of these cases involved nursing staff – as Nursing and Midwifery are the largest staff group within the Trust, this is to be expected
- The highest number of cases were within Theatres, with a total of 9 cases
- The main cause for investigations related to inappropriate behaviour (conduct)
- There have been a total of 5 dismissals following disciplinary hearings
- There were 5 grievances investigated during this period
- There are no significant concerns in relation to equality and diversity based on our gender or ethnic split of ER cases but further improvements to the process and staff/manager experience could be made through the development and implementation of a Managers Toolkit to provide managers with technical knowledge, skills and confidence in managing staff at informal stages as well as formal stages and to have an understanding of the potential impact of unconscious bias

4. <u>Key Findings – Disciplinary Investigations</u>

4.1 Analysis by Staff Group:



4.2 Analysis by Department:

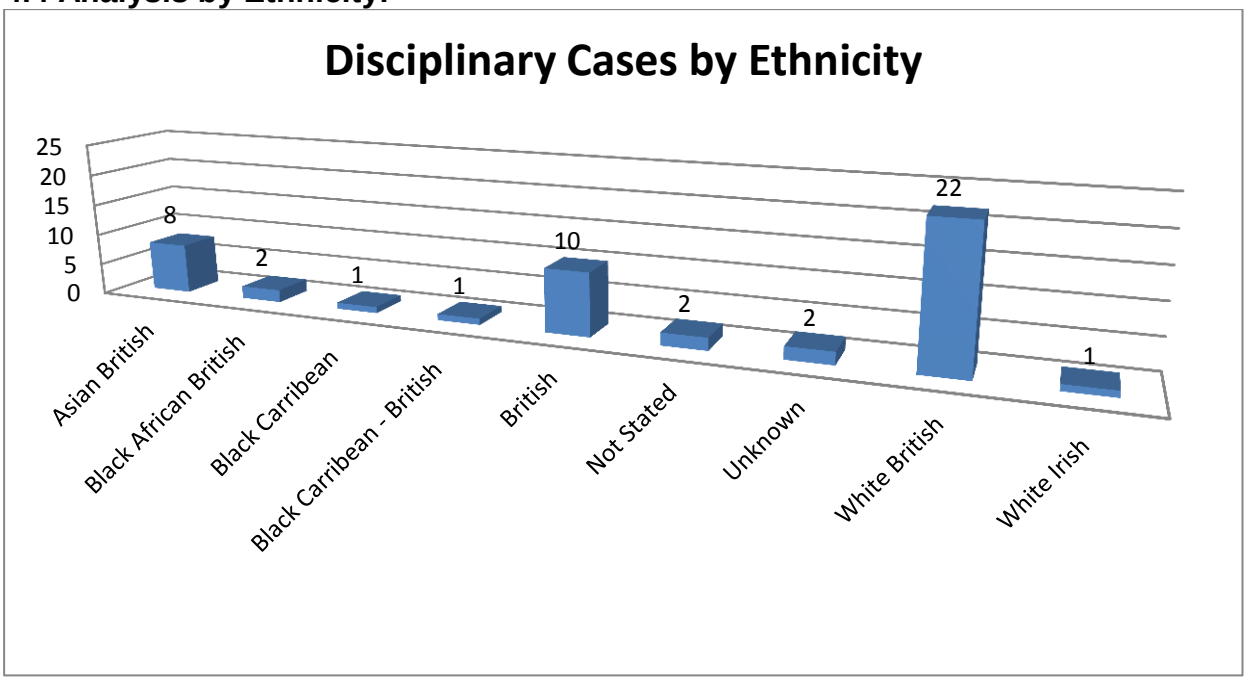
The highest numbers of cases were within Theatres, with a total of 9 cases. Case numbers within Care of the Elderly look comparatively high when compared to their headcount but a deeper review has revealed that three cases related to drug administration (two of which related to the same incident) and overall, it is considered that a number of cases just happened to occur during this 6 month period, rather than their being any ongoing issues or concerns across the year, for the Group.

Group	Number of Investigations	Headcount of Group (April 2018	% of Staff Under Investigation
Care of the Elderly	6	230	2.6
Clinical Diagnostics	11	966	1.1
Theatres and Anaesthetics	9	944	1
Cardiac and Respiratory	5	544	0.9
Emergency Department and Acute Medicine	4	573	0.7
Oncology, Haematology and Renal	4	599	0.7
Trauma and Orthopaedics and Hospital of St Cross	3	580	0.5
Neurosciences	1	272	0.4
Core	3	1037	0.3
Surgery	2	748	0.3
Women's and Childrens	2	853	0.2

4.3 Analysis by Gender:

73% of cases involved Females, this equates to 36 individuals. It is important to note that the Trust gender split is 79.64% Female and 20.36% Male and therefore as a proportion, this ratio is not a concern.

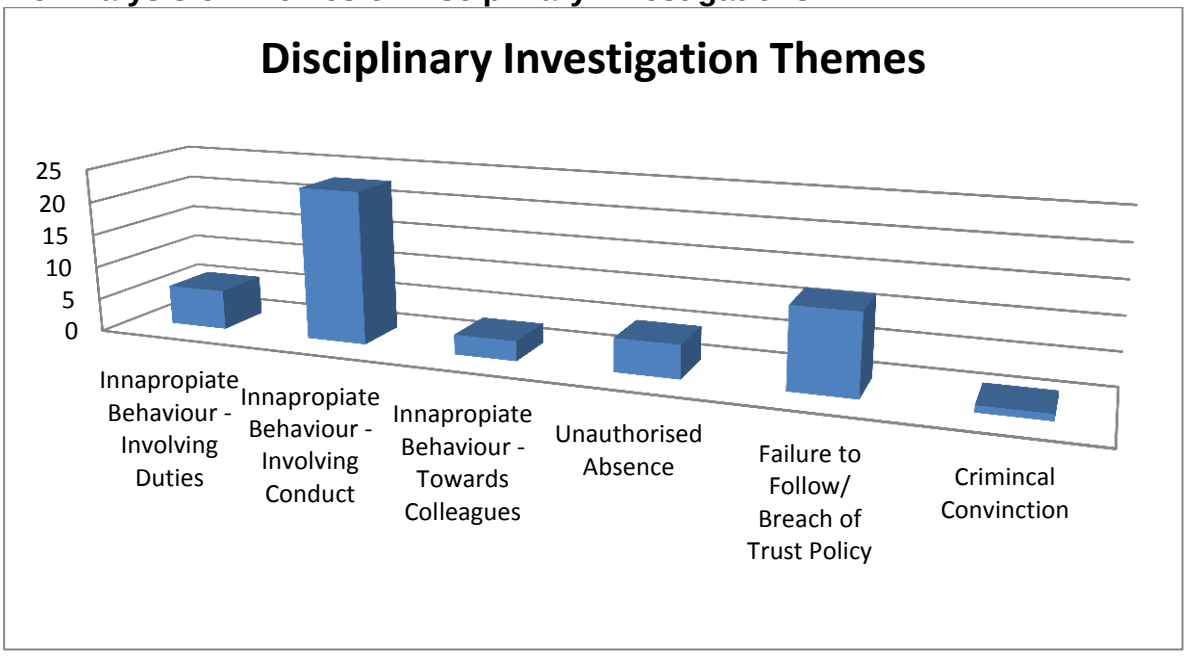
4.4 Analysis by Ethnicity:



56% of cases involved staff describing themselves as non-White British. It is important to note that the Trust ethnicity split of White British to other ethnic groups is 63%. This indicates that there is a slightly higher proportion of non-White British staff involved in formal ER cases than White British.

We do provide training to managers on managing performance, sickness absence and undertaking formal investigations. This forms part of the Leading Together Masterclasses. Managers are also supported by a member of the HR Operational team when they undertake investigations. A new Managers Toolkit is in development to further support managers with technical knowledge, skills and confidence in undertaking formal investigations, but importantly to also understand the importance of unconscious bias in managing staff generally and in managing matters before they become "formal".

4.5 Analysis of Themes of Disciplinary Investigations:



The main reasons for disciplinary investigations relates to inappropriate behaviour and failure to follow Trust policy. Examples include:

- Inappropriate use of social media – i.e. comments about staff and patients
- Inappropriate access to patient record systems – i.e. looking at relatives and friends patient records
- Inappropriate behaviour – i.e. rudeness to colleagues and patients, use of offensive language.
- Failure to follow the Drugs Administration policy
- Not undertaking patient observations/incorrect recording of patient observations

We routinely issue reminders of staff about these key issues in Trust wide communications and the Workforce Newsletter and will take action if a specific concern arises i.e. we have issued a social media guide for all staff to help them to understand the importance and impact of social media.

5. Key Findings - Suspensions by Staff Group:

A suspension (or exclusion for medics) will take place if there is an allegation of potential gross misconduct and also when there the employee's presence constitutes a serious risk to themselves, patients or other employees. Whilst technically a suspension is not considered as disciplinary sanction and is not a presumption of guilt, we recognise that any suspension can be damaging to both the individual affected and the longer term employment relationship between the individual and the Trust. It is imperative therefore that suspensions only occur when all other options (such as temporary redeployment or move to a different area) have been considered and rejected. It is also crucial that any suspension is only undertaken for the minimum period of time, that the investigation is completed as a priority and that regular and meaningful contact with the individual is maintained throughout, including the regular review of the suspension and consideration if the suspension can be lifted. All appropriate support should also be provided including Occupational Health, staff side representation and support from their manager and the Workforce Operational team.

During this time period there have been 8 suspensions across the Trust. 50% of these were nurses, 25% were Healthcare Assistants and 12.5% were admin/clerical staff, 12.5% were medics.

In summary, there are no equality or diversity concerns in relation to the number of suspensions that we have undertaken.

5.1 Suspensions by Department:

Department	Number
Medics	1
Ward 43	1
Ward 40	1
Ward 30	1
Theatres	1
Renal - Admin	1
General Critical Care	1
Cardiac Critical Care	1

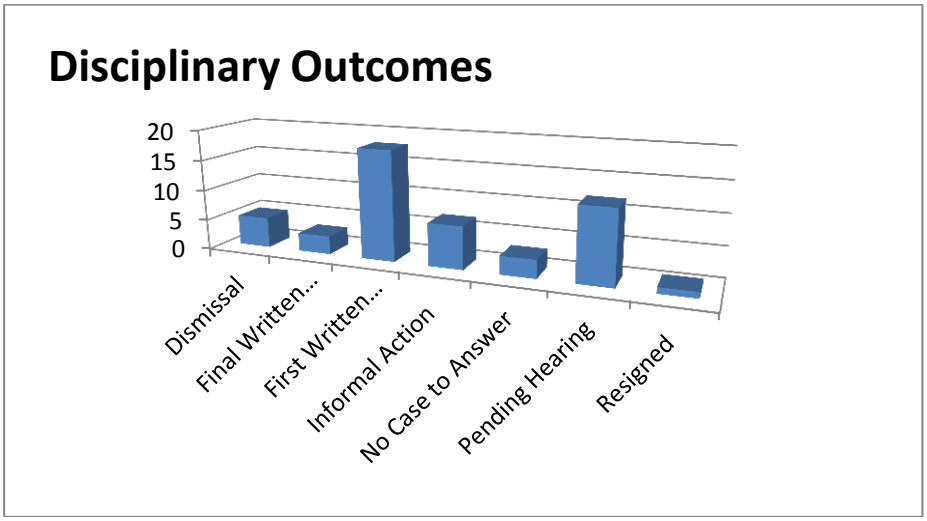
5.2 Suspensions by Gender:

Gender	Percentage
Male	37.5% (3)
Female	62.5% (5)

5.3 Suspensions by Ethnicity:

Ethnicity	Percentage
British	25% (2)
White Irish	12.5% (1)
White British	37.5% (3)
Asian British	25% (2)

6. Key Findings - Disciplinary Outcomes



In total, there were:

- 18 First Written Warnings issued with the highest number being issued to Nurses and Healthcare Assistants at 33% each. As previously stated these roles are our largest staff group.
- 3 Final Written Warnings issued.
- 5 Dismissals following disciplinary hearings, with 60% being Nurses, 20% Admin/Clerical staff and 20% Healthcare Assistants.
- 100% of those dismissed were female.
- The Dismissals were for the reasons of Inappropriate Behaviour (2), Breach of Medicines Management Policy (1), Breach of ICT Policy (1) and Unauthorised Absence (1). As stated above, we regularly issue key reminders to staff about these matters, in collaboration with our staff side representatives.

7. Key Findings – Grievances

- There were 5 grievances investigated during the specified time period. 40% of these were raised by Admin/Clerical staff and 40% by Medical.
- 60% of those whom raised a grievance were female.
- 60% of those whom raised a grievance were British Asian by ethnicity.

8. Key Findings – Formal Mediations

- There were a total of two Mediation cases during the specified time period.

9. Key Findings – Employment Tribunals

During the reporting period there have been 4 Employment Tribunal claims:

Staff Group	Demographic	Reason	Outcome
Medical	Male/Other Ethnic	Unfair Dismissal Disability Discrimination	Ongoing
Medical	Male/	Unfair Dismissal Constructive Unfair Dismissal Whistleblowing	Case Withdrawn
ISS (RoE)	Female	Unfair Dismissal Disability Discrimination Race Discrimination	Ongoing
Nursing	Female	Unfair Dismissal Disability Discrimination Less Favourable Treatment of Part Time Workers	Ongoing

10. Conclusion

This report has provided an overview of the Trust's approach to managing employee relation cases and also provided an analysis of the number and type of case during the period October 2017 to April 2018, including demographics.

Overall, the Trust provides a robust and fair system for managing employee relations issues but further improvements to the staff/manager experience could be made with the introduction of the Managers Toolkit.

11. Recommendations

The Board is invited to **note** this report on the Trust's approach to the management of employee relation matters.

Name and Title of Author: Wendy Bowes, Associate Director of Workforce
Date**:** 16.05.18

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Register of Interests 2018/19 and Gifts/Hospitality 2017/18**
Author	**Rebecca Hough Head of Corporate Affairs**
Responsible Chief Officer	**Andy Meehan, Chair**
Date	**31 May 2018**

1. Purpose

To present the Register of Interests for the Board of Directors of the Trust that stands as current and to provide the Register of Gifts & Hospitality for the Board of Directors of the Trust, for the financial year 2017/18.

2. Background and Links to Previous Papers

In accordance with the transparency, openness and accountability agenda, the Trust Board receives this report on an annual basis.

3. Narrative

In accordance with the NHS Code of Accountability, the Trust's Standing Orders and the Managing Conflicts of Interest in the NHS; Interests, Gifts, Sponsorship and Hospitality Policy & Procedure, the Trust is required to hold and maintain a Register of Interests and a Register of Gifts and Hospitality, and to make these available for public inspection.

In addition to meeting regulatory requirements, declaring any relevant interests, benefits and hospitality received in connection with an individual's employment at the Trust is in keeping with the Trust's openness value and supports the transparency agenda, thereby promoting public confidence in the organisation. It also evidences that there are processes in place to ensure compliance with statutory and regulatory requirements, including those of the Bribery Act 2010.

For the purpose of this report, the attached extract from the registers of interests and gifts and hospitality only details the interests of members of the Trust Board, although both registers contain relevant declarations made by other members of Trust staff. Board members are asked to declare any interests that they have that are relevant to their role as a Board member upon appointment, at each meeting of the Trust Board and also on an annual basis. Board members are also reminded of their on-going responsibility to declare interests to the Director of Corporate Affairs at the point that they arise during their tenure.

The attached extract from the register of Gifts and Hospitality details gifts and hospitality received by members of the Board during the period. All staff are however required to declare any gifts or hospitality received in the course of their employment, as described in the policy, and a corresponding entry is then made on the register. Staff are reminded of the requirement to declare interests, gifts and hospitality on an annual basis and the full registers are scrutinised at the Audit Committee on an annual basis.

4. Areas of Risk

There are no specific risks highlighted within the paper; the risk relates to failing to have processes for making declarations and registers in place, in that this does not comply with regulatory and statutory requirements and could adversely impact on the Trust's reputation and standing.

5. Governance

The Trust aspires to the highest standards in corporate governance, transparency and openness. Maintaining registers and reporting upon them periodically is in keeping with this and the responsibilities of the Board of Directors given that the Trust is a public body.

6. Responsibility

Andrew Hardy, Chief Executive Officer
Geoff Stokes, Director of Corporate Affairs

7. Recommendations

The Trust Board is asked to **APPROVE** the register of interests and register of gifts and hospitality and **NOTE** the requirement to declare interests and any gifts/hospitality received on an on-going basis.

Declaration of Interest April 2018 - March 2019

Surname	Forename	Job Title	Directorships	Ownership	Shareholdings	Charity or Voluntary Organisations	NHS Service Contracts:	Research Funding/Grants	Pooled Funds	Paid employment, office, profession:
Meehan	Andrew	Chairman	Director - Lanthorne Ltd- Business Consultancy and Ramsden Holdings PLC	Lanthorne Ltd - Business Consultancy	None	Chair of Coventry Cathedral Council Chairman of UHCW Charity Mayday Trust	Governor of Coventry University	None	None	Previous Chairman of direct healthcare services group which sells various types of equipment into health and social care sectors to prevent, amongst other things, pressure sores and related tissue viability problems 1% equity stake retained
Hardy	Andrew	Chief Executive Officer	None	None	None	Director/ Trustee Albany Theatre Trust Board member of CIPFA and Trustee	None	None	None	None
Beal	Barbara	Non-Executive Director	None	Griffiths Beal Healthcare Consultancy Ltd	None	None	Associate of The Finegreen Group	None	None	Part-time fixed term contract as Interim Chief Nurse - Shropshire Clinical Commissioning Group from April - August 2017. Undertook strategic review of Derbyshire Transforming Care Programme on behalf of Hardwick CCG in August - September 2017.
Buckley	Ian	Non-Executive Director	Director- Whitehall Manor Maintenance Ltd, Property management	None	None	Trustee - UHCW charity	Consultant/facilitator leadership Trust. Guest lecturer - Bristol Business School	None	None	None
Fraser	Nina	Chief Nursing Officer	University Hospital Coventry & Warwickshire charity	None	None	None	None	None	None	None
Kelly	Lisa	Chief Operating Officer	None	1 World Leadership, in process of closing down, used to work as an interim NHS manager	None	Trustee of GAPD - African charity for improving anaesthesia	None	None	None	None
Kumar	Sudhesh	Non-Executive Director	None	Medinova Ltd - Shareholder	Medinova Ltd - Shareholder (Minority shareholding only)	None	None	EU Horizon 2020 Funding	None	Employed by University of Warwick.
Macalister-Smith	Ed	Non-Executive Director	None	None	None	None	None	None	None	Chair NIHR HS&DR Panel (to March 2018) Occasional day-rate work (none for past 12 months) with CQC as IRR
Martin	Karen	Chief Workforce & Information Officer	Director of Qgov Consultancy	None	None	None	None	None	None	None
Pandit	Meghana	Chief Medical Officer and Deputy CEO	Nominal Director of JJ and M J Pandit Ltd - a company registered to receive private practice money.	None	None	None	None	None	None	Course director and professor of MSc at Warwick Manufacturing Group (Paid to UHCW not Professor Pandit). UHCW has entered into a collaborative project with University of Oxford on analysing theatre efficiency and operations management. The lead for this project at the Oxford side is Professor Jaideep J Pandit, of the Nuffield Department of Clinical Neurosciences. (Husband)
Poynton	David	Non-Executive Director	UHCW Non-Exec. Poyntons Enterprise Ltd. Inform Solutions	Poyntons Enterprise Ltd. Inform Solutions Ltd	Poynton Enterprises Ltd. Inform Solutions Ltd	None	None	None	None	None
Rollason	Susan	Chief Finance & Strategy Officer	None	None	None	None	None	None	None	None
Sheils	Brenda	Non-Executive Director	None	None	None	Trustee NARCO (National Association for the Care & Rehabilitation of Offenders)	Trustee NARCO (National Association for the Care & Rehabilitation of Offenders)	None	None	Director; Sheils Associates LTD. Provides mentoring/coaching/education & consultancy. Not provided for any NHS organisations.
Stokes	Geoff	Interim Director of Corporate Affairs	Director of Stokes Taylor Property Services Ltd - no direct connection to the NHS	Director of Stokes Taylor Property Services Ltd - no direct connection to the NHS	None	None	None	None	None	Concept Un Limited - a management consultancy company providing interim management to NHS and other organisations. This business is dormant and is being wound up

