University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD
HELD AT 10:00 AM ON THURSDAY 28 JANUARY 2021
VIA MS TEAMS

AGENDA

Ap: APPROVAL R: RATIFICATION As: ASSURANCE D: DISCUSSION I: FOR INFORMATION N: NOTE

Item	General Business	Lead	Format	Action	Time
1.	• Apologies for Absence • Confirmation of Quoracy • Declarations of Interest	S Manzie	Verbal	As	10:00
2.	• Minutes of last Public Trust Board meeting held on 28 November 2020 • Action Matrix • Matters Arising	S Manzie	Enclosures / Verbal	Ap / As	
3.	Chair's Report	S Manzie	Enclosure	N	10:05
4.	Chief Executive Officer Update	A Hardy	Enclosure	As	10:10
	Assurance Reports				
5.	• Audit and Risk Assurance Committee Report 14 January 2021 • Finance, Resources and Performance Committee Report 17 December 2020 • Quality and Safety Committee Report 17 December 2020	A Ismail J Gould S Kumar	Enclosures	As	10:15
6.	COVID and Restoration Update	L Crowne	Enclosure	As	10:15
7.	Response to the Ockenden Review and Assurance Tool	N Morgan	Enclosure	N	10:30
8.	Black Lives Matter - Tackling Racial Inequality [Guests: Barbara Hay and Lorna Shaw]	D Griffiths	Enclosure	N	10:45
9.	Freedom to Speak Up / Raising Concerns bi-Annual Report [Guest: Lorna Shaw]	G Stokes	Enclosure	As	11:00
10.	Guardian of Safe Working Hours Semester Report and Annual Report 2020 [Guest: Andreas Ruhnke]	K Patel	Enclosure	As	11:10
	Performance Reports				
11.	Integrated Quality, Performance and Finance Report: • Quality • Operations • Finance • Workforce	D Griffiths M Hussain L Crowne S Rollason D Griffiths	Enclosure	As	11:20
	For Information				
*(the following items marked with * are to be taken as read. Any questions from Board members should be raised in advance of the meeting)*					
12.	Safeguarding Adults and Children Report*	N Morgan	Enclosure	As	11:35

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	For Information (cont'd)				
13.	Integrated Care System Progress*	J Richards	Enclosure	As	11:35
14.	Patient Experience and Engagement Report*	M Hussain	Enclosure	As	
15.	• Audit and Risk Assurance Committee Approved Minutes 15 October 2020* • Finance, Resources and Performance Committee Approved Minutes 22 October 2020* • Quality and Safety Committee Approved Minutes 22 October 2020*	A Ismail J Gould S Kumar	Enclosures	As	11:35
	Administrative Matters				
16.	Draft Agenda for Next Meeting	S Manzie	Enclosure	Ap	11:35
17.	Questions from Members of the Public which relate to matters on the Agenda Please submit questions to the Director of Corporate Affairs by no later than 10am on 27 January 2021 (Geoff.Stokes@uhcw.nhs.uk)	S Manzie	Verbal	D	11:40

Resolution of Items to be Heard in Private (Chair)

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

University Hospitals
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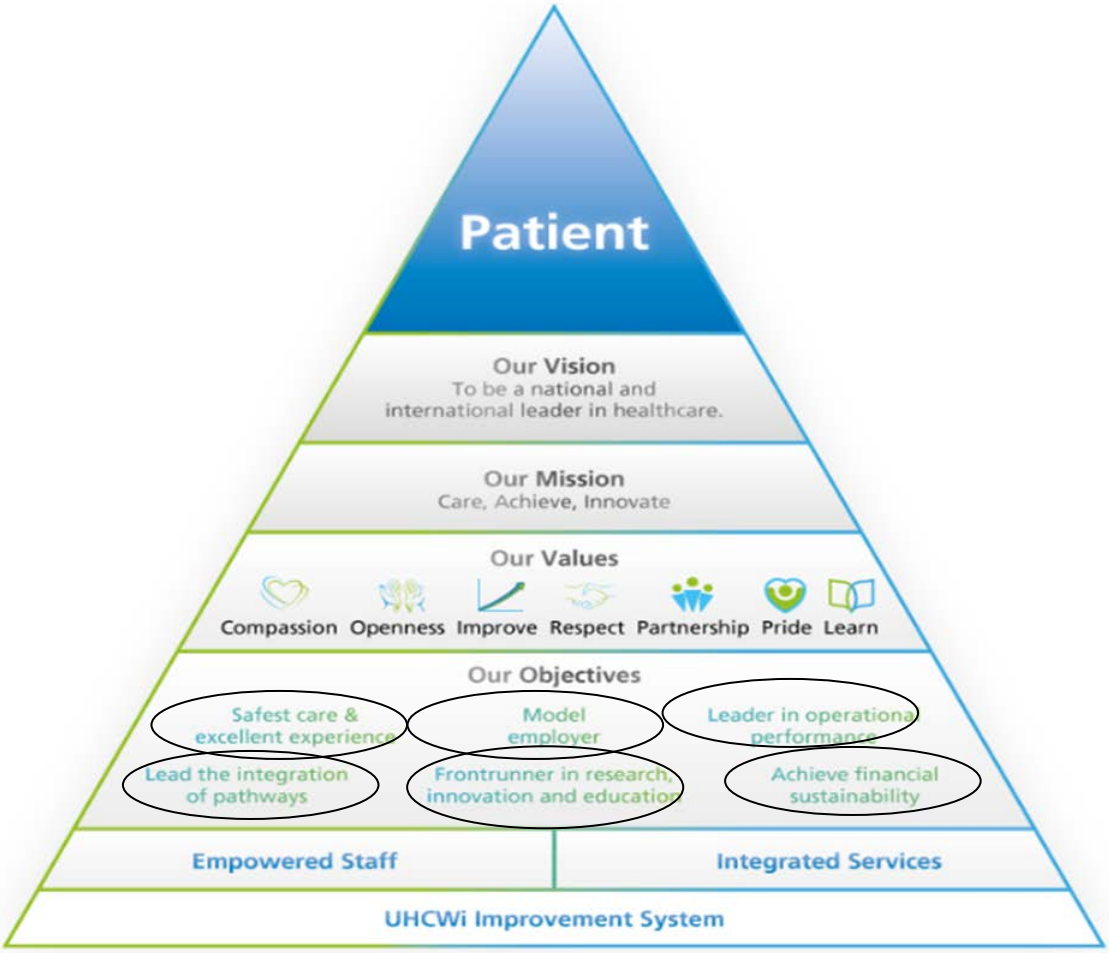
NHS Trust



University Hospitals Coventry and Warwickshire NHS Trust

MINUTES OF A PUBLIC MEETING OF THE TRUST BOARD OF UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST HELD ON 26 NOVEMBER 2020 AT 10:00, VIA MICROSOFT TEAMS AND LIVE STREAMED

MINUTE REFERENCE	DISCUSSION	ACTION

HTB 20/153 PRESENT

Stella Manzie (SM), **CHAIR**
Guy Daly (GD), Non-Executive Director
Jerry Gould (JG), Non-Executive Director
Donna Griffiths (DG), Chief People Officer
Andy Hardy (AH), Chief Executive Officer
Mo Hussain (MH), Chief Quality Officer
Afzal Ismail (AI), Non-Executive Director
Sudhesh Kumar (SK), Non-Executive Director
Jenny Mawby-Groom (JMG), Non-Executive Director
Carole Mills (CM), Non-Executive Director
Nina Morgan (NM), Chief Nursing Officer
Kiran Patel (KP), Chief Medical Officer
Justine Richards (JR), Chief Strategy Officer
Susan Rollason (SR), Chief Finance Officer
Brenda Sheils (BS), Non-Executive Director

HTB 20/154 IN ATTENDANCE

Lisa Armour (LA), Paediatric Nurse (for item HTB 20/155)
Gaynor Armstrong (GA), Group Director of Midwifery (for item HTB 20/170)
Tessa Dadley (TD), Pharmacy Procurement Manager (for item HTB 20/155)
Anthony Duggan (AD), Purchasing Officer (for item HTB 20/155)
Alex Johnson (AJ), Senior Executive Assistant (Minute Taker)
Geoff Stokes (GS), Director of Corporate Affairs
James Turner (JT), Communications Assistant

HTB 20/155 WORLD CLASS COLLEAGUE AWARDS

AH introduced the item, informing that there are two World Class Colleague Awards to present today. Firstly to Tessa Dadley and Anthony Duggan who both work in the non-clinical setting of pharmacy procurement. Tessa and Anthony were both nominated by colleagues in the partnership category, for their outstanding response to the pandemic this year and the support they have provided to clinical areas.

The second award goes to Lisa Armour, paediatric nurse, who was nominated in the compassion category. Colleagues say that Lisa provides an exemplary, world class level of care to babies in the challenging area of club foot casting and Lisa deserves to be recognised for her wonderful work in this area.

AH congratulated recipients of the awards and advised that their certificates will be sent to them.

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HTB 20/156 PATIENT STORY

MH introduced the item, which is the story of a patient named Lisa, who has shared her positive experience of the Trust's green pathway (Covid-free area of the hospital). MH advised that the story is complimentary of the Trust and all of the Trust values are embodied in Lisa's experience, despite the hospital and its teams being under such pressure at this time.

Lisa's video was played to the Trust Board. She detailed how her laparoscopic subtotal cholecystectomy operation went and her experiences of the green pathway both before and after the surgery.

Lisa explained that the process prior to coming to the hospital was organised and well streamlined. The green pathway was explained to her in enough detail and she was given clear instruction on what she needed to do in terms of self-isolation. Lisa said that she felt safe when entering the hospital on the day of surgery. Staff were very friendly, reassuring and a credit to the Trust.

Even when the surgery did not quite go to plan and when Lisa was quite ill on waking, she was made to feel as safe and secure as possible. Staff continued to explain what was happening and she was constantly monitored at a time when she was very sick. Lisa was never made to feel as though she was an inconvenience and commended all aspects of the care she received from staff

MH summarised the story, noting that despite surgery not going to plan, Lisa's experiences are still positive. She is glowing with praise for the staff and the organisation - this is a great example of patient care. It is important to share the examples of best practice, so that it can be replicated across all of our wards and learning taken. This will be done via Quality Improvement Patient Safety (QIPS) meetings.

The Board **NOTED** the Patient Story and SM thanked all the staff involved in Lisa's care.

HTB 20/157 APOLOGIES FOR ABSENCE

Laura Crowne (LC), Chief Operating Officer

HTB 20/158 CONFIRMATION OF QUORACY

The meeting was declared quorate.

HTB 20/159 DECLARATIONS OF INTEREST

Declarations of interest were duly noted as follows:

- GD – Coventry University
- SK – University of Warwick

HTB 20/160 MINUTES OF THE PUBLIC BOARD MEETING HELD ON 24

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SEPTEMBER 2020

DG advised that she was present at the last Trust Board meeting and requested the attendance list be updated to reflect this.

Other than this amendment, the minutes of the meeting held on 24 September were **APPROVED** by the Board.

HTB 20/161 ACTION MATRIX

The Board **RECEIVED** the updated matrix. All actions were noted as complete and the Board **APPROVED** the closure of all actions.

HTB 20/162 MATTERS ARISING

There were no matters arising.

HTB 20/163 CHAIR'S REPORT

In addition to the content of the report, SM personally thanked every member of staff for their continued hard work and response to the Covid challenge.

The Board **NOTED** the report.

HTB 20/164 CHIEF EXECUTIVE OFFICER UPDATE

The report was submitted by KP in his interim Chief Executive Officer role.

KP welcomed AH back to his position and noted that it has been a pleasure and positive experience for him to help lead the organisation through this continuing challenging time, with the support of highly capable colleagues around him. It has been particularly positive to see the continuation of the restoration of services whilst also managing the pandemic. The Trust continues to strive to provide elective care and do the best for its patients.

The Trust Board **NOTED** the report and **RATIFIED** the consultant appointments on page 2.

HTB 20/165 INTEGRATED QUALITY, PERFORMANCE AND FINANCE REPORT

<u>OPERATIONS</u>

JR summarised the operational position, noting that diagnostic waits of 6 weeks and over are a key area of focus, as well as cancer two-week wait targets. There is a backlog on endoscopy and colonoscopy; however, with the support of mutual aid and the independent sector, an improvement should be seen in the reduction of the backlog.

Another area of focus is the long length of stay (LLOS) position. The

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senior leadership team is working closely with clinical groups to tackle this, along with discharge and flow of patients.

A large number of patients are waiting longer than 52 weeks for their treatment. This backlog is due to the restoration of elective services and the clinical prioritisation of urgent and cancer work. This has inevitably had an impact on a number of patients who are now waiting longer for their procedure, however the team is fully sighted on this and there is a process in place to target the longest waiters by specialty, consultant and number of weeks waiting. A validation process is also being undertaken for all patients on the waiting list, whereby each patient will be clinically assessed and prioritised. This needs to be submitted nationally by 11 December.

AI asked what improvement activity is being undertaken in the challenging areas such as diagnostics, 52-week waits and 18-week referral to treatment time. As mentioned above, KP explained that that clinical assessment is being undertaken to identify the urgency for each patient. As part of phase 3 restoration of services, there is an increased focus on ensuring that patient inequalities are not widened. It is felt that the clinical prioritisation process is the best way to ensure that there is no significant effect on quality of life or prognosis for each patient.

KP acknowledged that some patients would have had to wait longer, given that urgent and cancer cases have been prioritised. Example cases of delayed procedures included hernia and varicose vein cases. He added that in some parts of the country, these types of referrals have been sent back to GPs, however UHCW has chosen not to do this. Although, there may now be a longer wait for such procedures, this wait should not significantly affect quality of life or prognosis. A recovery plan is being put in place and SR is in contract negotiations with the independent sector to provide capacity.

SM asked for more information on clinical assessment of patients. JR explained that the validation process takes into account the national categorisations of P1-P6 for every patient. A robust process and audit trail is place. The validation exercise will be completed by 11 December and by then, the Trust will know the number of patients and procedures required, which will in turn inform the trajectory. The longest waiting and most urgent patients will be prioritised and the use of independent sector and mutual aid utilised in order to get back on track. This work is being done alongside Covid and winter planning.

NM gave an update on long length of stay (LLOS) which shows an increase in numbers of patients staying over 21 days. There are 120 patients currently on the LLOS list and work is being undertaken to ensure a detailed review of each patient takes place to understand the reasons for LLOS. NM provided the detail around this, noting that it is clear that there has been a 10% increase in acuity in recent months. Of the 120 patients, 87 are not medically fit for discharge and of those:

- 40 are complex patients who can only be cared for in a

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tertiary setting such as UHCW.
- 39 patients are over 75 years of age.
- The remaining 8 patients are acutely unwell and not medically fit for discharge.

There are 33 patients who are classed as medically fit for discharge and UHCW is working closely with partners to support discharge to care homes or other appropriate settings. Eleven of these patients are Coventry based, twelve are Warwickshire based and ten are out of area.

NM added there is an active focus on discharge across the region, seven days a week. There is a weekly gold system call in place and all services are engaged to provide support and respond to individual patient needs. External support has been sought and offered in order to ensure that medically fit patients can be discharged. The safety of the patients is prioritised, with the appropriate swabbing and testing being undertaken prior to discharge.

JG queried whether there is enough community, care home and nursing capacity for the number of patients needing those services. NM explained that capacity across the system is variable. One contributing factor is that a number of care homes could be closed at any one time due to a Covid outbreak. There is also variability in district nurse/specialist health care capacity.

UHCW is exploring the use of the 'discharge to assess' model, where patients can continue their assessment once they have been discharged to a care home and an increased use of the 'UHCW@Home' model.

SK queried how the Trust had achieved such a large reduction in agency spend. DG explained that a comprehensive agency reduction programme has been in place. This involved focus on recruiting to substantive positions and reducing the number of vacancies, particularly in nursing where a large proportion of agency spending sat. Additional rigour and control has been put in place on booking of agency staff, which includes sourcing agency staff at more competitive rates. The reduced spend does not affect quality of care and DG added that during wave 1 of the pandemic, services were stood down which contributed to a reduction in agency spend.

SK also raised a query on hospital standardised mortality ratio (HSMR) and the reduction the Trust is seeing in this area. KP noted the reduction is very welcome and is mirrored with mortality rates. The improvement in coding for palliative care, co-morbidity and complexity is likely to have had the biggest impact on the HSMR. The Trust will continue to closely monitor this.

<u>QUALITY</u>

In addition to the points covered above, MH added that the Trust has recorded no never events or 12-hour trolley waits since the last Board meeting on 24 September. The national friends and family test (FFT)

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will start in December. There was one medication error causing serious harm and this will be managed through the serious incident process and reported up to Quality and Safety Committee.

FINANCE

SR reported that month 6 was the last month of the emergency financial regime and the Trust is at a break-even position.

In month 6, NHSE/I (NHS England and NHS Improvement) placed additional scrutiny around Covid reclaim costs and as yet, the Trust's claims have neither been approved or otherwise.

The month 7-12 financial plan shows a £636k deficit and at month 7 the Trust reported a £280k deficit. The Trust is on plan in month and forecast.

There are significant additional costs related to the Covid vaccination programme, Covid testing and critical care surge capacity and these would come with their own differing funding streams. Capital is also an area of increased focus.

WORKFORCE

DG summarised the vacancy rate which was currently 11.04% and the WTE position as outlined on page 21 of the report.

Daily staff absence is reported through the incident management structure. A 5.28% absence rate has been reported for the period to end of October 2020, which is an increase on previous months. Mental health is one of the main reasons for absence and Covid-related absence has also led to an overall increase in the rates.

There are 186 clinically extremely vulnerable staff who are currently shielding. Most are working from home and have been redeployed to work in different roles where necessary. These staff will be welcomed back into the Trust from 3 December, subject to national guidance.

BS queried whether there had been any change in the profile or pattern of sickness between the first and second wave of the pandemic. DG reiterated the increase in mental health reasons for absence, however she noted that this currently does not present a major concern - bespoke services are in place to support these staff through a variety of forums. Work is also being undertaken with system partners to increase specialist psychologist support over the next 18 months. Groups are in receipt of detailed information on reasons for absence and there have been some hotspot areas for Covid-related sickness.

In response to a query from AI on actions being taken to increase the uptake of mandatory training and the implications of staff non-compliance, DG informed that the mandatory training target is 95% which is a relatively high target for the NHS. This figure allows for an element of non-compliance due to absence from the Trust. A slight deterioration in compliance has been seen over the last 6 months

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and this is due to current pressures on staff. The Trust has an ongoing piece of work in place to review which roles require which training.

KP added that appraisals and revalidation process for medical staff were stood down from March to November 2020. This was in response to national guidance and the latest mandatory training figures will reflect this. DG confirmed that appraisals for AfC (Agenda for Change) staff were also suspended until April 2021 and this will also have an impact on the compliance rates. Some organisations took a decision to stand down mandatory training completely this year, however UHCW continues its commitment to deliver training to staff, despite the challenging circumstances.

AI noted that there may be a risk around the same individuals consistently missing their mandatory training target and this should be monitored.

Trust Board **RECEIVED** the report and particularly **NOTED** the updates on Trust operational targets, LLOS position, actions being taken around clinical prioritisation of patients and the detail on increased staff absence rates.

HTB 20/166 COVID-19 AND RESTORATION

JR provided the key points, noting that the NHS returned to incident level 4 on 5 November 2020, in response to the second wave of Covid. The Trust then stood up its incident control process of gold, silver and bronze in order to manage the daily operational and clinical challenges. Winter pressures, Covid and elective work are managed through this incident control process. The highest number of Covid-positive patients in the Trust during this wave so far has been 90 and the current number in the hospital is 78.

UHCW is assisting other parts of the region with mutual aid. This is the support put in place when Trusts are experiencing pressure in critical care and need to surge and/or need to cancel elective procedures. UHCW has accepted patients from other Trusts and provided support across the Midlands.

UHCW's surge plan is in place and this is included within the report (page 2). Critical care and respiratory are the main areas of impact and plans are in place to expand capacity if necessary. At the time of writing the report, the Trust was at escalation level 3.

Full Capacity Protocol (FCP) was enacted earlier this month, due to pressures in ambulance conveyance delays. FCP has now been stood down, however ambulance delays are still an area of focus across the region.

Flow, capacity and long length of stay are key areas of focus for the Trust. ED flow and side room capacity is impacted by how quickly the Trust can respond to the requirements of swabbing and testing patients. Fortunately, the Trust has a substantial number of side

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rooms and this helps patients to be managed and isolated whilst they await swab results.

A rolling national programme is in place for clinical validation and prioritisation of outpatients, as outlined in the Integrated, Quality and Performance & Finance report discussion earlier.

A summary of Senior Responsible Officer (SRO) areas is included in the report, as well as a debrief into the first wave of the Covid pandemic, which is required to be reported to the Trust Board in order to close down the incident response to the first wave.

In response to a query from BS, JR explained that there has been an unprecedented demand for swabs/tests in recent weeks and there have been some challenges in the pathology system around resilience of the equipment used to obtain swab results. The turnaround time for results is now 19 hours and the Trust is due to take receipt of rapid testing equipment in ED, which will help manage flow and the use of side rooms. In addition, alternative testing routes are being explored such as home testing for patients who are due to come into the Trust for an elective procedure.

During times of increased demand for swabs, UHCW has sought mutual aid from other Trusts in the region and a rapid improvement process was put in place to ensure patients were urgently identified and prioritised, in order to reduce impact on elective cases and discharges. JR noted that the response from the virology team has been fantastic and the new technology that is being put in place will help future swabbing and testing capacity and capability.

Also in response to a query from BS, JR confirmed that UHCW is piloting Think 111 in the region and is confident that it will go live on the scheduled date of 1 December 2020. She noted that patients are more open to alternative ways of accessing emergency care in the post-Covid era and there is opportunity in Think 111 and greater use of the urgent treatment centres.

SM thanked the contributors for the report, which provides a comprehensive overview of the current challenges. One of the Trust's priorities is to continue with elective services for as long as possible and SM supported the impetus on this.

Trust Board **NOTED** the report.

HTB 20/167 COVID-19 GOVERNANCE PROTOCOL

MH introduced the item, reminding Trust Board that the emergency governance protocol was brought to Trust Board in April 2020 for the Covid wave 1 incident management process and assurance.

On 5 November 2020, the NHS escalated to a level 4 incident and this updated protocol reflects the principles around daily incident management and operational requirements for decision-making and

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Board assurance.

Bronze, silver and gold daily incident management is in place and interim arrangements for operational decision-making and Trust Board and its committees are outlined. Committees will move to a reduced frequency until April 2021 and Trust Board will retain its usual schedule.

The Chair and non-executive directors will be kept up to date on key issues via a fortnightly Covid assurance meeting with the Chief Executive Officer. SM noted that if any urgent decisions were required, additional meetings could be convened as necessary.

Trust Board **NOTED** the report and interim governance arrangements.

BREAK

HTB 20/168 BOARD ASSURANCE FRAMEWORK (BAF) AND CORPORATE RISK REGISTER

GS introduced the report and highlighted a specific recommendation to change the basis of the scoring of BAF 4 – 'Financial Sustainability'. The score has previously been based on the 'finance including claims' category however on reflection it is felt that it is more appropriate to base it on the category 'adverse publicity/reputation'. The overall recommendation will bring the score for BAF 4 to 12. This recommendation has been discussed at Finance, Resource and Performance Committee as well as Audit and Risk Assurance Committee, where the recommendation was agreed. GS assured the Board that financial risk elements are reflected elsewhere in the corporate risk register.

GS reported that there are nine corporate risks with a risk score of 16 or above. One of the highest-level risks relates to the inadequate level of service from one of the Trust's suppliers.

He added that the BAF review is continuing under the Audit and Risk Assurance Committee.

Trust Board **RECEIVED ASSURANCE** from the report and **APPROVED** the recommendation to change the scoring for BAF 4.

HTB 20/169 BI-ANNUAL SAFER STAFFING REPORT: NURSING AND MIDWIFERY

NM introduced the report, which is required to come to the Trust Board every 6 months. She noted that data collection for some key metrics was ceased nationally due to the pandemic and data for two months either side of the non-collection period is provided for assurance.

The registered nurse to patient ratio has been impacted due to the

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pandemic and for some months the data has not been captured. However the average shows that the Trust has exceeded the ratio requirements. There is a difference between day and night ratios but the standard has been met throughout the period.

Safer staffing meetings take place twice daily to ensure any risk on any particular day can be mitigated.

NM also informed the Board that the acuity of patients has increased by 10%, which is significant. The Care Hours Per Patient marker shows that actual hours were the same or higher than the previous reporting period. There was a reduction in instances of falls and pressure ulcers over the last 6 months.

For transparency, JG noted that he had submitted questions to NM prior to Trust Board today in relation to staff ratios, mix of staff on the ward and NM covered these points in her verbal update.

When discussing nursing ratios, NM explained there is a mix of staff on the nursing team – registered nurses, healthcare assistants (HCA) and other support workers. There is currently an 11% vacancy rate for HCAs, which is excessive and regular recruitment days are taking place in order bring this down.

NM added that the Care Clox app was introduced on the wards around 4 years ago. The app records the amount of time staff spend directly or indirectly with patients in any shift. It therefore provides the granular detail of which staff member is carrying out which activity and enables the Trust to change the way it works in order to provide more direct care to patients. As an example, a registered nurse may carry out patient observations rather than a HCA in order that the nurse spends more direct time with the patient. Care Clox is one of a number of tools available to help us understand the care the patient receives and by whom.

NM noted that the Trust has the average nurse ratio data available but the highest and lowest ratios are not known. The reason that only an average is provided is due to the way the data is recorded on e-rostering and the IT infrastructure. The twice-daily safe staffing meetings allow the Trust to be responsive to peaks and troughs of care required. Decisions are made during these meetings that may result in a nurse moving to another area for only a few hours and this may not always be recorded. NM gave assurance that this agile way of working and the ability to be immediately responsive, using professional judgement in the moment, is supported by the National Quality Board and NM confirmed that the data contained in the report meets the requirements of the National Quality Board.

Trust Board **RECEIVED ASSURANCE** from the report and NM/JG will meet outside of Trust Board to discuss safer staffing in more detail to demonstrate to JG the tools and kit available which support safer staffing. **NM**

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HTB 20/170	**MATERNITY IMPROVEMENT PLAN**	

GA joined the meeting and NM introduced the item, advising that it is a requirement to provide an update on the standards to the public Trust Board regularly and the Trust wants to be transparent and share the improvements on maternity safety with the public.

GA noted that the format of this report is shorter, following comments received at the last Trust Board. She added that the new paper reflects revised standards issued on 30 September 2020, due to the pandemic and the submission date for the ten standards is 20 May 2021.

GA summarised the current position against each of the safety standards as detailed within the report. There are some actions required and these are detailed on the safety improvement action plan (appendix 1). The Trust is on target to meet the new submission date for the standards.

BS raised the issue of the impact of Covid on inequalities in pregnancy and birth. She asked if there has been an increase in the number of women not attending appointments or post-natal depression once the mother is back in the community.

GA informed that there has been no significant difference in the number of women contacting the service since the start of the pandemic. There has been an increase in 'did not attend' appointments (DNA). The Trust is also seeing more patients from outside of the area, and there have been more stillbirths since the start of the pandemic. Some of the stillbirths have been to women who were not booked with the unit. Across the country, there has also been an increase in instances in placental abruptions but this is not believed to be Covid-related.

GA added that DNAs is an area of learning and is on the maternity safety production board. Data has been monitored over the last three months and actions now in place include a timely notification sent to the GP and community midwife immediately after the DNA. Usually, the community midwife will then make contact with the patient. Once the new maternity system is in place, all patient information will be available on a phone, tablet or computer.

JG referred to safety action five – 'demonstration of an effective system of midwifery workforce planning to the required standard'. He queried progress on the neonatal workforce business case. GA advised that there was a pause on this due to Covid, however it is now progressing, alongside a neonatal outreach service. JR added that the neonatal outreach service would, where possible, allow mother and baby to be supported at home when they might otherwise have been in special care. UHCW is working with George Eliot Hospital NHS Trust (GEH) and South Warwickshire NHS Foundation Trust (SWFT) on the implementation of this service, which has come out of the work from the provider alliance on maternity and paediatrics. Resource is now in place for the outreach service

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(through specialised commissioning) and although the leadership model has not yet been agreed, an options appraisal is being carried out. GA added that neonatal staffing is being looked at to support the business case.

JG also asked if any recommendations have been received as a result of the Healthcare Safety Investigation Branch (HSIB) reports.

GA noted that one recommendation is to ensure that rooms are appropriately stocked for instrumental deliveries and that equipment required is immediately on hand. This recommendation is being reinforced with staff, whilst also taking in to consideration the wishes of the patient, who may have wanted a more home-from-home environment. Therefore the equipment for instrumental deliveries is discretely stored in the room.

There were also suggestions made around the consideration and timely escalation from the Lucina birthing centre to the labour ward and increased awareness on maternal condition. Feedback has been provided to staff on this.

Trust Board **RECEIVED ASSURANCE** from the report and **NOTED** the updates on each of the safety standards and actions required.

HTB 20/171 CANCER SERVICES REPORT

KP noted that some elements of the report have been covered in the discussions held already today and reiterated that the Trust continues to deliver cancer services during the pandemic.

GD commended the work being undertaken to hit cancer targets at such a challenging time. He referred to the faster diagnostic standard, which will be implemented in 2021 and queried whether the Trust is confident in meeting this target. KP responded that capacity is currently being built in to ensure the faster diagnostic target is met and that artificial intelligence will also have a positive impact on this.

GD also asked whether UHCW is participating in the best practice pathways and KP confirmed that is the case. He gave some examples, such as work in ophthalmology to diagnose a rare type of retinal cancer and a pilot of CT scanning for smokers. KP added that some work is also being undertaken with the cancer board on late referrals from partners.

The Trust Board **NOTED** the report and commended the Trust on work undertaken to continue with cancer services.

HTB 20/172 FINANCE, RESOURCES AND PERFORMANCE COMMITTEE (FRPC) MEETING AND APPROVED MINUTES

JG summarised that the discussions held at the FRPC related to scrutiny of the financial position, Board Assurance Framework/corporate risks and elective restoration update. FRPC also received a report on the six projects related to the hospital

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pharmacy transformation programme and the risks around this. One of the key risks is the ability for organisations to undertake the actions necessary due to the impact of Covid. FRPC also reviewed the Workforce Disability Equality Standard (WDES) and the Workforce Race Equality Standard (WRES) reports.

The hybrid theatre business case was also considered and suggestions made to improve the case. The recommendation to Trust Board from FRPC is to approve the hybrid theatre business case.

Trust Board **RECEIVED ASSURANCE** from the FRPC report and **NOTED** the recommendation on the hybrid theatres business case which will be discussed at the Private Trust Board.

HTB 20/173 QUALITY AND SAFETY COMMITTEE (QSC) MEETING MONTHLY REPORT AND APPROVED MINUTES

SK noted the report refers to the key discussions held at the meeting held on 22 October and the approved minutes are for the meeting held on 17 September.

SC confirmed that QSC has been stood down on alternate months in line with the review of corporate meetings during this incident management period. Of course, if any urgent matters arise in between meetings, ad hoc arrangements will be made. Good rigour and process will be maintained despite these new working arrangements.

SK added that one of the key points discussed at QSC on 22 October was the format of future CQC inspections and the likely focus on a more continuous review, rather than one short snapshot in time. SM requested that the new CQC approach is scheduled for discussion at a future strategic workshop, as there are implications of this which require a collective board discussion. GS

Trust Board **NOTED** the report and minutes from the Quality and Safety Committee.

HTB 20/174 AUDIT AND RISK ASSURANCE COMMITTEE (ARAC) MEETING MONTHLY REPORT AND APPROVED MINUTES

AI advised that ARAC is actively involved in reviewing the Board Assurance Framework and the Trust's approach to risk in order to ensure the Trust Board is fully sighted on any risks. An update will be provided to Trust Board in due course.

Another area of focus for ARAC is the increasing threat of cyber security and protecting the Trust's data. An update on current arrangements will be discussed at the next ARAC. ARAC also received its usual updates on internal and external audit.

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

HTB 20/175 QUESTIONS FROM MEMBERS OF THE PUBLIC

MINUTE REFERENCE	DISCUSSION	ACTION

No questions were received from members of the public.

HTB 20/176 DATE AND TIME OF NEXT MEETING

The next meeting will take place on Thursday 28 January 2021.

SIGNED	**…….....**
	CHAIR
DATE	**…….....**

PUBLIC TRUST BOARD MASTER ACTION MATRIX 2020/21

Meeting Date	Item	Minute Reference	Action	Lead Officer	Deadline	Update
24 Nov 20	Quality and Safety Committee Meeting Monthly Report and Approved Minutes	HTB 20/173	SM requested that the new CQC approach is scheduled for discussion at a future strategic workshop, as there are implications of this which require a collective board discussion.	SM/GS	28 Jan 21	**24 Nov** This has been added to the planner for a future Board Strategic Workshop
24 Nov 20	Bi-annual Safer Staffing Report:Nursing and Midwifery	HTB 20/169	NM/JG will meet outside of Trust Board to discuss safer staffing in more detail and demonstrate to JG the tools and kit available which support safer staffing.	NM	28 Jan 21	**7 Dec** Meeting set up for 7 Jan 2021
24 Sep 20	Patient Story	HTB 20/125	Ensure that the issues raised by the patient story have been followed up and that improvements have been made in those specific areas	MH	26 Nov 20	**24 Nov** MH confirmed that the follow up actions are complete. The incident where a patient was discharged with a canular has been shared with the Modern Matron and ward staff via the daily huddle. Another patient who was discharged has been followed up in the in community, seen by their GP and the Trust has made contact to ensure ongoing care is in place.
24 Sep 20	Patient Story	HTB 20/125	Explore the possibility of providing an online or virtual resource for patients to access, which would provide an opportunity to modify, improve and change advice	MH	26 Nov 20	**24 Nov** MH clarified that this action was related to car parking and signage. The action is closed. ISS has shared information with the team and a process is being put in place improve. SM noted that there is a continuing issue on information provided to the public on how the car park works and this is tied into the signage review. MH confirmed that NM/MH are liaising with Patient Experience and Engagement Committee (PEEC) on signage and car parking.

Deadline Key:	
	Not started
	In Progress
	Overdue
	Completed

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD ON 28 JANUARY 2021

Subject Title	Chair's Report
Executive Sponsor	Dame Stella Manzie, Chair
Author	Dame Stella Manzie, Chair
Attachments	None
Recommendation(s)	Trust Board is asked to **NOTE** the report

EXECUTIVE SUMMARY

As we start the new year it looks like the Trust will be facing another extremely challenging few weeks/months ahead as we have seen rising cases of Covid-19 patients requiring medical intervention along with the demands that the typical winter pressures usually present. All of our staff have worked so hard over the last few months, whether you look at the commitment and dedication of our frontline doctors, nurses and AHPs who have valiantly battled through the last few months or the many people working behind the scenes on finance, human resources, ICT, cleaning, estates and so many other functions, including our partners in ISS and Vinci. We know that everyone is feeling some physical and emotional wear and tear at this time. Later on this agenda, the Board will be updated on the latest position.

This report covers the period since the last Board meeting in November 2020. Given the on-going social restrictions, tier systems and the current national 'lockdown' it has inevitably meant I have attended the vast majority of meetings virtually.

Chief Executive Officer Andy Hardy has continued to keep myself and the other Non-Executive Directors fully updated around the on-going issues and challenges of Covid-19 (both locally and nationally) and I have joined the regular Covid-19 Update call with Dale Bywater (NHS England and NHS Improvement Midlands Regional Director). I have also joined the Covid-19 Update for System Leaders Webinars.

My internal commitments have included my regular update meeting with Lorna Shaw (our Freedom to Speak Up Guardian) and Janine Beddow (Rugby St Cross Hospital Manager). I conducted a virtual Board Walk-round for Outpatients / Ophthalmology (Clinic 9) and undertook some Consultant Interview training. Appropriately masked and distanced I helped 'deliver' some "thank you" boxes to members of staff in Neonatal Unit, Children's Ward, Labour Ward, Children's Outpatients and the Centre for Reproductive Medicine and joined the leaving celebrations of a staff member who had completed 42 years' service. I also attended the Christmas Carol Service in the Faith Centre.

Externally I was involved in the Interviews for the Coventry and Warwickshire CCG Chair role, and have joined the regular STP Chairs meetings with Chris Ham (STP Chair). System-wide working has been extremely important in the last few months. I have also joined the Coventry and Warwickshire Champions meeting attended the Warwickshire Health and Well-being Board as a member and the Coventry Health and Well–being Board as an observer.

At the time of writing I am due to join a preliminary meeting about the Coventry and Warwickshire Reciprocal Mentoring for Inclusion Programme (MFIP) organised through the Leadership Academy. This is part of the actions that the Board has committed to explore to tackle Racial Inequality. I will report back on this to Board members.

While all the fantastic effort to help both Covid-19 and non Covid-19 patients has been taking place, work has continued across the system on the future plans for an Integrated Care System in line with the national direction. We are also in constant discussion with Board colleagues about how we maintain standards of governance while minimising the burden on Executive members and other staff supporting the Board.

Finally, I would like to repeat again my personal 'thank you' to Board colleagues, every staff member at the Trust and staff at our partner agencies for their hard work, commitment and dedication during these very tough and demanding times.

Stella Manzie

PREVIOUS DISCUSSIONS HELD

Not applicable

KEY IMPLICATIONS

Financial	The induction on NHS finance is relevant to governance of financial issues.
Patient Safety or Quality	The Covid Assurance meeting relates to governance of patient safety and quality issues.
Human resources	Human resources issues were discussed at the Covid Assurance meetings
Operational	Operational issues were discussed at the Covid Assurance meetings.

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 28 JANUARY 2021

Subject Title:	Chief Executive Officer Update
Executive Sponsor:	Chief Executive Officer
Author:	Andrew Hardy, Chief Executive Officer
Attachments:	None
Recommendations:	Trust Board is asked to **RECEIVE ASSURANCE** from the report and to **RATIFY** the consultant appointments listed on page 2.

EXECUTIVE SUMMARY:

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

The Chief Executive Officer has provided brief details of his key areas of focus during December 2020 and January 2021.

Professor Andrew Hardy – Chief Executive Officer

Whilst my secondment to the Department of Health and Social Care in relation to the national role around Point of Care testing for Covid-19 (which came to a natural end in November last year) was a fantastic opportunity, it is great to be back in my substantive role here at University Hospital. Regrettably, however, we now find ourselves in the midst of the second wave of Covid-19 and experiencing unprecedented pressures and a higher demand for our services than ever before. I would like to take this opportunity to commend and praise our wonderful staff (and particularly those doctors and nurses on the front line) who continue to give everything they have to help those in need …. a huge "thank you" to everyone.

With the on-going Covid-19 pandemic, I have virtually attended various Covid-19 related meetings including the local regular Covid-19 Gold meetings; a vaccine briefing event; an NHSE/I STP ICS Clinical and Professional Leaders' Network work meeting (for the national Covid vaccine programme); a Vaccination Weekend Planning Call; I joined a Covid-19 Vaccine Centre Experience Seminar event; the 'Spotlight on the new Covid-19 variant event with Dr Meera Chand presently by the Department of Health and joined the Update for System Leaders webinar (which covered vaccinations and EU Brexit). Internally I have attended some of the Staff Briefing sessions and kept our Chair and Non-Executive Directors fully updated around Covid related issues via the virtual assurance meetings. I have also undertaken various interviews with Sky News, BBC CWR, The Guardian and the Coventry Telegraph.

In terms of STP related meetings I have attended the regular local Partnership Executive Group meetings; the NHS Midlands Leaders Update meetings with Dale Bywater (NHS England and NHS Improvement Midlands Regional Director); the Joint ICS/STP Leaders and Chairs session around Engagement opportunities on the NHSI paper on ICS development and the proposals for legislative change; the first Assurance Group meeting along with partner agencies across the STP footprint; I led

the Non-Executive and Lay Members meeting with Chris Ham (Chair of Coventry and Warwickshire STP); the NHSE/I ICS and STP Leaders' meeting and I joined the Coventry and Warwickshire STP Quarterly System Review meeting.

NHSE/I meetings I have virtually attended include the Coventry and Warwickshire System Winter Preparedness Review meeting; the Lessons Learned Review sessions for West Midlands and the monthly Inequalities Working Group. Other meetings attended have included the monthly NHS Midlands Leadership Team meeting; an International Seminar Series with the 'Kings Fund'; the City Council's Health and Well-being meeting and Health and Social Care Scrutiny Board and the ICS Network Executive Leaders meeting.

My internal commitments since the last Board meeting have included the VMI Transformation Board; meeting with all our Clinical Groups as part of the Quarterly Performance Reviews; I visited the new Pharmacy Unit and met the Pharmacy Team and I virtually met with Mark Pawsey (MP for Rugby) to discuss the non-Covid issues the Trust is currently facing including delays to appointments and operations. I also had the pleasure of meeting and presenting all the Outstanding Service and Care Awards (OSCA) winners with their trophy and 'care box' and undertaking some filming so the celebration event could be presented virtually. I also attended the Christmas Carol Service in the Faith Centre and went to the leaving celebration of a member of staff who had completed an amazing 42 years' service.

External commitments included the CIPFA Board; CIPFA Trustee meeting; CIPFA Commercial Board and CIPFA Council meeting. I joined the Building Resilient and Sustainable Economies Forum (a public health sector event) and the Leadership and Resilience On-line session organised through the Leadership Centre Team.

And finally …. I would like to reflect on the day University Hospitals Coventry and Warwickshire NHS Trust made international history on Tuesday 8th December 2020 by delivering the first ever Covid-19 vaccine globally to Margaret Keenan. I am sure it is a day that none of us will forget and it was a huge privilege and honour for the Trust to be chosen to kick-start the global Covid-19 vaccination programme.

The Trust is also set to be granted Freedom of Entry to the City of Coventry – the honour was proposed by the Leader of Coventry City Council (Councillor George Duggins) who has said it was in recognition of the 'incredible work' of healthcare staff. The Freedom of Entry to the City is given very rarely but I cannot think of a more deserving set of recipients than our wonderful teams and employees.

Consultant Appointments:

Through the nominated Chief Executive Representative and other Committee Members, the Trust Board is advised to note and ratify the following appointments:

Appointed Candidate
Dr Julia Reese - Consultant Children's Emergency Medicine Dr Bibi Leila Roofeida Ahmed and Dr Andrew Robinson - Consultants Pathologist in Cellular Pathology Ganesh Kasavkar - Consultant Rheumatologist Rachel Chapman - Consultant in Public Health

Dr Hamed Khan - Consultant Oncoplastic Breast Surgeon Dr Carol Perri - Consultant Neuro-radiologist Dr Nirojan Sivapathasundararajah - Consultant Anaesthetist with an interest in Obstetric Dr Rohit Mittal & Dr Christina Clare Tourville - Consultant Anaesthetist with an interest in Neuroanaesthesia

KEY IMPLICATIONS:

Financial:	None arising from this report
Patients Safety or Quality:	None arising from this report
Human Resources:	None arising from this report
Operational:	None arising from this report

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 28 JANUARY 2020

Audit and Risk Assurance Committee Report following the meeting held on **14 January 2021** via MS Teams
Chair of the Committee: Afzal Ismail, Non-Executive Director
Was this meeting quorate: Yes
Purpose: This report is to **provide assurance** that the Audit and Risk Assurance Committee has formally constituted its duties in accordance with the terms of reference and to advise of the business transacted.
Recommendation: The Board is asked to **RECEIVE ASSURANCE** from the business discussed at the meeting and to raise any questions in relation to the same.