Declaration of Gifts April 2017 - March 2018

Name	Job Title	Date gift/benefit rec'd	Source of Gift or benefit	Nature of gift/benefit	start/end date of visit	Date Declared	Destination	Event details	Purpose of visit	Annual leave taken for visit (Y/N/NA)	Study leave taken for visit (Y/N/NA)
Mathew Patteril	Consultant Anaesthetist	28 Jan 2017	FRCA Course Dinner	Educational Session and Dinner	28 Jan 2017	6 Sep 2017	Unknown	Educational Session and Dinner	Educational Session and Dinner	No	No
Dr T Saran	Consultant in Anaestheasia	1 Apr 2017	UHCW	Working lunch within department from drug rep.	N/A	15 Nov 2017	N/A	N/A	N/A	N/A	N/A
Ramesh Sadasivan	Consultant Anaesthetist	6 Apr 2017	B-Braun	Sposorship of Overseas Conference	6 - 10 Apr 2017	12 Oct 2017	San Franscisco	42nd Annual regional Anaesthesiology and Acute Pane Medicine Meeting	Presented an abstract	No	Yes
Karen French	VTE Nurse Specialist	1 Jul 2017	Bayer plc	One off grant (1,334.17) to attend International Society on Thrombosis and Haemostasis (ISTH) 2017 Congress	7 - 13 Jul 2017	18 Oct 2017	Berlin, Germany	ISTH 2017 Congress	Speaker	No	Yes
Martin Scott-Brown	Consultant Oncologist	5 Aug 2017	Believers Church Medical College Hospital	Travel, meals and accommodation	5 Aug to 15 Aug 2017	9 Sep 2017	Believers Church Medical College	Mentoring Ooncology department and	A team from GEH hospital (including colorectal	Yes	No
Janette Watson	Discharge Sister	9 Aug 2017	Patient	Gold necklace purchased from H.Samuel- value £80, as a thank you, I have known this patient for many years. She purchased a necklace with initial 'J' on for myself. I attempted to decline - patient was very offended by this.	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Jo Freelove	Physiotherapist	31 Aug 2017	Patient	£25 voucher (wedding present)	N/A	21 Sep 2017	N/A	N/A	N/A	N/A	N/A
Jitin Sharma	Consultant Anaesthetist	1 Sep 2017	Nil Return	Nil Return	N/A	1 Sep 2017	N/A	N/A	N/A	N/A	N/A
Nawaz Walji	Consultant Oncologist	7 Sep 2017	Astra Zeneca	Sponsorship to attend European Society for Medical Oncology (ESMO) Congress 2017	7 - 11 Sep 2017	28 Sep 2017	Madrid	ESMO Congress 2017	ESMO Congress 2017	No	Yes
Valerie Ross-Gilbertson	Consultant Biomedical Scientist	2 Oct 2017	Roche Diagnostics Limited	Attendance at conference and overnight stay in hotel.	2 - 3 Oct 2017	1 Nov 2017	Doubletree Hilton, Nottingham	Excellence in Cervical Screening 2017	To keep up to date with recent events in cervical screening programme.	No	No
Danielle Bate	Polycystic Ovary Syndrome Clinical Nurse Specialist	1 Nov 2017	Novo Nordisk	£614 funding for commercial sponsorship	10 Jan 2018	20 Dec 2017	UHCW	PCOS Support Group Meeting	Patient Support Group Meeting	N/A	N/A

*All Trust Board members are Trustees of the UHCW Charity

Name	Job Title	Date gift/benefit rec'd	Source of Gift or benefit	Nature of gift/benefit	start/end date of visit	Date Declared	Destination	Event details	Purpose of visit	Annual leave taken for visit (Y/N/NA)	Study leave taken for visit (Y/N/NA)
Tessa Dadley	Pharmacy Purchasing Manager	2 Nov 2017	Mawdsley Brookes Ltd	Sponsorship to attend the Guild of Healthcare Pharmacists Procurement and Distribution and Interest Group Autumn Symposium. Value £95.00	6 Nov 2017	30 Oct 2017	Hilton Birmingham Metropole Hotel . National Exhibition Centre. B40 1PP	Guild of Healthcare Pharmacists Procurement and Distribution and Interest Group Autumn Symposium	Lectures on: Hospital pharmacy transformation, NHS e-procurement strategy and scan4safety, Pharmacy response to major incidents, Managing shortages of a critical product, The path to market for new medicines, Current challenges facing buyers and suppliers.	No	Yes
Dr Peter Correa	Consultant Clinical Oncologist	9 Nov 2017	Shire Pharmaceuticals	Honorarium for participation in Advisory Board	N/A	24 Nov 2017	N/A	N/A	N/A	Yes	No
Robert Spencer	Group Manager	6 Dec 2017	Dr S Silva (Medical Outlier Consultant	Christmas Gift - Bottle of Dalmore Whiskey	N/A	6 Dec 2017	N/A	N/A	N/A	N/A	N/A
Oliver White	Associate Group Manager	12 Dec 2017	Remedium Partners	Gift Hamper	N/A	12 Dec 2017	N/A	N/A	N/A	N/A	N/A
Richard King	Consultant Orthopaedic Surgeon	11 Jan 2018	Corin Group PLC	£4800 fee for educational services - Preparation and delivery of presentations at their "New Realities" meeting in Cirencester. Accommodation and other miscellaneous expenses provided also	16-17 Nov 2017	18 Apr 2018	Cirencester, UK	I was co-covener & speaker at Corin's "New Realities" meeting in Cirencester	Education of other surgeons	No	No
Andrew Hardy	Chief Executive Officer	31 Jan 2018	Deloitte	Healthcare Dinner and Discussion with Ed Smith	31 Jan 2018	11 May 2018	Birmingham	Healthcare Dinner and Discussion with Ed Smith	Networking event	No	No
Anne Scase	Consultant anaesthetist, Clinical Director	15 Feb 2018	Salford Professional Development	Attendance conference	15 Feb 2018	17 Apr 2018	Oval Cricket Ground	Future of Operating Theatres	Information, at request of UHCW Corporate Team	No	Yes
Matthew Jones	Consultant Orthopaedic Surgeon	7 Mar 2018	British Society for Surgery of the Hand	Put up in a hotel for 2 nights and provided with 2 dinners whilst I co-ordinated and facilitated the British Society for Surgery of the Hand Diploma exam in Birmingham. Travel expenses paid (mileage)	7 -9 Mar 2018	19 Apr 2018	Hyatt Hotel and Royal Orthopaedic Hospital, Birmingham	Put up in a hotel for 2 nights and provided with 2 dinners whilst I co-ordinated and facilitated the British Society for Surgery of the Hand Diploma exam in Birmingham. Travel expenses paid (mileage)	Put up in a hotel for 2 nights and provided with 2 dinners whilst I co-ordinated and facilitated the British Society for Surgery of the Hand Diploma exam in Birmingham. Travel expenses paid (mileage)	No	Yes
Dr Andrea Lindahl	Consultant Neurologist	11 May 2017	Abbvie, Bial, Britannia Pharmaceuticals, GE Healthcare, Global Kinetics Corporation, Medtronic, Parkinsons UK, Profile Pharma, UCB Pharma	£1000 donation each for supporting the West Midlands Parkinson's Network meeting 11th May 2017 at the Crowne Plaza Hotel Birmingham	11 May 2017	8th May 2017	Crowne Plaza Hotel, Birmingham	West Midlands Parkinsons Network Meeting	West Midlands Parkinsons Network Meeting	N/A	N/A

Name	Job Title	Date gift/benefit rec'd	Source of Gift or benefit	Nature of gift/benefit	start/end date of visit	Date Declared	Destination	Event details	Purpose of visit	Annual leave taken for visit (Y/N/NA)	Study leave taken for visit (Y/N/NA)
Rebecca Southall	Director of Corporate Affairs	14 Jun 2017	Capsticks LLP	Evening meal as part of the NHS Confederation Conference, value circa £35	14 -15 Jun 2017	14 Jul 2017	Liverpool	NHS Confedertion 2017: A number of suppliers to the NHS arrange dinners that NHS delegates can attend. This was one of the several offers that were made to the Trust and it is commonplace for exhibitors at the event to take clients/potential clients to dinner on the evening between the two days.	NHS Confederation 2017	N/A	N/A
Tracey Cox	Cardiothoracic Surgical Care Practitioner	15 Jun 2017	Acelity	Educational Session and Dinner	15 Jun 2017	12th June 2017	Woodland Grange Conference Centre, Leamington Spa, CV32 6RN	Introduction and education on new VAC VERAFLOW device followed by discussion and dinner	Learn about new product as an advancement from what we already use	No	No
Dr Bander Dallol	Consultant Stroke Physician	17 Sep 2017	Allergan company	Sponsorship (paid expense) to attend a spasticity and rehabilitation course in Liverpool including a night stay in the hotel before the course date	16 Sep 2017	14th August 2017	Liverpool University	One day course about rehabilitation and Spasticity post stroke	One day course about rehabilitation and Spasticity post stroke	As it falls on a weekend no AL/SL was taken as no in lieu days will be given or reinbrsement of event	As it falls on a weekend no AL/SL was taken as no in lieu days will be given or reinbrsement of event
Jonathon Young	Consultant Orthopaedic Surgeon	19 Jan 2017	Stryker UK Ltd	Invitation to attend the Stryker UK Major Trauma Centre 24th - 25th April 2017	24 - 25 Apr 2017	19 Jan 2017	Coombe Abbey Hotel, Warwickshire	Conference focused on Trauma Case Controversies	Conference focused on Trauma Case Controversies	No	No
Mateen Arastu	Consultant Orthopaedic Surgeon	19 Jan 2017	Stryker UK Ltd	Invitation to attend the Stryker UK Major Trauma Centre 24th - 25th April 2017	24 - 25 Apr 2017	19 Jan 2017	Coombe Abbey Hotel, Warwickshire	Conference focused on Trauma Case Controversies	Conference focused on Trauma Case Controversies	No	No
Yasir Chowdhuy	ST3 Neurosurgery	24 Aug 2017	Globus Medical	Travel grant to attend WFNS Congress of Neurosurgery	20 - 25 Aug 2017	20 Aug 2017	Istanbul Congress Center	World Congress of Neurosurgery organised by World Federation of	Presenting case series of patients who have undergone cervical	No	Yes
Samantha Clarke	Registered Nurse	24 May 2017	Bayer Drug Co	Anticoagulation Study Event	24 - 25 May 2017	19 Jun 2017	Raddison Blue, East Midlands	Anticoagulation Study Event	Anticoagulation Study Event	No	Yes
Dr Peter Correa	Consultant Clinical Oncologist	28 Jun 2017	Celegene Pharmaceuticals	Sponsored invitaton to the ESMO World GI Congress	28 Jun 2017 - 1 Jul 2017	6 Jul 2017	Barcelona	ESMO World GI Cancer Congress	Educational Congress	Yes	No
Dr Bander Dallol	Consultant Stroke Physician	28 Sep 2017	Pfizer Drug Company	Paid expenses (transport, hotel and conference fees)	28 - 30 Sep 2017	14 Aug 2017	Berlin, Germany	Conference	Conference	No	Yes
Shyam Balasubramanian	Consultant in Pain Medicine and Anaesthesia	2 May 2017	Abbott Capulet House Stratford Upon Avon	£2250 Honorarium for being a faculty in a two day pain intervention workshop in Nottingham	24 - 25 Mar 2017	4 May 2017	Postgraduate Medical Education Centre, Nottingham	Interventional Pain Medicine workshop attended by pain clinicians throughout the UK	To teach ultrasound guided pain interventions to benefit patients living with chronic pain.	No	No

Name	Job Title	Date gift/benefit rec'd	Source of Gift or benefit	Nature of gift/benefit	start/end date of visit	Date Declared	Destination	Event details	Purpose of visit	Annual leave taken for visit (Y/N/NA)	Study leave taken for visit (Y/N/NA)
Christine Hopley	Medical Secretary	4 Aug 2017	Patient	Toiletries set	N/A	4 Aug 2017	N/A	N/A	N/A	N/A	N/A
Catherine Bradley	Macmillan Palliative Care CNS	4 May 2017	Patients Relative	£50 marks and spencer's voucher, spoke with relative and explained I could not accept kind gift, in its current form. Explained the monetary value of the voucher could be donated to the UHCW palliative care charitable fund. Relative agreeable with this plan therefore, palliative care nurse exchanged voucher for cash. Cash credited to the charitable fund.	N/A	5 May 2017	N/A	N/A	N/A	N/A	N/A

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Trust Seal Register 2017/18**
Author	**Rebecca Hough, Head of Corporate Affairs**
Responsible Chief Officer	**Andy Meehan, Chairman**
Date	**31 May 2018**

1. Purpose

The report sets out the usage of the common seal of the Trust during the year 2017/18 and is provided for noting.

2. Background and Links to Previous Papers

A report detailing the use of the common seal of the Trust is reported to the Trust Board on an annual basis and was last presented in April 2017.

3. Narrative

The common seal of the Trust is affixed when a document needs to be executed as a deed as opposed to a simple contract. Affixation is governed by the Trust's Standing Orders, which dictate that a report detailing the usage of the seal shall be periodically submitted to the Trust Board. This report therefore satisfies these requirements in that it details each time the seal has been affixed during the year 2017/18.

4. Areas of Risk

There are no areas of risk as corporate governance requirements are satisfied through the submission of this report.

5. Governance

The seal is kept in safe custody by the Director of Corporate Affairs and is affixed in line with the requirements laid out in the Standing Orders, which are aimed at preventing it from misuse.

6. Responsibility

Geoff Stokes, Director of Corporate Affairs

7. Recommendations

The Board is asked to **NOTE** the usage of the common seal of the Trust 2017/18.

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Register of Sealings 2017/18

Consecutive Number	Date of Sealing	Description of document sealed	Names and titles of persons attesting sealing	Dissemination of Document:	Name of Solicitor
306	28.12.2017	UHCW NHS Trust and Barrowboys Frott Strands Ltd lease agreement	Mr Andrew Meehan, Chairman Professor Andrew Hardy, Chief Executive Officer	Lincoln Dawkin	Mills and Reeve Solicitors LLP

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	Gender Pay Gap
Author	Satpal Gill, Head of Employment Services
Responsible Director	Karen Martin, Chief Workforce and Information Officer
Date	31 May 2018

1. Purpose

This report details the Trust results from the gender pay review analysis undertaken for publication by 30th March 2018 as part of the Equality Act 2010 specific duties.

2. Background

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 requires employers to report their gender pay gaps for any year where they have a headcount of 250 or more employees with effect from 31 March 2017. Employers must publish the results on their Trust website and the government website within 12 months (30th March 2018).

In is important to note the difference between gender pay gap and equal pay as being:

- Equal pay relates to men and women earning equal pay for the same or similar work.
- Gender pay gap refers to the difference between men and women's average pay within an organisation.

Generally, the average pay for women tends to be lower than men due to less women working in senior posts. There are a number of reasons for imbalances in pay which include:

- A higher proportion of women choose occupations that offer less financial reward (e.g. administration). Many high paying sectors are disproportionately made up of male workers (e.g. information and communications technology).
- A much higher proportion of women work part-time, and part-time workers earn less than their full-time counterparts on average.
- Women are still less likely to progress up the career ladder into high paying senior roles.

The regulations have been brought to highlight any imbalances in pay and allow employers to consider reasons for any inequality and take the necessary steps.

3. Summary

Employers are required to review employee data in line with the national guidance which requires six specific calculations to be undertaken and published on the national government gender pay gap website and Trust website by 30th March each year.

To support and enable NHS organisations to extract the data in a consistent way the national Employee Staff Record (ESR) team launched a module in December 2017 to Trusts to enter their data into a pre-built system that would calculate the Gender Pay Gap in a way that could be benchmarked across the NHS. To date no benchmarking data has been published but, when this is available a review will be undertaken.

3.1 Results

It is important to note the following when reviewing the results:

- All Trust staff are included in the gender pay analysis including bank workers who we pay directly.
- ISS staff have not been included as nationally ISS have completed their own analysis for submission.
- The calculations are based on all staff and on their net pay.
- The bonus gender pay gap for UHCW is based on the Consultant Clinical Excellence Awards (CEAs) which is a consistent approach used by other NHS Trusts.

The results from the six mandatory calculations for the Gender Pay Analysis for March 2017 are detailed below:

Calculation 1: Average gender pay gap as a mean average (table 1)

Group	Average Hourly Rate of Pay
Male	£23.98
Female	£15.46
Difference	£8.52
Percentage Variance	**35.53%**

The average hourly rate of pay is calculated from a specific pay period (March 2017). The hourly rate is calculated for each employee based on 'ordinary pay' which includes basic pay, allowances and shift premium pay.

The percentage variance for the average hourly rate of pay is just over 35.5%. This calculation is based on the average hourly rate of 6281 Female staff compared to 1606 Male staff; because the average is calculated over different number of staff (there are almost 4 times more female staff), some variance is to be expected.

It is important to note that the Trust gender split is 79.64% (Female) and 20.36% (Male). National data published by NHS employers (Infographic - May 2018) indicates that national gender workforce split is 77% (Female) and 23% (Male).

Calculation 2: Average gender pay gap as a median average (table 2)

Group	Median Hourly Rate of Pay
Male	£19.53
Female	£14.15
Difference	£5.38
Percentage Variance	**27.53%**

The median hourly rate of pay is calculated from a specific pay period (March 2017). The median rate is calculated by selecting the average hourly rate at the mid-point for each gender group. The percentage variance for the median hourly rate of pay is just over 27.5%.

Overall, the Staff Group with the highest levels of pay are the Medical and Dental Consultant group which has the largest proportion of males (66.91%) compared with female (33.09%) staff. This has a direct impact on the median hourly rate being significantly higher for male staff.

Calculation 3: Average bonus gender pay gap as a mean average (table 3)

Group	Average Bonus Payments
Male	15,876.27
Female	7,990.79
Difference	7,885.48
Pay Gap %	**49.67%**

Calculation 4: Average bonus gender pay gap as a median average (table 4)

Group	Median Bonus Payments
Male	11,934.30
Female	4,952.95
Difference	6,981.35
Pay Gap %	**58.50%**

Calculation 5: Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment (table 5)

Group	Number of Staff Receiving Bonus Pay	Total Relevant Employees	%
Female	44.00	7,425.00	**0.59**
Male	119.00	1,971.00	**6.04**

In relation to the three tables above, as previously outlined these relate to the CEA payments. Medical & Dental Consultants who have at least one years' service are eligible to apply for CEA scheme on an annual basis. Consultants can apply every year until they reach the maximum CEA threshold. To gain the awards consultants need to be able to demonstrate that they have made a difference above and beyond their role to research, innovative ways of working or developing the service.

Table 5 details the total number of female and male Consultant staff that are in receipt of a CEA bonus and details the total number of employees at UHCW. The relevance of this indicator for our organisation is less significant as bonus pay applies to just 2% of all staff employed. However, it is recognised that the proportion of female consultants is low and by increasing this it will have an impact on the Trusts overall gender average pay/bonus pay split.

Calculation 6: Proportion of Males and Females when divided into four groups ordered from lowest to highest pay (table 6)

Quartile	Female	Male	Female %	Male %
1 - Lower	1702	257	86.88	13.12
2 – Lower Middle	1682	298	84.95	15.05
3 – Upper Middle	1704	271	86.28	13.72
4 – Upper	1193	780	60.47	39.53

- In order to create the quartile information all staff are sorted by their hourly rate of pay, this list is then split into 4 equal parts (where possible).

- When reviewing the quartile information it is important to take into account the types of roles available within the organisation and the different gender splits that occur within specific roles.

- The highest variances for the quartiles when compared to the overall Trust value are in the lower and upper middle quartiles.

- There is a higher proportion of female staff in the lower quartile which includes Admin & Additional Clinical (e.g. Healthcare Assistant's) staff groups that generally have a higher proportion of female staff which is reflected in the calculation result.

- 75% of the quartiles are representative of the Trust as a whole with a less than 2% variance.

- The upper quartile has the highest proportion of Male staff.

3.2 Analysis

Overall, the % gender split within UHCW NHS Trust relates to higher proportion of male staff employed within the upper quartile with 39.53% of all male staff employed within this quartile. The variance in this quartile is mainly relates to the type of roles within this quartile which are Medical and Dental and Managerial roles which proportionally have a higher % of males within these roles.

Whilst, there has been a slight increase in the proportion of females in Medical and Dental Consultant roles since 2015 there has also been a positive shift in the % of women employed at Director level from 27% in 2015 to 42% in 2017 (Nationally, 47% of women hold very senior manager roles).

4.0 Benchmarking

It is expected that national data will be released regarding benchmarking within the NHS however, organisations are able to view data for any organisation (private and public) via the national government website.

Outlined below is a comparison of data between Trusts which also includes UHCW NHS Trust data for both 2017 and 2018. The 2018 data will be due for publication in March 2019 but, has been collated to allow local comparison regarding any improvements.

It is noted that has been a positive shift UHCW results for 2018 however, these remain relatively high in comparison to other Trusts. The median % (is calculated by selecting the average hourly rate at the mid-point for each gender group) shows the largest variation. Therefore, this does indicate that as a Trust a greater proportion of women are on a lower pay point within salary scales (which relates to seniority of years in service).

Table 7: Results Comparisons

Trusts	**Average Hourly Rate (Mean) %**	**Average Hourly Rate (Median) %**
UHCW NHS Trust (2017)	35.53%	27.53%
UHCW NHS Trust (2018) *	34.53%	25.65%
Royal Orthopaedic Hospitals	34.8%	25.9%
Norfolk and Norwich University Hospitals NHS Foundation Trust	34.2%	23.7%
Burton Hospitals	33.8%	22.7%
Nottingham University Hospitals NHS Trust	30.3%	18.1%
Derby Teaching Hospitals NHS Foundation Trust	30.2%	14.2%
Heart of England NHS Foundation Trust	28.8%	17.5%
Papworth Hospitals NHS Trust	28.8%	9.9%
Cambridge University Hospitals NHS Trust	22.3%	3.4%
University Hospitals Birmingham Foundation NHS	17.4%	11.3%

the data for 2018 has been already run as the reporting period relates to position as at 31st March 2018.

In the sample of Trusts reviewed UHB has the smallest gender pay gap. It is not possible without thorough analysis of UHB data to fully understand the reasons for such a difference in their pay gender gap compared to other Trusts. However, the following observations can be made between UHCW NHS Trust and UHB based on available data:

- UHB have a lower proportion of female staff (72%) compared with UHCW (79.64%).

- UHB have a higher split of men within the lower pay quartiles compared to UHCW NHS Trust therefore, bringing down the overall average rate of pay for men (see table 8).

The above points would reduce the gender pay difference between men and women at UHB.

Table 8: UHCW NHS Trust and UHB – Quartile comparison

Trust	Quartile	Female %	Male %
UHCW NHS Trust	1 - Lower	86.88 %	13.12 %
UHB	1 - Lower	72.4 %	27.6 %
UHCW NHS Trust	2 – Lower Middle	84.95 %	15.05 %
UHB	2 – Lower Middle	78.3 %	21.7 %
UHCW NHS Trust	3 – Upper Middle	86.28 %	13.72 %
UHB	3 – Upper Middle	78.5 %	21.5 %
UHCW NHS Trust	4 – Upper	60.47 %	39.53 %
UHB	4 – Upper	57.8 %	42.2 %

5.0 Next Steps

In order to fully understand the gender pay gap data, further detailed analysis is required to understand the Median pay gap information so that appropriate steps can be taken.

Further to the in-depth analysis of data, an action plan will be developed which focuses on actions over the next 12months and longer term. The plan would review key areas which would include Recruitment, Flexible Working, Parental Leave and Returners and Pay, Reward and Promotion. These key areas have been identified by the Chartered Institute of Personnel Development (CIPD) to support the reduction of gender pay gap inequality.

The following actions would also form part of the action plan:

- Increased promotion of flexible working options to existing staff and new applicants at all levels of posts across all staff groups.

- Additional work is undertaken to encourage women to apply for bonuses (CEAs). The bonus gender pay gap is 49.67% which is significant but, also not unusual given 39.14% of the staff group are female.

- Further focus on career development for women providing training and encouragement through mentors and coaching.

- Promotion of existing measures in place to support gender pay equality e.g. shared parental leave, flexible working etc.

It is important to note that the above actions would have an impact on data reviewed on 30th March 2019 which would be due for publication on 30th March 2020.

6.0 Areas of Risk

The impact on the Trust to demonstrate that they are an equal opportunity employer.

7.0 Link to Trust Objectives and Corporate/Board Assurance Framework Risks

To be an employer of choice

8.0 Governance

Requirement to publish data annually and take appropriate actions to reduce the gender pay gap.

9.0 Responsibility

Karen Martin, Chief Workforce and Information Officer

10.0 Recommendations

The Board is invited to

- note the contents of the report
- approve actions

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	Medical Revalidation Annual Organisational Audit 2017/18
Author	Louise Siddall, Medical Revalidation Officer
Responsible Director	Meghana Pandit, Deputy CEO and Chief Medical Officer
Date	31st May 2018

1. Purpose

This report presents the Annual Organisational Audit (AOA) to provide assurance to the Board around Medical Appraisal and Revalidation.

2. Background and Links to Previous Papers

The Trust submitted its last AOA in April 2017 the outcome of which was presented to Board in the Medical Appraisal and Revalidation Board Report in July 2017.

3. Executive Summary

The Framework of Quality Assurance (FQA) for Responsible Officers (RO) and Revalidation states the AOA is a mandatory return that must be issued to the Higher Level RO at NHS England (NHSE).

The aims of the AOA exercise are to:

- gain an understanding of the progress that the organisation has made.
- provide a tool to helps an RO assure themselves and the Board that the systems underpinning the recommendations they make to the General Medical Council (GMC) on doctors' fitness to practise, the arrangements for medical appraisal and responding to concerns, are in place;
- provide a mechanism for assuring NHSE and the GMC that systems for evaluating doctors' fitness to practice are in place, functioning, effective and consistent.

The deadline for submission of this report to NHSE is 8th June 2018. Returns from across England will then be collated to provide an overarching status report of progress.

UHCW AOA can be found at Appendix 1 and details that of the 677 doctors connected to the Trust at 31st March 2018, 613 doctors were compliant with appraisal requirements. This means compliance for 2017/2018 was 90.54%.

Compared to last year UHCW now has a process in place to ensure reasons for missed appraisals are appropriately recorded (Section 2.2).

However the Trust has not yet undertaken a review of processes relating to appraisal and revalidation (Section 1.2). In previous years this requirement has been met with CW Audit review and NHSE Independent Verification Visit. Plans are in place to conduct an internal review against FQA - Core Standards and in future seek a peer review by another organisation.

Following completion of this AOA UHCW will await the comparator report from NHSE to further assess the Trusts position. This will be reported on in July 2018, along with the review against core standards and a comprehensive list of objectives to develop the revalidation and appraisal process in 2018/2019.

4. Areas of Risk

Risk arises out of failing to comply with RO Regulations and GMC/NHS England requirements, which could impact negatively on patient safety along with the Trust's reputation. In order to mitigate the risk it is imperative to ensure commitment to revalidation is established across the Trust, which will be supported by ongoing assessment against the FQA.

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

The information reported on does not link directly to Trust Objectives or the BAF however the process of Medical Revalidation is a statutory requirement with which the Trust must comply.

6. Governance

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

7. Responsibility

The Trust as a Designated Body has a statutory duty to support the Chief Medical Officer as Responsible Officer in discharging their duties under the RO Regulations.

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

- Dr Richard de Boer, Deputy CMO and Revalidation Lead
- Dr Mathew Patteril, Consultant Anesthetist and Deputy Revalidation Lead
- Louise Siddall, Medical Revalidation Officer

8. Recommendations

The Trust Board is invited to **NOTE** the AOA and **RAISE** any queries or concerns.

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

Date: 10th May 2018

Appendix 1 – AOA

Section 1 – The Designated Body and the Responsible Officer

Section 1	The Designated Body and the Responsible Officer		
1.1	**Name of designated body:**		
	Address line 1 University Hospitals Coventry & Warwickshire, NHS Trust		
	Address line 2 University Hospital Coventry		
	Address line 3 Clifford Bridge Road		
	Address line 4 Walsgrave		
	City Coventry		
	County West Midlands	Postcode CV2 2DX	
	Responsible officer: Title Professor GMC registered first name Meghana GMC reference number 4324678 Email Meghana.Pandit@uhcw.nhs.uk	GMC registered last name Pandit Phone 0247 696 7616	
	Medical Director: Title GMC registered first name GMC reference number Email	GMC registered last name Phone	Same as RO [X] No Medical Director [ ]
	Clinical Appraisal Lead (if applicable): Title Dr GMC registered first name Richard GMC reference number 3125957 Email Richard.deBoer@uhcw.nhs.uk	GMC registered last name de Boer Phone 0247 696 6173	Same as RO [ ] No Clinical Appraisal Lead [ ]
	Chief Executive (or equivalent): Title Professor First name Andy GMC reference number (if applicable) Email Andy.Hardy@uhcw.nhs.uk	Last name Hardy Phone 0247 696 7621	

1.2	**Type/sector of designated body:** (tick one)	NHS	Acute hospital/secondary care foundation trust	
			Acute hospital/secondary care non-foundation trust	X
			Mental health foundation trust	
			Mental health non-foundation trust	
			Other NHS foundation trust (care trust, ambulance trust, etc)	
			Other NHS non-foundation trust (care trust, ambulance trust, etc)	
			Special health authorities (NHS Litigation Authority, NHS Trust Development Authority, NHS Blood and Transplant, etc)	
		NHS England	NHS England (local office)	
			NHS England (regional office)	
			NHS England (national office)	
		Independent / non-NHS sector (tick one)	Independent healthcare provider	
			Locum agency	
			Faculty/professional body (FPH, FOM, FPM, IDF, etc)	
			Academic or research organisation	
			Government department, non-departmental public body or executive agency	
			Armed Forces	
			Hospice	
			Charity/voluntary sector organisation	
			Other non-NHS (please enter type)	

1.3	**The responsible officer's higher level responsible officer is based at:** [tick one]	NHS England North	
		NHS England Midlands and East	X
		NHS England London	
		NHS England South	
		NHS England (National)	
		Department of Health NHS	
		Faculty of Medical Leadership and Management - for NHS England (national office) only	
		Other (Is a suitable person)	
1.4	**A responsible officer has been nominated/appointed in compliance with the regulations.** To answer 'Yes': • The responsible officer has been a medical practitioner fully registered under the Medical Act 1983 throughout the previous five years and continues to be fully registered whilst undertaking the role of responsible officer. • There is evidence of formal nomination/appointment by board or executive of each organisation for which the responsible officer undertakes the role.		☒ Yes ☐ No

1.5	**Where a Conflict of Interest or Appearance of Bias has been identified and agreed with the higher level responsible officer; has an alternative responsible officer been appointed?** (Please note that in The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2013), an alternative responsible officer is referred to as a second responsible officer) To answer 'Yes': The designated body has nominated an alternative responsible officer in all cases where there is a conflict of interest or appearance of bias between the responsible officer and a doctor with whom the designated body has a prescribed connection. To answer 'No': A potential conflict of interest or appearance of bias has been identified, but an alternative responsible officer has not been appointed. To answer 'N/a': No cases of conflict of interest or appearance of bias have been identified. Additional guidance Each designated body will have one responsible officer but the regulations allow for an alternative responsible officer to be nominated or appointed where a conflict of interest or appearance of bias exists between the responsible officer and a doctor with whom the designated body has a prescribed connection. This will cover the uncommon situations where close family or business relationships exist, or where there has been longstanding interpersonal animosity. In order to ensure consistent thresholds and a common approach to this, potential conflict of interest or appearance of bias should be agreed with the higher level responsible officer. An alternative responsible officer should then be nominated or appointed by the designated body and will require training and support in the same way as the first responsible officer. To ensure there is no conflict of interest or appearance of bias, the alternative responsible officer should be an external appointment and will usually be a current experienced responsible officer from the same region. Further guidance is available in *Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer* (NHS Revalidation Support Team, 2014).	☐ Yes ☐ No ☒ N/A

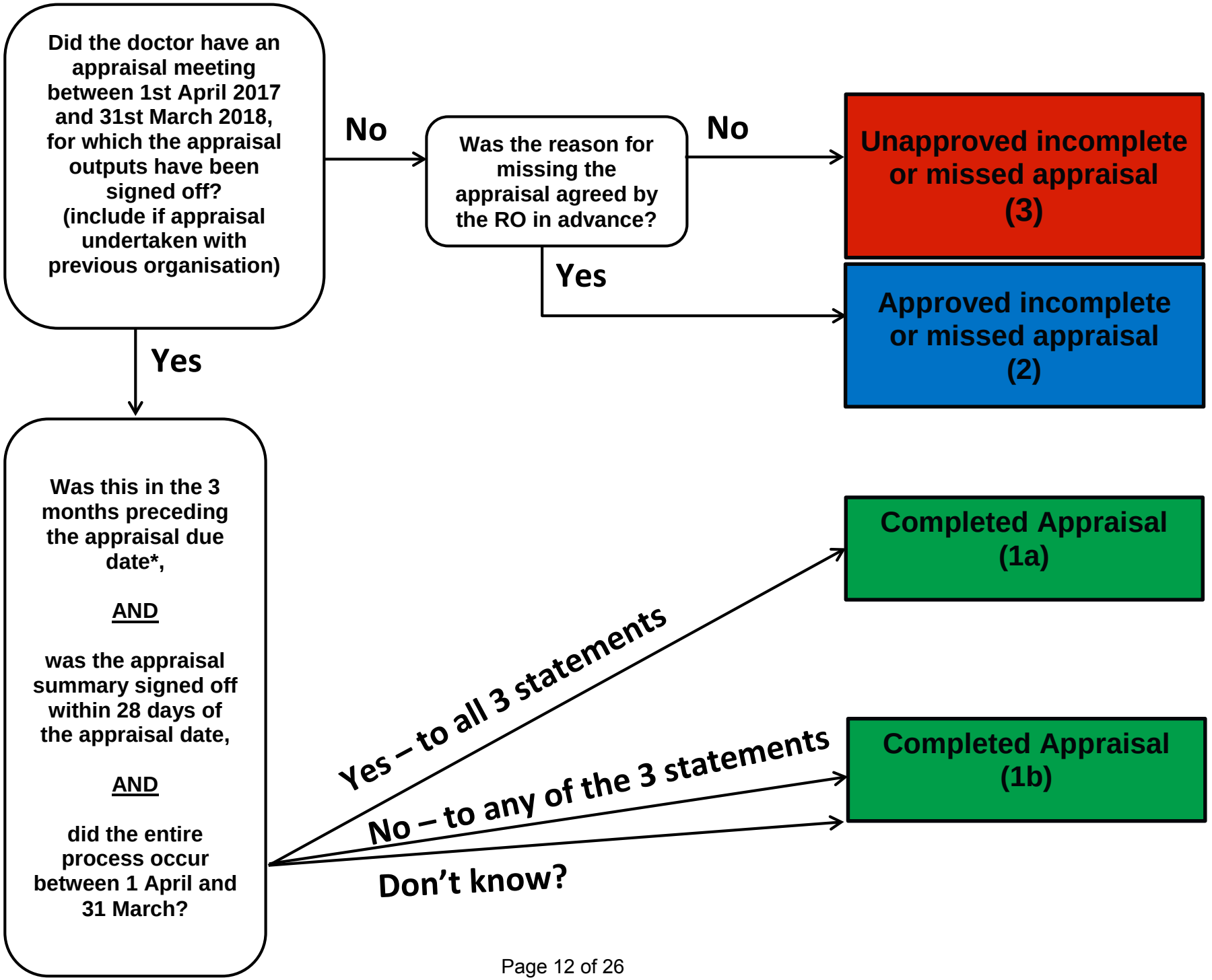
1.6	**In the opinion of the responsible officer, sufficient funds, capacity and other resources have been provided by the designated body to enable them to carry out the responsibilities of the role.** Each designated body must provide the responsible officer with sufficient funding and other resources necessary to fulfil their statutory responsibilities. This may include sufficient time to perform the role, administrative and management support, information management and training. The responsible officer may wish to delegate some of the duties of the role to an associate or deputy responsible officer. It is important that those people acting on behalf of the responsible officer only act within the scope of their authority. Where some or all of the functions are commissioned externally, the designated body must be satisfied that all statutory responsibilities are fulfilled.	☒ Yes ☐ No
1.7	**The responsible officer is appropriately trained and remains up to date and fit to practise in the role of responsible officer.** To answer 'Yes': • Appropriate recognised introductory training has been undertaken. • Appropriate ongoing training and development is undertaken in agreement with the responsible officer's appraiser. • The responsible officer has made themselves known to the higher level responsible officer. • The responsible officer is engaged in the regional responsible officer network. • The responsible officer is actively involved in peer review for the purposes of calibrating their decision-making processes and organisational systems. • The responsible officer includes relevant supporting information relating to their responsible officer role in their appraisal and revalidation portfolio including the results of the Annual Organisational Audit and the resulting action plan.	☒ Yes ☐ No

1.8	**The responsible officer ensures that accurate records are kept of all relevant information, actions and decisions relating to the responsible officer role.** The responsible officer records should include appraisal records, fitness to practise evaluations, investigation and management of concerns, processes relating to 'new starters', etc.	☒ Yes ☐ No
1.9	**The responsible officer ensures that the designated body's medical revalidation policies and procedures are in accordance with equality and diversity legislation.** To answer 'Yes': • An evaluation of the fairness of the organisation's policies has been performed (for example, an equality impact assessment).	☒ Yes ☐ No
1.10	**The responsible officer makes timely recommendations to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and the GMC Responsible Officer Protocol.** To answer 'Yes': • The designated body's board report contains explanations for all missed and late recommendations, and reasons for deferral submissions.	☒ Yes ☐ No
1.11	**The governance systems (including clinical governance where appropriate) are subject to external or independent review.** Most designated bodies will be subject to external or independent review by a regulator. Designated bodies which are healthcare providers are subject to review by the national healthcare regulators (the Care Quality Commission or Monitor). Where designated bodies will not be regulated or overseen by an external regulator (for example locum agencies and organisations which are not healthcare providers), an alternative external or independent review process should be agreed with the higher level responsible officer.	☒ Yes ☐ No

1.12	**The designated body has commissioned or undertaken an independent review* of its processes relating to appraisal and revalidation.** **(*including peer review, internal audit or an externally commissioned assessment)**	☐ Yes ☒ No

Section 2 – Appraisal

Section 2	Appraisal						
2.1	IMPORTANT: Only doctors with whom the designated body has a prescribed connection at 31 March 2018 should be included. **See guidance notes on pages 16-18 for assistance completing this table**	Number of Prescribed Connections	1a Completed Appraisal (1a)	1b Completed Appraisal (1b)	2 Approved incomplete or missed appraisal (2)	3 Unapproved incomplete or missed appraisal (3)	Total
2.1.1	**Consultants** (permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work).	420	376	12	10	22	420
2.1.2	**Staff grade, associate specialist, specialty doctor** (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff).	54	47		1	6	54
2.1.3	**Doctors on Performers Lists** (for NHS England and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs).						
2.1.4	**Doctors with practising privileges** (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade).						
2.1.5	**Temporary or short-term contract holders** (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc).	203	178		3	22	203
2.1.6	**Other doctors with a prescribed connection to this designated body** (depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc).						
2.1.7	**TOTAL** (this cell will sum automatically 2.1.1 – 2.1.6).	677	601	12	14	50	677


Did the doctor have an appraisal meeting between 1st April 2017 and 31st March 2018, for which the appraisal outputs have been signed off? (include if appraisal undertaken with previous organisation)
No
Was the reason for missing the appraisal agreed by the RO in advance?
No
Unapproved incomplete or missed appraisal (3)
Yes
Approved incomplete or missed appraisal (2)
Yes
Was this in the 3 months preceding the appraisal due date*,
AND
was the appraisal summary signed off within 28 days of the appraisal date,
AND
did the entire process occur between 1 April and 31 March?
Yes – to all 3 statements
Completed Appraisal (1a)
No – to any of the 3 statements
Completed Appraisal (1b)
Don't know?

2.1	**Column - Number of Prescribed Connections:** **Number of doctors with whom the designated body has a prescribed connection as at 31 March 2018** The responsible officer should keep an accurate record of all doctors with whom the designated body has a prescribed connection and must be satisfied that the doctors have correctly identified their prescribed connection. Detailed advice on prescribed connections is contained in the responsible officer regulations and guidance and further advice can be obtained from the GMC and the higher level responsible officer. The categories of doctor relate to current roles and job titles rather than qualifications or previous roles. The number of individual doctors in each category should be entered in this column. Where a doctor has more than one role in the same designated body a decision should be made about which category they belong to, based on the amount of work they do in each role. Each doctor should be included in only one category. For a doctor who has recently completed training, if they have attained CCT, then they should be counted as a prescribed connection. If CCT has not yet been awarded, they should be counted as a prescribed connection within the LETB AOA return. **Column - Measure 1a Completed medical appraisal:** A *Category 1a completed annual medical appraisal* is one where the appraisal meeting has taken place in the three months preceding the agreed appraisal due date*, the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting, and the entire process occurred between 1 April and 31 March. For doctors who have recently completed training, it should be noted that their final ACRP equates to an appraisal in this context. **Column - Measure 1b Completed medical appraisal:** A *Category 1b completed annual medical appraisal* is one in which the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor, but one or more of the following apply: - the appraisal did not take place in the window of three months preceding the appraisal due date; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor between 1 April and 28 April of the following appraisal year; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor more than 28 days after the appraisal meeting. However, in the judgement of the responsible officer the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation.	

	Where the organisational information systems of the designated body do not permit the parameters of a *Category 1a completed annual medical appraisal* to be confirmed with confidence, the appraisal should be counted as a *Category 1b completed annual medical appraisal*. **Column - Measure 2: Approved incomplete or missed appraisal:** An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*. **Column - Measure 3: Unapproved incomplete or missed appraisal:** An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*. **Column Total:** Total of columns 1a+1b+2+3. The total should be equal to that in the first column (Number of Prescribed Connections), the number of doctors with a prescribed connection to the designated body at 31 March 2018. * Appraisal due date: A doctor should have a set date by which their appraisal should normally take place every year (the 'appraisal due date'). The appraisal due date should remain the same each year unless changed by agreement with the doctor's responsible officer. Where a doctor does not have a clearly established appraisal due date, the next appraisal should take place by the last day of the twelfth month after the preceding appraisal. This should then by default become their appraisal due date from that point on. For a designated body which uses an 'appraisal month' for appraisal scheduling, a doctor's appraisal due date is the last day of their appraisal month. For more detail on setting a doctor's appraisal due date see the Medical Appraisal Logistics Handbook (NHS England, 2015)	

2.2	**Every doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded** If all appraisals are in Categories 1a and/or 1b, please answer N/A. To answer Yes: • The responsible officer ensures accurate records are kept of all relevant actions and decisions relating to the responsible officer role. • The designated body's annual report contains an audit of all missed or incomplete appraisals (approved and unapproved) for the appraisal year 2017/18 including the explanations and agreed postponements. • Recommendations and improvements from the audit are enacted. Additional guidance: A missed or incomplete appraisal, whether approved or unapproved, is an important occurrence which could indicate a problem with the designated body's appraisal system or non-engagement with appraisal by an individual doctor which will need to be followed up. Measure 2: Approved incomplete or missed appraisal: An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*. Measure 3: Unapproved incomplete or missed appraisal: An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*.	☒ Yes ☐ No ☐ N/A

2.3	**There is a medical appraisal policy, with core content which is compliant with national guidance, that has been ratified by the designated body's board (or an equivalent governance or executive group)** To answer 'Yes': • The policy is compliant with national guidance, such as *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), *Supporting Information for Appraisal and Revalidation* (GMC, 2012), *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014), *The Role of the Responsible Officer: Closing the Gap in Medical Regulation, Responsible Officer Guidance* (Department of Health, 2010), *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014). • The policy has been ratified by the designated body's board or an equivalent governance or executive group.	☒ Yes ☐ No
2.4	**There is a mechanism for quality assuring an appropriate sample of the inputs and outputs of the medical appraisal process to ensure that they comply with GMC requirements and other national guidance, and the outcomes are recorded in the annual report template.** To answer 'Yes': • The appraisal inputs comply with the requirements in *Supporting Information for Appraisal and Revalidation* (GMC, 2012) and *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), which are: o Personal information. o Scope and nature of work. o Supporting information: 1. Continuing professional development, 2. Quality improvement activity, 3. Significant events, 4. Feedback from colleagues, 5. Feedback from patients, 6. Review of complaints and compliments. o Review of last year's PDP. o Achievements, challenges and aspirations. • The appraisal outputs comply with the requirements in the *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014) which are: o Summary of appraisal, o Appraiser's statement, o Post-appraisal sign-off by doctor and appraiser.	☒ Yes ☐ No