KEY HIGHLIGHTS OF DISCUSSION HELD DURING MEETING	
Key Issue discussed	Resolution or outcome of discussion
7 Internal Audit Recommendations Update	The Committee was pleased with the small number of outstanding recommendations but expressed concern about actions to address some recommendations that have been deferred several times.
9 Cyber Security Survey: the impact of Covid-19 on the NHS	The Committee saw the results of a survey carried out amongst NHS trusts about cyber security, in particular the impact of COVID. A report has been commissioned for the next meeting to understand the Trust's position in relation to the recommendations from that survey.
10 Internal Audit review- Financial Systems including Payroll	The internal report on financial systems highlighted some issues with overpayments through payroll and heard the efforts the organisation needs to make to improve processes so that leavers and other changes are notified and actioned promptly.
13 External Audit Plan	The Committee were assured about the plans for carrying the audit of the annual report and accounts and the quality account.
22 Update on Register of Interests	There has been an improvement in achieving compliance of decision makers to submit declarations of interests on an annual basis and the Committee also heard plans to utilise a new module in ESR (the national Electronic Staff Record system) to further streamline processes.

ITEMS FOR ESCALATION, WHY AND TO WHERE		
Item or issue	**Purpose for escalation**	**Escalated to**

TERMS OF REFERENCE: Did the meeting agenda achieve the delegated duties?	
Item from terms of reference	State which agenda item achieved this
Advise the Trust Board on the strategic aims and objectives of the Trust	
Receive assurance on the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and recommend modifications	10 Internal Audit review - Financial Systems including Payroll 11 Internal Audit review - Data Quality Audit - RTT 18 WW Incomplete Pathway target

TERMS OF REFERENCE: Did the meeting agenda achieve the delegated duties?	
Item from terms of reference	State which agenda item achieved this
Receive reports from the Chief Officers relating to organisational performance and quality within the remit of the Committee	
Receive assurance on the delivery of strategic objective and annual goals within the remit of the Committee	
Review the annual audit letter from the external auditor	
Review the Head of Internal Audit opinion	
Review any breaches of standing orders	
Review write-off of losses or the making of special payments	17 Losses and Special Payments 18 Debt Write-Offs 19 Waivers of SO/SFIs/SoRD
Review the Trust's annual report, accounts and quality account and recommend approval to the Trust Board	13 External Audit Plan 21 Annual Report and Accounts 2020/21 Timetable
Review the effectiveness of financial reporting	
Receive assurance about the effectiveness of arrangements for; • Governance • Risk management • Internal audit • Internal control • External audit • Counter fraud • Clinical audit • Information governance	7 Internal Audit Recommendations Update 8 Internal Audit Progress Report 9 Cyber Security Survey: the impact of Covid-19 on the NHS 12 Briefing Paper: Head of Internal Audit Opinion Update & conformance with Standards during the coronavirus pandemic 14 Counter Fraud Progress Report 15 NFI 2018 Closure Report 16 Finance and Procurement Staff Survey Results
Review the Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions	
Review the Trust's policies and procedures for the management of risk	20 Accounting Policies and Technical Accounting Update 2020/21
Review the arrangements for declaring interests, gifts and hospitality	22 Update on Register of Interests
Other	

MEETING CYCLE: Achieved for this month: Yes Reference any items that were not taken at this meeting, explaining why and when it has been rescheduled.	
Item from meeting cycle	**Reason for not taking item**

ATTENDANCE LOG						
		Apr 20	**Jun 20**	**Jul 20**	**Oct 20**	**Jan 21**
Was the meeting quorate?		Yes	Yes	Yes	Yes	Yes
Non-Executive Director (Afzal Ismail)	Chair	✓	✓	✓	✓	✓
Non-Executive Director (Guy Daly)	Member	×	×	✓	✓	✓
Non-Executive Director (Jerry Gould)	Member	✓	✓	✓	✓	✓
Non-Executive Director (Sudhesh Kumar)	Member	✓	✓	✓	×	✓

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 28 JANUARY 2021

Finance, Resources and Performance Committee Report following the meeting held on **17 December 2020**
Chair of the Committee: Jerry Gould
Was this meeting quorate: Yes
Purpose: This report is to **provide assurance** that **Finance, Resources and Performance Committee** has formally constituted its duties in accordance with the terms of reference and to **advise** of the business transacted.
Recommendation: The Board is asked to **RECEIVE ASSURANCE** from the business discussed at the meeting and to raise any questions in relation to the same.

KEY HIGHLIGHTS OF DISCUSSION HELD DURING MEETING	
Key Issue discussed	Resolution or outcome of discussion
Item 07 – Integrated Finance Report	The Committee expressed concern with delays in approval and release of capital funds from the centre and the risk that the funds allocated for 2020/21 will be lost and will create pressure in the allocations for 2021/22
Item 09 – Budget Setting Approach	The national financial framework is not expected until the middle of January 2021 and this means budget planning for the Trust is being delayed. There may need to be extraordinary meetings of the Committee to ensure it is sighted on the merging picture and the implications for the Trust
Item 10 – 2019/20 National Cost Collection – Post Submission Report	The Committee heard the challenges there have been this year arising from changes of submission dates and relaxing of standards which will make some costs difficult to compare. The data was submitted on time.
Item 14 – 'No deal' EU Exit Preparations Update	Assurances were provided to the Committee on the preparations made under business continuity arrangements to manage the impact of the exit of the UK from the European Union.

ITEMS FOR ESCALATION, WHY AND TO WHERE		
Item or issue	Purpose for escalation	Escalated to
None		

TERMS OF REFERENCE: Did the meeting agenda achieve the delegated duties?	
Item from terms of reference	State which agenda item achieved this
Advise the Trust Board on the strategic aims and Objectives of the Trust	
Review risks to the delivery of the Trust's strategy as delegated by the Trust Board	Item 15 – Board Assurance Framework and Corporate Risks
Review the financial strategy	
Review outline and final business cases for capital investment the value is above that delegated to the Chief Officers	
Receive assurance on the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and recommend modifications	

TERMS OF REFERENCE: Did the meeting agenda achieve the delegated duties?	
Item from terms of reference	State which agenda item achieved this
Receive reports from the Chief Officers relating to organisational performance within the remit of the Committee	
Receive assurance on the delivery of strategic objective and annual goals within the remit of the Committee	
Review performance against financial and operational indicators and seek assurance about the effectiveness of remedial actions and identify good practice	Item 07 – Integrated Finance Report Item 08 – Waste Reduction Programme Planning Item 10 – 2019/20 National Cost Collection – Post Submission Report Item 13 – Integrated Quality, Performance and Finance Report
Review the capital programme	
Receive assurance about the effectiveness of arrangements for; • Financial management • Operational performance • Recruitment, employment, training and workforce management • PFI arrangements • Organisational development • Emergency preparedness • Insurance and risk pooling schemes (LPST/CNST/RPST) • Cash management • Waste reduction and environmental sustainability	Item 09 – Budget Setting Approach Item 11 – Elective Restoration Update Item 12 – Emergency Care Update Item 14 – 'No deal' EU Exit Preparations Update
Receive reports from the Chief Finance Officer on actual and forecast financial performance against budget and operational plan	Item 6 - Integrated Finance Report
Review proposals for the acquisition, disposal or change of use of land and/or buildings.	
Review the terms of reference for the Committee and recommend approval to the Trust Board	
Other	

MEETING CYCLE: Achieved for this month: Yes Reference any items that were not taken at this meeting, explaining why and when it has been rescheduled.
None

ATTENDANCE LOG													
		Apr[1]	**May[1]**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Was the meeting quorate?		**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**CANCELLED**	**Yes**	**CANCELLED**		
Non-Executive Director (Jerry Gould)	Chair	✓	✓	✓	✓	✓	✓	✓		✓			

ATTENDANCE LOG												
		Apr[1]	**May**[1]	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Associate Non-Executive Director (Jenny Mawby-Groom)	Member	✓	✓	✓	✓	×	✓	✓		✓			
Chief Finance Officer	Member	✓	✓	✓	×	✓	✓	✓		✓			
Chief Operating Officer	Member	✓	✓	✓	✓	✓	✓	×		✓			
Chief People Officer	Member	✓[2]	✓[2]	✓[2]	×[2]	×[2]	✓	✓		✓			
Non-Executive Director (Carole Mills)	Member	✓	✓	✓	×	✓	✓	✓		✓			
Non-Executive Director (Brenda Sheils)	Member	✓	✓	✓	✓	✓	✓	✓		✓			

1 Finance and Performance Committee
2 Chief Workforce and Information Officer

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 28 JANUARY 2021

Quality and Safety Committee Report following the meeting held on **17 December 2020**
Chair of the Committee: Sudhesh Kumar, Non-Executive Director
Quorate: Yes
Purpose: This report is to provide assurance that Quality and Safety Committee has formally constituted its duties in accordance with the terms of reference and to advise of the business transacted.
Recommendation: The Board is asked to **RECEIVE ASSURANCE** from the business discussed at the meeting and to **raise** any questions in relation to the same.

Meeting Key Issues	**Resolution or outcome of discussion**
Item 07 Serious Incident and Never Event Report	The Committee received a summary of the serious incidents recorded between July 2019 and September 2020 and discussed the improvements in applying duty of candour that have been maintained throughout the pandemic. There was also positive news about the timeliness of investigations being carried out and actions closed.
Item 09 Board Walk Round Approach 2020/21	A report from the Chief Quality Officer noted that the revised approach to Board walk rounds has started and the improved paperwork was noted.
Item 10 External Assurance Insight Paper	The external reviews of various Trust activities that have taken place recently were highlighted. The CQC's changed approach to carrying out visits was also explained and the likely areas to be visited were shared. The Ockenden report, that had just been published was referenced, along with a letter received asking for assurance about changes in processes.
Item 12 Covid Update (incl. IPC Update / Staff Wellbeing / Restoration)	The Committee receive an update on the current COVID situation, and in particular focussed on nosocomial infections (those assumed to have been contracted in the Trust).

Item or issue for escalation	**Purpose for escalation**	**Escalated to**

Terms of reference	**Agenda item**
Advise the Trust Board on the strategic aims and objectives of the Trust	
Review risks to the delivery of the Trust's strategy as delegated by the Trust Board	Item 13 Board Assurance Framework and Corporate Risks Item 11 CQC Action Plan Update
Approval of the quality strategy	
Review the Quality Account	
Receive assurance on the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and recommend modifications	
Receive reports from the Chief Officers relating to organisational performance and quality within the remit of the Committee	Item 12 Covid Update (incl. IPC Update / Staff Wellbeing / Restoration)
Receive assurance on the delivery of strategic objective and annual goals within the remit of the Committee	
Review performance against quality indicators and seek	Item 08 Integrated Quality, Performance and Finance

Terms of reference	**Agenda item**
assurance about the effectiveness of remedial actions and identify good practice.	Report
Receive assurance about the effectiveness of arrangements for; • infection prevention and control • patient safety • patient experience • clinical effectiveness • managing patients with mental health issues • health and safety	Item 07 Serious Incident and Never Event Report Item 09 Board Walk Round Approach 2020/21 Item 10 External Assurance Insight Paper
Review the terms of reference for the Committee and recommend approval to the Trust Board	
Other	

Meeting cycle achieved for this month: Yes
Reference any items that were not taken at this meeting, explaining why and when it has been rescheduled.
None

Attendance		**Apr[1]**	**May[1]**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Was the meeting quorate?		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Meeting cancelled	Yes	Meeting Cancelled		Meeting cancelled
Non-Executive Director (Sudhesh Kumar)	Chair	✓	✓	✓	✓	✓	✓	✓		✓			
Chief Medical Officer	Member	✓	✓	✓	✓	×[2]	×[2]	×[2]		×[3]			
Chief Nursing Officer	Member	✓	✓	×	✓	✓	×[3]	×[3]		×[3]			
Chef Quality Officer	Member	✓	✓	✓	✓	✓	✓	✓		✓			
Non-Executive Director (Guy Daly)	Member	✓	✓	✓	✓	✓	✓	✓		×			
Non-Executive Director (Carole Mills)	Member	✓	✓	✓	×	✓	✓	✓		✓			
Non-Executive Director (Brenda Sheils)	Member	✓	✓	✓	✓	✓	✓	✓		✓			

1 Quality Governance Committee
2 Chief Medical Officer was Acting CEO during this period and therefore was represented by a Deputy Chief Medical Officer
3 Chief Nursing Officer and Chief Medical Officer addressing other operational issues

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON *28* JANUARY 2021

Subject Title	Assurance Report: Covid-19 and Restoration
Executive Sponsor	Laura Crowne, Chief Operating Officer
Author	Kara Marshall, Interim Deputy Chief Operating Officer
Attachment(s)	Assurance Report: Covid-19 and Restoration
Recommendation(s)	The Board are requested to **RECEIVE ASSURANCE** from the content of the report

EXECUTIVE SUMMARY

The purpose of this report is to outline the current Trust position in relation to the impact of Wave 2 Covid-19, with adherence to internal triggers and escalation.

The Trust is currently responding to the pressures of Covid-19 Wave 2 to ensure designated inpatient Covid capacity and non-Covid capacity is in place across both hospital sites to maintain flow and safety for patients as well as supporting redeployment of staff to enact a super surge into critical care.

The Trust maintained elective care pathways as long as possible before standing down routine surgery at the beginning of January 2021. Further support from the Independent Sector has been negotiated to prioritise those patients that can safely receive their treatment in an alternative setting.

The Trust has seen a significant increase in patients that are Covid positive during December 2020 and into January 2021 with an expected peak w/c 25th January 2021 as per national and regional forecasting

PREVIOUS DISCUSSIONS HELD

Trust Board – November 2020

KEY IMPLICATIONS	
Financial	None
Patients Safety or Quality	Enabling patients to access services safely across emergency and elective pathways.
Human Resources	Supporting staff in response to shielding, redeployment, change in service delivery and managing absence to maintain delivery of core services.

Operational	Utilising all available capacity including both hospital sites and the Independent Sector. Ensuring robust triggers and escalation are adhered to during Wave 2.

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

REPORT TO PRIVATE / PUBLIC TRUST BOARD

Assurance Report: COVID-19 and Restoration

1. INTRODUCTION

The NHS declared a Level 4 National Incident on 5 November 2020 in response to the Public Health emergency created by Covid-19 Wave 2. The Trust has responded to this national incident through the established daily command and control governance structure of Silver and Gold Command and extended onsite presence of senior managers on call and emergency planning support.

The Trust is currently responding to the pressures of Covid-19 Wave 2 to ensure designated inpatient covid capacity and non-covid capacity is in place across both hospital sites to maintain flow and safety for patients as well as supporting redeployment of staff to enact a super surge into critical care.

The Trust maintained elective care pathways as long as possible before standing down routine surgery at the beginning of January 2021. Further support from the Independent Sector has been negotiated to prioritise those patients that can safely receive their treatment in an alternative setting. Elective care on the UH site is in place for patients that are clinically urgent requiring critical care to support their recovery. These are patients classed as P1 or P2 which is a national categorisation which classifies patients based on the time they are able to wait for surgery. P1 and P2 are the highest criteria and we to admit these patients onto the Green pathway.

The Trust has seen a significant increase in patients that are Covid positive during December 2020 and into January 2021 with an expected peak w/c 25th January 2021 as per national and regional forecasting.

Figure 1: Covid Positive – Wave 1 and 2 Combined

Cumulative COVID-19 Patients Admitted	2216
Current Inpatients: Critical Care	36
Current Inpatients: Rest of Hospital	218
Discharged: Recovered	1483
Discharged: Deceased Submitted	468
Discharged: Deceased +ve Swab Awaiting Confirmation	11

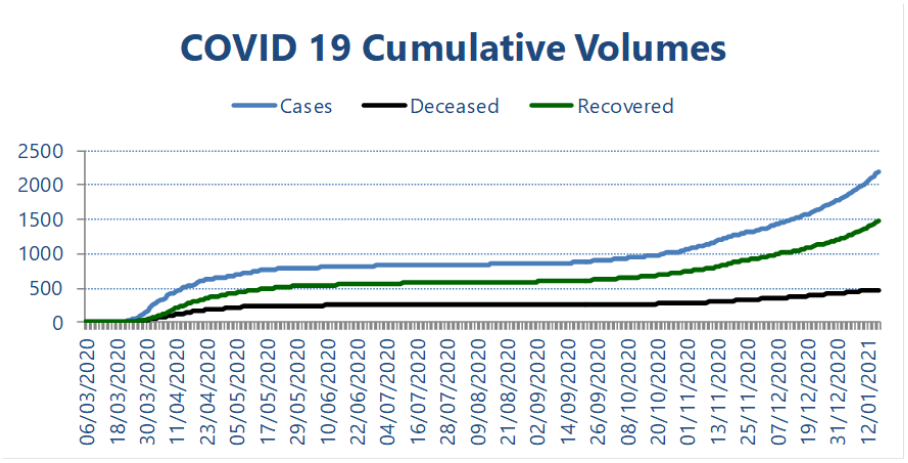
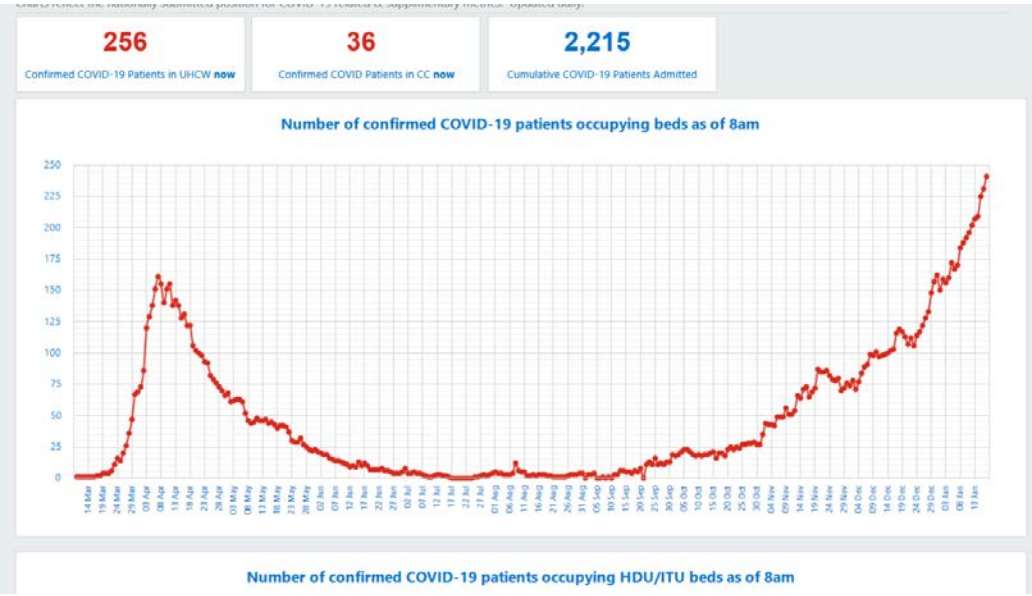


Figure 2: Current COVID-19 Admission Summary (as at 18/01/2021)



2. **CONTENT**

Critical Care Surge

The trust is currently at a critcon level 3 within the critical care unit (of a scale of 1-4) and managing patient flow across the network through mutual aid. Most recently UHCW has also assisted with the London and South East incident by accepting patients from these areas on a daily basis. The response to mutual aid requests and local increasing demand has required the Trust to enact plans to surge to a total of 79 beds against a baseline of 33 pre-covid. This has required redeployment of staff across all disciplines across the Trust.

Figure 3: Internal Critical Care Stages 1-6 (currently operating at Stage 5)

Surge Status				Staff Requirements		Bed Configuration						Bed Allocation		
Stage	% Capacity	Beds Required	Patients	Total Registered Practitioner required Per shift	Total HSCW Required per shift	GCC (30)		CTCC (22)		Ward 11 (30)		Total Beds Allocated	COVID Beds	NON COVID Beds
						COVID	NON-COVID	COVID	NON-COVID	COVID	NON-COVID			
1	100	33	1	33	3	15 (5 Side Rooms, 4 Bed Bay, 6 Bed Bay)	10 (10 Bed Bay)	0	15 (6 Side Rooms, 2 x 4 Bed Bay)	0	0	40	15	25
2	133	44	1.5	29	4	25 (10 Bed bay, 5 Side Rooms, 4 Bed Bay, 6 Bed Bay)	5 (5 Bed Bay)	0	18 (6 Side Rooms, 3 x 4 Bed Bay)	0	0	48	25	23
3	150	50	3	33	5	30 (10 Bed bay, 6 Bed Bay, 5 Side Rooms, 2 x 4 Bed Bays)	0	4 (4 Bed Bay)	18 (6 Side Rooms, 3 x 4 Bed Bay)	0	0	52	34	18
4	175	58	3	58	6	30 (10 Bed bay, 6 Bed Bay, 5 Side Rooms, 2 x 4 Bed Bays)	0	22 (6 Side Rooms, 4 x 4 Bed Bay)	0	0	15 (3 Side Rooms, 3 x 4 Bed Bay)	67	52	15
5	200	65	4	65	7	30 (10 Bed bay, 6 Bed Bay, 5 Side Rooms, 2 x 4 Bed Bays)	0	22 (6 Side Rooms, 4 x 4 Bed Bay)	0	7 (3 Side Rooms, 1 x 4 Bed Bay)	19 (3 Side Rooms, 4 x 4 Bed Bay)	78	59	19
6	250 (super Surge)	79	4	79	8	30 (10 Bed bay, 6 Bed Bay, 5 Side Rooms, 2 x 4 Bed Bays)	0	22 (6 Side Rooms, 4 x 4 Bed Bay)	0	11 (3 Side Rooms, 2 x 4 Bed Bay)	19 (3 Side Rooms, 4 x 4 Bed Bay)	82	63	19

Patients with higher respiratory needs that do not require critical care, or can step down from critical care, are managed on the respiratory wards. There is provision for cpap outside the critical care environment within the respiratory wards. Oxygen provision and supply on the wards is augmented with the ability to use oxygen concentrators where required and is closely monitored on a regular basis through the central site team and an electronic report that highlights Oxygen levels.