	Additional guidance: Quality assurance is an integral part of the role of the responsible officer. The standards for the inputs and outputs of appraisal are detailed in *Supporting Information for Appraisal and Revalidation* (GMC, 2012), *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013) and the *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014) and the responsible officer must be assured that these standards are being met consistently. The methodology for quality assurance should be outlined in the designated body's appraisal policy and include a sampling process. Quality assurance activities can be undertaken by those acting on behalf of the responsible officer with appropriate delegated authority.	
2.5	**There is a process in place for the responsible officer to ensure that key items of information (such as specific complaints, significant events and outlying clinical outcomes) are included in the appraisal portfolio and discussed at the appraisal meeting, so that development needs are identified.** To answer 'Yes': • There is a written description within the appraisal policy of the process for ensuring that key items of supporting information are included in the doctor's portfolio and discussed at appraisal. • There is a process in place to ensure that where a request has been made by the responsible officer to include a key item of supporting information in the appraisal portfolio, the appraisal portfolio and summary are checked after completion to ensure this has happened. Additional guidance: It is important that issues and concerns about performance or conduct are addressed at the time they arise. The appraisal meeting is not usually the most appropriate setting for dealing with concerns and in most cases these are dealt with outside the appraisal process in a clinical governance setting. Learning by individuals from such events is an important part of resolving concerns and the appraisal meeting is usually the most appropriate setting to ensure this is planned and prioritised. In a small proportion of cases, the responsible officer may therefore wish to ensure certain key items of supporting information are included in the doctor's portfolio and discussed at appraisal so that development needs are identified and addressed. In these circumstances the responsible officer may require the doctor to include certain key items of supporting information in the portfolio for discussion at appraisal and may need to check in the appraisal summary that the discussion has taken place. The method of sharing key items of supporting information should be described in the appraisal policy. It is important that information is shared in compliance with principles of information governance and security. For further detail, see *Information Management for Revalidation in England* (NHS Revalidation Support Team, 2014).	☒ Yes ☐ No

2.6	**The responsible officer ensures that the designated body has access to sufficient numbers of trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection** To answer 'Yes': The responsible officer ensures that: • Medical appraisers are recruited and selected in accordance with national guidance. • In the opinion of the responsible officer, the number of appropriately trained medical appraisers to doctors being appraised is between 1:5 and 1:20. • In the opinion of the responsible officer, the number of trained appraisers is sufficient for the needs of the designated body. Additional guidance: It is important that the designated body's appraiser workforce is sufficient to provide the number of appraisals needed each year. This assessment may depend on total number of doctors who have a prescribed connection, geographical spread, speciality spread, conflicts of interest and other factors. Depending on the needs of the designated body, doctors from a variety of backgrounds should be considered for the role of appraiser. This includes locums and salaried general practitioners in primary care settings and staff and associate specialist doctors in secondary care settings. An appropriate specialty mix is important though it is not possible for every doctor to have an appraiser from the same specialty. Appraisers should participate in an initial training programme before starting to perform appraisals. The training for medical appraisers should include: • Core appraisal skills and skills required to promote quality improvement and the professional development of the doctor • Skills relating to medical appraisal for revalidation and a clear understanding of how to apply professional judgement in appraisal • Skills that enable the doctor to be an effective appraiser in the setting within which they work, including both local context and any specialty specific elements. Further guidance on the recruitment and training of medical appraisers is available; see *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014).	☒ Yes ☐ No

2.7	**Medical appraisers are supported in their role to calibrate and quality assure their appraisal practice.** To answer 'Yes': The responsible officer ensures that: • Medical appraisers have completed a suitable training programme, with core content compliant with national guidance (Quality Assurance of Medical Appraisers), including equality and diversity and information governance, before starting to perform appraisals. • All appraisers have access to medical leadership and support. • There is a system in place to obtain feedback on the appraisal process from doctors being appraised. • Medical appraisers participate in ongoing performance review and training/development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers). Additional guidance: Further guidance on the support for medical appraisers is available in *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014).	☒ Yes ☐ No

Section 3 – Monitoring Performance and Responding to Concerns

Section 3	Monitoring Performance and Responding to Concerns	
3.1	**There is a system for monitoring the fitness to practise of doctors with whom the designated body has a prescribed connection**. To answer 'Yes': • Relevant information (including clinical outcomes, reports of external reviews of service for example Royal College reviews, governance reviews, Care Quality Commission reports, etc.) is collected to monitor the doctor's fitness to practise and is shared with the doctor for their portfolio. • Relevant information is shared with other organisations in which a doctor works, where necessary. • There is a system for linking complaints, significant events/clinical incidents/SUIs to individual doctors. • Where a doctor is subject to conditions imposed by, or undertakings agreed with the GMC, the responsible officer monitors compliance with those conditions or undertakings. • The responsible officer identifies any issues arising from this information, such as variations in individual performance, and ensures that the designated body takes steps to address such issues. • The quality of the data used to monitor individuals and teams is reviewed. • Advice is taken from GMC employer liaison advisers, National Clinical Assessment Service, local expert resources, specialty and Royal College advisers where appropriate. Additional guidance: Where detailed information can be collected which relates to the practice of an individual doctor, it is important to include it in the annual appraisal process. In many situations, due to the nature of the doctor's work, the collection of detailed information which relates directly to the practice of an individual doctor may not be possible. In these situations, team-based or service-level information should be monitored. The types of information available will be dependent on the setting and the role of the doctor and will include clinical outcome data, audit, complaints, significant events and patient safety issues. An explanation should be sought where an indication of outlying	☒ Yes ☐ No

	quality or practice is discovered. The information/data used for this purpose should be kept under review so that the most appropriate information is collected and the quality of the data (for example, coding accuracy) is improved. In primary care settings this type of information is not always routinely collected from general practitioners or practices and new arrangements may need to be put in place to ensure the responsible officer receives relevant fitness to practise information. In order to monitor the conduct and fitness to practise of trainees, arrangements will need to be agreed between the local education and training board and the trainee's clinical attachments to ensure relevant information is available in both settings.	
3.2	**The responsible officer ensures that a responding to concerns policy is in place (which includes arrangements for investigation and intervention for capability, conduct, health, and fitness to practise concerns) which is ratified by the designated body's board (or an equivalent governance or executive group)**. To answer 'Yes': • A policy for responding to concerns, which complies with the responsible officer regulations, has been ratified by the designated body's board (or an equivalent governance or executive group). Additional guidance: It is the responsibility of the responsible officer to respond appropriately when unacceptable variation in individual practice is identified or when concerns exist about the fitness to practise of doctors with whom the designated body has a prescribed connection. The designated body should establish a procedure for initiating and managing investigations. National guidance is available in the following key documents: • *Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013). • *Maintaining High Professional Standards in the Modern NHS* (Department of Health, 2003). • The National Health Service (Performers Lists) (England) Regulations 2013. • *How to Conduct a Local Performance Investigation* (National Clinical Assessment Service, 2010). The responsible officer regulations outline the following responsibilities: • Ensuring that there are formal procedures in place for colleagues to raise concerns. • Ensuring there is a process established for initiating and managing investigations of capability, conduct,	☒ Yes ☐ No

	health and fitness to practise concerns which complies with national guidance, such as *How to conduct a local performance investigation* (National Clinical Assessment Service, 2010).
	• Ensuring investigators are appropriately qualified.
	• Ensuring that there is an agreed mechanism for assessing the level of concern that takes into account the risk to patients.
	• Ensuring all relevant information is taken into account and that factors relating to capability, conduct, health and fitness to practise are considered.
	• Ensuring that there is a mechanism to seek advice from expert resources, including: GMC employer liaison advisers, the National Clinical Assessment Service, specialty and royal college advisers, regional networks, legal advisers, human resources staff and occupational health.
	• Taking any steps necessary to protect patients.
	• Where appropriate, referring a doctor to the GMC.
	• Where necessary, making a recommendation to the designated body that the doctor should be suspended or have conditions or restrictions placed on their practice.
	• Sharing relevant information relating to a doctor's fitness to practise with other parties, in particular the new responsible officer should the doctor change their prescribed connection.
	• Ensuring that a doctor who is subject to these procedures is kept informed about progress and that the doctor's comments are taken into account where appropriate.
	• Appropriate records are maintained by the responsible officer of all fitness to practise information
	• Ensuring that appropriate measures are taken to address concerns, including but not limited to:
	  • Requiring the doctor to undergo training or retraining,
	  • Offering rehabilitation services,
	  • Providing opportunities to increase the doctor's work experience,
	  • Addressing any systemic issues within the designated body which may contribute to the concerns identified.
	• Ensuring that any necessary further monitoring of the doctor's conduct, performance or fitness to practise is carried out.	

3.3	**The board (or an equivalent governance or executive group) receives an annual report detailing the number and type of concerns and their outcome.**	☒ Yes ☐ No

3.4	**The designated body has arrangements in place to access sufficient trained case investigators and case managers.** To answer 'Yes': The responsible officer ensures that: • Case investigators and case managers are recruited and selected in accordance with national guidance *Supporting Doctors to Provide Safer Healthcare, Responding to concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013). • Case investigators and case managers have completed a suitable training programme, with essential core content (see guidance documents above). • Personnel involved in responding to concerns have sufficient time to undertake their responsibilities • Individuals (such as case investigators, case managers) and teams involved in responding to concerns participate in ongoing performance review and training/development activities, to include peer review and calibration (see guidance documents above). Additional guidance The standards for training for case investigators and case managers are contained in *Guidance for Recruiting for the Delivery of Case Investigator Training* (NHS Revalidation Support Team, 2014) and *Guidance for Recruiting for the Delivery of Case Manager Training* (NHS Revalidation Support Team, 2014). Case investigators or case managers may be within the designated body or commissioned externally.	☒ Yes ☐ No

Section 4 – Recruitment and Engagement

Section 4	Recruitment and Engagement	
4.1	**There is a process in place for obtaining relevant information when the designated body enters into a contract of employment or for the provision of services with doctors (including locums).** In situations where the doctor has moved to a new designated body without a contract of employment, or for the provision of services (for example, through membership of a faculty) the information needs to be available to the new responsible officer as soon as possible after the prescribed connection commences. This will usually involve a formal request for information from the previous responsible officer. Additional guidance The regulations give explicit responsibilities to the responsible officer when a designated body enters into a contract of employment or for the provision of services with a doctor. These responsibilities are to ensure the doctor is sufficiently qualified and experienced to carry out the role. All new doctors are covered under this duty even if the doctor's prescribed connection remains with another designated body. This applies to locum agency contracts and also to the granting of practising privileges by independent health providers. The prospective responsible officer must: • Ensure doctors have qualifications and experience appropriate to the work to be performed, • Ensure that appropriate references are obtained and checked, • Take any steps necessary to verify the identity of doctors, • Ensure that doctors have sufficient knowledge of the English language for the work to be performed, and • For NHS England regional teams, manage admission to the medical performers list in accordance with the regulations. It is also important that the following information is available: • GMC information: fitness to practise investigations, conditions or restrictions, revalidation due date, • Disclosure and Barring Service check (although delays may prevent these being available to the responsible officer before the starting date in every case), and	☒ Yes ☐ No

	• Gender and ethnicity data (to monitor fairness and equality; providing this information is not mandatory). It may be helpful to obtain a structured reference from the current responsible officer which complies with GMC guidance on writing references and includes relevant factual information relating to: • The doctor's competence, performance or conduct, • Appraisal dates in the current revalidation cycle, and, • Local fitness to practise investigations, local conditions or restrictions on the doctor's practice, unresolved fitness to practise concerns. See *Good Medical Practice: Supplementary Guidance: Writing References* (GMC, 2007) and paragraph 19 of *Good Medical Practice* (GMC, 2013) for further details.	

Section 5 – Comments

Section 5	Comments	
5.1		

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Trust Board Annual Work Plan**
Author	**Rebecca Hough, Head of Corporate Affairs**
Responsible Director	**Geoff Stokes, Director of Corporate Affairs**
Date	**31 May 2018**

1. Purpose

The report advises the schedule of reports to Trust Board for 2018-19.

2. Background and Links to Previous Papers

The work plan is provided on a yearly basis for review. Since June 2017, Trust Board meetings have been held on bi-monthly on a trial basis. It was confirmed at the strategic Board meeting on 26 April 2018 that the meetings will remain bi-monthly. The work plan has been reviewed and the schedule of reports have been realigned this change.

3. Executive Summary

The previous work plan for the Trust Board was developed when the meetings were held monthly. Since the introduction of bi-monthly meetings, the scheduling of reports did not fall neatly, in particular those reports scheduled on a quarterly cycle. These quarterly reports have been reviewed and the reporting structure has been realigned where possible.

Where amendments have been made to a reporting cycle, the lead of the report has been contacted and advised the Head of Corporate Affairs of any statutory requirements or any other implication which determines the schedule.

The annual work programme for 2018/19 highlights the frequency of reports and where these have been amended.

4. Areas of Risk

None have been identified.

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

The work plan ensures that reports are received by Trust Board to receive assurance on the Trust's performance.

6. Governance

There will be a number of statutory requirements and reporting requirements that the Trust has to adhere to.

7. Responsibility

Geoff Stokes – Director of Corporate Affairs

8. Recommendations

The Board is invited to **AGREE** the updated work plan.

Rebecca Hough, Head of Corporate Affairs
24 May 2018

University Hospitals Coventry and Warwickshire NHS Trust: Trust Board (Public Session) Annual Work Plan 2018-19 v0.1

			Quarter 1			Quarter 2			Quarter 3			Quarter 4							
COMMITTEE	SPONSOR	LEAD	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR		PURPOSE OF THE REPORT	IS THIS REPORT CONSIDERED BY ANOTHER COMMITTEE IF SO WHICH ONE?	WHY DOES IS THIS REPORT REQUIRED TO GO TO TRUST BOARD	ACTION
World Class Colleague Award	Chairman/CEO	Lynda Scott		🗁				🗁				🗁		🗁	Four times per year	To announce the winner of the nominations and present them with the award in recognition of their contribution to the organisation in support of the the achievement of the Trust's strategic objectives	No	Demonstrates the Trust's core values and behaviours and supports the strategic objectives 'To Deliver Excellent Patient Care and Experience and To be an Employer of Choice'	Noting
Patient Experience																			
Patient Story	Meghana Pandit	Sarah Brennan		🗁		🗁		🗁		🗁		🗁		🗁	Bimonthly	Forms part of the Patient Story Programme agreed by the Patient Experience and Engagement Committee	No	To demonstrate the Trust's vision of becoming a national and international leader in healthcare and align to the Trust's values and behaviours	Noting
Patient Quality and Safety																			
Board Assurance Framework	Meghana Pandit	Geoff Stokes				🗁				🗁				🗁	Three times per year ~~Four times per year~~	To receive assurance in relation to the management and mitigation of the risks as appropriate and that the BAF remains reflective of the current risks to the achievement of the strategic objectives.	QGC on a quarterly basis (Feb, May, Aug & Nov)	The Board is responsible for identifying and monitoring risks to achievement of the strategic objectives that it sets through the development of a BAF, which is monitored at the Trust Board on a quarterly basis	Approval
Corporate Risk Register	Meghana Pandit	Jenny Gardiner				🗁				🗁				🗁	Three times per year ~~Four times per year~~	To inform the Board of the Trust's highest rated risks which are currently logged on the Corporate Risk Register.	QGC on a quarterly basis (Feb, May, Aug & Nov) Risk Committee monthly	This quarterly report is included as part of the Board reporting framework.	Noting
CIP Quality Impact Assessment	Nina Fraser/Meghana Pandit	Laura Crowne/Lynda Cockrill								🗁					Annual	To explain the importance of quality impact assessments within the Trusts assurance processes that support its Cost Improvement Programme, and to provide a detailed update on the completion of quality impact assessments	GQC on a quarterly basis	The Board is responsible for preparing a plan which is deliverable and not detrimental to the quality of patient care. QGC monitor progress around the number of QIA's completed.	Assurance
Infection Prevention and Control Annual Report and Plan (including Annual Work Plan)	Nina Fraser	Kate Prevc						🗁							Annual	To provide an update on the Trust's Infection Prevention & Control activities and information on actions in place	Infection, Prevention & Control Committee/Nursing & Midwifery Committee	in order to provide assurance to the Board of compliance with The Health & Social Care Act (2008): Code of Practice for the Prevention & Control of Healthcare Associated Infections.	Assurance
Infection Control Quarterly Plan	Nina Fraser	Kate Prevc												🗁	Annual ~~Three times per year + annual report~~	To inform the Trust Board of the infection prevention and control position for each quarter against National and locally set targets	Infection, Prevention & Control Committee	To provide assurance to the Board confirming compliance with the requirements under the Health & Social Care Act (2008) Hygiene Code. No longer received by GQC but Board may delegate matters as required.	Assurance
Medical Revalidation and Appraisal Update	Meghana Pandit	Louise Siddall				🗁									Annual	Provides an update on Medical Appraisal and Revalidation within the Trust,	No	Revalidation is a statutory obligation with which the Trust must comply. Reports provide assurance that requirements are being met and that governance arrangements are robust. Information regarding medical appraisal is available in the IPR presented monthly.	Assurance
Mortality (SHMI and HSMR) Update	Meghana Pandit	Sharon Oulds		🗁		🗁				🗁		🗁			Four times per year	To monitor the Trust's mortality performance	Mortality Review Committee/Patient Safety Committee	National requirement to report mortality to the Trust Board.	Assurance
Controlled Drug	Meghana Pandit	Mark Easter		🗁											Annual	To provide the Board with an update on systems and processes that lead to the safe management of controlled drugs, to advise of any incidents reported within the 12months and to report any major concerns	Patient Safety Council	To provide the Board with assurance that safe management of controlled drugs is maintained as an organisational priority	Assurance
Safer Staffing	Nina Fraser	Elaine Clarke		🗁						🗁					Twice a year	To provide an update to Board on the standards relating to Safer Staffing	Nursing and Midwifery Committee	It is a national requirement that a staffing assessment is submitted twice a year in order that the Board is aware of the Trust's position against national guidance and can take action where appropriate.	Assurance
Patient Experience Quarterly Report	Meghana Pandit	Jenny Gardiner		🗁				🗁				🗁			Three times per year ~~Four times per year~~	The report brings together information on Compliments, Complaints, PALS, Patient feedback and involvement and health information	No	The trust is accountable to the public, communities and patients that it serves and this report ensures that the Trust Board has oversight of areas of good practice and improvement areas	Assurance

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COMMITTEE	SPONSOR	LEAD	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR		PURPOSE OF THE REPORT	IS THIS REPORT CONSIDERED BY ANOTHER COMMITTEE IF SO WHICH ONE?	WHY DOES IS THIS REPORT REQUIRED TO GO TO TRUST BOARD	ACTION
Patient Led Assessments of the Care Environment (PLACE) Annual Report	Lisa Kelly	Lincoln Dawkin						🗁							Annual	To provide the Board with a summary update of the outcome of the Patient-Led Assessments of the Care Environment	No	The NHS Constitution gives patients the right to be treated in a clean, safe, secure and suitable environment and to receive suitable and nutritious food and hydration and the PLACE assessment links to this.	Assurance
2017-2019 CQUIN Scheme	Lisa Kelly	Lincoln Dawkin		🗁											Annual	To provide the Board with a summary and evidence of improvements of the Health Food for NHS Staff, Visitors and Patients, has been formally agreed with the CCG		The Trust is required to publish a public report and to provide evidence of improvements made.	Assurance
Safeguarding Children and Vulverable Adults Report	Nina Fraser	Lisa Maycock				🗁						🗁			Twice a year ~~Four times per year~~	To update the Trust Board on safeguarding activity, issues and risks	Safeguarding Adult and Childrens Committee/Patient Safety Committee	To provide assurance meeting statutory compliance with safeguarding legislation.	Assurance
Significant Incident Group Report including Never Events	Meghana Pandit	Jenny Gardiner				🗁						🗁			Twice a year	To provide the Board with a summary of the Serious Incidents reported and a progress report on the completion of action plans relating to Serious Incidents	No	Provides assurance to the Board that serious incidents are being managed effectively and in accordance with both the Trust incident reporting policy and the national policy for reporting incidents.	Assurance
End of Life Care Annual Report	Nina Fraser	Sarah MacLaran				🗁									Annual	To provide the Trust Board with an update regarding end of life care for adult services.	End of Life Committee	To receive assurance around progress against the improvement plan for EOLC as required by Care Quality Commission	Assurance
Medical Education Report	Meghana Pandit	Sailesh Sankar				🗁				🗁				🗁	Three times per year ~~Four times per year (inc annual report)~~	To provide the Board with updates in relation to key issues and pressures within Medical Education	Training, Education and Research Committee	The Trust sees education, research and training as central to service transformation and supports meeting the conditions of the Sustainability and Transformation Fund	Assurance
Equality and Diversity Annual Report	Karen Martin	Barbara Hay				🗁									Annual	To inform the Board of the work of Equality and Diversity throughout the Trust and progress in relation to the actions in the Equality and Diversity System2	Workforce and Engagement Committee and actions monitored by QGC	The Trust is required, by the Equality Act 2010, to eliminate discrimination, victimisation and harassment, advance equality of opportunity and foster good relations between different groups and required to publish Equality data annually	Assurance
Workforce Race Equality Standard (WRES) Action Plan	Karen Martin	Barbara Hay				🗁									Annual	To approve progress against the action plan developed to support the WRES reporting template	Workforce and Engagement Committee a	To ensure employees from BME backgrounds have equal access to career opportunities and receive fair treatment in the work place - aligned to the strategic objective to be an employer of choice	Approval
Complaints Annual Report	Meghana Pandit	Jenny Gardiner				🗁									Annual	To provide assurance on key work undertaken by the Quality Department around the management of Complaints	QGC	The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 statutory instrument 309 requires NHS bodies to provide an annual report on its complaints handling, which must be available to the public. To provide the Board with oversight around the management of complaints following the report of the Chief Inspector of Hospitals Inspection.	Assurance
Cancer Services Annual Report	Lisa Kelly	Helen West								🗁					Annual	To provide assurance of the actions that have been taken to demonstrate improved performance against delivery of the cancer standards to improve patient outcomes and provide a positive experience	Cancer Board	It is a requirement of the TDA that Trust demonstrates performance again eight key priorities for local health systems	Assurance
Update on the Trust's strategic approach to information	Karen Martin	Dan Whiston				🗁									Annual	To provide the Trust Board with an update regarding improvements within the ICT infrastructure to enable high quality patient care	No	An efficient ICT infrastructure is critical to delivering high quality clinical care, patient safety and experience, and staff access to essential information	Assurance
Guardian of Safe Working Hours Update	Meghana Pandit/Karen Martin	Andreas Ruhnke				🗁				🗁				🗁	Three times per year	The report is to demonstrate the work of the Guardian in championing safe working hours in the trust to ensure the protection of patients and doctors	No	For the Board to receive assurance that risks are reduced to ensure the safety of patients and staff and monitor compliance against safe working hours	Assurance
Caldicot Guardian Annual Report	Meghana Pandit	Jenny Gardiner												🗁	Annual	To advise the Board of work undertaken by and in support of the Caldicott Guardian during the preceding year	No	The Caldicott Guardian is appointed by the Trust Board and The Caldicott Guardian has a key role in ensuring that the Trust achieves the highest practical standards for handling patient information. This includes representing and championing confidentiality requirements and issues at Board Level, and wherever appropriate within the Trust's overall governance framework.	Assurance
Strategy																			