Covid-19 Cohort Inpatient Ward Capacity

Alongside the surge required in Critical Care, the Trust has expanded its designated Covid cohort bed base. To support additional capacity for patients with COVID-19 and ensure safety of all patients across the Trust by reducing contact and potential transmission, ward areas continue to be reconfigured to create designated areas for COVID-19 positive and negative patients. Patients awaiting results of a covid swab are admitted into a side room until onward admission to an inpatient ward can be confirmed however we are also using other testing kits within emergency pathways to support patient pathways effectively.

Prior to enacting any further expansion of Covid cohort areas, a set of 4 triggers must be met. This ensures a balance is made between demand for covid capacity and non-covid capacity.

Currently, the following ward areas have been configured for designated Covid cohort capacity:

Positive Cohort Capacity																
Ward	30	31	31A	20	40	RSX	20A	42	52	23G						Total
Beds Open	20	20	16	24	28	8	16	28	28	8						196

Figure 4: Covid-19 Cohort Triggers

In order to prepare a ward area for opening cohort capacity the following triggers must **ALL** be met:

1. Covid triggers must be Level 4 or 5 continuously for previous 24 hours
2. Less than 5 patients >14 days Covid positive that can move into closed beds or to Cedar Ward, Rugby St Cross
3. Less than 4 siderooms or cohort beds available for DTAs in ED for patients requiring a S/R or cohort bed
4. Demand for single sex accommodation is more than available capacity

The Trust has not established designated Covid cohort areas at Rugby St Cross site, however where a patient may test positive after transfer (when the virus may have been incubating) the patient is not transferred back to UH site unless clinically indicated.

In addition to creation of covid cohort capacity, the Trust has developed areas for step down once a patient is more than 14 days since their positive test but still requires inpatient care. An area at Rugby St Cross site has been converted for this purpose.

Infection Prevention & Control alongside Virology have also enabled beds that are closed due to exposure across the site to be accessed for this specific patient cohort which has been through the IPC council and both silver and gold incident command.

Emergency Pathways

Ambulance off load times of more than 60 minutes are reported internally each day and a root cause analysis is undertaken to understand lessons learnt and to ensure no harm is caused to a patient as a result of a delay.

The pressure experienced across the site has resulted in ambulance off load delays particularly in the evening period. To improve flow into the hospital site the Emergency Medicine group are piloting from 22nd January a post assessment area for respiratory or non-respiratory patients in two bays of 4 that are confirmed as requiring admission. This will enable movement of patients into the department in order to release ambulance crews in a more timely way. Clear triggers and escalation standard operating procedures have been implemented to enact these changes.

Covid-19 Rapid Testing

A satellite lab in the ED footprint continues to facilitate rapid testing (NUDGE). This enables patients presenting clinically with covid-19 being confirmed for direct admission to a cohort area thus avoiding significant pressure on side rooms.

Lateral flow will also shortly be used to facilitate direct admission from the ED department and a confirmed process is in place to support this launch from week beginning 25th January.

Discharge Planning and Long Length of Stay

Internal data supports operational teams to prioritise swabs for patients that are ready for discharge to a care home or with a package of care to reduce incidents of failed discharges. There are now both blue and light blue beds available within the community setting for patients requiring a care home placement that remain covid positive at discharge (blue) and those patients that have a 14 day exposure to covid and require isolation (light blue).

A Confirm and Challenge programme is established to facilitate discharge for long length of stay patients and provide visibility across the ward areas on specific patients with an extended length of stay. The actions and support required from system partners are prioritised through escalations at Bronze, Silver and Gold level to progress discharges for this cohort of patients, accessing appropriate beds as required.

A MADE event (Multi-Agency Discharge Event) took place w/c 11th January to promote timely discharge and access for patients and will be followed up with a comprehensive report and clear actions.

Elective Care

Use of the Independent Sector

To maintain elective care pathways, negotiation has been underway with the independent sector to return to the quarter 3 arrangements at both the Nuffield Hospital in Leamington and the BMI in Coventry. From the 1st of February increased capacity has been agreed with the Nuffield and the BMI for cancer and urgent patient diagnostics and treatments.

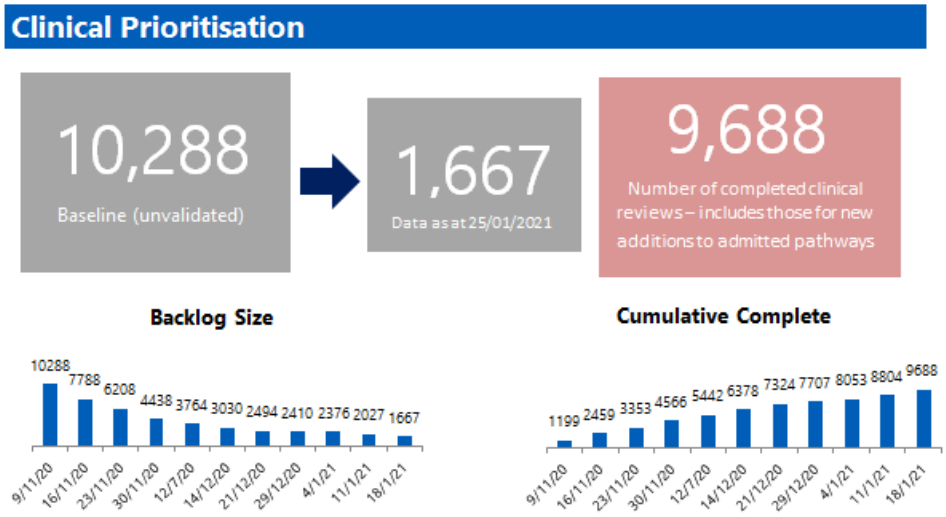
This includes 1 robotic theatre 5 days per week plus 3 days of a second theatre, endoscopy and diagnostic prostate biopsy sessions, 4 days of the cardiac cath lab and CT scanning. Breast services are transferring back to the Nuffield.

The Trust is also collaborating with both SWFT and GEH for support with colorectal urgent two week wait pathways and access to CT colongraphy at their hospital sites.

Clinical Prioritisation

All patients continue to be clinically prioritised in line with national requirement. The majority of all patients currently on the waiting list have being contacted to ascertain whether they wish to remain on the waiting list. Any new patient requiring surgery is being prioritised at the point of listing on the waiting list. Furthermore patients that are now having surgery put on hold due to emergency pressures will be added to this prioritisation list for review if not completed prior to their surgery date.

Figure 5: Clinical Prioritisation



Treatment continues at the UH site for those patients categorised in P1-P2 with a daily review of capacity to admit patients that generally are those requiring critical care or enhanced care post operatively.

In addition use of Independent sector is being managed similarly to wave 1 with exploration of in-sourcing for low complex cases being worked through for consideration.

Waiting List Prioritisation

Clinical Urgency	Priority code
Emergency<24 hrs	P1a
Emergency<72 hrs	P1b
< 1 month	P2
< 3 months	P3
> 3 months	P4
Patient wishes to postpone surgery because of Covid concerns	P5
Patient wishes to postpone surgery because of non- Covid concerns	P6

3. CONCLUSIONS

A clear governance structure is well established through Silver and Gold Command to ensure decision-making and escalation of risk occurs in response to the national Level 4 incident.

The Trust is maintaining safety for patients and staff through adherence to triggers and escalations and is working collaboratively with partners to ensure flow across the system as well as providing support to the Midlands and beyond.

There continues to be focus on collaborative projects that will accelerate patient pathways in support of managing an increase in patients that are covid positive and the corresponding stand down of elective care is controlled and managed to ensure minimal disruption and an ability to switch services back on when safe to do so.

Author Name: Kara Marshall
Author Role: Interim Deputy Chief Operating Officer
Date report written: 22/01/2021

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 28 JANUARY 2021

Subject Title	Response to the Ockenden Review and Assurance Tool
Executive Sponsor	Nina Morgan, Chief Nursing Officer
Author	Gaynor Armstrong, Group Director of Midwifery
Attachment(s)	Ockenden Emerging Findings & Assessment and Assurance Tool
Recommendation(s)	Trust Board is asked to **NOTE** the current position in response to the findings and recommendations of the Ockenden report (December 2020), along with the assessment and assurance against the seven Immediate and Essential Actions (IEAs)

EXECUTIVE SUMMARY
As a result of the independent review into maternity services at Shrewsbury and Telford Hospital NHS Trust the first report was shared at the Health Select Committee on 15th December 2020. The report was in response to the request of Jeremy Hunt in 2017 whilst secretary of state for an 'independent review of the quality of investigations and implementation of their recommendations of a number of alleged avoidable neonatal and maternal deaths and harm at the trust'. The first report relates to the findings of 250 cases out of the 1,862 that will be reviewed. Each trust received a letter on 14th December 2020 outlining the initial findings and recommendations, along with seven IEA's to be addressed and responded to on the 21st December 2020. The purpose of this report is to share the gap analysis against all of the 59 findings, and 27 elements within the IEA's and provide assessment and assurance within the tool provided by NHS England (December 2020) of the maternity service provided within UHCW.
PREVIOUS DISCUSSIONS HELD
Maternity Safety Improvement Plan – shared at PSEC and Trust Board November 2020

KEY IMPLICATIONS	
Financial	Risk of Litigation. Cost of additional recruitment to meet the needs of the Birthrate Plus workforce assessment findings 2020.
Patients Safety or Quality	Non-compliance with all of the safety actions, including elements of the SBLCB v2 may result in higher rates of stillbirth, neonatal death and intrapartum brain injury.
Human Resources	Continued support with recruitment of midwives required to achieve the Birthrate Plus workforce assessment tool
Operational	Meeting the needs of the training requirements whilst maintaining safe staffing levels during the Covid pandemic.

Maternity services assessment and assurance tool

We have devised this tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of *effective* implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams. Rather than a tick box exercise, the tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and any support requirements. We have cross referenced the 7 IEAs in the report with the urgent clinical priorities and the ten Maternity incentive scheme safety actions where appropriate, although it is important that providers consider the full underpinning requirements of each action as set out in the technical guidance.

We want providers to use the publication of the report as an opportunity to objectively review their evidence and outcome measures and consider whether they have *assurance* that the 10 safety actions and 7 IEAs are being met. As part of the assessment process, actions arising out of CQC inspections and any other reviews that have been undertaken of maternity services should also be revisited. This holistic approach should support providers to identify where existing actions and measures that have already been put in place will contribute to meeting the 7 IEAs outlined in the report. We would also like providers to undertake a maternity workforce gap analysis and set out plans to meet Birthrate Plus (BR+) standards and take a refreshed view of the actions set out in the Morecambe Bay report. We strongly recommend that maternity safety champions and Non-Executive and Executive leads for Maternity are involved in the self-assessment process and that input is sought from the Maternity Voices Partnership Chair to reflect the requirements of IEA 2.

Fundamentally, boards are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the same tragic outcomes could not happen in their organisation. We expect boards to robustly assess and challenge the assurances provided and would ask providers to consider utilising their internal audit function to provide independent assurance that the process of assessment and evidence provided is sufficiently rigorous. If providers choose not to utilise internal audit to support this assessment, then they may wish to consider including maternity audit activity in their plans for 2020/21.

Regional Teams will assess the outputs of the self-assessment and will work with providers to understand where the gaps are and provide additional support where this is needed. This will ensure that the 7 IEAs will be implemented with the pace and rigour commensurate with the findings and ensure that mothers and their babies are safe.

Section 1

Immediate and Essential Action 1: Enhanced Safety

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.
- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.
- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?
Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Link to urgent clinical priorities:

(a) A plan to implement the Perinatal Clinical Quality Surveillance Model
(b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
The maternity service has a	The Trust report to the LMNS	The process in place is	None	Not	Not	Not

detailed clinical dashboard in place, which is reported internally throughout the governance structure within our Trust. This is shared with the LMNS for our system and compiled into a LMNS dashboard. This is tabled and discussed at least every 3 months at the LMNS.	on a quarterly basis a Maternity Dashboard for the LMNS. This includes the local and network compliance against national targets. The discussion at the LMNS targets actions required for improvement, escalations from the data and sharing lessons from across our system.	structured to monitor trends and themes on our outcomes, to ensure that actions taken to improve safety are having the intended impact. This is monitored in a number of ways from the ward based daily huddles, compliance audits to ensure implementation of actions, board safety champions fortnightly meeting oversight and Trust board reporting.	Identified	Applicable	Applicable	Applicable
UHCW NHS Trust have 100% compliance with the HSIB process, this has provided robust assurance that all of the described cases have had clinical specialist opinion from outside the Trust, since the commencement of HSIB. UHCW continues to work closely with the HSIB process to ensure this continues. In any such occurrence where one of the described cases should occur, and HSIB investigation does not take place, then UHCW Serious Incident Group would seek external support from within our region.	All HSIB and Serious Incident reports are reviewed by the women and their families, the staff involved in their care as well as the wider maternity service ,Trust Serious Incident Group and Trust Board. This process supports an open learning culture, with an independent perspective and engagement from service users and staff on how best to drive improvements.	All Serious Incident reports are shared with the local team, maternity service, and LMNS on a monthly basis. In addition the Trust has taken steps to increase reporting to the Trust Board from quarterly to Monthly for all maternity serious incidents. Robust governance and oversight of the effectiveness of actions from serious incidents, is monitored through themes and trends on our Maternity Dashboard.	None Identified	Not Applicable	Not Applicable	Not Applicable
All maternity serious incidents (a summary of the key issues) have been shared with the Trust Board and LMNS every quarter. Since receipt of the letter, the Trust has taken steps to increase the reporting schedule	Both the Trust Board (including the Board level Maternity Safety Champions) and LMNS provide scrutiny, oversight and transparency of Maternity incidents . They provide supportive direction in	The LMNS share collated learning across the region. Further assurance of the improvements made following serious maternity incidents is provided to the system Quality Surveillance Group.	None Identified	Not Applicable	Not Applicable	Not Applicable

to monthly.	identifying any actions for further improvement.					
The Trust is compliant with the National Perinatal Mortality Review Tool.	The Trust has a weekly Multi-disciplinary Perinatal Mortality Meeting which reviews all perinatal deaths using the national tool. Actions for improvement are identified from each review.	The Maternity service report regular to the Trust Mortality Committee on identified learning, themes, trends and any actions for improvement. Progress against this is governed by the Trusts Patient Safety and Effectiveness Committee.	None Identified	Not Applicable	Not Applicable	Not Applicable
The Trust implemented a full Electronic Patient Record system on the 3rd December 2020, which is compliant with the maternity dataset. Data will be submitted in 2021 to meet this requirement.	The Maternity Dataset is used to validate activity and improve data quality for Maternity Services.	Not Applicable	None Identified	Not Applicable	Not Applicable	Not Applicable
UHCW NHS Trust have 100% compliance with the HSIB process and have a robust process for the identification of incidents for the NHS Resolutions Early Notification Scheme.	All HSIB and Serious Incidents including those reportable to NHS Resolution, are reviewed by the women and their families, the staff involved in their care as well as the wider maternity service ,Trust Serious Incident Group and Trust Board. This process supports an open learning culture, with an independent perspective and engagement from service users and staff on how best to drive improvements.	All Serious Incident reports are shared with the local team, maternity service, and LMNS on a monthly basis. In addition the Trust has taken steps to increase reporting to the Trust Board from quarterly to Monthly for all maternity serious incidents. Robust governance and oversight of the effectiveness of actions from serious incidents, is monitored through themes and trends on our Maternity Dashboard.	None Identified	Not Applicable	Not Applicable	Not Applicable
The Maternity Service has identified how is currently meets the requirements of the Perinatal Clinical quality Surveillance Model and has implemented a Maternity Safety Improvement	The Maternity Service has benchmarked themselves against the proposed principles of the model and defined actions required for full compliance in a Safety	Once the Perinatal Clinical Quality Surveillance Model is formally published the Trust will monitor progress of the Safety Improvement plan both within the Trust and a system level via	None Identified	Not Applicable	Not Applicable	Not Applicable

Plan to inform future plans.	Improvement plan.	the LMNS.				
UHCW NHS Trust have 100% compliance with the HSIB process, this has provided robust assurance that all of the described cases have had clinical specialist opinion from outside the Trust, since the commencement of HSIB. UHCW continues to work closely with the HSIB process to ensure this continues. In any such occurrence where one of the described cases should occur, and HSIB investigation does not take place, then UHCW Serious Incident Group would seek external support from within our region.	All HSIB and Serious Incident reports are reviewed by the women and their families, the staff involved in their care as well as the wider maternity service ,Trust Serious Incident Group and Trust Board. This process supports an open learning culture, with an independent perspective and engagement from service users and staff on how best to drive improvements.	All Serious Incident reports are shared with the local team, maternity service, and LMNS on a monthly basis. In addition the Trust has taken steps to increase reporting to the Trust Board from quarterly to Monthly for all maternity serious incidents. Robust governance and oversight of the effectiveness of actions from serious incidents, is monitored through themes and trends on our Maternity Dashboard.	None Identified	Not Applicable	Not Applicable	Not Applicable

Immediate and essential action 2: Listening to Women and Families
Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

Link to Maternity Safety actions:
Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Link to urgent clinical priorities:

(a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.
(b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

What do we have in place currently to meet all requirements of IEA 2?	How will we evidence that we are meeting the requirements?	How do we know that these roles are effective?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?
The Trust has support mechanisms in place for women who require an	The Trust provides support to women and continually captures and responds to	In the interim of implementing a dedicated Senior Advocate role within	Explore Senior Advocate	Clinical Director, Group	Publication of National Role	Women are currently supported by the

advocate in their care. This is currently provided through a number of methods such as Maternity Voices Partnership and Bereavement Midwifery support. The role of an independent senior advocate is welcomed by the Trust and when the role description is available the Trust will explore full implementation of such a role for our women.	feedback. Where required, actions for improvement will be initiated and monitored through the Maternity governance structure.	the maternity service, the Trust measures that the advocacy needs of women are being met through the Maternity Voices Partnership Chair who attends all LMNS Board meetings.	Role once role description is Nationally defined.	Director of Midwifery and Women and Childrens Risk Manager by 31.01.2021	description	Bereavement Team as an advocate if a bereavement has occurred, in addition this will be extended to the LMNS MVP chair.
The Trust has an identified non-executive director for maternity services who will work with the other Board level Maternity Safety Champions. The importance of maternity safety and experience is well recognised and embedded within the Trust from the service to the Trust Board. This is reflected in the Trust's Chief Medical Officer's specific responsibility for maternity services, which plays an integral part in the governance and oversight of Maternity services at UHCW NHS Trust.	We are proud of the safety culture at UHCW NHS Trust and this is well supported by the leadership of the Chief Medical Officer and Chief Nursing Officer, both of whom are Board level Maternity Safety Champions and have regular visibility within the maternity department.	This enables regular engagement with staff and service users, as well as supporting a bi-weekly safety improvement huddle with the multidisciplinary team, focusing on key safety measures such as reducing stillbirths, quality improvement initiatives and performance.	None Identified	Not Applicable	Not Applicable	Not Applicable
The Trust is compliant with the National Perinatal Mortality Review Tool.	The Trust has a weekly Multi-disciplinary Perinatal Mortality Meeting which reviews all perinatal deaths	The Maternity service report regular to the Trust Mortality Committee on identified learning, themes, trends	None Identified	Not Applicable	Not Applicable	Not Applicable

	using the national tool. Actions for improvement are identified from each review.	and any actions for improvement. Progress against this is governed by the Trusts Patient Safety and Effectiveness Committee.				
The Group Director of Midwifery attends the MVP meetings on a quarterly basis. These are also attended by stakeholders and service users, providing the opportunity to share face to face feedback and deliver updates about the service. In addition the MVP has a dedicated Facebook page and Facebook group to share information with the wider audience for the LMNS. The Trust also has a robust complaints procedure which ensures any feedback is reviewed in a timely manner, often through face to face meetings with service users, with clear action plans for improvement.	The maternity service at UHCW NHS Trust have a dedicated Facebook page with over 1300 followers and has enabled a social network for women to be able to support one another. This also provides women with an opportunity to share comments and ask questions through the private messaging function. These are then responded to by the department within 48 hours, answering any queries or concerns raised. During the COVID-19 pandemic the service has seen an increase in anxieties from women and their families therefore; an additional communication method via a dedicated email address was established. This is used as an additional method to support personalised care and support plans (PCSP) for women and their families during this time.	The Trust has a dedicated Patient Experience Midwife who supports the engagement of our women and their families with the National Maternity Survey and Friends and Family Test (FFT). This role has enabled the service to collect monthly feedback questionnaires which are developed into action plans for improving the service. The questions align with those detailed within the national maternity survey to ensure that the department has continuous oversight of the experience of women.	None Identified	Not Applicable	Not Applicable	Not Applicable

The Trust has an identified maternity safety champions to work with the Board level Maternity Safety Champions. The importance of maternity safety and experience is well recognised and embedded within the Trust from the service to the Trust Board. This is reflected in the Trust's Chief Medical Officer's specific responsibility for maternity services, which plays an integral part in the governance and oversight of Maternity services at UHCW NHS Trust. they meet fortnightly on the labour ward with multi-disciplinary staff, service users and all level safety champions to review and discuss any issues and identify any actions required.	We are proud of the safety culture at UHCW NHS Trust and this is well supported by the leadership of the Chief Medical Officer and Chief Nursing Officer, both of whom are Board level Maternity Safety Champions and have regular visibility within the maternity department.	This enables regular engagement with staff and service users, as well as supporting a bi-weekly safety improvement huddle with the multidisciplinary team, focusing on key safety measures such as reducing stillbirths, quality improvement initiatives and performance.	None Identified	Not Applicable	Not Applicable	Not Applicable
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dedicated Facebook page and Facebook group to share information with the wider audience for the LMNS. The Trust also has a robust complaints procedure which ensures any feedback is reviewed in a timely manner, often through face to face meetings with service users, with clear action plans for improvement.	private messaging function. These are then responded to by the department within 48 hours, answering any queries or concerns raised. During the COVID-19 pandemic the service has seen an increase in anxieties from women and their families therefore; an additional communication method via a dedicated email address was established. This is used as an additional method to support personalised care and support plans (PCSP) for women and their families during this time.	developed into action plans for improving the service. The questions align with those detailed within the national maternity survey to ensure that the department has continuous oversight of the experience of women.				