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Annual Corporate Objectives	Su Rollason	Sarah Phipps												🗁	Annual	For the Board to formally approve the agreed Trust's Annual Corporate Objectives following discussion and risk mapping exercise against the BAF at the Board Seminar in February	No	For the Board to formally approve the agreed Trust's Annual Corporate Objectives following discussion and risk mapping exercise against the BAF at the Board Seminar in February	Approval
Together Towards World Class (TTWC) Biannual update	Karen Martin	Donna Griffiths						🗁						🗁	Biannual	To inform the Board of progress of the Together Towards World Class programme	No	The Chief Executive Officer has overall ownership of the TTWC programme, reporting through the programme board to Trust Board.	Assurance
NHS Staff Attitude & Opinion Survey Results	Karen Martin	Donna Griffiths												🗁	Annual	Provides an overview of the annual NHS National Staff Survey	Chief Officers Group and TTWC Programme Board	Supports the strategic objective to be an employer of choice. Actions arising outside of the annual report will be picked up via TTWC workstream and fed through bi-monthly TTWC report to Board	Noting
Winter Plan	Lisa Kelly	Emma Livesley						🗁							Annual	The plan sets out the actions the Trust is taking to ensure it is resilient to the pressures placed on the whole healthcare system during the winter period.	Chief Officers Group	To provide assurance to the Board that there is a the winter plan developed to ensure operational resilience for the winter period	Assurance
UHCWi Quarterly Report	Karen Martin	Dan Whiston		🗁				🗁		🗁					Three times per year ~~Quarterly~~	To provide the Board with an update on the Trust's journey as part of the five year organisational development programme with the Virginia Mason Institute	No	To provide the Board with an update on the Trust's journey as part of the five year organisational development programme with the Virginia Mason Institute	Review
Research and Innovation																			
Research and Development Annual Report	Meghana Pandit	Ceri Jones		🗁											Annual	Sets out the strategic objectives, how the strategy is delivered, benchmarking data and provides commentary around income and future developments.	No	Research, development and innovation are fundamental to excellence in healthcare which is one of the guiding principles of the NHS as set out in the NHS Constitution. The Trust is required to demonstrate adherence to national guidance and current legislation.	Noting
Reasearch, and Development Update	Meghana Pandit	Ceri Jones						🗁				🗁			Twice a year ~~Three times per year + annual report~~	To present a summary of the research, development and innovation activities that have been on-going across the Trust	No	Research, development and innovation are fundamental to excellence in healthcare which is one of the guiding principles of the NHS as set out in the NHS Constitution. The Trust is required to demonstrate adherence to national guidance and current legislation.	Assurance
Performance																			
Integrated Quality, Performance and Finance Monthly Report • Operational Performance • Quality and Safety • Finance • Workforce	Karen Martin	Laura Crowne/Lynda Cockrill		🗁		🗁		🗁		🗁		🗁		🗁	Bimonthly	To inform the Board of the performance against the key performance indicators	Committee Specific Scorecards presented to QGC and F&P	The Trust has an obligation to meet operational, financial and contractual targets. Committee Specific Scorecards will be presented to the Board Committees to facilitate closer scutiny and support discussion around matters delegated by the Board.	Assurance
Feedback from Key Meetings																			
Audit Committee Meeting Report	Chair of Audit	Geoff Stokes		🗁		🗁		🗁		🗁				🗁	Five times per year	To provide assurance on key work of Board-Committee and escalate matters as appropriate	No	As part of the overall governance structure for the organisation	Assurance
Finance and Performance Committee MeetingMonthly Report	Chair of F&P	Geoff Stokes		🗁		🗁		🗁		🗁		🗁		🗁	Bimonthly	To provide assurance on key work of Board-Committee and escalate matters as appropriate	No	As part of the overall governance structure for the organisation	Assurance
Quality Governance Committee Meeting Monthly Report	Chair of QGC	Geoff Stokes		🗁		🗁		🗁		🗁		🗁		🗁	Bimonthly	To provide assurance on key work of Board-Committee and escalate matters as appropriate	No	As part of the overall governance structure for the organisation	Assurance
Regulatory, Compliance and Corporate																			
CQC Registration Report	Meghana Pandit / Nina Fraser	Jenny Gardiner						🗁							Annual	To provide an update on the Trusts current CQC Registration status and outline changes proposed to the system of statutory regulation	Chief Officers Group	Compliance with the proposed Fundamental Standards of Safety and Quality	Assurance
Trust Board Code of Conduct & Statement of Responsibility	Geoff Stokes	Geoff Stokes										🗁			Annual	To seek commitment from the Trust Board on an individual and collective basis to comply with the provisions of the Code of Conduct and Statement of Responsibilities for the Board of Directors	No	The document demonstrates the Trust's commitment to embedding world class corporate governance and compliance with statutory requirements.	Approval
Audit Committee Annual Report	Chair of Audit Committee	Geoff Stokes		🗁											Annual	To provide assurance to the Trust Board that the Audit Committee is functioning in accordance with its Terms of Reference and in line with the requirements of the NHS Audit Committee Handbook	Audit Committee	In line with the requirements of the NHS Audit Committee Handbook and contributes to the Annual Governance Statement	Approval
Forward Work Programme	Geoff Stokes	Rebecca Hough												🗁	Annual	To review and approve annual programme of work	No	To review and approve annual programme of work	Approval
Timetable of Board and Committee Meetings	Geoff Stokes	Rebecca Hough						🗁							Annual	To approve the annual timetable of Board and Committee meetings for the year ahead	No	As part of the overall governance structure for the organisation	Approval

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Emergency Preparedness Resilience and Response (EPRR) Annual Report	Lisa Kelly	Luke Peachey								🗁					Annual	The Civil Contingencies Act 2004 and the NHS EPRR Framework requires NHS Acute organisations to plan for, respond to and recover from major incidents. The purpose of this paper is for information purposes detailing the work of the Emergency Planning Team.	No	As part of the NHS EPRR Framework NHS organisations are required to submit, no less than annually a report to the Board on the actions of the Emergency Planning Department.	Noting
EPRR Self-Assessment Assurance Report	Su Rollason	Luke Peachey						🗁							Annual	It is a requirement of NHS England that UHCW NHS Trust submits a self-assessment report against the NHS EPRR National Core Standards. The purpose of the report is to identify the current status of EPRR within UHCW NHS Trust, and the work plan to ensure full compliance within the year.	Emergency Planning Steering Committee	It is a requirement that the report receives executive support and is approved by the Trust Board.	Approval
Health and Safety Risk Management Annual Report	Lisa Kelly	David Lord										🗁			Annual	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	Health and Safety Committee	Trust Board has overall responsibility for the health and safety of the organisation	Approval
Health and Safety Annual Work Programme	Lisa Kelly	David Lord										🗁			Annual	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	Health and Safety Committee	Trust Board has overall responsibility for the health and safety of the organisation	Approval
Employee Relations	Karen Martin	Wendy Bowes		🗁						🗁					Two times per a year	The report is to provide assurance regarding engagement, quality amd people management matters across the Trust.	Workforce and Engagement Committee	Trust Board has overall responsibilty	Assurance
Information Governance Toolkit Annual Submission	Lisa Kelly	Harjit Matharu												🗁	Annual	For the Trust Board to approve the annual submission of the IG Toolkit	IG Committee	Information Governance is a key component of the Trust's governance framework and has regulatory cnsequences if requirements are not adhered to. QGC will monitor progress against the action plan	Approval
Register of Gifts and Interests Annual Update	Andy Hardy	Geoff Stokes		🗁											Annual	To present the Register of Interests and Register of Gifts & Hospitality for the Board of Directors of the Trust for approval	Audit Committee	In accordance with the NHS Code of Accountability, the Trust's Standing Orders and the Business Conduct Policy, the Trust is required to hold and maintain a Register of Interests and a Register of Gifts and Hospitality, and to make these available for public inspection.	Approval
Register of Signings and Sealing's Annual Update	Andy Hardy	Geoff Stokes		🗁											Annual	The report sets out the usage of the common seal of the Trust during the year 2014/15 and is provided for noting	No	Affixation is governed by the Trust's Standing Orders, which dictate that a report detailing the usage of the seal shall be periodically submitted to the Trust Board.	Noting
Trust Annual Report & Accounts including Governance Statement and quality account	Su Rollason	Alan Jones/Geoff Stokes/Jennyh Gardiner		🗁											Annual	To seek approval of the Annual Report and adoption of the annual accounts	No	The Trust is required to publish an Annual Report and Annual Accounts	Approval
Quality Account	Meghana Pandit	Jenny Gardiner		🗁											Annual	To formally adopt the Quality Account in public session	Private board	The Trust is rquired discuss the Quality Account in a puiblic session prior to submission	Approval
Fit and Proper Persons	Geoff Stokes	Geoff Stokes										🗁			Annual	To provide assurance that all members of the Trust Board meet the requirements set out in Regulation 5 of the Care Quality Commission fundamental standards,	No	To provide assurance that all members of the Trust Board meet the requirements set out in Regulation 5 of the Care Quality Commission fundamental standards,	Assurance
Review of SOs, SFIs and the Scheme of Reservation and Delegation (next due 2018)	Su Rollason	Geoff Stokes		🗁											Biennial	To present proposed amendments to the Standing Orders (SO), Standing Financial Instructions (SFI) and Scheme of Reservation and Delegation (SoRD) to the Trust Board for approval, on the recommendation of the Audit Committee	Audit Committee	The Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation are the Trust's core corporate governance documents, which describe how the Trust Board will conduct its business,	Approval
Cancer Operational Policy (next due 2019)	Lisa Kelly	Helen West										🗁			Triennial	To present the Cancer Services Operational Policy to the Trust Board for approval in order to comply with the NHS Trust Development Authority's Sustaining Cancer Improvement: 8 High Impact Actions	Cancer Board	Every Trust should have a cancer operational policy in place and approved by the Trust Board in accordance with requirement of the TDA	Approval
Raising Concerns Policy (formerly Whistleblowing) - next due 2019	Geoff Stokes	Geoff Stokes										🗁			Biennial	To approve the Policy updates in line with national guidance	Audit Committee and Partnership and Engagement Forum	The Trust Board is responsible for setting the culture and tone of the organization and in line with the Trust's values of openness, compassion and learning	Approval
Complaints Policy - next due 2019	Meghana Pandit	Andrew Wilkins						🗁							Triennial	To approve the Policy updates	Quality Governance Committee	To demonstrate compliance with the complaints and concerns process and the NHS Complaints (England) Regulations (2009).	Approval

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Health and Safety Policy - next due 2019	Lisa Kelly	David Lord				🗁									Triennial	To approve the Policy Updates	Health and Safety Committee, Quality Governance Committee	To set the direction for health and safety in the Trust and to comply with section 2(3) of the Health and Safety at Work etc. Act 1974.	Approval
Infection, Prevention and Control Policy - next due 2018	Nina Fraser	Kate Prevc								🗁					Annual	To approve the Policy Updates	Infection Control Committee, Patient Safety Committee	The prevention and control of Healthcare Associated Infections is a high priority for all parts of the NHS. Health Act (DH 2008)	Approval
Clinical Strategy (next due 2019)	Meghana Pandit	Jenny Gardiner		🗁											Triennial	To approve Strategy Updates	No	The Clinical Strategy articulates the organisational vision and aims and, expresses the desired model of delivery of healthcare across Coventry and Warwickshire for the next ten years.	Approval
Quality Strategy (next due 2021)	Meghana Pandit	Jenny Gardiner				🗁									Quinquennial	To approve Strategy Updates	Quality Governance Committee	The Quality Strategy sets out the key objectives that will drive the delivery of Quality at UHCW over the next five years 2016- 2021	Approval
Research, Development and Innovation Strategy (next due 2018)	Meghana Pandit	Ceri Jones						🗁							Triennial	To approve Strategy Updates	Research Governance and Human Tissue Committee	Research and Innovation are essential to the development of world leading excellence in clinical care. They enable the Trust to develop and continuously improve its services and to attract and maintain highly skilled and motivated staff.	Approval
Development & Management of Trust-wide Corporate Business Records Procedure (next due 2018)	Meghana Pandit	Justin King												🗁	Triennial	To approve policy Updates	No	Provides a clear and comprehensive procedure for the management of Trust-wide corporate strategies, policies and procedures, ensuring that a high level of consistence and uniformity is achieved across the Trust	Approval
Risk Management Strategy (next due 2019)	Meghana Pandit	Justin King												🗁	Biennial	To approve Strategy Updates	Risk Committee	The management of risk underpins all strategies, processes and activities that lead to the achievement of the aims and objectives of the Trust.	Approval
Freedom to Speak Up Guardian	Geoff Stokes	Geoff Stokes				🗁						🗁			Biannual	To provide thematic reporting to the Board on the themes and issues that are being reported to the F2SUG and the Confidential Contacts	No	The requirement for NHS organisations to establish a Freedom to Speak Up Guardian (F2SUG) arose from the recommendations made by Sir Robert Francis in his report into failings at Mid Staffordshire Hospitals NHS Foundation Trust. There is also an expectation that the F2SUG will report directly to the Chief Executive Officer and the Trust Board on the issues that are being reported to them.	Assurance
Provider Licence Self Certification	Su Rollason	Geoff Stokes		🗁											Annual	To receive assurance	No	To receive assurance	Assurance
Questions from the Public	Chairman			🗁		🗁		🗁		🗁		🗁		🗁	Monthly				
		Total	**0**	**23**	**0**	**22**	**0**	**19**	**0**	**18**	**0**	**18**	**0**	**20**					

Please note: other ad hoc quality matters will be scheduled on the Quality Governance Committee agenda, as and when required, during the course of the year

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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: Quality Governance Committee
Committee Meeting Date: 16 April 2018
Quoracy: Yes
Apologies: Sudhesh Kumar, Lisa Kelly
Committee Chair: Ed Macalister-Smith
Report submitted by: Ed Macalister-Smith
1. Addressing Bullying and Harassment The Committee heard from the Head of Diversity and the Staffside Chair about the current position to address bullying and harassment. Staff survey results have shown improvements to relevant questions but there is still under-reporting. The level of reporting of the most recent incident is <50%
2. CQC Inspection Preparation for the CQC inspection continues with dates of all elements of the inspection now confirmed. An initial focus group was held by CQC with front line staff and good engagement has been reported.
3. Improving communication between Audit Committee and Quality Governance Committee The Chair raised the point that had arisen in Audit Committee that there are Internal Audit reports that have patient safety and experience implications and asked the executive to review how learning can be shared across the various teams. Particular reference to Ward Prescribing and Rostering – Safe Staffing.
4. Integrated Quality, Performance and Finance Report QGC discussed the current 'flash' report that highlighted up to date quality metrics and were encouraged by the continuing progress being made across most areas.
5. Quality Account Priorities The Chief Medical Officer gave an update on progress made during 2017/18 and advised the Committee that the quality priorities will continue for the forthcoming year. These will be; 1. Patient Safety: a) Eliminating avoidable hospital acquired pressure ulcers b) Falls 2. Clinical Effectiveness: Mortality Review 3. Patient Experience: Customer Care Course
6. Risk Committee The report from the Risk Committee gave assurance that risk processes have developed and improved with better engagement across the Trust in respect of risk.

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

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Committee Name: Quality Governance Committee
Committee Meeting Date: 21 May 2018
Quoracy: No
Apologies: Ed Macalister-Smith, Barbara Beal, Sudhesh Kumar, Meghana Pandit
Committee Chair: Brenda Sheils
Report submitted by: Brenda Sheils
1. Quoracy It was noted that the meeting was inquorate so some decisions will need to be escalated to the Board for decision. These include decisions relating to policies that cannot wait until the next committee meeting
2. Patient Experience Update The Committee heard about progress made on the Patient Experience Delivery Plan approved in February 2018. Most of the terms of reference for the eight sub-committees of the Patient Experience Committee have been approved and there has been good engagement from across the clinical groups.
3. Integrated Quality, Performance and Finance Report The flash report showing April's data was discussed and it was noted that there appeared to be higher number of RIDDOR events. Explanations for this will be provided to the chair of the meeting and updated at the next meeting of the committee. It was noted that performance in signing of complaints within the Trust's 25 day target had deteriorated and the Associate Director for Quality – Patient Experience explained that this was due to a combination of consistently higher numbers of complaints combined with some sickness and annual leave clashes.
4. Quality Account The final draft of the Quality Account was presented and it was noted that any further changes could still be made. It was agreed that the process for producing next year's Quality Account will be shared with the Committee in good time so that expectations can be managed.
5. CQC Inspection The Committee heard that encouraging feedback had so far been received from CQC inspectors. It was particularly noted that there have been no patient safety concerns raised during the inspection, which is unusual, especially for a trust of this size. Planning continues with preparation for the Well Led inspection but the planned review of Never Events has been postponed.
6. Policies The Trust reviewed and recommended for approval the following policies; • Injectable Medicines Policy • Printing Policy Both these policies need to be approved before the next meeting of the Committee and therefore **Board is asked to approve them**, as the Committee was inquorate. A third policy, Managing Safeguarding Allegations Against Staff and Persons in Position of Trust Policy and Procedure, was discussed and recommended for approval in principle, but there were questions related to whether consultation had been completed.

The Board is asked to **NOTE** the business discussed at the meeting and to **APPROVE** policies attached.

University Hospitals Coventry and Warwickshire NHS Trust

Title of Trust-wide CBR: **PRINTING POLICY**	
eLibrary ID Reference No: *This id will be applied to all new Trust-wide CBRs by the Quality Department and will be retained throughout its life span.*	
Newly developed Trust-wide CBRs will be allocated an eLibrary reference number following Trust approval. Reviewed Trust-wide CBRs must retain the original eLibrary reference number. *The Quality department will progress all new, re-written and reviewed CBRs for final Trust approval.*	
Version: *(must be a rounded number, i.e. 6.0,7.0 etc.)*	0.3
Title of Approving Committee:	Managed Print Service Project Board Information Governance Committee Quality Governance Committee
Date Approved:	*(to be applied by Quality Dept.)*
Risk Rating: *(this must be applied by the Author prior to being submitted to the Quality Dept. (refer to CBR guidance pack on eLibrary)*	
Next Review Date: *(this must be applied by the Author dependant on risk rating or record alternative date if required to meet national guidance)*	
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 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)*	Corporate printing policy covering cost effective printing and print security in the workplace
Purpose of Trust-wide CBR: *(Purpose of the Corporate Business Record)*	To set out approved methods for printing To standardise printing, follow best practice guidelines and reduce costs
Audience *(Who the CBR is intended for)*	Trust wide
Trust-wide CBR to be read in conjunction with: *(List overarching/underpinning strategies, policies and procedures – refer to CBR Evidence Summary)*	Fax policy, ICT Security policy, Information Governance Strategy/Policy, Mobile Devices Policy, Confidentiality and Data Protection Policy, Information Sharing Policy.
Relevance: *(State one of the following: Governance, Human Resource, Finance, Clinical, ICT, Health & Safety, Operational)*	ICT
Superseded Trust-wide CBRs (if applicable): *(Should this CBR completely override a previously approved Trust-wide CBR, please complete the 'Request for Removal of CBR' form and submit to Quality Dept – please refer to eLibrary and state full title and eLibrary reference number and the CBR will be removed from eLibrary)*	

Author's Name, Title and email address: *(must not be the same as reviewer)*	David Hope - ICT Project Manager david.hope@uhcw.nhs.uk
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Chief Officer's Name, Title:	Su Rollason - Chief Finance Officer su.rollason@uhcw.nhs.uk
Title of Group/Department/Specialty:	ICT

Version	Consulting & Endorsing Stakeholders, Committees/Meetings/Forums etc for this version only *List **all** Consulting & Endorsing Stakeholders for this version, this can include direct consultation with individuals, Committees/Forums/Bodies/Groups, refer to guidance pack.*	Date
0.1	Submission to the Managed Print Service Project Board	February 2018
0.2	Resubmission to the Managed Print Service Project Board Submission to the Information Governance Committee and the Quality Governance Committee	April 2018
0.3	Updates applied following review and recommended approval at the Information Governance Committee and the Quality Governance Committee	May 2018

Corporate Business Record Policy/Procedure Summary

Printing Policy

Purpose of CBR:

This CBR policy introduces printing standards as an integral part of the Managed Print Service. It details best practice, aims to reduce the potential for Information Security and Information Governance breaches, as well as the reduction of costs.

Description of vision of CBR:

To provide the standards which underpin a secure, effeicient, cost effective and auditable Printing Services for the Trust.

Who does CBR affect?

This policy will apply to all staff employed by UHCW in all locations, it includes those directly employed or in a temporary or locum capacity without exception.

Key Points of CBR:

To minimise the risk of Information Security and Information Governance breaches by utilising 'secure release' printing, where appropriate.

To ensure print devices are allocated depending on need, and appropriate for their intended use and volumes of print.

To ensure business critical clinical areas have access to alternative devices in the event of failure.