The Trust has an identified non-executive director for maternity services who will work with the other Board level Maternity Safety Champions. The importance of maternity safety and experience is well recognised and embedded within the Trust from the service to the Trust Board. This is reflected in the Trust's Chief Medical Officer's specific responsibility for maternity services, which plays an integral part in the governance and oversight of Maternity services at UHCW NHS Trust.	We are proud of the safety culture at UHCW NHS Trust and this is well supported by the leadership of the Chief Medical Officer and Chief Nursing Officer, both of whom are Board level Maternity Safety Champions and have regular visibility within the maternity department.	This enables regular engagement with staff and service users, as well as supporting a bi-weekly safety improvement huddle with the multidisciplinary team, focusing on key safety measures such as reducing stillbirths, quality improvement initiatives and performance.	None Identified	Not Applicable	Not Applicable	Not Applicable

Immediate and essential action 3: Staff Training and Working Together
Staff who work together must train together

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

Link to Maternity Safety actions:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

(a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
(b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place

What do we have in place currently to meet all requirements of IEA 3?	What are our monitoring mechanisms?	Where will compliance with these requirements be reported?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?
The service has MDT training in place for PROMPT (Practical Obstetric Multi-Professional Training) and this is scheduled	The requirement to host regular multi-disciplinary training for our staff is nationally recognised as a supportive measure for improving safety culture.	As recognised by the CNST Maternity Safety Standards mutli-disciplinary training has numerous benefits for enhancing the safety	The compliance to the Maternity Service PROMPT training needs to be externally validated by the LMNS at least 3 times per	Group Director of Midwifery and Clinical Director, by 31.01.2021	Support from the LMNS.	Compliance is monitored fortnightly by the Trusts Maternity Safety

each month with support from all of the teams outlined within the CNST Maternity Safety Standard including obstetric consultants, obstetric doctors, midwives, maternity support workers and theatre staff.	The training programme hosted by the maternity service allows staff to train together in a psychologically safe environment including debrief and improvement discussion on how best to deliver safe care for our women.	culture of the maternity service, the Trust monitors its compliance for the training through its Safety Improvement Plan.	year. Proposal to include on the Maternity Dashboard.			Champions meeting.
The Maternity service delivers a Consultant Led labour ward round twice daily as a minimum over a 24 hour period, 7 days per week and has Consultant presence for 96 hours per week.	This is monitored as part of the CNST Maternity Safety Standards and is detailed within the Trust's Maternity Unit Staffing Policy.	The Trust monitors its compliance to the CNST Maternity Safety Standards and gathers robust evidence to ensure the requirements are met.	None Identified	Not Applicable	Not Applicable	Not Applicable
Funding received for maternity staff training is ring fenced within the service and the refunds received for the CNST MIS is used solely for the purpose of improving maternity safety.	The Maternity service is supported by the Trust finance team in ensuring appropriate management of these funds to ensure they are used to drive improvement.	The Trust monitors its compliance to the CNST Maternity Safety Standards continually and gathers robust evidence for submission as required.	None Identified	Not Applicable	Not Applicable	Not Applicable
The maternity services demonstrates its compliance to clinical workforce planning in line with Safety Actions 4 and 5 of the CNST Safety Standards.	This is monitored as part of the CNST Maternity Safety Standards and is detailed within the Trust's Maternity Unit Staffing Policy.	The Trust monitors its compliance to the CNST Maternity Safety Standards and gathers robust evidence to ensure the requirements are met.	None Identified	Not Applicable	Not Applicable	Not Applicable
The service has MDT training in place for PROMPT (Practical Obstetric Multi-	The requirement to host regular multi-disciplinary training for our staff is nationally recognised as a	As recognised by the CNST Maternity Safety Standards mutli-disciplinary training has	Following the impact of COVID-19 the Trust is working to restore its 90% compliance.	Director of Midwifery and Clinical Director.	None required.	The PROMPT training is well embedded within the Trust

Professional Training) and this is scheduled each month with support from all of the teams outlined within the CNST Maternity Safety Standard including obstetric consultants, obstetric doctors, midwives, maternity support workers and theatre staff.	supportive measure for improving safety culture. The training programme hosted by the maternity service allows staff to train together in a psychologically safe environment including debrief and improvement discussion on how best to deliver safe care for our women.	numerous benefits for enhancing the safety culture of the maternity service, the Trust monitors its compliance for the training through its Safety Improvement Plan. The compliance to the training is also monitored fortnightly at the Maternity Safety Champions Meeting.		Trajectory for 90% by May 2021		and is ahead of its current trajectory for restoring pre Covid compliance.
The Maternity service delivers a Consultant Led labour ward round twice daily as a minimum over a 24 hour period, 7 days per week and has Consultant presence for 96 hours per week.	This is monitored as part of the CNST Maternity Safety Standards and is detailed within the Trust's Maternity Unit Staffing Policy.	The Trust monitors its compliance to the CNST Maternity Safety Standards and gathers robust evidence to ensure the requirements are met.	None Identified	Not Applicable	Not Applicable	Not Applicable
The service has MDT training in place for PROMPT (Practical Obstetric Multi-Professional Training) and this is scheduled each month with support from all of the teams outlined within the CNST Maternity Safety Standard including obstetric consultants, obstetric doctors, midwives, maternity support workers and theatre staff.	The requirement to host regular multi-disciplinary training for our staff is nationally recognised as a supportive measure for improving safety culture. The training programme hosted by the maternity service allows staff to train together in a psychologically safe environment including debrief and improvement discussion on how best to deliver safe care for our women.	As recognised by the CNST Maternity Safety Standards mutli-disciplinary training has numerous benefits for enhancing the safety culture of the maternity service, the Trust monitors its compliance for the training through its Safety Improvement Plan.	When further National Guidance is published, the Trust must take action to review and implement any recommendations.	Director of Midwifery and Clinical Director. TBC when guidance available.	To be confirmed when guidance available.	The Trust continues to provide MDT PROMPT training in the meantime.

Immediate and essential action 4: Managing Complex Pregnancy
There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

- Women with complex pregnancies must have a named consultant lead
- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team

Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

What do we have in place currently to meet all requirements of IEA 4?	What are our monitoring mechanisms?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
All women with a high-risk pregnancy have a named lead Consultant and Midwife as part of the Continuity of Care model at the Trust. This is evidenced through the patient management plans.	The Trust is proud of its implementation of the Continuity of Care model above and beyond women having a named consultant lead and continually seeks to review the quality of care provided to women with complex	Compliance with this is monitored within the evaluation of the Continuity of Care model and the introduction of the Maternity Information System will enable	None Identified	Not Applicable	Not Applicable	Not Applicable

	pregnancies. From this, further improvements have been identified to enhance the service for women such as; Obstetric Consultants also work towards providing continuity of care in dedicated clinics alongside Cardiology, Nephrology, Haematology and Endocrinology Consultants.	monitoring through referrals made at booking.				
The Trust is compliant with all five elements of the SBLCB V2 and subsequent national guidelines. The Trust has recently implemented a new Maternity EPR system to support the compliance with fetal monitoring elements (Dawes Redman CTG). The Trust will continue to monitor assurance of the outputs of compliance to all five elements.	Compliance with the SBLCB v2 is monitored through various committees within the Trust and CCG including Trust Board. This information is shared within the Maternity Dashboard report and Maternity Safety Improvement Plan.	These reports are shared on a monthly basis within the Maternity Service and quarterly to various committee meetings including Patient Safety and Effectiveness Committee and Trust Board. These are also shared with the LMNS.	None Identified	Not Applicable	Not Applicable	Not Applicable
All women with a high-risk pregnancy have a named lead Consultant and Midwife as part of the Continuity of Care model at the Trust. This is evidenced through the patient management plans.	The Trust is proud of its implementation of the Continuity of Care model above and beyond women having a named consultant lead and continually seeks to review the quality of care provided to women with complex pregnancies. From this, further improvements have been identified to enhance the service for women such as; Obstetric Consultants also work towards providing continuity of care in dedicated clinics alongside Cardiology, Nephrology, Haematology and Endocrinology Consultants.	Compliance with this is regular audited and the introduction of the Maternity Information System in 2020 has enabled monitoring through referrals made at booking.	None Identified	Not Applicable	Not Applicable	Not Applicable
The Trust is engaged with the clinical network to support the	An application was submitted for the Trust to become one of the	Once the application process recommences the	None Identified	Not Applicable	Not Applicable	Not Applicable

proposal for a tiered system of maternal medicine specialist centres. An application for the Trust to be a level 2 centre has been submitted. The Consultant Midwife at UHCW is also working with Health Education England to provide midwifery input to supporting women with complex pregnancy.	referral centres for Abnormally Invasive Placenta in the Midlands; this is set to recommence in January 2021, following being postponed due to COVID-19.	Trust will continue with its engagement.				

Maternity services assessment and assurance tool

Immediate and essential action 5: Risk Assessment Throughout Pregnancy
Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

- All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional
- Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.

What do we have in place currently to meet all requirements of IEA 5?	What are our monitoring mechanisms and where are they reported?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Risk assessments are completed at booking, at each admission and throughout pregnancy and these are discussed with women at the time of completion therefore assisting in the decision making around place of birth. Where women indicate a choice to birth outside of local/national guidance they are supported within a dedicated clinic with the	Previously these were recorded within the paper records; however since 3rd December 2020 the Trust has implemented an electronic Maternity Information System which enables improved recording and auditing that PCSPs are completed. Women using our service have the opportunity to record questions for their	Since 3rd December 2020 the Trust has implemented an electronic Maternity Information System which enables improved recording and auditing that PCSPs are completed. The Trust will use this to audit completion of risk assessments against national guidance and	None Identified	Not Applicable	Not Applicable	Not Applicable

Consultant Midwife for Better Births, who meets with the woman and her partner to assess individual risk and discuss PCSP for sharing with the MDT.	relevant healthcare professional either within their electronic Patient Held Record (PHR) or alternative method during their next consultation for those who cannot access the PHR.	identify learning.				
The Trust is compliant with all five elements of the SBLCB V2 and subsequent national guidelines. The Trust has recently implemented a new Maternity EPR system to support the compliance with fetal monitoring elements (Dawes Redman CTG). The Trust will continue to monitor assurance of the outputs of compliance to all five elements.	Compliance with the SBLCB v2 is monitored through various committees within the Trust and CCG including Trust Board. This information is shared within the Maternity Dashboard report and Maternity Safety Improvement Plan.	These reports are shared on a monthly basis within the Maternity Service and quarterly to various committee meetings including Patient Safety and Effectiveness Committee and Trust Board. These are also shared with the LMNS.	None Identified	Not Applicable	Not Applicable	Not Applicable
Risk assessments are completed at booking, at each admission and throughout pregnancy and these are discussed with women at the time of completion therefore assisting in the decision making around place of birth. Where women indicate a choice to birth outside of local/national guidance they are supported within a dedicated clinic with the Consultant Midwife for Better Births, who meets with the woman and her partner to assess individual risk and discuss PCSP for sharing with the MDT.	Previously these were recorded within the paper records; however since 3rd December 2020 the Trust has implemented an electronic Maternity Information System which enables improved recording and auditing that PCSPs are completed. Women using our service have the opportunity to record questions for their relevant healthcare professional either within their electronic Patient Held Record (PHR) or alternative method during their next consultation for those who cannot access the PHR.	Since 3rd December 2020 the Trust has implemented an electronic Maternity Information System which enables improved recording and auditing that PCSPs are completed. The Trust will use this to audit completion of risk assessments against national guidance and identify learning.	None Identified	Not Applicable	Not Applicable	Not Applicable

Immediate and essential action 6: Monitoring Fetal Wellbeing

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

- Improving the practice of monitoring fetal wellbeing –
- Consolidating existing knowledge of monitoring fetal wellbeing –
- Keeping abreast of developments in the field –
- Raising the profile of fetal wellbeing monitoring –
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

What do we have in place currently to meet all requirements of IEA 6?	How will we evidence that our leads are undertaking the role in full?	What outcomes will we use to demonstrate that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

The Trust has a dedicated specialist midwife responsible for this element of the SBLCB v2 who has been in post since December 2019, alongside a lead Consultant Obstetrician who leads best practice, learning and support via a monthly full day training session. These training sessions include local case studies, human factors and competency based assessment. Staff from within the LMNS are also welcome to attend these sessions for a wider approach to fetal monitoring training. During 2019 the Trust launched educational SBLCB v2 booklets for staff and patients which have been shared nationally. These booklets help to ensure that all staff are familiar with the care bundle demonstrating our commitment to this important guidance and improving outcomes for women and their families through partnership working.	Compliance with the SBLCB v2 is monitored through various committees within the Trust and CCG including Trust Board. This information is shared within the Maternity Dashboard report and Maternity Safety Improvement Plan.	These reports are shared on a monthly basis within the Maternity Service and quarterly to various committee meetings including Patient Safety and Effectiveness Committee and Trust Board. These are also shared with the LMNS.	None Identified	Not Applicable	Not Applicable	Not Applicable
The Trust has a dedicated specialist midwife responsible for this element of the SBLCB v2 who has	Compliance with the SBLCB v2 is monitored through various committees within the Trust and CCG including	These reports are shared on a monthly basis within the Maternity Service and quarterly to various	None Identified	Not Applicable	Not Applicable	Not Applicable

been in post since December 2019, alongside a lead Consultant Obstetrician who leads best practice, learning and support via a monthly full day training session. These training sessions include local case studies, human factors and competency based assessment. Staff from within the LMNS are also welcome to attend these sessions for a wider approach to fetal monitoring training.	Trust Board. This information is shared within the Maternity Dashboard report and Maternity Safety Improvement Plan.	committee meetings including Patient Safety and Effectiveness Committee and Trust Board. These are also shared with the LMNS.				
Compliance with this element is demonstrated by daily case note reviews of FHR interpretation and practice. In addition, this is a key focus of the Board level Safety Champion Meeting (fortnightly) and is also reported on the Maternity Dashboard.	Compliance with the SBLCB v2 is monitored through various committees within the Trust and CCG including Trust Board. This information is shared within the Maternity Dashboard report and Maternity Safety Improvement Plan.	These reports are shared on a monthly basis within the Maternity Service and quarterly to various committee meetings including Patient Safety and Effectiveness Committee and Trust Board. These are also shared with the LMNS.	None Identified	Not Applicable	Not Applicable	Not Applicable
The Trust is compliant with all five elements of the SBLCB V2 and subsequent national guidelines. The Trust has recently implemented a new Maternity EPR system to support the compliance with fetal monitoring elements (Dawes Redman CTG). The Trust will continue to monitor assurance of the	Compliance with the SBLCB v2 is monitored through various committees within the Trust and CCG including Trust Board. This information is shared within the Maternity Dashboard report and Maternity Safety Improvement Plan.	These reports are shared on a monthly basis within the Maternity Service and quarterly to various committee meetings including Patient Safety and Effectiveness Committee and Trust Board. These are also shared with the LMNS.	None Identified	Not Applicable	Not Applicable	Not Applicable

outputs of compliance to all five elements.						
The Trust is compliant with all five elements of the SBLCB V2 and subsequent national guidelines. The Trust has recently implemented a new Maternity EPR system to support the compliance with fetal monitoring elements (Dawes Redman CTG). The Trust will continue to monitor assurance of the outputs of compliance to all five elements.	Compliance with the SBLCB v2 is monitored through various committees within the Trust and CCG including Trust Board. This information is shared within the Maternity Dashboard report and Maternity Safety Improvement Plan.	These reports are shared on a monthly basis within the Maternity Service and quarterly to various committee meetings including Patient Safety and Effectiveness Committee and Trust Board. These are also shared with the LMNS.	None Identified	Not Applicable	Not Applicable	Not Applicable
The service has MDT training in place for PROMPT (Practical Obstetric Multi-Professional Training) and this is scheduled each month with support from all of the teams outlined within the CNST Maternity Safety Standard including obstetric consultants, obstetric doctors, midwives, maternity support workers and theatre staff.	The requirement to host regular multi-disciplinary training for our staff is nationally recognised as a supportive measure for improving safety culture. The training programme hosted by the maternity service allows staff to train together in a psychologically safe environment including debrief and improvement discussion on how best to deliver safe care for our women.	As recognised by the CNST Maternity Safety Standards mutli-disciplinary training has numerous benefits for enhancing the safety culture of the maternity service, the Trust monitors its compliance for the training through its Safety Improvement Plan. The compliance to the training is also monitored fortnightly at the Maternity Safety Champions Meeting.	Following the impact of COVID-19 the Trust is working to restore its 90% compliance.	Director of Midwifery and Clinical Director. Trajectory for 90% by May 2021	None required.	The PROMPT training is well embedded within the Trust and is ahead of its current trajectory for restoring pre Covid compliance.
The Trust has a dedicated specialist midwife responsible for this element of the SBLCB v2 who has been in post since December 2019, alongside a lead Consultant	Compliance with the SBLCB v2 is monitored through various committees within the Trust and CCG including Trust Board. This information is shared within the Maternity Dashboard report and	These reports are shared on a monthly basis within the Maternity Service and quarterly to various committee meetings including Patient Safety and Effectiveness	None Identified	Not Applicable	Not Applicable	Not Applicable

Obstetrician who leads best practice, learning and support via a monthly full day training session. These training sessions include local case studies, human factors and competency based assessment. Staff from within the LMNS are also welcome to attend these sessions for a wider approach to fetal monitoring training.	Maternity Safety Improvement Plan.	Committee and Trust Board. These are also shared with the LMNS.				

Immediate and essential action 7: Informed Consent
All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care

Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care

Women's choices following a shared and informed decision-making process must be respected

Link to Maternity Safety actions:

Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Link to urgent clinical priorities:

a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

What do we have in place currently to meet all requirements of IEA 7?	Where and how often do we report this?	How do we know that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
The Group Director of Midwifery attends the MVP meetings on a quarterly basis. These are also attended by stakeholders and service users, providing the opportunity to share face to face feedback and deliver updates about the service. In addition the MVP	The maternity service at UHCW NHS Trust have a dedicated Facebook page with over 1300 followers and has enabled a social network for women to be able to support one another. This also provides women with an opportunity to share comments and ask questions	The Trust has a dedicated Patient Experience Midwife who supports the engagement of our women and their families with the National Maternity Survey and Friends and Family Test (FFT). This role has enabled the service to collect monthly feedback questionnaires which	None Identified	Not Applicable	Not Applicable	Not Applicable

has a dedicated Facebook page and Facebook group to share information with the wider audience for the LMNS. The Trust also has a robust complaints procedure which ensures any feedback is reviewed in a timely manner, often through face to face meetings with service users, with clear action plans for improvement.	through the private messaging function. These are then responded to by the department within 48 hours, answering any queries or concerns raised. During the COVID-19 pandemic the service has seen an increase in anxieties from women and their families therefore; an additional communication method via a dedicated email address was established. This is used as an additional method to support personalised care and support plans (PCSP) for women and their families during this time.	are developed into action plans for improving the service. The questions align with those detailed within the national maternity survey to ensure that the department has continuous oversight of the experience of women.				
The current pathways of care are included on the Trust website and since the COVID-19 pandemic a letter has been developed and provided to women, either by post or face to face, to inform them about any changes in pathways following the various updates in Royal College guidance. The Trust website has been continually updated to reflect all changes. With the introduction of the Maternity Information System women are able to access the Trust maternity information leaflets via their PHR, which ensures that they have accessible information to inform their decision making and enhance their PCSP.						

Section 2						
MATERNITY WORKFORCE PLANNING						
Link to Maternity safety standards: **Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard** **Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?**						
We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.						
What process have we undertaken?	**How have we assured that our plans are robust and realistic?**	**How will ensure oversight of progress against our plans going forwards?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
The maternity services demonstrate it's compliance to clinical workforce planning in line with Safety Actions 4 and 5 of the CNST Safety Standards.	This is monitored as part of the CNST Maternity Safety Standards and is detailed within the Trust's Maternity Unit Staffing Policy.	The Trust monitors its compliance to the CNST Maternity Safety Standards and gathers robust evidence to ensure the requirements are met.	None Identified	Not Applicable	Not Applicable	Not Applicable

UHCW NHS Trust completed the BR+ workforce assessment between May and October 2020 and the final report was shared by the BR+ team on 30th November 2020. The report will be reviewed by the Board Maternity Safety Champions and shared with Trustboard. The output from this report outlines that additional establishment is required. A proposal for this with recommendations will be discussed with Chief Officers prior to confirmation at our Trust Board in February thereafter.	A recruitment strategy is to be developed with Board Safety Champions to recruit to meet the needs of the BR+ workplace assessment.	Maternity staffing is included within the monthly Maternity Dashboard report and quarterly Maternity Safety Improvement Plan shared at PSEC and Trust Board.	A recruitment strategy is to be developed to recruit to meet the needs of the BR+ workplace assessment report. The BR+ report is scheduled to be presented and discussed with recommendations for consideration to Board Safety Champions and Chief Officers in January 2021 and shared at Trust Board in February 2021. The recruitment strategy will also include medical workforce to meet the needs of the report.	Director of Midwifery, Group Director of Operations, Group Head of Workforce, Plan by 31.01.2021	Financial support to recruit to recommended establishment. Recruitment support	Continue to monitor midwife to birth ratio and safe staffing levels until new workforce recruitment achieved

MIDWIFERY LEADERSHIP

Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care

The Group Director of Midwifery is accountable to the Chief Nursing Officer, meeting the leadership requirements.