To have 90% of users within approximately 30 meters of a standard device and a maximum of two unlocked or one locked door.

To standardise the types of print devices used across the trust.

To avoid unnecessary ordering of print consumables using "just in time" consumables replenishment.

To encourage users to consider whether printing is necessary and therefore help to reduce costs.

To promote awareness and understanding of the features of the Managed Print Service. This includes printing in black and white and double sided as a default. Colour printing should only be used where business critical and operationally necessary, access to this feature will be restricted.

Where disability issues may affect a member of staff's ability to access a printing solution, provide reasonable adjustments to support their needs.

1.0 SCOPE

1.1 This policy will apply to:

1.1.1 All staff employed by UHCW (University Hospitals Coventry and Warwickshire NHS Trust) in all locations, whether directly employed or in a temporary or locum capacity without exception;

1.1.2 All staff that hold honorary contracts with UHCW;

1.1.3 All students in the placement of UHCW;

1.1.4 Any person who has need or cause to access information held by the Trust for the purpose of direct patient care or secondary use;

1.1.5 All contract staff and third party suppliers;

1.1.6 Anyone else authorised to use the Trust's Managed Print Service.

1.2 For the purpose of the policy, production of printed materials will be through the following output equipment:

1.2.1 Managed Print Service In scope devices:

- Multi-functional devices (MFD's)
- Single Function printers

1.2.2 Managed Print Service Out of scope devices

- Label printers (Radiology/Pathology requesting)
- Trust ID/Smart Card printers
- Line printers
- Plotters / Computer Aided Design
- Medical Equipment and Bioengineering Services (MEBS) printers
- Medical Photography printers
- Medical Records Off-site label printers
- Library printer (separate library solution not hosted on UHCW ICT network)
- Other printers that are not covered by MPS In scope devices

2.0 INTRODUCTION

The Trust has decided to implement a Managed Print Service across the Trust and this policy has been produced to introduce printing standards as an integral part of the service. This will include adoption of best practice; engagement with Trust staff throughout the policy development process; reduce the potential for Information Security and Information Governance breaches; and to reduce costs.

A Managed Print Service will introduce a centralised print and fax service, including MFD's across the Trust that have the capability to scan and fax, as well as printing and copying. A stand-alone library solution will be delivered as part of the Managed Print Service.

The latest versions of Fax and ICT Security policy will supersede this Printing policy in the key areas they cover and this policy will be updated as required to ensure alignment.

This policy seeks to provide staff with guidance aimed at minimizing the potential Information Governance (IG) risks associated with printing.

3.0 STATEMENT OF INTENT

3.1 **Aims and Objectives**

The aims of this policy are:

3.1.1 To give clear direction on the use of print devices and output options to ensure all Trust printers and MFDs are located and used appropriately.

3.1.2 To raise staff awareness of the risks associated with printing and copying information containing person identifiable or confidential information and provide guidance to minimize those risks.

3.1.3 To discourage the use of printing unless business critical.

The objectives of this policy are:

3.1.4 To minimise the risk of Information Security and Information Governance breaches by utilising 'secure release' printing, where appropriate. Printing functionality on all in-scope devices as identified in section 1.2.1 of this policy.

3.1.5 To ensure a full Managed Print Service is provided across the Trust including appropriate support for standard devices as identified in section 1.2.1 of this policy.

3.1.6 To ensure print devices are allocated depending on need, and appropriate for their intended use and volumes of print.

3.1.7 To ensure business critical clinical areas have access to alternative devices in the event of failure.

3.1.8 To have 90% of users within approximately 30 meters of a standard device and a maximum of two unlocked or one locked door.

3.1.9 To standardise the types of standard print devices used across the trust.

3.1.10 To avoid unnecessary ordering of print consumables using "just in time" consumables replenishment.

3.1.11 To encourage users to consider whether printing is necessary.

3.1.12 To promote awareness and understanding of the features of a managed print service.

3.1.13 To reduce cost.

3.1.14 Where disability issues may affect a member of staff's ability to access a suggested printing solution reasonable adjustments will be made proportionate to their printing requirements.

3.2 This policy forms part of the Trust's Information Governance Strategy where the confidentiality, availability and integrity of printing services is managed consistently.

4.0 DETAILS OF POLICY

General Printing Principles for Managed Print Service

4.1 Equipment Configuration, Features and Specifics

4.1.1 MFD's are shared devices that are networked to the Trusts IT infrastructure and configured to provide print, copy, scan and where required fax functionality.

4.1.2 Shared MFD's will be the preferred printer type and deployed where possible.

4.1.3 The size/functionality of the MFD will be determined by the expected print volumes.

4.1.4 All MFDs have scan to PDF capabilities. The scanned document will be sent as a PDF file to the users Trust personal network share (H: drive) as a minimum. Scan to Trust network share or scan to email can be configured if scanning to H: drive does not support business requirement.

4.1.5 Duplex Printing (double sided); all devices will automatically default to double sided printing. All printing should be double sided as standard. Single sided printing should be used only when critically and operationally necessary.

4.1.6 Mono printing (black & white); all devices will automatically default to black and white printing and copying.

4.1.7 Where colour printing and copying is available as an option, the user must select this for every print job that requires colour. Colour printing should be used only when critically and operationally necessary and access will be restricted.

4.1.8 Colour printing is discouraged to help reduce costs.

4.1.9 Power Save; where possible, all print devices will be configured to utilise Power Save / Auto Shut off modes. The warm up time taken for the first print will be no longer than 30 seconds.

4.1.10 Tray configuration; where possible these will be standardised across the Trust, with each paper tray being configured in line with local operational processes and requirements. This will include but not exclusively, plain A4, A3, letterheads, labels, wristbands.

4.1.11 Secure Release Printing; this MPS solution printing functionality means a user's print job will not be printed until the user identifies themselves at the printer using their own NHS Smartcard or Trust ID. A dedicated print ID token option will be used where required in specific circumstances. Windows/network login solution will also be used as a backup in case the NHS Smartcard or Trust ID are unavailable. This functionality offers the following benefits:

- Print jobs can be released from any printer set up with Secure Release Printing functionality across all Trust sites.
- If a printer breaks, the user can release their print job at the next nearest printer that has
  Secure Release Printing, there is no need to send it again.
- Unwanted print jobs can be deleted from the printer once the user has authenticated themselves at the printer.

4.1.12 Uncollected print jobs are stored for 7 days after which time they are automatically deleted from the print servers. This duration will be reduced to 48 hours following an initial 6 month bedding in period. If users do not release their print job before that time has elapsed, they will need to resend their print job.

4.1.13 Print is provided for Trust purposes; users are expected to refrain from using Trust devices for personal use as the library will provide pay per copy printing

services.

4.1.14 The Trust reserves the right to pass any charges incurred for personal printing to the individual user.

4.2 Audit

4.2.1 Device usage is audited to ensure compliance with this policy and the effective operation of print services.

4.2.2 Departments will be monitored and reviewed on a usage basis.

4.2.3 Printer consumables e.g. toners, drums, staples, will be provided by the Managed Print Supplier.

4.3 Additional, replacement devices and relocations

4.3.1 All requests for additional print devices will be made via ICT's Procurement service for Standard Stock Items.

4.3.2 No standard print devices as defined in section 1.2.1 of this policy will be purchased by individual departments.

4.3.3 Requests for personal and non-centralised printers will only be granted in specific situations, for example to support Disability Discrimination Act compliance. The process and criteria for requesting these are detailed in Appendix 1. This process will become applicable following the implementation of the MPS at the Trust.

4.3.4 Requests to move a device to a different location will be made via the ICT Service Desk.

4.3.5 Equipment Disposal; The Managed Print Service provider is responsible for the disposal of obsolete or faulty standard print devices ensuring adherence to WEEE Regulations 2013 or any other current and relevant Government regulations.

4.5 Information Security

4.5.1 All print jobs that have not been printed within 7 days will automatically be deleted. This duration will be reduced to 48 hours following an initial 6 month bedding in period.

4.5.2 Confidentiality; any uncollected confidential material found lying on a device must be treated as a breach of confidentiality and should be reported in accordance with the Trust's Incident Reporting and Management procedures. It is the responsibility of all users to secure their print jobs.

4.6 **Best Practice**

4.6.1 It is the responsibility of all users to inform the relevant party, either the Trust ICT or the Managed Print Service Provider Service Desk, as notified on the device, of any noticed concerns or faults with a print device as they are encountered.

4.6.2 The Trusts preferred communication and storage methods are electronic. Users should print only when necessary and in line with local operating procedures.

4.6.3 Users should delete their print jobs, if they are no longer required.

4.6.4 PowerPoint presentations; whenever possible, users should print in outline mode or hand-out mode with multiple slides on one page. Please use the Trust PowerPoint presentation template.

4.6.5 Large documents with multiple pages should be printed to the most appropriate MFD device.

4.6.6 Printer consumables are replenished on a "just in time" basis by monitoring stock levels. Toners should only be replaced when instructed to do so by the equipment i.e. they are empty. This will ensure that we are working in the most efficient manner.

5.0 DUTIES / RESPONSIBILITIES

As per Section 2.0 Introduction, the latest versions of Fax and ICT Security policy Duties/Responsibilities supersede this Printing policy in the key areas they cover.

Individual Responsibilities:

5.1 Executive Team

Executive Team is accountable to the Trust Board for ensuring Trust-wide compliance with policy.

5.2 Group Managers and Heads of Service

Group Managers and Heads of Service are responsible to the Executive Team for ensuring policy implementation.

5.3 Information Asset Owners

Information Asset Owners are responsible for ensuring compliance with WEEE and information security requirements detailed in Trust policies for safe disposal of out of scope and speciality printers not covered by this policy and under their control.

5.4 Managers

Managers are responsible for all printers located in their service or department. Managers are also responsible for ensuring that staff in their area of responsibility understand and adhere to this policy.

5.5 Staff

5.5.1 All staff who utilise printing facilities must ensure that they have read and understood this policy, any concerns must be raised with their line manager in the first instance.

5.5.2 Loss of NHS Smartcard or Trust ID; it is the responsibility of all users to follow the normal Trust procedures and report the loss of their card as soon as it happens. In relevance to this policy, this is to avoid the possibility of unauthorised use of the card to access confidential print jobs.

5.5.3 Device out of paper or paper jams; if a device runs out of paper or jams whilst printing, the user is responsible for refilling paper or clearing the jam to allow the device to complete the print job. Every attempt must be made to retrieve the printed material or remove from the print queue to reduce the risk of an Information Security breach. If a user is not able to clear a paper jam, then a named Trust individual must be detailed on the incident logged with the Service Provider and the allocated engineer will pass over any output found when clearing jam for correct disposal.

5.6 All Other Users

All staff that utilise printing facilities, must ensure that they have read and understand this policy, and to raise any concerns.

6.0 DISSEMINATION AND IMPLEMENTATION

6.1 This policy will be stored on the Trust's eLibrary system, which is available to all Trust staff. The production of each new version will be advertised via the corporate communications, and managers must ensure that it is implemented within their areas.

6.2 It is the responsibility of managers to ensure that local processes reflect the principles and requirements of this policy.

7.0 TRAINING

7.1 Staff will receive training covering printers and MFDs from a number of key sources:

7.2 Provided either by the Managed Print Service provider or the Trust representatives as appropriate.

7.3 Documented processes and procedures will accompany the training for the system.

8.0 MONITORING COMPLIANCE

Compliance with this policy will be monitored through the review of reports available through the Managed Print Service solution, and review of reports from speciality printers where available. The results of this audit and analysis of incidents relating to printing solutions and printed material will be reviewed at the appropriate level to monitor and enforce compliance.

8.1 Monitoring Table

Aspect of compliance or effectiveness being monitored	Monitoring method (i.e. regular audits/reviews)	Individual/ department responsible for the monitoring	Frequency of the monitoring activity (i.e. Monthly/ Annually)	Group / committee which will receive the findings / monitoring report	Group / committee / individual responsible for ensuring that the actions are completed
Print Policy Compliance	Audit Reports	ICT	Monthly	TBC – an outstanding Project Board action	TBC – an outstanding Project Board action
Data Protection / GDPR	Audit / Reports	ICT	Monthly	Information Governance Committee	Information Governance Committee
Internal & External Audit Reviews	Audit	Audit Committee	Annually	Information Governance Committee	Information Governance Committee

9.0 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.

10.0 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.

11.0 ETHICAL CONSIDERATIONS

The Trust recognises its obligations to maintain high ethical standards across the organisation and seeks to achieve this by raising awareness of potential or actual ethical issues through the CBR consultation and approval process. Authors of CBRs are therefore encouraged to liaise with the Trust's Clinical Ethics Forum to seek input where necessary.

12.0 DEFINITIONS

The following acronyms, abbreviations and terms are used in this document

Terms/Acronyms/ Abbreviations	Full Description
Business Critical	Crucial to the operation of the Trust
IG	Information Governance
Information Asset Owner	Senior individuals whose role is to understand and address risks to the information assets they 'own'
MEBS	Medical Equipment and Bioengineering Services
MFD	Multi-Function Device – supports printing, scanning, copying and potential to fax
Managed Print Service	Printing service supplied and maintained by external provider
PC	Desktops, laptops, net books, tablet PCs, and media centre PCs
PDF	Portable Document Format – Universal document file format to ease sharing across different ICT platforms
PID	Patient Identification
Print ID Token	Key fob token used to authenticate to a printer or MFD when an NHS Smartcard or Trust ID are not the most appropriate solution.
Secure Release Printing	User authentication required to release print job and print
SFD	Single-Function Device – supports printing only
Smartcard	National token, using 'chip and pin' technology, to support user identification/authentication
UHCW	University Hospitals Coventry and Warwickshire NHS Trust
WEEE	Waste Electrical and Electronics Equipment 2013 is current

	version of national legislation

13.0 REFERENCES AND BIBLIOGRAPHY

Record referenced sources of evidence that underpin this procedural document e.g. statute, NHS, other relevant guidance, information or a professional body and insert bibliography where relevant.) *(Delete upon insertion of text)*

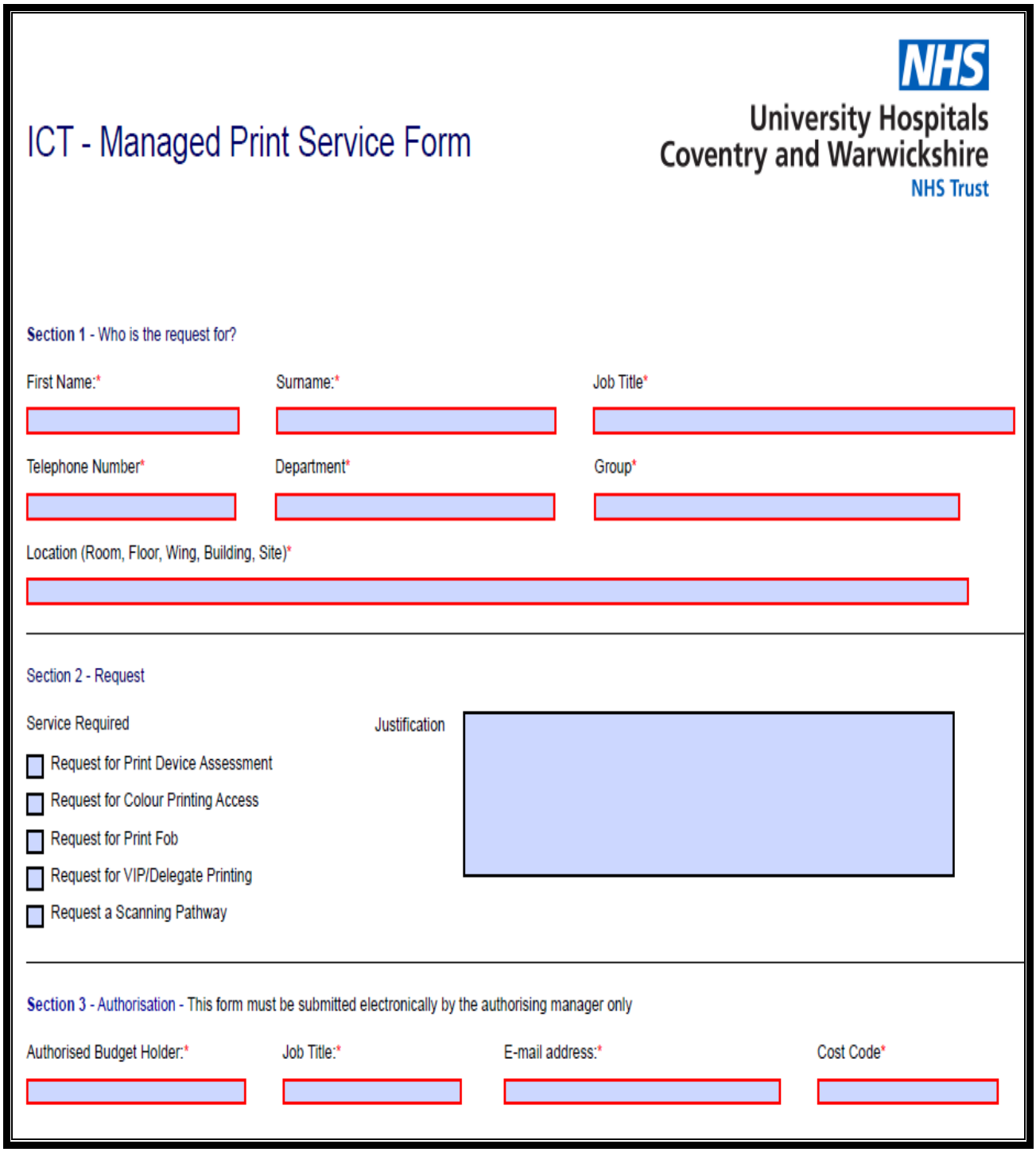
13.1 n/a

14.0 UHCW ASSOCIATED RECORDS

- ICT Security Policy
- Fax Policy
- Information Governance Strategy
- Information Governance Policy
- Information Governance Incident Management Policy
- Mobile Devices Policy
- Confidentiality and Data Protection Policy
- Information Sharing Policy

15.0 APPENDICES

Appendix 1 – Managed Print Service Form



ICT - Managed Print Service Form

NHS
University Hospitals Coventry and Warwickshire
NHS Trust

Section 1 - Who is the request for?

First Name:* | Surname:* | Job Title*

Telephone Number* | Department* | Group*

Location (Room, Floor, Wing, Building, Site)*

Section 2 - Request

Service Required

- ☐ Request for Print Device Assessment
- ☐ Request for Colour Printing Access
- ☐ Request for Print Fob
- ☐ Request for VIP/Delegate Printing
- ☐ Request a Scanning Pathway

Justification

Section 3 - Authorisation - This form must be submitted electronically by the authorising manager only

Authorised Budget Holder:* | Job Title:* | E-mail address:* | Cost Code*

University Hospitals Coventry and Warwickshire NHS Trust

Title of Trust-wide PPS: **INJECTABLE MEDICINES POLICY**	
eLibrary ID Reference No: *This id will be applied to all new Trust-wide CBRs by the Quality Department and will be retained throughout its life span.*	
Newly developed Trust-wide PPSs will be allocated an eLibrary reference number following Trust approval. Reviewed Trust-wide PPSs must retain the original eLibrary reference number. *The Quality department will progress all new, re-written and reviewed PPSs for final Trust approval.*	
Version: *(must be a rounded number, i.e. 6.0,7.0 etc.)*	1.0
Title of Approving Committee:	*(to be applied by Quality Dept.)*
Date Approved:	*(to be applied by Quality Dept.)*
Risk Rating: *(this must be applied by the Author prior to being submitted to the Quality Dept. (refer to CBR guidance pack on eLibrary)*	HIGH
Next Review Date: *(this must be applied by the Author dependant on risk rating or record alternative date if required to meet national guidance)*	APRIL 2020
If printed, copied or otherwise transferred from eLibrary, Trust-wide Policies, Procedures and Strategies will be considered 'uncontrolled copies'. Staff must always consult the most up to date PDF version registered on eLibrary. ***As a controlled Trust-wide PPS, this record should not be saved onto local or network drives but should always be accessed from eLibrary.***	

Summary of Trust-wide PPS: *(Brief summary of the Trust-wide Corporate Business Record)*	Description of expected practices when prescribing, preparing, administering or monitoring injectable medicines.
Purpose of Trust-wide PPS: *(Purpose of the Corporate Business Record)*	• To promote compliance with NPSA guidance • To reduce risk and prevent harm to patients from injectable medicines therapy • To standardise injectable medicines practice across UHCW • To educate and share exemplary injectable medicines practice
Audience *(Who the CBR is intended for)*	All healthcare professionals that prescribe, prepare, administer and/or monitor injectable medicines.
Trust-wide PPS to be read in conjunction with: *(List overarching/underpinning strategies, policies and procedures – refer to CBR Evidence Summary)*	Medicines Optimisation Strategy Medicines Policy CLIN-POL-004-10 See section 14 for full list of associate policies
Relevance: *(State one of the following: Governance, Human Resource, Finance, Clinical, ICT, Health & Safety, Operational)*	Clinical
Superseded Trust-wide PPSs (if applicable): *(Should this CBR completely override a previously approved Trust-wide CBR, please complete the 'Request for Removal of CBR' form and submit to Quality Dept – please refer to eLibrary and state full title and eLibrary reference number and the CBR will be removed from eLibrary)*	Sections of Medicines Policy Sections of Training/Competency Package for administration of Intravenous Drugs.