Within the RCM document detailed there are seven standards to achieve:

1. **A Director of Midwifery in every trust and health board, and more Heads of Midwifery across the service**
   At UHCW the title of the Head of Midwifery was changed in March 2020 to Group Director of Midwifery but the post holder is not a member of the board of Directors and is not additional to a Head of Midwifery as suggested within the manifesto. The Group Director of Midwifery has bi-weekly access to the Chief Nurse and access to the Trust board on a quarterly basis to present the Maternity Safety Improvement plan and provide necessary updates about the service. Across the LMNS there are two Heads of Midwifery and one group Director of Midwifery all Band 8C.

2. **A lead midwife at a senior level in all parts of the NHS, both nationally and regionally**
There are regional and national Chief Midwifery Officers and deputies in post in England.

3. **More Consultant midwives**
UHCW have demonstrated their commitment to provide improved and safer care to the patients of Coventry and Warwickshire with the appointment of their first Consultant Midwife in July 2020. The Consultant Midwife's primary role will be to lead on supporting the Group Director of Midwifery on delivering the national maternity strategy – five year plan.

4. **Specialist midwives in every trust and health board**
At UHCW we recognise the importance of the wider public health agenda and during 2020 have developed some important specialist midwife role within the maternity department to support the population served as suggested, with the following:

- Public Health midwife (focussing on smoking cessation, vaccination programme in pregnancy and weight management)
- Trainee Advanced Clinical Practitioner for Perinatal Mental Health
- Perinatal Parent Education Midwife
- Perineal Health specialist midwife
- Complex Care continuity team providing support to women who are pregnant and known history of substance misuse

5. Strengthening and supporting sustainable midwifery leadership in education and research

Through the Centre for Excellence partnership working with Coventry University the trust has developed strong relationships with the education leads. Interviews for the collaborative appointment of the role of Professor of Midwifery will be carried out in January 2021.

6. A commitment to fund ongoing midwifery leadership development

The trust is committed in the education of future leaders with a dedicated internal leadership development programme including: Leading Together and Lean for Leaders in addition to this staff who are identified as potential leaders are encouraged and supported to complete the MSc apprenticeship in Healthcare Management. We currently have 4 midwives on this course.

7. Professional input into the appointment of midwife leaders

At present the Trust do not have a Royal College of Midwives workplace representative as suggested, however the recruitment advertisement was shared with all staff internally and via the RCM in December 2020. To date there has been one application and this currently at the ballot stage. This will support the Trust in being able to meet the proposal to include a local representative at leader interviews (Band 7 ward managers and above). We do however include focus groups at all senior management interviews to ensure that the decision is representative of the team.

Maternity services assessment and assurance tool

NICE GUIDANCE RELATED TO MATERNITY						
We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.						
What process do we have in place currently?	**Where and how often do we report this?**	**What assurance do we have that all of our guidelines are clinically appropriate?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
The Trust has a NICE implementation policy in place that outlines the process for implementation of relevant NICE guidance. In summary, The release of new and updated NICE guidance is communicated Trust wide each month through Trust wide communication emails and via a list, circulated to Clinical Directors and clinical leads in	Monthly reports are provided to all specialties outlining the NICE guidance identified as relevant for the specialty and the degree of implementation based on returned self-assessments. Technical Appraisals are identified monthly and shared with the high cost pharmacist. All technical appraisals are discussed at the Trust Drugs and Therapeutics	The level of implementation is monitored by the Clinical Effectiveness Team as not applicable, not implemented, partially implemented or fully implemented. Partially implemented guidance requires the development of an action plan with progress reported to the Patient Safety and Clinical Effectiveness Committee. Progress with the implementation of NICE guidance is reported into the Patient Safety and Clinical Effectiveness	Review outstanding recommendations and plan implementation as appropriate, with clear timescales. Identify guidance that is partially implemented and introduce a risk based approach to achieving full implementation of relevant recommendations.	Clinical Directors and Clinical Leads. Clinical Effectiveness Team, Quality Department, March 2021	Dedicated time and allocated leads, with responsibility for delivery. Support from Clinical Effectiveness team to complete baseline assessments	Specialties will indicate if guidance is not applicable to the organisation, or if specific technologies and procedures are not performed such as, specific Interventional Procedure Guidance (IPG) Highly Specialised Technologies (HST) or Medical Technologies Guidance (MTG). In the incidence that Clinical Guidelines or Technical Appraisals are not being implemented fully, reasons are reported to the Patient Safety and Clinical Effectiveness

each specialty. A specific request for self-assessment, using a baseline assessment tool provided by NICE is sent to the identified lead and clinical director of the relevant specialty, by the Head of Clinical Effectiveness. The specialty is asked to discuss the guidance as part of the team Quality Improvement and Patient Safety meetings, complete the assessment and accompanying action plan for any gaps identified in meeting all recommendations. The plan is returned to the Clinical Effectiveness Team. The Trust has a database which records and tracks progress with	Committee to ensure appropriate measures are put in place for implementation where appropriate. The Trust reports overall progress with NICE guidance quarterly to Patient Safety and Effectiveness Committee.	Committee. Guidance that requires attention from specialties follows an escalation process with progress also reported into the Patient Safety and Clinical Effectiveness Committee. NICE guidance is audited as part of the Trust wide audit programme and through completion of national audits. Auditing of NICE guidance is reported to the Patient Safety and Clinical Effectiveness Committee within the Clinical Audit report bi-monthly. NICE guidance which is fully implemented is cross referenced where appropriate on the e library clinical guidance system for access Trust wide to support delivery of care to patients.				Committee and recorded on the specialties local risk register. Specialties partially implementing guidance based on current services are identified as doing so with a view to implement as far as possible. The Implementation of Technical Appraisals (TA) is monitored through the Drugs and Therapeutics Committee with a view to fully implement all relevant TA guidance.

implementation of NICE guidance. Risks associated with not meeting NICE guidance is managed locally within the clinical group via the risk register.						

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 28 JANUARY 2021

Subject Title	Black Lives Matter (BLM) – Tackling Racial Inequality
Executive Sponsor	Donna Griffiths, Chief People Officer
Author	Barbara Hay, Head of Diversity
Attachment(s)	Black Lives Matter (BLM) – Tackling Racial Inequality Appendix 1 Co-development Group Actions
Recommendation(s)	Trust Board is asked to **NOTE** the progress made and actions developed in this report relating to tackling racial inequality at UHCW. Trust Board is asked to **CONTINUE** its commitment to tackling racial inequality ensuring development of a strategic work programme which will be developed and delivered together with our co-development group

EXECUTIVE SUMMARY

The Equality Act 2010 seeks to advance equal opportunity and eliminate discrimination in relation to a series of protected characteristics including race. Following the death of George Floyd and the resurgence of Black Lives Matter (BLM) movement the Trust has strengthened its commitment to identifying and tackling racial inequality. The Board has held some strategic discussions on these issues.

To support this aim the following actions have taken place:

(a) A series of listening events were held from which a number of key themes as expressed by participants were identified

- Managers' lack of ability or unwillingness to deal with racism
- Not knowing who to talk to or where to go to address their concerns
- Being held back from progression
- No Black people in senior leadership
- Expectation they should put up with hurtful and insensitive comments from colleagues
- No protection from racist patients
- No consequences for racist patients.

(b) 3 Co-development group meetings with over 40 participants, have developed an initial action plan to address the issues related to the themes identified over the short to medium term

(c) The Trust is about to embark on a Reciprocal Mentoring for Inclusion programme between very senior managers and staff of colour

PREVIOUS DISCUSSIONS HELD
Trust Board seminars June 2020 and November 2020
Chief Officers Forum September 2020

KEY IMPLICATIONS	
Financial	Maximising the potential of all our staff and ensuring fair treatment of patients from all backgrounds and being recognised as an organisation with a real imperative to tackle inequality will lead to greater sustainability in employment and therefore operational and financial effectiveness.
Patients Safety or Quality	It is essential that patients from all backgrounds are treated fairly and with respect. Low staff satisfaction can have a direct impact on care
Human Resources	The Trust has a legal requirement to comply with the Equality Act 2010 Not addressing racial inequalities and discrimination would go against the values of open – ness, compassion and respect . It would also breach out duty of care to employees and to patients and could impact our: • engagement and retention levels with staff of colour • ability to fully utilise existing and potential talent • reputation both amongst our diverse staff groups and the wider community.
Operational	Maximising the potential of all our staff and ensuring fair treatment of patients from all backgrounds and being recognised as an organisation with a real imperative to tackle inequality will lead to greater sustainability in employment and therefore operational and financial effectiveness.

University Hospitals Coventry and Warwickshire NHS Trust

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

REPORT TO PUBLIC TRUST BOARD

Black Lives Matter (BLM) – Tackling Racial Inequality

1. INTRODUCTION

1.1 Following the tragic and untimely death of George Floyd, May 25th 2020, the world saw resurgence in the Black Lives Matter movement. The movement has been in existence since 2013, initially in protest against incidents of police brutality and all racially motivated violence against Black people in America but has now come to symbolise the fight back against all forms of racism against Black people and people of colour globally.

1.2 Black is a term used to identify people of African and African Caribbean descent and although the BLM movement relates to specific issues impacting Black people, it is important to recognise by addressing those issues there will be a positive impact on Asian and other Minority Ethnic groups who experience inequality and or discrimination.

1.3 Like all employers the Trust is legally required to meet the terms of the Equality Act 2010 which not only gives specific obligations in relation to protected characteristics like race, disability and sexuality but also has a general duty to advance equality of opportunity and tackle discrimination.

1.4 As a major employer with nearly two and a half thousand people of colour out of a workforce of over nine thousand it is only right that the Trust listen, take note and respond appropriately to the concerns and issues affecting our diverse workforce and our patients.

2. WHAT'S BEEN DONE SO FAR

2.1 After a statement of support for the principles of the BLM movement was communicated across the Trust on 12th June 2020, a Board discussion took place in late June 2020 to ascertain what UHCW needed to do in response to the global raised awareness of the discrimination and inequalities Black people face. A small BLM steering group has since developed and co-coordinated initial actions to enable the Trust to begin to understand issues affecting Black staff and other staff of colour in their workplace. The first step was to hear the issues and the experiences of those members of our workforce directly affected by racial discrimination and inequality.

2.2 A listening event with the Supporting People of Colour (SPOC) network was held. A a further thirteen Tackling Racial Inequality listening events, chaired by the Trust Chair, Chief Executive, Chief Officers and Non-Executive Directors, were held and staff were able to relay their stories and share their experiences. The key themes which emerged, as expressed by participants, were:

(a) Managers' lack of ability or unwillingness to deal with racism
(b) Not knowing who to talk to or where to go to address their concerns
(c) Being held back from progression
(d) No Black people in senior leadership
(e) Expectation they should put up with hurtful and insensitive comments from colleagues
(f) No protection from racist patients
(g) No consequences for racist patients.

2.3 It was clear that there was a strong view that in some contexts the Trust's values of Openness, Compassion and Respect were not being reflected in behaviours.

2.4 The listening events did also receive some feedback in relation to concerns about attitudes to patients and these are being dealt with as part of a separate exercise.

3 RESPONDING TO THE ISSUES

Board and Chief Officer Discussions and setting up the Co- development group

3.1 Following the listening events in which non - executives and chief officers including the Chair and Chief Executive participated, there have been discussions feeding back the findings to Chief Officers Forum 25th September 2020 and informal discussions looking at next actions. As part of this process it was agreed that in order to formulate actions in response to the issues there should be a call out to all people of colour, and allies, inviting them to join a co-development group. This yielded over 70 responses. Three workshops were held and more than 40 staff members have contributed to identifying suggested actions to help minimise racial inequalities and discrimination.

Short to medium term actions

3.2 Through the workshops the co-development group were able to determine which processes and procedures needed further actions or reviews to make them less discriminative (see Appendix 1). Work is underway to confirm specific timescales, targets and measures which will be monitored through a racial equality group including members of the co-development group, Staff Side and the Supporting People of Colour (SPOC) Network.

Long term actions to address systemic issues

3.3 The co-development group are pleased that the issues of racial inequality and discrimination are now prominent on the Trust's agenda. The actions in Appendix 1 will go some way to making the Trust more conscious of the need to eliminate racial bias. However, the co-development group is mindful of the need to look at the more deep rooted systemic culture, policies, behaviours and practices impeding racial equality in the Trust.

3.4 For example, the lack of Black people in very senior posts cannot be addressed adequately in the short term, the co-development group recognise longer term actions will be needed which may include partnering with external organisations and work with specific communities.

3.5 Similarly tackling very obvious and overt discrimination can be done quickly and efficiently using our policies and procedures, but changing attitudes towards and perceptions of Black people will need a series of actions and training to make meaningful change.

3.6 The co-development group believe critical to the success of Tackling Racial Inequality is honouring the 'no decision about me without me' principle. The Trust needs to remain committed to be ensuring that actions taken forward are informed, influenced and overseen by our staff of colour through shared decision making. Further work is therefore underway in partnership with Trust Board members and the co-development group to consider our approach to achieving this systematic change. Had it not been for the current Level 5 emergency faced by the Trust and the NHS nationally those discussions would have been taking place now, and they will restart immediately the management of the Covid 19 pandemic is less intense than currently.

3.7 However to maintain the momentum to tackle wider cultural change issues, the Trust has been successful in being accepted to take part in the nationally organised NHS Leadership Reciprocal Mentoring for Inclusion programme. The 18 month programme is a systemic leadership development intervention designed to create transformational change and enable a culture of diversity, equality and inclusion, where the power of difference is valued. Reciprocal mentoring provides opportunities for individuals from under-represented groups to work as equal 'partners in progress' with senior executive leaders in a relationship where knowledge and understanding of both sides of lived experiences creates awareness, insights and action that directly contributes towards the creation of a more equitable and inclusive organisation where the factors that generate inequity are positively and proactively addressed.

3.8 We are also actively engaged in the recently formed Coventry and Warwickshire Health and Care Partnership - Equality, Diversity and Inclusion sub-group which is a system-wide network group exploring and developing a Racial Equality strategy. We are committed to wider change across our system in our role as an anchor organisation.

4 RECOMMENDATIONS

Trust Board is asked to **NOTE** the progress made and actions developed in this report relating to tackling racial inequality at UHCW NHS Trust

Trust Board is asked to **CONTINUE** its commitment to tackling racial inequality ensuring the development of a strategic work programme which will be developed and delivered together with our co-development group.

Author Name: Barbara Hay
Author Role: Head of Diversity
Date report written: January 2021

Action Plan proposed by Co – Development Group: January 2021 Appendix 1

Theme	Identified issues	Actions
Discrimination and Experience • Managers' lack of ability or unwillingness to deal with racism • Staff are expected to put up with hurtful and insensitive comments from colleagues • No protection from racist patients • No consequences for racist patients *Our latest Staff Survey and WRES showed that:* - *24.5% of BAME colleagues report experiencing harassment, bullying or abuse from patients, relatives or the public.* - *Staff who are people of colour continue to experience harassment, bullying or abuse from other colleagues at a slightly higher rate than white staff* - *People of colour continue to report experiencing discrimination from their manager at over double the rate of white staff*	1) Issues with policies and interpretation 2) Managers' skills and knowledge is lacking in relation to dealing with racial harassment and discrimination 3) Not enough resources and training available for new and established staff 4) Employees not knowing which policies protect them 5) No obvious clear pathways for colleagues to raise an issue 6) Unfair practices 7) Datix clearly not working or usable for many staff particularly as the concern is report up to the manager	a) Implementation of equality aim or achievement or learning in all staff annual PDR b) Review of Violence and Aggression Policy with explicit reference to racism (other protected characteristics) c) The policy brief should be zero tolerance on racist behaviours i.e. inappropriate/insensitive comments not just physical violence d) Summarise policies to 2xA4 including examples of policy application in practice e) Introduce bullying, harassment and discrimination mandatory training for ALL staff and assessment mechanisms f) All racial complaints, actions taken and outcomes must be recorded and analysed g) Promote to staff that protection is offered, staff may not be aware h) Explore alternative reporting methods e.g. phone app, becoming a Hate Crime reporting centre

		Current actions: The Head of Diversity is working with Coventry City Council's Community Safety Officer to explore issues relating to reporting of hate crimes including how we can make the process more accessible. The Trust has been successfully shortlisted to participate in the national Reciprocal Mentoring for Inclusion Programme. The programme is one demonstration of the Trust's commitment to tackling the systemic and cultural issues which exist A recent Trust Board seminar to look at systemic issues was stood down due to the COVID pandemic but will be reconvened as soon as it becomes appropriate to do so.
Recruitment and Career Progression • Being held back from progression *Our January 2020 Equality data showed that BAME colleagues currently make up the following*	1) Multiple unsuccessful applications 2) People of colour not progressing 3) Link to Appraisal process (PDP); recognised that attendance at training	a) Starting all job adverts with a statement on E&D in the Trust b) Ensure the policy of advertising all posts is robustly applied. Expressions of Interest need to

percentages of AfC bandings 8a and above: *o 8a: 12.07%* *o 8b: 16.46%* *o 8c: 17.65%* *o 8d: 16.00%* *o 9: 0%* *These numbers decrease dramatically with Black members of staff*	sessions is often blocked by manager due to 'demand on service'. This is treated like a get out clause 4) Jobs have a 'name ' attached to them even before advert 5) Appears that everyone at the very senior levels either came up through the same route i.e. graduate schemes or knew each other from previous jobs	be assessed against a JD/JS and must be scored c) Ensure all JDs/PSs go out with essential criteria of commitment to E&D and is robustly assessed as part of the selection process for all roles involving management responsibility d) Introduce an audit of recruitment scoring sheets e) Introduction of structured feedback for all internal candidates f) All recruitment processes openly reported on once candidate appointed (e.g. x number of POC applied, X number of women etc.) to allow for comparative data of ethnicity promotion within Trust g) Ensure all interview panels are diverse through panel member representation h) All recruitment panel members to have had recruitment and selection equality training i) Analysis of all (non-mandatory) course attendance and analyse diversity, this will highlight if inclusive. j) Introduce peer reviews of completed appraisals to ensure equity.

		Current actions: The recruitment process will begin early February for our third cohort for the NHS Leadership Academy BAME (Black Asian and Minority Ethnic) Stepping Up Programme. To date 36 UHCW staff members have participated and it is anticipated another 16 will take part this year.
Who do I talk to, where can I go?	1) Staff don't read/always have time to access TrustNav/ 2) Information is not well promoted especially at the clinical level 3) Communications is very Eurocentric does not reflects the diversity that exists here i.e. images, jargon used, front page stories 4) Equality issues hard to find tend to be hidden away	a) Alternative communication methods are necessary not just use of TrustNav and cascading of information b) Continue and increase attendance at team meetings from SPOC, Freedom to Speak Up Guardian, Confidential Contacts, Unions etc. at huddles, QIPPS, department meetings, clinical areas etc. to raise the profile c) Communications to work closely with SPOC to develop campaign targeting staff of colour i.e. more inclusive images, language, stories etc.
No black people in senior leadership • *Never been a Black Chief Officer* • *There are no Black Trust Board members*	Recruitment criteria • Are black people applying, but not being employed or are black people not applying, why don't they want to come to UHCW?	a) Ensure transparency of senior role recruitment b) Regular analysis of applications c) Explore recruitment approaches, including utilisation of targeted adverts inclusion black media. d) Black mentorship/coaching representation at a

		senior level to encourage internal staff to apply e) Undertake recruitment analysis for specific senior leadership roles, to identify diversity of applicants and recruitment decisions. **Current actions:** The SPOC network is making contact with very senior Black NHS managers with a view to inviting them to share their experiences and any advice and guidance as to how we as a Trust can address this issue of no very senior Black managers.

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD HELD ON 28 JANUARY 2021

Subject Title	Freedom to Speak Up / Raising Concerns Bi-Annual Report
Executive Sponsor	Geoff Stokes, Director of Corporate Affairs (Executive Lead for Raising Concerns)
Author	Lorna Shaw, Freedom to Speak Up Guardian
Attachment(s)	None
Recommendation(s)	Trust Board is asked to **RECEIVE ASSURANCE** from the report

EXECUTIVE SUMMARY
Attached is the bi-annual report from the Freedom to Speak Up Guardian on activities carried out highlighting any issues raised.
PREVIOUS DISCUSSIONS HELD
Trust Board July 2020

KEY IMPLICATIONS	
Financial	None directly relating to this report
Patients Safety or Quality	A robust policy on raising concerns is important for patient well-being and the risk of staff not feeling able to raise concerns is on the corporate risk register.
Human Resources	A robust policy on raising concerns is important for patient well-being and the risk of staff not feeling able to raise concerns is on the corporate risk register.
Operational	There are no direct operational implications arising from this report although the Trust's performance and service could be affected if staff don't feel able to raise concerns

Introduction

During the last six months the Guardian focused on:

1. Continuing in raising the profile of the updated Raising Concerns Policy, Guardian and Confidential Contacts' roles and providing local, how to raise concerns training
2. Networking internally to improve triangulation of information, learning and sharing best practice from concerns raised.
3. Responding to National Guardian's Office (NGO) updates
4. Supporting staff with COVID-19 concerns

Raising Profile of Roles

The Guardian continued to walk the wards and departments, meeting staff face to face in order to introduce herself and raise the profile of the role. With the recent COVID-19 pandemic, UHCW Communications Teams has provided additional support in ensuring the profile of the Guardian/Confidential Contacts' roles were highlighted via TrustNav, in light of recent changes for many employees.

Gathering further intelligence from conversations with staff over the last year, it is clear staff would appreciate another avenue for raising concerns that provides further anonymity. Evidence from data collated, shows less than half of total concerns are raised openly. The Guardian has started development meetings with the Organisational Development Team and ICT to enable the Trust to explore the development of a bespoke Raising Concerns app which will not only enable staff to raise concerns anonymously, but also allow the Guardian to forensically analyse reasons behind choosing to raise concerns in this manner and actively address the issues highlighted.

Networking internally to improve triangulation of information / Learn and share best practice and learning from Raised Concerns

There have been constructive meetings with colleagues from staff side, workforce, occupational health, patient safety team, the Head of Equality and Diversity and staff engagement teams.

Working in collaboration with our Head of Equality and Diversity, we have three active staff networks; BME/BAME, LGBTQ+ and Disabilities. These will provide an opportunity to bring together all the people and areas of work that either support or investigate issues relating to these protected characteristic groups to share issues and identify any themes with a view to developing strategies to address them. This input should contribute to improvements in our staff survey results and the reduction of bullying, harassment and incivility.

Triangulating information from all these sources will enable us to identify trends, themes and areas of the Trust that may require additional support.

Occupational Health and the Patient Safety Team have provided dashboard reports which highlight key concerns for the Guardian to review and investigate.

The Guardian continues to liaise with our ED consultant specialising in 'Civility Saves Lives' and continues to meet with the Guardian of Safe Working Hours and together they are looking at common challenges.

Speaking Up Month October 2020

There was a debate about whether to actively participate in the national Speaking Up month for October 2020. In the most recent East / West Midlands combined Regional Guardian meeting it was felt:

- It is not a priority at present given the challenges of COVID-19
- A month may be too long to sustain activity.
- It clashes with October half term
- A more effective focus may be on the potential benefits of a toolkit with top tips for new guardians to be developed

Discussions with our Communications team will determine the best time for planning UHCW Raising Concerns / Speaking Up events for 2021, which will ensure maximum exposure for campaigns and events.

NGO Update

Data collected from CQC well-led reports and national staff surveys confirm UHCW has had an 80.5% increase in speaking up, since being recorded in 2015 [ref.1 National Guardian ''Freedom to Speak Up Index Report 2020'']

Measuring the effects of culture change can be difficult. The NHS Annual Staff Survey can help to give some indication as to whether Freedom to Speak Up is embedded within trusts detailing whether staff feel knowledgeable, encouraged and supported to raise concerns and if they agree they would be treated fairly if involved in an error, near miss or incident.

Fostering a positive speaking up culture sits firmly with the leadership and we can see that organisations with higher FTSU Index scores tend to be rated as Outstanding or Good by CQC.

Freedom to Speak Up Review Tool

NHS England and NHS Improvement has also produced a self-assessment tool for trusts to use to help determine plans to improve the culture and processes to encourage speaking up. The Guardian has discussed drafts of this with the Chair, Non-Executive Director Lead for Raising Concerns and the Chief Quality Officer and a session with all Board members will be programmed in due course.

Supporting Staff with COVID-19 Concerns

Of the 21 concerns raised since the last report in July 2020, the Guardian received 2 written concerns between July and December, which were raised formally and were COVID-19 related. There were additional query phone calls to both the Guardian and Confidential Contacts which required signposting to information on TrustNav or relevant professional bodies.

There are two COVID related concerns identified from the latest data:

- Furlough /SSP pay [ISS staff]
- Redeployment concerns [UHCW staff]

In all the cases raised, escalation to their line manager or department manager resulted in immediate action and input to address any disparities.

Of the two concerns raised, both were raised openly.

These numbers are reflected in the analysis below (within workplace relationships) and are included in the total number of raising concerns.

Raising Concerns Activity

Since the initial raising concerns policy was approved in March 2017, there have been a total of 142 concerns raised, shown below.

Period	No.	Commentary
Dec 2016 – Jun 2017	9	
Jul 2017 – Dec 2017	12	Policy approved May 2017
Jan 2018 – Jun 2018	8	
Jul 2018 – Dec 2018	21	Guardian appointed on a part- time basis Sep 18
Jan 2019 – Jun 2019	20	
Jul 2019 – Dec 2019	23	Guardian appointed on a full- time basis Jul 19
Jan 2020 – Jun 2020	28	
July 2020 – December 2020	21	Plus an additional 18 phone calls have also been received requesting advice only, during this 6 month period

In the period from July 2020 to December 2020 there was a reduction in documented concerns raised but an increase in telephone calls requesting support or asking advice which is now being recorded. This indicates the Trust continues to create an environment where staff feel safe to speak up and raise concerns.

The analysis of the cases from July to December 2020 is shown below;

Types of Incidents	No.
Workplace Relationships	14
Bullying / Harassment /Aggressive Behaviours	1
Discrimination	2
Patient Safety	1
Staff Safety	1
Financial Irregularity	1
Malpractice/Unacceptable Practice in the Workplace	1
Other	0

Staff Groups	No.
Doctors	↑ 5
Nurses	↓ 3
Healthcare Assistants	↑ 2
Administrative / Clerical	↓ 6
Estates and Ancillary	↑ 3
Allied Healthcare	↓ 1

Staff Groups	No.
Professional Scientific/Technical	↓ 0
Anonymous	↑ 1

COVID-19 Related Concerns	No.
PPE	0
Risk Assessments	0
Social Distancing	0
Furlough / SSP	1
Redeployment	1

Outcomes	No.
Speak directly to line manager	1
Seek further information to decide next steps	↑ 12
Raise formal concerns using Trust Policies	↓ 7
No further action	1

Concern Raised	No.
Open	↑ 12
In Confidence	↓ 8
Anonymously	↓ 1

Plans for the next six months will prioritise

1. Continue networking internally/externally to improve triangulation of information and learn and share best practice from Raised Concerns
2. FTSU Guardian to share the role of the Guardian and Confidential Contacts, with our agencies and agency staff which make up nearly a fifth of our workforce, to empower and encourage raising concerns
3. Carrying out audits of data collected
4. Continue to develop a collaborative action plan using the Freedom to Speak Up self-review tool from NHS England & NHSI with the Board

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 28 JANUARY 2021

Subject Title	Guardian of Safe Working Hours Semester Report and Annual Report 2020
Executive Sponsors	Professor Kiran Patel, Chief Medical Officer Donna Griffiths, Chief People Officer
Author	Dr Andreas Ruhnke, Guardian of Safe Working
Attachments	Guardian of Safe Working Hours Semester Report June to December 2020 and Annual Report from 01 January to 31 December 2020
Recommendation(s)	Trust Board is asked to **RECEIVE ASSURANCE** from the report.

EXECUTIVE SUMMARY

This paper provides a summary of the following areas related to Junior Doctors in Training and the 2016 Terms and Conditions:

- Exception reports
- Work schedule reviews
- Locum processes

PREVIOUS DISCUSSIONS HELD

Previous Trust Board Report

KEY IMPLICATIONS

Financial	Potentially added costs, as a result of exception reporting
Patient Safety or Quality	Safe Working Hours for Doctors in Training leading to improved patient safety
Human resources	Requirement to appoint more staff to fill rota gaps
Operational	N/A

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

REPORT TO TRUST BOARD

Guardian of Safe Working Hours Semester Report June to December 2020 and Annual Report from 01 January to 31 December 2020

1. Purpose

To give assurance to the Trust Board that Junior Doctors in Training (JDT) are safely rostered and their working hours are compliant with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (TCS).

This paper provides a summary of the following areas related to JDT and the 2016 TCS:-

- Exception reports
- Rota Redesign
- Work schedule review
- Locum processes
- Rotational Training Vacancies

2. Background and Links to Previous Papers

In October 2016 a new contract was introduced for JDT with a new schedule of 2016 TCS. As part of the new 2016 TCS the post of Guardian of Safe Working Hours (GSW) was introduced. A renegotiated contract (2018 contract review) was introduced on 07 August 2019.

The role of the GSW is to:

- Ensure the confidence of doctors that their concerns will be addressed
- Require improvements in working hours and work schedules for JDTs
- Provide Boards with assurance that junior medical staff are safe and able to work, identifying risks and advising Board on the required response
- Ensure the fair distribution of any financial penalty income, to the benefit of JDTs.

This Semester Report covers the period from 01 June to 31 December 2020 and the Annual Report section covers the year 2020.

UHCW NHS Trust currently employs 440 JDTs working under the new 2016 TCS.

Additionally there are Trust Doctors of various grades who also work on JDT rotas. For the purpose of this report, these Trust doctors are not included in the scope of the Guardian role and in the data presented here.

The GSW receives 2 job-planned Programmed Activities (PAs) to undertake this role.
Educational supervisors receive 0.25 job-planned PAs per trainee.

3. Exception reports (with regard to working hours)

Exception reports are a new requirement under the 2016 TCS. Where JDTs feel that their working arrangements in practice deviate significantly and/or regularly from the agreed work schedule, they should raise their concerns to their Educational Supervisor or Clinical Supervisor through the electronic exception reporting system (Allocate Software at UHCW). Primarily the variations will be:

- Differences in the total hours of work (including rest breaks)
- Differences in the pattern of hours worked
- Differences in the educational opportunities and support available to the doctor
- Differences in the support available to the doctor during service commitments

The role of the Guardian is to provide oversight of these exception reports.

Exception reports (ERs) received between 01Jun2020 and 31Dec2020 by specialty:

Specialty	ERs carried over from last report	ERs raised	ERs closed	ERs outstanding
General Surgery	40	4	28 (26*)	16
General Medicine	9	6	6	9
Ophthalmology	6	5	5	6
RespMed	9	0	2*	7
Gastro	2	1	1	2
Gerontology	1	6	5	2
Acute Med	0	1	0	1
Psychiatry	8	0	3*	5
Anaesthetics	3	0	0	3
ITU	2	1	0	3
Urology	2	0	2*	0
Endocrinology	1	0	0	1
Neurosciences	3	15	9 (1*)	9
Renal	2	0	2*	0
MaxFax	1	0	0	1
ENT	3	0	0	3
Total	92	39	63 (36*)	68

* GSW actioned ERs

ERs by grade:

Grade	ERs carried over from last report	ERs raised	ERs closed	ERs outstanding
F1	53	6	35 (31*)	24
F2/CT/ST1-2	34	20	20 (5*)	34
ST3+	5	13	8	10
Total	92	39	63 (36*)	68

*GSW actioned ERs

ERs response time:

Response time	<48h	<7d	>7d	Still outstanding
F1	0	4	31*	24
F2/CT/ST1-2	0	1	19 (5*)	34
ST3+	0	0	8	10
Total	0	5	58	68

*GSW actioned ERs

This Semester Trust Board Report covers a 6-month-period from June to December 2020 during which 39 ERs have been reported. Again, the main reasons for staying late were: increased workload and being unable to handover in time. The contractual obligation to review exception reports within 7 days has been breached in almost 83% of ERs covered by this report. This is worse compared to the previous trimester. The overall review rate of exception reports has further improved to just under 70%. A total of 36 of 92 ERs outstanding from the previous report have been actioned by the Guardian of Safe Working Hours. This meant ERs which were never reviewed by their educational supervisors were closed awarding payment instead of TOIL for the additional work (approx.70 hours).

The highest number of ERs raised was in Neurology this time (15 ERs). Unfortunately due to a shift length of 13 hours in neurology there were 5 breaches of the maximum 13 working hours and automatic penalties were imposed. A change of the handover time has been discussed but not yet implemented.
As reported previously there were login credential requests despite of several emails to all parties involved in the exception reporting process explaining how to receive or how to reset login credentials for the Allocate Software. Despite of overall improvement there is still a lack of engagement from some educational supervisors with the reviewing process.
Overall Exception Reporting has dropped significantly during the pandemic. This probably reflects a 'just-getting-on-with-it' attitude and not a significant improvement of the working conditions.

Annual Summary of Exception Reports submitted between 01 January and 31 December 2020

There were 89 ERs in total of which 54 were completed and 19 were logged as 'unresolved'. The 'unresolved' cases were all reviewed and an outcome had been logged electronically but the trainees did not close the ERs properly to complete those reviews. 16 ERs still appear as 'pending' on Allocate. Most of these 'pending' ERs have never been reviewed and will need to be closed by the Guardian of Safe Working Hours. Unfortunately a few educational supervisors still do not seem to engage with the exception reporting process.

Most ERs were submitted by F1 Doctors in various specialties (38 ERs) closely followed by F2/CT Doctors (34 ERs). Only 17 were submitted by Specialty Trainees. This mirrors what happens in other Trusts that Specialty Trainees do not seem to engage as much with the exception reporting process.

The vast majority of ERs were due to overtime working (76 ERs). 5 each were due to a change in 'pattern' or labeled as 'educational'.
ERs submitted as change in 'service support' were mostly due to staff shortages (3 ERs).

Annual summary per specialty by category

Specialty	Hours	Pattern	Service Support	Educational	Total
A&E JNR	1	0	0	0	1
AcuteMed SNR	0	0	1	0	1
Anaesthetics SNR	0	0	0	1	1
Endocrinology F1	1	0	0	0	1
ENT JNR	1	0	0	0	1
Gastro F1	1	0	0	0	1
GenMed F1	4	0	0	0	4
GenMed JNR	6	1	0	0	7
GenSurg F1	22	1	0	0	23
Gerontology JNR	4	0	0	2	6
ITU JNR	0	1	2	2	5
Neurology JNR	8	0	0	0	8
Neurology SNR	7	0	0	0	7
Ophthalmology JNR	4	2	0	0	6
Ophthalmology SNR	8	0	0	0	8
Psychiatry F1	3	0	0	0	3
Renal F1	6	0	0	0	6
Total	**76**	**5**	**3**	**5**	**89**

Annual summary per specialty by review status

Specialty	Complete	Unresolved	Request for more information	Pending	Total
A&E JNR	1	0	0	0	1
AcuteMed SNR	0	0	0	1	1
Anaesthetics SNR	1	0	0	0	1
Endocrinology F1	1	0	0	0	1
ENT JNR	1	0	0	0	1
Gastro F1	1	0	0	0	1
GenMed F1	4	0	0	0	4
GenMed JNR	1	6	0	0	7
GenSurg F1	9	12	0	2	23
Gerontology JNR	4	1	0	1	6
ITU JNR	4	0	0	1	5
Neurology JNR	4	0	0	4	8
Neurology SNR	3	0	0	4	7
Ophthalmology JNR	6	0	0	0	6
Ophthalmology SNR	8	0	0	0	8
Psychiatry F1	3	0	0	0	3
Renal F1	6	0	0	0	6
Total	**54**	**19**	**0**	**16**	**89**

4. Rota Redesign

The rota redesign work was previously overseen by the Junior Doctor Project Group of which the Guardian had been a member of.

The Rota Oversight Committee is the group which has been established to look into all medical rotas at UHCW NHS Trust. The Guardian is a member of this group.

5. Work schedule reviews

In Medicine a new rota was implemented for the December 2020 rotation. This made rotas in Geriatric, Respiratory and St Cross Medicine TCS 2016-compliant. There were some rota transcription errors which affected 6-month-post holders due to their rotas being changed for the last 2 months (02 Dec 2020 to 02 Feb 2021). The rotations starting 03 Feb 2021 and thereafter should no longer be affected by this initial problem.

In neurology discussions are ongoing with regards to handover times and night time cover.

6. Locum Processes

Locum Bookings and Expenditure
Information on locum expenditure is reported through to the Finance and Performance Committee and Trust Board so are not included in this report.

Locum Process
JDT are able to undertake voluntary additional hours at this or any other Trust under the 2016 TCS, these are normally for a whole shift. When undertaking these additional voluntary hours within the Trust, these hours are worked as a locum duty conducted through the internal bank paid at set pay rates. Requests for locum duties are submitted by departments and are approved and agreed in line with current internal authorisation processes.

At group level, JDT can sometimes be asked to stay over to provide additional cover which is not captured centrally as they would not be classed as locum duties but claimed as extra hours or time off in lieu at a local level. The Trust is working on a process to capture these additional hours for monitoring and reporting, moving forward.

Additional Duties under 2016 Contract
When transferring to the 2016 contract and being auto-enrolled onto the internal Trust bank, trainees will be asked if they wish to opt out of the European Working Time Directive (EWTD) limit of 48 hours per week on average, which they are entitled to do.

This is an individual decision and the Trust does not exert any pressure for trainees to do so. Anyone who does not wish to opt out of the EWTD will be limited to a maximum of 48 hours of work in total within the Trust.

Locum Work carried out by trainees
All Junior Doctors in Training at UHCW NHS Trust are now working under the 2016 TCS which oblige them but also the employing Trust to monitor their working hours for compliance with the WTR.
Allocate's e-roster software is in use at UHCW which allows monitoring of Junior Doctor working hours in their individual rota slots (as long as the rota template has been transcribed correctly) but there is no automatic link with locum work so that breaches of their working hours could potentially occur. It's important to remind the trainees of their obligation to comply with the working time regulations and to inform their employer about any planned or already completed locum work immediately.

As emphasized in my previous reports, breaching of WTR limits of average weekly working time constitutes a risk to patient-safety and doctor's wellbeing. By opting out of the 48h WTR limit a Junior Doctor in Training declares themselves mentally and physically fit to safely undertake this additional work.

7. Vacancies

The vacancy information received from ESR covering November and December 2020:

Specialty	Grade	Nov20	Dec20
Acute Medicine	ST	1	2
Emerg Medicine	F2	5	5
Cardiology	F2	1	1
Care of Elderly	F2	8	8
	ST	2	2
Endocrinology	F2	1	1
Gastroenterology	F2	0	1
Haematology	F2	1	0
Renal	F1	0	1
	F2	1	1
	ST	4	2
Respiratory	F2	2	4
	ST	2	2
Rheumatology	F1	1	1
	F2	1	1
	ST	1	1
Anaesthetics	F1	0	1
ITU	F2	1	0
Pathology	F2	0	2
ENT	ST	3	3
Gen Surgery	F1	1	0
	ST	1	0
Neurology	ST	1	1
Stroke	ST	2	2
T&O	ST	7	7
Paeds	F1	1	1
	F2	7	7
Obs&Gynae	F2	3	3
	ST	1	0

The data received from ESR for November and December 2020 showed a vacancy rate of 7.96% averaged over 687.78 WTE posts. These posts are covered by Doctors in Training and by Trust Grade of all specialties. In some specialties the vacancy rate is much higher amongst Doctors in Training: e.g. Rheumatology (all grades) 75% or paediatrics (F2) 78%. In

Care of the Elderly the vacancy rate amongst F2 doctors was 64% which was balanced by recruitment of 8 Trust Grade Doctors in General Medicine.

There is no guarantee future recruitment rounds will attract enough doctors to fill all HEE hospital training posts, however the Trust has continued recruiting Trust Grade Doctors (non-training grade doctors) directly into gaps across specialties.

8. Fines

There were several breaches of the maximum 13 hour shift and a breach of the minimum of 5 hours uninterrupted rest during a non-resident on-call. The balance of the GSW penalty account is £368.

9. Qualitative Information

All 58 JDT rotas have been checked with Allocate Software and appear TCS 2016-compliant.

Information about the GSW's role and exception reporting is available under ‘Junior Doctors’ in the A-Z Departments listing of the intranet.

Virtual Guardian of Safe Working Hours dial-in sessions have been introduced on MS Teams.

10. Issues arising

Staff shortages were the main reason for exception reports leading to an increased workload and additional working hours. Until many more doctors are trained, UHCW specialties should continue or explore recruiting non-medical staff and overseas doctors (Medical Training Initiatives) to ensure safe staffing levels.

As there are still trainees not receiving their Allocate Exception Reporting Software passwords it is planned that all login credentials will be handed-out and signed-for at their Trust induction days starting 03 February 2021.

There are still long-term outstanding ERs which will be actioned by the Guardian of Safe Working Hours.

11. Conclusions

1. The GSW is able to give assurance to the Board that all published specialty rotas of all current JDTs (2016 TCS) are compliant with Working Time Regulations.

2. Assurance of support with regard to the exception reporting process should be given to all trainees. Educational Supervisors will have to be reminded of the contractual obligation to engage with the exception reporting system.

3. Recruitment of more non-training-grade medical staff (nationally or internationally) and non-medical staff would improve cover of the 58 training rotas and reduce workloads considerably.

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

To provide world-class education and training.

13. Governance

The GSW works in conjunction with the Associate Director of Medical Education reporting to the CMO and CWIO.

14. Responsibility

GSW Dr Andreas Ruhnke
CMO Professor Kiran Patel
CWIO Donna Griffiths

15. Recommendations

The Board is invited to note the content of the report and receive assurance

Name and Title of Author: Dr Andreas Ruhnke, Guardian of Safe Working Hours
Date**:** 11/03/2021

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 28 JANUARY 2021

Subject Title:	Integrated Quality, Performance & Finance Report (Month 9) 2020/21
Executive Sponsor:	Donna Griffiths, Chief People Officer
Author:	Daniel Hayes, Director of Performance & Informatics
Attachments:	Integrated Quality, Performance & Finance Report – Reporting period: December 2020
Recommendations:	Trust Board is asked to **REVIEW ASSURANCE** and **NOTE** the contents of the report.