Author's Name, Title and email address: *(must not be the same as reviewer)*	Rebecca Mills Medication Safety Officer Rebecca.mills@uhcw.nhs.uk
Reviewer's Name, Title & email address: *(must not be the same as author)*	Elaine Clarke Associate Director of Nursing Elaine.clarke@uhcw.nhs.uk
Chief Officer's Name, Title:	Nina Fraser Chief Nursing Officer
Title of Group/Department/Specialty:	Trustwide

Version	Consulting & Endorsing Stakeholders, Committees/Meetings/Forums etc for this version only *List **all** Consulting & Endorsing Stakeholders for this version, this can include direct consultation with individuals, Committees/Forums/Bodies/Groups, refer to guidance pack.*	Date
	Injectable Medicines Task and Finish Group	April – January 2017
	Medicines Management Committee	24th May 2017
	Nursing and Midwifery Care Quality Forum	9th November 2017
	Medicines Management Committee	27th March 2018
	Medicines Optimisation Committee	12th April 2018
	Patient Safety & Clinical Effectiveness Committee	19th April 2018

Document Summary

Injectable Medicines Policy

Purpose of PPS

- To promote compliance with NPSA guidance
- To reduce risk and prevent harm to patients from injectable medicines therapy
- To standardise injectable medicines practice across UHCW
- To educate and share exemplary injectable medicines practice

Description of vision of PPS

All healthcare professionals minimising risk of adverse effects, extravasation, or infection associated with prescribing, preparing, administering or monitoring of injectable medicines.

Who does PPS affect?

All healthcare professionals who are prescribing, preparing, administering or monitoring of injectable medicines.

Key Points of PPS

- All medications must be administered in accordance with current legislation, professional guidance and UHCW Medicines Policy.
- Medicines should be given by injection when clinically indicated, or where no other route is possible or acceptable to the patient.
- Only staff who have received training and are competent may undertake injectable medicines preparation and administration.
- All injectable medicines are for single patient use only with the exception of radiopharmaceuticals when prepared in accordance with IR(ME)R
- IV medications must be prepared and administered using a standard or surgical ANTT dependent upon risk assessment (refer to trust ANTT policy)
- The line/cannula/vascular device should be flushed between medicines when administering multiple medicines, and after medicines are administered.
- A second check should be performed of the preparation and administration of all injectable medicines.
- The second check by a healthcare professional must incorporate the whole preparation and administration process

Table of Contents

1.0 SCOPE

This policy should be used by:
- All clinical areas that prepare, administer and monitor injectable medicines
- All healthcare professionals that prescribe, prepare, administer and/or monitor injectable medicines.

Injectable medicines covered in this document are those given by one of the following methods:
- Intramuscular injection
- Direct subcutaneous injection or Subcutaneous infusion
- Intradermal injection
- Intravenous bolus into vein or infusion line tubing, and continuous or intermittent intravenous infusion

Other injectable routes not covered in this policy are:
- Intrathecal
- Epidural
- Intra-arterial, Intraosseous, intraventricular, intravitreal, intrapleural and intra-ocular
- Injection into subcutaneous medical devices e.g. gastric band port

Refer to guidelines in specific clinical areas. The principles and basic preparation procedures covered in this policy will generally apply.

This policy should be used in conjunction with a number of UHCW policies and guidelines – see cover of policy.

2.0 INTRODUCTION

The complexities associated with prescribing, preparing and administering injectable medicines means that there are greater potential risks for patients than for other routes of administration. Weak operating systems increase the potential risk of harm and safe systems of work are needed to minimise these risks.

This document has been developed following guidance from the National Patient Safety Agency Alert 20: Promoting Safer Use of Injectable Medicines. It describes exemplary practice for the prescribing, safe preparation, checking, labelling, administration and monitoring of injectable medicines in all clinical area
The objectives of this document are:
- To promote compliance with NPSA guidance
- To reduce risk and prevent harm to patients from injectable medicines therapy
- To standardise injectable medicines practice across UHCW
- To educate and share exemplary injectable medicines practice

3.0 STATEMENT OF INTENT

The objectives of this document are:

- To promote compliance with NPSA guidance
- To reduce risk and prevent harm to patients from injectable medicines therapy
- To standardise injectable medicines practice across UHCW
- To educate and share exemplary injectable medicines practice

4.0 DETAILS OF POLICY

4.1 General standards & principles

All medications must be administered in accordance with current legislation, professional guidance and UHCW Medicines Policy.

Medicines should be given by injection when clinically indicated, or where no other route is possible or acceptable to the patient.

Only staff who have received training and are competent may undertake injectable medicines preparation and administration.

Parenteral nutrition and cytotoxic preparations must not be prepared in clinical areas. The following types of infusions require a local risk assessment which healthcare professionals must be familiar with prior to preparing infusions:

- Administration via an Elastomeric device
- Cardioplegia solutions
- Epidural injections and infusions
- Intrathecal injections/infusions
- Intra-ocular and intra-vitreal injections
- Use of concentrated Potassium or infusion containing more than 40mmol in 1 litre.
- Anaesthetic agents used by non-specialist staff or outside of theatres, critical care or resus environment.
- Additions to purchased neonatal TPN bags

Other High risk medicines - as defined by an NPSA risk assessment score of 6 or above on MEDUSA should be supplied as commercially prepared infusions or via a Central Intravenous Additive Service (CIVAS) where possible. If not possible, a risk assessment should be undertaken and steps must be taken to mitigate risk.

Each clinical area must have a clean and uncluttered area with adequate lighting, and hand washing facilities suitable for the preparation of injectable medicines.

Most medicines licensed for injectable use are intended for single use only and should not be used more than once. Exceptions include the administration of radio-pharmaceuticals when given in accordance with (IR(ME)R and vials of insulin, which contain antibacterial preservatives.

All injectable medicines are for single patient use only with the exception of radiopharmaceuticals when prepared in accordance with IR(ME)R

4.2 Prescribing

For all inpatients medications given as bolus injections by the intravenous, subcutaneous or Intramuscular route and intermittent or one off infusions must be prescribed on the standard prescription and administration chart or a specifically designed chart which has been approved by the Medicines Management Committee (MMC).

Electrolytes added to intravenous fluids and continuous infusions of medication should be prescribed on the intravenous infusion chart or a specifically designed chart which has been approved by MMC (e.g. critical care infusions, or continuous subcutaneous infusion chart)

Approved names must be printed clearly and quantities expressed in System International Units.

Administration instructions must include:

- For bolus doses: the route, the dose, the dose interval and administration time
- For Intermittent Infusion: the route, the dose, the dose interval, administration time and the duration of infusion.
- For continuous infusion: the quantity of medicine, nature and volume of fluid and rate of administration – it is good practice to record the final concentration of the preparation administered.

If a medicine is for central line administration only this must be clearly stated by the prescriber

Medicines must not be added to intravenous infusion fluids unless absolutely necessary and only then if the prescriber is satisfied that the medicine, infusion fluid and infusion container are compatible.

If there is any doubt about the method of administration or compatibility of the drug and vehicle refer to the manufacturers SPC (www.medicines.org.uk), MEDUSA website or contact pharmacy.

The prescription of injectable medicines (including fluids) for patients under general anaesthetic must be recorded on the anaesthetic chart which should be filed in the patient's case notes.

The most common reason for errors are illegibility, ambiguity and alterations in prescriptions.

Pharmacists and healthcare professionals administering injectable medicines are expected to refer any prescriptions not complying with the above back to the prescriber for amendment. In the case of time critical medicines this may be after administration if the intention is clear.

4.3 Preparation

Practitioners should have a thorough understanding of principles relating to the preparation of medicines including compatibilities, calculations, displacement values and labelling.

When checking calculations all calculations must be conducted independently and the results of the calculations must correspond. If they do not, calculations must be repeated independently. If there is still a discrepancy between the two calculations, assistance should be sought from a third competent and trained person.

Where the dose of a medicine is less than a complete vial and the vial requires reconstitution, e.g. for paediatrics, it is necessary to take into account the displacement value of the medicine (see MEDUSA)

When administering injections of medication doses less than 1ml in volume, a 1ml syringe graduated to 0.05ml must be used. When administering radioactive products the most appropriate volume syringe must be selected to minimise staff exposure.

Filter straws or needles should be used for withdrawal of medicines from glass ampoules.

All devices used in the preparation and administration of injectable medicines must be CE marked. Infusion sets should contain in-line filtration appropriate to the solution being administered.

Aseptic Non Touch Technique (ANTT)

IV medications must be prepared and administered using a standard or surgical ANTT dependent upon risk assessment (refer to trust ANTT policy) and type of vascular access device.
Hands must be washed and alcohol gel applied prior to any contact with the IV system in accordance with Trust Hand decontamination policy (UHCW 2014).

Injectable medicines must never be transferred to an open system e.g. drawing up from a gallipot. Single or double needle free devices should be used wherever possible and connections should be kept to a minimum. A leur lock connection between the cannula and the administration set should be used at all times. Do not use three way taps outside of Critical Care, Cardiac Cath Lab or Nuclear Medicine, and ensure these are removed prior to transfer to other areas.

Injectable medicines mixed in clinical areas are for immediate use only and once prepared must not be stored for later use. Products prepared for infusion in the clinical area must not be administered for duration of more than 24 hours.

Injectable medicines must not be left unsupervised once prepared, for example at the patient's bedside or cot.

Infusion pumps should be used where possible for all infusions to allow continuity of infusion rate and accuracy when administering small volumes. Use of a pump also reduces risk related to fluid overload and monitors air in system and alerts the practitioner to cannula issues. High risk medicines must be administered via a pump.

The compatibility of injectable medicines should be checked before administering via the same intravenous line.

The line/cannula/vascular device should be flushed between medicines when administering multiple medicines, and after medicines are administered.

Injectable medicines must never be added to Polyfusors or other products designed to void their entire contents, Total Parenteral Nutrition (TPN) or to blood or blood products, with the exception of the radio-labelling of blood products in nuclear medicine.

Refer to Appendix 2 for instructions regarding reconstitution and withdrawal from ampoules and vials.

Follow the appropriate Clinical Operating Procedure for the type of injection you are preparing.

1. Intravenous Bolus
2. Intravenous Infusion
3. Subcutaneous bolus
4. Subcutaneous Infusion
5. Intramuscular injection

4.4 Labelling

- All injectable medicines should be labelled immediately after preparation, except for those intended for immediate bolus administration by the person who prepared them.
- Volume graduations on small syringes must not be obscured
- Prepared injections must not be left unsupervised.
- Under no circumstances should any practitioner be in possession of more than one unlabelled syringe at any one time, even if the syringes appear easily distinguishable by other means.
- All the injectable medicines required for an individual patient should be prepared, labelled and administered BEFORE preparing treatments for another patient
- Labels should be applied so that they will remain visible throughout the administration process, and do not obliterate the graduation markings on the syringe.
- Giving sets must be labelled with a date and time and if multiple giving sets then drug name too.

When a drug is added to an infusion an approved and clearly written label with details of the following must be attached to the infusion container:

- patient's name and ward
- drug name and amount added
- batch number
- date and time drug prepared
- expiry date and time
- route of administration
- signature of the person adding the drug
- signature of the second person checking the process

4.5 Checking of injectable medicines preparation & administration

A second check should be performed of the preparation and administration of all injectable medicines.

The second check by a healthcare professional must incorporate the whole preparation and administration process i.e.

In Clinical Preparation Room

- Valid prescription (Patient name & number, drug name, route, infusion fluid, rate, time due, prescribers signature)
- Correct product selection
- Expiry date
- Calculation of dose required

- Appropriate reconstitution and compatible diluent (where necessary)
- Infusion label is correct

And at the bedside

- Correct patient (wrist band, verbal check, drug chart and label where used)
- Inspection of injection site for oedema, redness, pain or discomfort
- Correct infusion rate via appropriate device (where necessary)

Exceptions to the second checking of administration requirement for healthcare professionals are:

- Vaccinations administered by occupational health nurses, or peer vaccinators working under a PGD.
- Injectable medicines administered by midwives in an emergency situation or during a home birth when a second person is not present.
- UH@Home Nurses working as a lone worker in a patient home.
- Anaesthetists, when preparing their own medicines and working in according with the standards from their Royal College.

Any variations to this must be risk assessed and approved by the Medicines Management Committee

No practitioner should check a medication if they are unfamiliar with the drug, its effects and usual method of preparation/administration. Reference should be made to information sources, such as the MEDUSA, manufacturers data sheet (www.medicines.org.uk) and the current British National Formulary (BNF). If it is beyond their sphere of competence they should decline to check, without fear of reprisal, and an alternative checker be found.

If there are insufficient staff to prepare, check and administer medicines in accordance with this policy, the Assigned Healthcare Professional-in-Charge must be informed at once who must escalate to the Matron or Nurse / Midwife bleep holder or appropriate clinical manager if the situation cannot be resolved, and complete an incident report via DATIX.

4.6 Documentation

Documentation must be accurately completed to conform with required professional standards for Record Keeping (NMC, IR(ME)R), approved documents/programmes for recording include:

- Medicines Prescription and Administration Chart
    - Direct injections of loading doses should be prescribed on the once-only section
    - Antibiotics should be prescribed in the designated section

    - Approved stickers should be used for high risk medicines, e.g. Epidurals and PCAs
- Intravenous Infusion Prescription sheet
    - Continuous infusions administered via rate controlling device (cross reference on main chart)
- MOSAIQ prescriptions for chemotherapy
- Anaesthetic Chart
- Additive label (as appropriate)
- Giving set label
- Infusion Monitoring Chart
- Fluid Balance Chart
- Solitron (RIS)

Documentation must include a record of all sodium chloride flushes administered.

4.7 Monitoring

Prior to administration and during ongoing infusion monitoring the injection site should be inspected for:

- Oedema - fluid extravasation
- Redness - indicating phlebitis
- Pain, discomfort

If any of the above are present do not proceed and refer to the medical team and healthcare professional in charge.

The Infusion Monitoring Chart should be used to document monitoring of any infusion. Rate/dosage must only be altered by competent registered practitioners.

If an infusion is disconnected e.g. for a patient to have a scan. The product must be discarded. It must not be reconnected and administered to the patient. The healthcare practitioner disconnecting the medicine must document accurately how much has been given. When the patient returns a prescriber should review the patient and prescribe further treatment as necessary based on the volume infused previously.

4.7 Adverse Drug Reactions

For Anaphylaxis see Trust Guideline.

For Extravasation see Trust Guideline for Anti-cancer treatments or Radiopharmaceuticals, for all other medicines refer to MEDUSA

- http://medusa.wales.nhs.uk/Docs/TreatmentSummaryPoster.pdf

If a patient exhibits any adverse reaction whilst receiving an injectable medicine it must be stopped and the prescriber notified. It should only be continued on his/her decision.

The prescriber is responsible for taking a full clinical history. List signs, temperature, all medicines and the times and batch number of any infusions given. The Adverse Medicine Reaction box on the front of the patient's medicine chart should be updated. A yellow card must be completed www.yellowcard.mhra.gov.uk for all adverse reactions causing significant harm e.g. anaphylaxis and a DATIX report should be completed including the yellow card reference.

If a defect in an infusion is suspected, for example if it becomes discoloured, forms a precipitate or fails for work as expected, take specimens for blood culture from another vein, inform pharmacy and return packaging/containers and any remaining infusion wherever possible. Pharmacy will complete report to MHRA following internal investigation.

5.0 DUTIES / RESPONSIBILITIES

Each **Healthcare Professional** is accountable for their own practice and must be aware of their legal and professional responsibilities relating to their competence in the prescribing, preparing, labelling, checking, administering, recording and monitoring of injectable medicines therapy.

All healthcare professionals are personally responsible and professionally accountable in ensuring that they receive training in the safe use and observation of any medical device used in the delivery of intravenous therapy.

All healthcare professionals and trained technologists are required to prevent and manage healthcare acquired infection as part of the Health Act 2008: Code of Practice on the control of infections and related guidance (DoH 2015)

All healthcare professionals and trained technologists are responsible for reporting any errors involving injectable medicines, or deviations from the stated practice which could result in a patient safety incident.

Staff not trained in use of injectable medicines must not be involved in, any part of the prescribing, preparation or administration process, this including disconnection of line, and starting of infusion pumps or devices.

Prescribers are responsible for:

- Ensuring all prescriptions for injectable medicine comply with the Trust Medicines Policy.
- Ensuring the prescribed medicines are appropriate for the injectable route and for the vehicle of administration, taking account of stability and incompatibility information. If in doubt, prescribers should seek information from Pharmacy.
- Documenting on the prescription 'For central line only' if the medicine is not suitable for peripheral administration.
- Establishing that the patient has appropriate intravenous access for any intravenous medicine prescribed.

- Reviewing the use of the IV route regularly and switching to oral administration as soon as clinically appropriate.

Healthcare professionals trained in administration of medicines via parenteral routes may:

- Prepare solutions for injection or infusion when these are not readily available from Pharmacy.
- Give medicines via the subcutaneous or Intramuscular route
- Give intravenous injections via an approved IV additive port
- Commence infusions of medicines
- Continue supervision of infusions

When undertaking these duties **healthcare professionals are responsible for**:

- Ensuring they have an appropriate prescription and technical information available to enable safe preparation and administration.
- Using aseptic non-touch technique throughout the preparation and administration of medicines.
- Only preparing injectable medicines in appropriate medical devices with luer connectors.
- Labelling all syringes and infusions. The only exception to this is in situations where preparation and bolus (push) administration is one uninterrupted process and the unlabelled product does not leave the hands of the person who prepared it. Only one unlabelled medicine must be handled at one time.
- Ensuring they have completed relevant competency for the required infusion devices.
- Assessing the injection site.
- Documenting what medications have been administered and when.
- The ongoing monitoring of infusions

Trained Technologists: May administer injectable medicines as above after completing training as per section 8 and having their scope of practice approved at Medicines Management Committee.

Departmental managers are responsible for ensuring all staff administering injectable medicines in their department are trained and competent in the preparation, checking, administration and monitoring of injectable medicines therapy to allow appropriate delegation of duties. Managers should ensure that facilities and resources are available to allow practitioners to meet the required competencies. Managers must ensure that all injectable products used within the department are supplied via pharmacy or blood bank, any exceptions to this must be approved by the Medicines Management Committee.

Medical Consultants must ensure that they and all junior doctors in members of their team are trained and competent to prescribe, prepare, administer and monitor injectable therapy, they must also be familiar with their responsibilities concerning the addition of medicines to intravenous infusion fluids, and aware of the hazards associated with injectable medicines, particularly when using an infusion pump or syringe pump / drivers.

Third Party (Agency) Healthcare Professionals who are not employed by the Trust are permitted to administer injectable medicines within their own competence and scope of practice. Third Party Agency healthcare professionals who are not employed by the Trust must involve a substantive trained and competent healthcare professional in the second check process.

Healthcare professionals in training may participate in the preparation and administration of injectable medicines appropriate to their level of training under the direct supervision of two trained and competent registered healthcare professionals.

UHCW Drug and Therapeutics Committee are responsible for ensuring that an NPSA risk assessment is available via MEDUSA or has been completed locally prior to approval of injectable medicines.

UHCW Research Governance Committee are responsible for risk assessing the use of injectable investigational medicinal products (IMPs) prior to their use within the Trust.

Medicines Management Committee are responsible for the review of annual audit data around injectable medicines practices.

Medicine Safety Committee are responsible for monitoring incidents involving injectable medicines and making recommendations to minimise errors.

Pharmacy department are responsible for implementation of the purchasing for safety policy & reviewing the scope for preparation of high risk medicines via a CIVAS service. The ward based teams will challenge inappropriate prescribing and advise on the compatibility of medicines where necessary.

6.0 DISSEMINATION AND IMPLEMENTATION

This document will be uploaded to e-library.

The practice described in the policy will be included in Injectable medicines teaching.

The nursing team will complete a gap analysis of current practice against this policy and create an action plan in order to bring all areas to the desired standard.

A Weekly Safety Message and Intranet banner will be used to raise awareness of the policy.

Monitoring in the form of audit will be carried out 6 months after launch and then annually as below to ensure staff are aware of correct practices.

7.0 TRAINING

	Role	*Example profession*	*Training*
group a	healthcare professionals who prescribe, monitor, review, prepare or administer injectable medicines in practice	Medical and nursing staff, physicians assistants, radiographers	Professional qualification. ANTT e-learning competency based assesment.
group b	staff administering radiopharmaceuticals	Doctors, clinical technologists, clinical scientists, nurses	ANTT e-learning competency assessment (UHCW certificate in administration of radiopharmaceuticals)
group c	Healthcare professionals who prescribe, monitor or review injectable medicines but **do not administer or prepare**	e.g. Pharmacists Doctors	professional qualification approved e-learning e.g. BMJ http://learning.bmj.com/learning/search-

	products.		result.html?moduleId=10009161

Healthcare professionals returning to practice after a break of up to a year should update their training. It is good practice for all healthcare professionals to update training every 3 years.

8.0 MONITORING COMPLIANCE

8.1 Monitoring Table

Aspect of compliance or effectiveness being monitored	Monitoring method (ie regular audits/reviews)	Individual/ department responsible for the monitoring	Frequency of the monitoring activity (ie Monthly/ Annually)	Group / committee which will receive the findings / monitoring report	Group / committee / individual responsible for ensuring that the actions are completed
Preparation and Administration	Peer review Audit	Nursing Practice Facilitators	Annual	Medicines Management Committee	Medicines Management Committee
Availability of pre-made high risk products, or policies to mitigate risk	Audit	Pharmacy via Regional Aseptic services group	Annual	Medicines Management Committee	Medicines Management Committee

9.0 STAFF COMPLIANCE STATEMENT *(Do not delete)*

All staff must comply with this Trust-wide Policy, Procedure or Strategy 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.

10.0 EQUALITY & DIVERSITY STATEMENT *(Do not delete)*

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.

11.0 ETHICAL CONSIDERATIONS *(Do not delete)*

The Trust recognises its obligations to maintain high ethical standards across the organisation and seeks to achieve this by raising awareness of potential or actual ethical issues through the PPS consultation and approval process. Authors of PPSs are therefore encouraged to liaise with the Trust's Clinical Ethics Forum to seek input where necessary.

12.0 DEFINITIONS

Ampoule: A small sealed, single use, vessel holding a liquid preparation for injection. Usually made of plastic or glass.

ANTT: Aseptic Non-Touch Technique – see Trust Policy

Bolus or Direct injection: Injection of a small volume of medicine solution. Performed using a syringe via the cannula or injection port of an IV line. Administered slowly over 3-5 minutes unless otherwise specified. Recommended when high peak blood level is required rapidly e.g. Antibiotics, or where a medicine is unstable when diluted.

Central Venous Catheter (CVC) 'Central line', 'central venous line' is placed into a large vein in the neck (internal jugular), chest (subclavian vein) or groin (femoral line). In neonates, this also includes umbilical artery & venous catheters. Some medication are best delivered via a central line e.g. inotropes; chemotherapy; TPN. Additional evidence of competency to use this type of access is required before administering medication via this device.

Competent: Demonstrating the knowledge and skills to perform the task to UHCW standards consistently and without supervision.

Continuous infusion: Administration of a volume of fluid with or without medicines added over a number of hours to achieve a clinical end point. Infusions may be repeated over a number of days or delivered continuously.

Cytotoxic: Cytotoxic drugs describe a group of medicines that contain chemicals which are toxic to cells, preventing their replication or growth, and so are used to treat cancer. They can also be used to treat a number of other disorders such as rheumatoid arthritis and multiple sclerosis. Once inside the body, their action is not generally tightly targeted, and they can produce side effects both to the patients and others who become exposed.

Defective medicine: A medicine which is not ideally suited to use & may prove to be harmful when used as intended due to:

- Faulty manufacture
- Product deterioration
- Falsification
- Non-compliance with marketing authorisation
- Any other quality problem

Displacement value: the displacement of solute by solvent is a factor that must be considered in their formulation and preparation. Displacement values for powders for injection become important when only part of a reconstituted vial is to be administered to a patient, a situation that commonly arises when small doses

are administered to neonates and children. In this situation it is important to know the final drug concentration per ml of the reconstituted injection so that an accurate dose can be withdrawn from the vial.

Elastomeric Pump: Non-electronic medication pumps designed to provide ambulatory infusion therapy. Must be prepared in Pharmacy or purchased pre-filled.

Extravasation: the inadvertent administration of vesicant drugs or solutions into the surrounding tissues instead of the intended vascular pathway (RCN 2010)

Healthcare Professional: A registered member of staff, including nurses, midwives, operating department practitioners, doctors, dentists, physicians assistants, pharmacists, pharmacy technicians and radiographers.

High Risk medicine: An injectable medicine with an NPSA risk score of 6 or more.

Implantable ports such as Portacath are used for long term intermittent venous access. Additional evidence of competency to use this type of access is required before administering medication via this device.

Infiltration: The deposition of a solution directly into soft tissue, this may be intentional e.g. local anaesthetic during surgical procedures or unintentional when a product intended for intravenous use leaks into tissue. .

Infusion Pump: A rate controlling device used to administer Intravenous infusions.

Injectable medicine: A medicine manufactured to appropriate standard for parenteral administration by one or more specified route(s). This includes Contrast media.

Intramuscular (IM): refers to the administration of a prescribed drug into a patient's muscle. Often one of the gluteal muscles. The volume is usually less than 2ml.

Intravenous (IV): refers to the administration of a prescribed drug(s) or fluid(s) into a patient's vein via a bolus, continuous or intermittent infusion.

Intermittent infusion: Administration of an infusion (medicine added to infusion fluid) over a set time period, this may be a one-off or repeated at specific time intervals. Usually used when a medicine could cause venous irritation or needs to be administered more slowly than can be accommodated by bolus injection.

Mixing of medicines: This is the combining of two or more medicinal products together for the purpose of administering them to meet the needs of an individual patient. This technically produces an 'unlicensed' product. The Medicines Healthcare products Regulatory Agency (MHRA) has put into place changes to medicines regulations to enable the mixing of IV medicines prior to administration in clinical practice

NPSA Risk assessment: Tool to assess the risk associated with preparing a medicine in a clinical area (Appendix 1). Score of 6 or greater is considered high risk.

Skin tunnelled catheter is a long-term catheter that lies in a subcutaneous tunnel before entering a central line. Examples include: Hickman line; Broviac line. Additional evidence of competency to use this type of access is required before administering medication via this device

Subcutaneous (SC): refers to the administration of a prescribed drug into the layer of skin beneath the dermis and epidermis (cutis). The volume is usually less than 2ml.

Syringe driver: A small battery operated device (pump) used to administer subcutaneous infusions.

Trained: For the purpose of this policy 'trained' means meeting the minimum training standards set in section 8.

Trained technologist: A member of staff holding voluntary registration who holds a certificate in the administration of radiopharmaceuticals granted by the ARSAC license holder.

Vial: A small glass or plastic bottle holding liquid or powder medicines for injection. Typically has a rubber bung at the neck of the vial and a plastic or metal cap to seal this until use.

Y site connector: A connector device used to deliver IV medicines from different sources into one vein.

13.0 REFERENCES AND BIBLIOGRAPHY

- Promoting Safer Use of Injectable Medicine, NPSA/2007/20, March 2007
- NMC Code (2015)
- Standards for Medicines Management, NMC, accessed electronically https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-for-medicines-management.pdf
- Standards for infusion therapy, RCN
- Mixing of Medicines Prior to Administration, MHRA, 2010
- NUH Intravenous Drug Administration Policy (2016)

14.0 UHCW ASSOCIATED RECORDS

- Medicines Optimisation Strategy
- Medicines Policy CLIN-POL-004-10
- Controlled Drugs Policy CLIN-POL-001-17
- Intravenous Administration of Potassium Chloride Policy CLIN-POL-01-16
- Transfusion of Blood and its Components Policy CLIN-POL-001-10
- Adverse Drug Reaction Guideline GOV-POL-013-06
- Medical Devices Policy GOV-POL-02-18
- Management of Sharps/splash Injuries and Post Exposure procedures for Hepatitis B Virus, Hepatitis C Virus and Human Immunodeficiency Virus (HIV). HS-POL-001-10
- Latex Allergy Management Policy H&S-POL-004-07
- Scope of Professional Practice Training/Competency Package for administration of Intravenous Drugs. TW/NG/21
- Anaphylaxis in Adults and Children CG1720
- Aseptic Non-Touch Technique COP193
- Insertion and Management of Peripheral Venous Cannulation SOPP6
- Care and maintenance of Skin Tunnelled Central Venous Catheters SOPP8
- Care and Maintenance of Long term vascular access devices SOPP51
- Monitoring of vascular access devices including insertion, ongoing care and maintenance.COP592
- Use of the T34 Ambulatory Syringe Driver in Adult Palliative Care Patients CG 1897
- Theatres COP for the drawing up for fluids for multiple infusions on a single patient.

15.0 APPENDICES

Appendix 1

Preparing Medicines for Injection

Withdrawing a solution from an ampoule (plastic or glass)
Inspect the solution for cloudiness or particulate matter – if this is present, discard and quarantine for Pharmacy.
Tap the neck of the ampoule gently.
Cover the neck of the ampoule with a sterile swab and snap open.
Inspect the solution for glass fragments – if present discard.
Open packaging and attach the 21 guage needle onto the syring – use a filter needle if the ampoule is made of glass.
Withdraw the required amount of solution, tilting the ampoule to avoid air bubbles.
Expel air carefully.
Attach new needle if required and discard used needle in sharps container.
Keep all ampoules/vials and diluents in the tray with the syringe until administration to the patient is complete.

Reconstituting powder
Follow procedure above to withdraw required diluent (Water for injection or sodium chloride 0.9%)
Remove the tamper evident seal from the vial and wipe the rubber septum with a 2% Chlorhexidine wipe & allow to dry for 30 seconds.
Inject the diluent into the vial, keeping the needle tip above the solution in the vial.
Consider the displacement value of the solution if using part of the vial as opposed to the full vial.
Follow the procedure below for withdrawing solution from a vial into a syringe.

Withdrawing solutions or suspensions from a vial
Remove the tamper evident seal from the vial and wipe the rubber septum with a 2% Chlorhexidine wipe & allow to dry for 30 seconds.
With the needle sheathed draw into the syringe a volume of air equivalent to the required volume of solution to be drawn up.
Remove the needle cover and insert the needle into the vial through the rubber septum.
Invert the vial, keep the needle in the solution and slowly depress the plunger to push air into the vial.
If the vial contains a suspension rather than solution, it should be gently swirled before drawing into the syringe.
Release the plunger.
Repeatedly inject small volumes of air and draw up an equal volume of solution until the required total is reached.
Withdraw the needle and syringe containing the solution from the vial.
Tap the syringe lightly to expel excess air.
Remove and dispose of needle and replace with a new needle or sterile blind hub.
Keep all vials in the tray with the syringe until administration to the patient is complete.

University Hospitals Coventry and Warwickshire NHS Trust

Appendix 2: Risk assessment summary for high and moderate-risk injectable medicines products

Name of clinical area					Directorate:								Date:		
Risk factors															
Prepared injectable medicine	**Strength**	**Diluent**	**Final volume**	**Bag/syringe**	**Therapeutic risk**	**Use of concentrate**	**Complex calculation**	**Complex preparation**	**Reconstitute vial**	**Part/multiple**	**Infusions pump or driver**	**Non-standard infusion set**	**Risk assessment score**	**Risk reduction method(s)**	**Revised score**
					✓	✓	✓	✓	✓	✓	✓	✓			
Risk assessment undertaken by:			**Name of pharmacist:**							**Name of clinical practitioner:**					

University Hospitals Coventry and Warwickshire NHS Trust

EQUALITY IMPACT ASSESSMENT FORM

Function, policy or practice:	Injectable Medicines Policy
Lead(s):	Rebecca Mills
Other members of EIA team:	Medicines Management Committee
Specialty:	All
Group (if applicable):	All

What function, policy or practice is being assessed?	○ Building Works ○ Consultation ○ Data Collection ◉ Policy ○ Process ○ Re-configuration ○ Re-structure ○ Research ○ Strategy
Status	○ Existing ◉ Proposed
What is the purpose of the function, policy or practice?	• To promote compliance with NPSA guidance • To reduce risk and prevent harm to patients from injectable medicines therapy • To standardise injectable medicines practice across UHCW • To educate and share exemplary injectable medicines practice
Is there any reason why the EIA does not need to be completed i.e. legislation, regulations, official guidance or policy?	○ No - please complete the rest of the form ○ Yes - please provide an explanation and obtain sign off (see back page) *Please explain:*

STAGE 1: SCOPING THE FUNCTION, POLICY OR PRACTICE	
1. Who are the stakeholders?	• Patients • All healthcare professionals that prescribe, prepare, administer and/or monitor injectable medicines.
2. Who is the function, policy or practice intended to benefit?	• Patients
3. What are the intended outcomes?	• Minimising risk of adverse effects, extravasation, or infection associated with prescribing, preparing, administering or monitoring of injectable medicines.
4. What are the key performance indicators, drivers, targets, standards, legislation etc.	• Reduction in harm from injectable medicines • Compliance with NPSA 20 issued by NHSE in 2006 • Compliance with NMC standards & best practice documents
5. What is already known about equality impact or need in relation to this function, policy or practice?	*It is known that:* • Certain medicines contain products, or are derived from substances which some people may have a preference not to receive.
6. Is there any indication that the function, policy or practice will cause particular problems for specific groups?	*Please provide details:* • No
7. Who else is involved with this function, policy or practice?	*Please list:* • All healthcare professionals
8. Who else will be involved in the implementation of this function,	*Please list:* • All healthcare professionals

policy or practice?	
9. Do they need to be involved with this impact assessment?	○ Yes ◉ No - please explain why Involved in policy developement
STAGE 2: CONSULTATION (to be completed after consultation or engagement has taken place)	
10. Engagement - what groups or individuals have legitimate interests?	*Please list:* • Patients • Healthcare professionals working at UHCW
11. Is there ongoing dialogue with relevant interest or user groups?	○ Yes ○ No *If yes, please list:* • Injectable Medicines task and finish group containined multidisviplinary representation. • Medicines Management Committee consulted • Nursing and Midwifery Care Quality Forum consulted. • Awaiting appointment of patient to medicines committees.
12. Is there enough information from recent consultations to give the information required?	◉ Yes ○ No
13. What methods have been employed to ensure that these groups or individuals are part of the consultation?	See above
14. Will the results of any consultation be published? E.g. annual reports, surveys	○ Yes ◉ No *Please give details.*

FINDINGS FROM DATA AND/OR CONSULTATIONS			
Findings	**Source**	**Are there any problems with this data?**	**What does the data indicate?**
none			

STAGE 3: ADDRESSING ANY ISSUES IDENTIFIED	
15. Are there any areas of low take up or under/over representation by different groups?	○ Yes ◉ No *If yes, please provide details.*
16. Does consideration of geography and demography of service users reveal any differential impact?	○ Yes ◉ No *If yes, please provide details*.
17. Is the function, policy or practice directly or indirectly discriminatory under the Equality Act 2010?	○ Yes ◉ No *If yes, please provide details*

STAGE 4: PUBLICATION AND SIGN OFF

In line with the Trust's Values of Openness and Learning, the findings of this EIA will be published both internally and externally. Please provide a summary ensuring the following points are covered:

- Data and consultation that has been used to inform the EIA.
- Any findings of particular needs or requirements, differential and/or adverse impact.
- A summary of the actions identified addressing issues.
- The expected outcome(s).

SUMMARY:

SIGN OFF:

This EIA has been completed by (*please sign below):*

Name of Team Lead : _____Rebecca mills_____

Signature: _____ Date: __16/04/18_____

Please brief the relevant Chief Officer/Clinical Director/Group Manager/Modern Matron or equivalent responsible for this function, policy or practice on the results of this EIA.

I have been briefed on the results of this EIA.

Print Name: _____

Signature: _____ Date: _____

Equality and Diversity SIGN OFF:

Comments:

☐ **Approved** ☐ **Conditionally Approved** ☐ **Not approved, please contact Equality & Diversity team**

Print Name: _____

Signature: _____ Date: _____

University Hospitals Coventry and Warwickshire NHS Trust

EQUALITY IMPACT ASSESSMENT FORM

Function, policy or practice:	Policy for the Use and Management of Controlled Drugs
Lead(s):	
Other members of EIA team:	
Specialty:	Pharmacy
Group (if applicable):	

What function, policy or practice is being assessed?	○ Building Works ○ Consultation ○ Data Collection ◉ Policy ○ Process ○ Re-configuration ○ Re-structure ○ Research ○ Strategy
Status	○ Existing ◉ Proposed
What is the purpose of the function, policy or practice?	The purpose of this document is to inform staff about the legislation and regulatory standards for Controlled Drugs and provide guidance to enable the safe management and use for prescribing, storage, custody, handling and administration of these medicines.
Is there any reason why the EIA does not need to be completed i.e. legislation, regulations, official guidance or policy?	○ No - please complete the rest of the form ◉ Yes - please provide an explanation and obtain sign off (see back page) *Please explain: This policy has been developed to inform staff of the legislation and regulatory standards*

	for these medicines.

STAGE 1: SCOPING THE FUNCTION, POLICY OR PRACTICE	
1. Who are the stakeholders?	•
2. Who is the function, policy or practice intended to benefit?	•
3. What are the intended outcomes?	•
4. What are the key performance indicators, drivers, targets, standards, legislation etc.	•
5. What is already known about equality impact or need in relation to this function, policy or practice?	*It is known that:* •
6. Is there any indication that the function, policy or practice will cause particular problems for specific groups?	*Please provide details:* •
7. Who else is involved with this function, policy or practice?	*Please list:* •
8. Who else will be involved in the implementation of this function, policy or practice?	*Please list:* •

9. Do they need to be involved with this impact assessment?	○ Yes ◉ No - please explain why

STAGE 2: CONSULTATION (to be completed after consultation or engagement has taken place)	
10. Engagement - what groups or individuals have legitimate interests?	*Please list:* •
11. Is there ongoing dialogue with relevant interest or user groups?	○ Yes ○ No *If yes, please list:* •
12. Is there enough information from recent consultations to give the information required?	○ Yes ○ No
13. What methods have been employed to ensure that these groups or individuals are part of the consultation?	
14. Will the results of any consultation be published? E.g. annual reports, surveys	○ Yes ○ No *Please give details.*

FINDINGS FROM DATA AND/OR CONSULTATIONS

Findings	**Source**	**Are there any problems with this data?**	**What does the data indicate?**

STAGE 3: ADDRESSING ANY ISSUES IDENTIFIED	
15. Are there any areas of low take up or under/over representation by different groups?	○ Yes ○ No *If yes, please provide details.*
16. Does consideration of geography and demography of service users reveal any differential impact?	○ Yes ○ No *If yes, please provide details*.

From the data and information you have collected, please complete the following:

Protected Characteristic	**Is there a differential impact?**	**What issues have been identified?**	**Is the impact justifiable?**	**Action to address any issues**

Gender	○ Yes ○ No ○ Insufficient Evidence		○ Yes ○ No ○ More data required	
Gender reassignment	○ Yes ○ No ○ Insufficient Evidence		○ Yes ○ No ○ More data required	
Race/ethnicity/ nationality	○ Yes ○ No ○ Insufficient Evidence		○ Yes ○ No ○ More data required	
Disability	○ Yes ○ No ○ Insufficient Evidence		○ Yes ○ No ○ More data required	
Age	○ Yes ○ No ○ Insufficient Evidence		○ Yes ○ No ○ More data required	
Religion and Beliefs	○ Yes ○ No ○ Insufficient Evidence		○ Yes ○ No ○ More data required	
Sexual Orientation	○ Yes ○ No ○ Insufficient Evidence		○ Yes ○ No ○ More data required	
Pregnancy and Maternity	○ Yes ○ No		○ Yes ○ No	

	○ Insufficient Evidence		○ More data required	
Marriage and Civil Partnership	○ Yes ○ No ○ Insufficient Evidence		○ Yes ○ No ○ More data required	
17. Is the function, policy or practice directly or indirectly discriminatory under the Equality Act 2010?		○ Yes ○ No *If yes, please provide details*		

STAGE 4: PUBLICATION AND SIGN OFF

In line with the Trust's Values of Openness and Learning, the findings of this EIA will be published both internally and externally. Please provide a summary ensuring the following points are covered:

- Data and consultation that has been used to inform the EIA.
- Any findings of particular needs or requirements, differential and/or adverse impact.
- A summary of the actions identified addressing issues.
- The expected outcome(s).

SUMMARY:

SIGN OFF:

This EIA has been completed by (*please sign below):*

Name of EIA Team Lead : _____ Date: _____

Signature: _____

Please consult either the relevant Chief Officer/Group Manager/Clinical Director/Modern Matron responsible for this function, policy or practice on the results of this EIA.

I have been briefed on the results of this EIA. Date: _____

Name: _____ Title: _____

Signature: _____

Equality and Diversity SIGN OFF:

Comments:

☐ **Approved** ☐ **Conditionally Approved** ☐ **Not approved, please contact Equality & Diversity team**

Name:_____

Signature: _____ Date: _____

NHS
University Hospitals
Coventry and Warwickshire
NHS Trust

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: 25 April 2018
Quoracy: Yes
Apologies: None
Committee Chair: Ian Buckley
Report submitted by: Ian Buckley
1. Decision regarding financial position The Committee received an update from the Chief Finance and Strategy Officer on the latest control total position, following further communication from NHS Improvement. It was acknowledged that the latest position will be challenging for the Trust and the Committee explored the implications of agreeing to the revised control total before being discussed by the Board at the additional meeting on 26 April 2018.
2. Referral to Treatment Performance The Chief Operating Officer reported that there had been a deterioration in the RTT performance although there have been improvements in many specialties. Unfortunately, this has been offset with issues in other specialties, especially those with high volumes of patients, such as ophthalmology. It was noted that NHSI's expectation is that the Trust's position does not deteriorate further during the year, rather than expecting performance at 92% overall. The number of patients waiting 52 weeks is declining but not as quickly as was hoped.
3. A&E Performance Update The Committee heard about some of the key factors that if addressed should improve A&E performance. These including identifying patients that can be referred directly to the Medical Decisions Unit (MDU) or the Surgical Assessment Unit (SAU), and improvements in tracking, governance and 'grip'.

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

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Committee Name: Finance and Performance Committee
Committee Meeting Date: 22 May 2018
Quoracy: Yes
Apologies: David Poynton
Committee Chair: Ian Buckley
Report submitted by: Ian Buckley
1. Operational Performance – RTT and Urgent Care The Committee was pleased to hear that progress is being made on improving performance against the 4 hour standard in A&E. There appears to be more rigour and grip which is yielding sustained improvements and reducing the recovery time when performance drops. Similarly good progress is being made on referral to treatment although some specialties continue to struggle, in some cases due to constrained capacity.
2. 2018/19 Financial Challenge The Committee recognised the financial challenge for the Trust in the coming year, especially given the need to deliver substantial savings through the three productivity schemes and the income maximisation work. It heard that Chief Officers have invested time in overseeing these programmes to ensure they are properly resourced, governed and overseen.
3. Potential Lost to Follow Up The Chief Operating Officer reported that a review is underway of patients whose follow up appointments may not have been fulfilled. All relevant patients are being reviewed to ensure that records are updated correctly or their follow-up appointments are arranged. The Committee will receive a further report on this at the next committee.

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Committee Name: Audit Committee
Committee Meeting Date: 09 April 2018
Quoracy: Yes
Apologies:
Committee Chair: David Poynton
Report submitted by: David Poynton
1. Internal Audit Recommendations The Committee received an update against the current recommendations. The Committee welcomed the improvement in position were pleased to note that there were no outstanding recommendations.
2. Review of Ward Prescribing and Administration The internal audit focused on the assessment of controls in place on wards for the safe prescribing and administering of medicines, appropriately documented within patient notes, in line with Trust policy. This received a moderate assurance opinion and some of the concerns raised were in relation to patient drug charts, and a number of policies past the review date. Mark Easter, Clinical Director provided an update on actions being taken to address the concerns. The Committee deferred the audit to the Quality Governance Committee.
3. Audit Fraud Plan 2018/19 The Committee approved the plan for 2018/19. The number of days and cost of delivery has not changed since last year.
4. Systemisation of Internal Audit Reports The Committee raised their concern regarding the flow of the internal reports being presented to other Committees.

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