EXECUTIVE SUMMARY

The attached Integrated Quality, Performance & Finance Report covers the reported performance for the period ending 31st December 2020.

The Trust has achieved 10 of the 29 ragged indicators reported within the Trust's performance scorecard. The Trust scorecard aligns Trust level indicators with the objectives outlined in the Trusts 2018-2021 Organisational Strategy.

Some national submissions have been suspended due to the pandemic. Where possible the KPI remains reported within scorecards.

Key indicators in breach are the Trusts performance against:

- 18 Weeks Referral to Treatment Time – 57.9% for November (target 92%)
- RTT 52 Week Waits Incomplete – 1995 patients
- Diagnostic Waiters 6 Weeks and Over – 9.59% (target no more than 1%)

Key indicators achieving the target include:

- HSMR
- Complaints Turnaround
- All Grant Income

The Trust delivered performance of 80.4% for December for the four hour standard below the national standard of 95%. This is a deterioration of 1.8% from last month. UHCW was above the benchmarked position for England and for the Midlands.

The RTT incomplete position remains below the 92% national target and stands at 57.9% for November. The average weeks wait was 20.2.

The Trust continues to see an increase in RTT 52 Week wait patients as a result of service changes required in response to Covid-19. There were 1995 breaches reported for November. This compares to a national average of 1071.

Cancer performance for November 2020 was:
Cancer TWW: 98.21% (target 93%)
Cancer 31 day diagnosis to treatment: 96.36% (target 96%)
Cancer 62 day referral to treatment: 73.98% (target 85%)
Cancer 104+ days wait: 7.5 breaches, 9 patients (target 0)
Cancer 31 day subsequent surgery: 89.83% (target 94%)

Phase 3 restoration position December – target 100% of activity for same time last year:
Outpatients restored to 96.2% with 19.7% (target 25%) of new and 41.4% (target 60%) of follow up appointments held as virtual.
Overnight electives restored to 91.4%.

Day cases restored to 94.4%.

The average number of long length of stay patients was 120.
Reason to Reside data collection compliance for eligible areas is 76%.

HSMR is reported at 95.38 which is within Dr Foster's calculated relative risk range.

The Trust has reported a Never Event in December for wrong route administration of medication. Details are included in the report.

Sickness Absence in December 2020 has increased (0.29%) from November 2020 to 6.23%.
Covid-19 Absence was 1.41% with Non Covid-19 being 4.82%.

The Trust has delivered 15,678 Covid-19 vaccinations (as at 17/01/21).

At Month 9, the Trust reported a £824k favourable position, which is £1.5m favourable compared to plan.

PREVIOUS DISCUSSIONS HELD

Standard bi-monthly report to Trust Board

KEY IMPLICATIONS

Financial	Deliver value for money and compliance with NHSI
Patient Safety or Quality	NHSI and other regulatory compliance
Human resources	To be an employer of choice
Operational	Operational performance and regulatory compliance

University Hospitals Coventry and Warwickshire NHS Trust

Integrated Quality, Performance and Finance Reporting Framework

Reporting period: December 2020

Contents

NHS
University Hospitals Coventry and Warwickshire NHS Trust

Executive Summary

10 KPIs achieved the target in December

	Indicators achieved	Indicators in exception	Indicators in watching status	Total indicators
Safest care and excellent experience	5	3	0	8
Leader in operational performance	1	9	0	10
Model employer	1	2	1	4
Achieve financial sustainability	2	0	0	2
Frontrunner in research innovation and education	1	3	1	5
All domains	**10**	**17**	**2**	**29**

KPI Hotspot

What's Good?

Complaints Turnaround
All Grant Income

What's Not So Good?

Diagnostic Waiters 6 weeks and over
RTT 52 Week Waits Incomplete
Never Events

The Trust has achieved 10 of the 29 rag rated indicators reported within the Trust's performance scorecard. The Trust scorecard aligns Trust level indicators with the objectives outlined in the Trusts 2018-2021 Organisational Strategy.

Some national submissions have been suspended due to the pandemic. Where possible the KPI remains reported within scorecards.

The Trust delivered performance of 80.4% for December for the four hour standard below the national standard of 95%. This is a deterioration of 1.8% from last month. UHCW was above the benchmarked position for England and for the Midlands.

The RTT incomplete position remains below the 92% national target and stands at 57.9% for November. The average weeks wait was 20.2.

The Trust continues to see an increase in RTT 52 Week wait patients as a result of service changes required in response to Covid-19. There were 1995 breaches reported for November. This compares to a national average of 1071.

The cancer 62 day referral to treatment and 31 day subsequent surgery targets were not achieved in November.

HSMR is reported at 95.38 which is within Dr Foster's calculated relative risk range.

The average number of long length of stay patients was 120.

The Trust has reported a Never Event in December for wrong route administration of medication. Details are included in the report.

The Trust has delivered 15,678 Covid-19 vaccinations (as at 17/01/21).

At Month 9, the Trust reported a £824k favourable position, which is £1.5m favourable compared to plan.

Trust Scorecard
Reporting Month : December 2020

University Hospitals Coventry and Warwickshire NHS Trust

DoT
Improving
No change
Falling

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

Target Type
National Target
Regional Target
Local Target

Trust Board Scorecard

Type	Measure	Previous Position	Latest Position	DoT	Current Target	Annual Target	Executive Lead	Trend
Safest care and excellent experience								
	Infection Control							
	Healthcare associated incidents of Clostridioides difficile - Cumulative	49	55	⇩			CNO	
	MRSA Bacteremia - Trust Acquired - Cumulative	0	0	⇨	0	0	CNO	
	Safe Care							
	Never Events - Cumulative	0.0	1.0	⇩	0	0	CMO	
	Serious Incidents - Number	7	7	⇨	15	15	CQO	
	HSMR - Basket of 56 Diagnosis Groups (3 months in arrears)	101.55	95.38	⇧	RR	RR	CMO	
	SHMI - Quarterly (6 months in arrears)	1.10	1.11	⇩	RR	RR	CMO	
	Average Number of Long Length of Stay Patients	122	120	⇧	109	109	CNO	
	Patient Experience							
	Friends & Family Test - Recommender Targets Achieved	N/A	2		7	7	CQC	
	Complaints Turnaround <= 25 Days (1 month in arrears)	100%	100%	⇨	90%	90%	CQO	
Leader in operational performance								
	Patient Flow							
	Emergency Care 4 Hour Wait	82.2%	80.4%	⇩	95%	95%	COO	
	Bed Occupancy Rate - KH03 (3 months in arrears)	79.3%	79.3%	⇨	93%	93%	COO	
	Delayed Transfers as a Percentage of Admissions	N/A	N/A		3.5%	3.5%	COO	
	Breaches of the 28 Day Readmission Guarantee	4	16	⇩	0	0	COO	
	Diagnostic Waiters - 6 Weeks and Over	8.19%	9.59%	⇩	1%	1%	COO	
	RTT							
	18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears)	52.6%	57.9%	⇧	92%	92%	COO	
	RTT 52 Week Waits Incomplete (1 month in arrears)	1639	1995	⇩	0	0	COO	
	Last Minute Non-clinical Cancelled Operations - Elective	0.9%	0.9%	⇧	0.8%	0.8%	COO	
	Cancer							
	Cancer 62 Day Standard plus 31 Day Rare Cancers (1 month in arrears)	78.54%	73.98%	⇩	85%	85%	COO	
	Cancer 104+ Day Waits (1 month in arrears)	7.5	7.5	⇨	0	0	COO	
	National Cancer Standards Achieved (1 month in arrears)	5	6	⇧	8	8	COO	

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

Trust Scorecard

Reporting Month : December 2020

NHS
University Hospitals Coventry and Warwickshire NHS Trust

DoT
Improving
No change
Falling

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

Target Type
National Target
Regional Target
Local Target

Trust Board Scorecard								
Type	Measure	Previous Position	Latest Position	DoT	Current Target	Annual Target	Executive Lead	Trend
Model employer								
	Mandatory Training Compliance	93.86%	93.92%	⇧	95%	95%	CWIO	
	Appraisal - Non-Medical	78.89%	79.46%	⇧	90%	90%	CWIO	
	Appraisal - Medical	98.49%	99.31%	⇧	90%	90%	CWIO	
	Sickness Rate	5.94%	6.23%	⇩	3.99%	3.99%	CWIO	
	Staff Survey - Recommending as a Place of Work (Quarterly)	N/A	N/A		70%	70%	CWIO	
Achieve financial sustainability								
	Income & Expenditure Margin Rating						CFO	
	Forecast Income & Expenditure - £'000	176	1009	⇧	-636	-636	CFO	
	WRP Delivery - £'000	1228	1841	⇧	1841		CFO	
Frontrunner in research innovation and education								
	Patients Recruited into NIHR Portfolio-Cumulative (2 months in arrears)	1527	2045	⇧	2455	4261	CMO	
	Commercial Income Invoiced £000s - Cumulative (1 month in arrears)	417	434	⇧	600	900	CFO	
	NIHR Research Capability Funding (£000s)	266	266	⇨	500	1000	CMO	
	Trial Recruitment Income (£000s)	796	796	⇨	1062.5	2125	CMO	
	All Grant Income (£000s)	1161	1161	⇨	1000	2000	CMO	

Some national submissions have been suspended due to the pandemic. Where possible the KPI remains reported within scorecards.

Trust Heatmap

Reporting Period:								December 2020	
Measure	Emergency Medicine	Medicine	Trauma and Neuro Services	Surgical Services	Women and Children's Services	Clinical Diagnostics Services	Clinical Support Services	Trust	Trust Target
Group Level Indicators									
Safest care and excellent experience									
Healthcare associated incidents of Clostridioides difficile - Cumulative	1	25	5	6	0		0	55	
MRSA Bacteremia - Trust Acquired - Cumulative	0	0	0	0	0		0	0	0
Never Events - Cumulative	1.0	0.0	0.0	0.0	0.0		0.0	1.0	0
Serious Incidents - Number	1	2	2	0	1	1	0	7	15
HSMR - Basket of 56 Diagnosis Groups (3 months in arrears)	109.97	91.21	50.01	40.02	346.48			95.38	100
Average Number of Long Length of Stay Patients	0	69	33	11	0	0	7	120	109
Friends & Family Test - Recommender Targets Achieved	0	0	1	1	2		0	2	7
Complaints Turnaround <= 25 Days (1 month in arrears)	100%	100%	100%	100%	100%	100%	100%	100%	90%
Leader in operational performance									
Emergency Care 4 Hour Wait	78.4%			100.0%	99.8%			80.4%	95%
Breaches of the 28 Day Readmission Guarantee			5	10	1		N/A	16	0
Diagnostic Waiters - 6 Weeks and Over		27.15%	45.56%	9.93%		1.48%		9.59%	1%
18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears)		71.1%	56.0%	53.8%	56.6%	94.1%	22.6%	57.9%	92%
RTT 52 Week Waits Incomplete (1 month in arrears)		71.0	604.0	1031.0	164.0	0.0	125.0	1995.0	0
Last Minute Non-clinical Cancelled Operations - Elective	0.0%	0.0%	1.6%	3.3%	1.6%	0.0%	0.0%	0.9%	0.8%
Cancer 62 Day Standard plus 31 Day Rare Cancers (1 month in arrears)		83.33%	N/A	69.77%	71.43%			73.98%	85%
Cancer 104+ Day Waits (1 month in arrears)		0.5	0.0	6.5	0.5			7.5	0
National Cancer Standards Achieved (1 month in arrears)		5	5	6	4			6	8
Model employer									
Mandatory Training Compliance	93.19%	93.01%	94.72%	90.98%	92.64%	93.73%	96.36%	93.92%	95%
Appraisal - Non-Medical	81.63%	76.36%	80.92%	75.56%	85.81%	78.65%	90.73%	79.46%	90%
Appraisal - Medical	98.91%	99.36%	100.00%	100.00%	100.00%	98.48%	97.96%	99.31%	90%
Sickness Rate	6.72%	6.56%	6.22%	6.76%	6.53%	6.13%	6.11%	6.23%	3.99%
Achieve financial sustainability									
WRP Delivery - £'000	149	352	193	178	173	94	311	1841	1841
Frontrunner in research innovation and education									
Patients Recruited into NIHR Portfolio-Cumulative (2 months in arrears)	809	321	128	68	501	55	163	2045	2455

Performance Trends

Improving

(3 months consecutive improvement)

Measure	Target	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020
18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears)	92%	80.8%	79.9%	73.4%	64.2%	54.2%	41.8%	33.5%	39.8%	46.8%	52.6%	57.9%	
Appraisal - Medical	90%	97.69%	95.55%	90.78%	83.90%	97.41%	97.13%	96.64%	97.89%	86.62%	95.39%	98.49%	99.31%
Appraisal - Non-Medical	90%	85.19%	86.66%	84.41%	85.80%	85.62%	72.71%	75.39%	78.91%	75.27%	76.33%	78.89%	79.46%

- 18 Weeks Referral to Treatment Time – Incomplete has shown continued improvement following restoration of services during Phase 3.
- Appraisal – Medical - Appraisals were restarted in September which explains the steady increase for the last three months. Doctors were asked to complete appraisals in order to support them - with an onus on Health and Well-Being during this difficult time. As we are allowing appraisals to be completed by the 31st March 2021 the dispensation would stand.
- Appraisal – Non-Medical - The appraisal period (Apr-Sep) was extended until Nov 2020 due to Covid-19 demands on service. The majority of groups have increased their compliance over the last 3 months to meet the revised target date, but all are still not meeting the target of 95%.

Deteriorating

(green indicators worsening)

(3 months consecutive deterioration)

- No indicators achieving target have shown a 3 month deterioration.

Deteriorating

(red indicators worsening)

(3 months consecutive deterioration)

Measure	Target	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020
Emergency Care 4 Hour Wait	95%	78.9%	82.0%	81.4%	91.4%	93.4%	94.3%	93.1%	91.0%	84.9%	83.6%	82.2%	80.4%
RTT 52 Week Waits Incomplete (1 month in arrears)	0	0	0	2	25	92	234	475	742	1150	1639	1995	

- Emergency Care 4 hour Wait - An increase in the number of patients staying in the hospital over 7 days, combined with lower discharge figures has led to decreased flow throughout the organisation over the last few months. This in turn results in patients in ED waiting longer for beds to become available for their onward care
- RTT 52 week waits continue to rise as a result of service changes required in response to Covid-19.

Failed Year End Target

Measure	Target	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020
Never Events - Cumulative	0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0

- A Never Event has been reported in December against the target of zero.

Quality and Safety | Headlines December 2020

NHS University Hospitals Coventry and Warwickshire NHS Trust

INFECTION CONTROL

This month 0 MRSA and 6 CDiff cases were reported.

Infection Rates
Cumulative

55 CDiff
YTD target tbc
Annual Target tbc

0 MRSA
0 YTD target
Annual Target 0

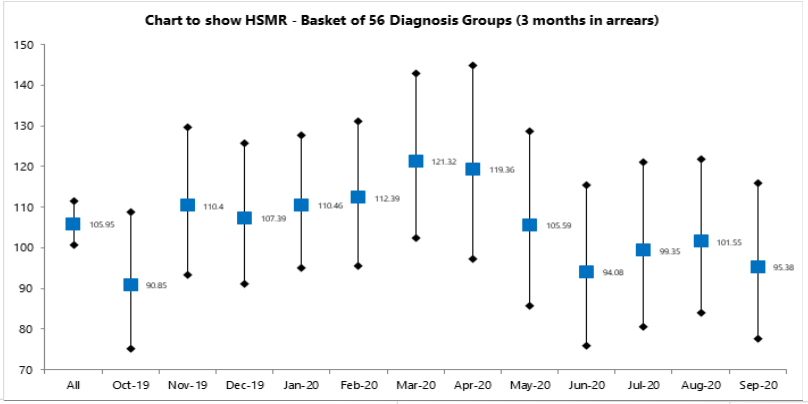
- **CDiff 29 RCAs** carried out and reviewed. 6 deemed avoidable. Further 4 RCAs held.
- **MRSA** High Risk Elective Inpatient Screening: **97.8%**
- **MRSA** High Risk Emergency Screening: **91.7%**

MEDICINE RELATED SERIOUS INCIDENTS

No medication errors causing serious harm have been reported.

HSMR

The latest HSMR score reported from Dr Foster is 95.38



Summary

RIDDOR – There were two injuries to staff reported for December.

HSMR is reported at 95.38 which is within Dr Foster's calculated relative risk range.

The Trust has reported a Never Event in December for wrong route administration of medication. Details are included in the report.

No 12 hour trolley waits

No urgent operations have been cancelled for a second time

RIDDOR

2

Incidents reported for December

4hr Achievement Overview - as at 15/1/2021

Stream	Last Month	Current Month	Last Year	This Year
Type 1 Majors	49.63%	47.91%	55.03%	66.14%
Type 1 Resus	44.44%	46.22%	52.34%	56.48%
Type 1 Paediatrics	89.99%	95.25%	87.57%	92.51%
Local Health Economy	80.39%	79.48%	82.47%	87.27%

100% Complaints turnaround in <= 25 days
Last month 100%
Target 90%

Never Events

1

YTD performance against target of 0

LLOS

Average number of patients with a length of stay 21 days and over

120

Reason to Reside
Data Collection compliance for eligible areas: 76% (13/01/2021)

Incomplete RTT pathways

52 Weeks

1995
(November)

Previous month 1639
Target 0

Quality and Safety Summary

Trust Scorecard – Quality and Safety Committee

Reporting Month : December 2020

NHS University Hospitals Coventry and Warwickshire NHS Trust

Quality and Safety Summary

Quality and Safety Scorecard									
Type	Measure	Previous Position	Latest Position	DoT	Current Target	Annual Target	Annual FOT	Executive Lead	Trend
Excellence in patient care and experience									
	Patient Outcomes								
	MRSA Bacteremia - Trust Acquired - Cumulative	0	0	⇨	0	0	0	CNO	
	Healthcare associated incidents of Clostridioides difficile - Cumulative	49	55	⇩				CNO	
	E. Coli - Trust Acquired - Cumulative	42	53	⇩	38	51	53	CNO	
	MRSA High Risk Elective Inpatient Screening	99.1%	97.8%	⇩	95%	95%	95%	CNO	
	MRSA High Risk Emergency Screening	93.9%	91.7%	⇩	90%	90%	90%	CNO	
	Serious Incidents - Number	7	7	⇨	15	15	15	CQO	
	Serious Incidents - Overdue	4	1	⇧	0	0	0	CQO	
	Medicine related serious incidents	0	0	⇨	0	0	0	CQO	
	Reported Harmful Patient Safety Incidents (1 month in arrears)	28.3%	29.1%	⇩	24.94%	24.94%	24.94%	CQO	
	CAS Alerts - Overdue	0	0	⇨	0	0	0	CQO	
	NCE POD Categorised E Deaths - Cumulative (3 months in arrears)	0	0	⇨	5	10	10	CMO	
	Never Events - Cumulative	0.0	1.0	⇩	0	0	1	CMO	
	Mixed Sex Accommodation Breaches	0	0	⇨	0	0	0	COO	
	HSMR - Basket of 56 Diagnosis Groups (3 months in arrears)	101.55	95.38	⇧	RR	RR	RR	CMO	
	SHMI - Quarterly (6 months in arrears)	1.10	1.11	⇩	RR	RR	RR	CMO	
	Pressure Ulcers Category 3 - Trust Associated (1 month in arrears)	0	0	⇨	1	1	1	CNO	
	Pressure Ulcers Category 4 - Trust Associated (1 month in arrears)	0	0	⇨	0	0	0	CNO	
	Pressure Ulcers Unstageable Category - Trust Associated (1 month in arrears)	0	1	⇩	2	2	2	CNO	
	Falls with Moderate Harm or Above per 1000 Occupied Bed Days	0.17	0.08	⇧	0.08	0.08	0.08	CNO	
	Eligible Patients Having VTE Risk Assessment (1 month in arrears)	96.5%	96.5%	⇩	95%	95%	95%	CNO	
	Average Number of Long Length of Stay Patients	122	120	⇧	109	109	109	CNO	
	Transfer of Patients at Night (UH to Rugby)	0	10	⇩	0	0	0	COO	
	Patient Experience								
	Friends & Family Test Inpatient Recommenders (Inc. Day Cases)	N/A	89.2%		95%	95%	95%	CQC	
	Friends & Family Test Inpatient Coverage (Inc. Day Cases)	N/A	21.2%		26%	26%	26%	CQO	
	Friends & Family Test A&E Recommenders	N/A	85.7%		87%	87%	87%	CQO	
	Friends & Family Test A&E Coverage	N/A	11.6%		15%	15%	15%	CQO	
	Friends & Family Test Outpatient Coverage	N/A	3.34%		8%	8%	8%	CQO	
	Maternity FFT Recommenders - 36 weeks	N/A	95.12%		97%	97%	97%	CQO	
	Maternity FFT Recommenders - Labour / Birth	N/A	100.00%		97%	97%	97%	CQO	
	Maternity FFT Recommenders - Postnatal Hospital	N/A	95.45%		97%	97%	97%	CQO	
	Maternity FFT Recommenders - Postnatal Community	N/A	100.00%		97%	97%	97%	CQO	
	Maternity FFT No of Touchpoints Achieving a 15% Response Rate	N/A	0		4	4	4	CQO	
	Number of Registered Complaints (1 month in arrears)	38	28	⇧	32	34	34	CQO	
	Complaints per 1000 Occupied Bed Days (1 month in arrears)	1.53	1.16	⇧	0.99	0.99	0.99	CQO	
	Complaints Turnaround <= 25 Days (1 month in arrears)	100%	100%	⇨	90%	90%	90%	CQO	

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

Target Type
National Target
Regional Target
Local Target

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

DoT
⇧ Improving
⇨ No change
⇩ Falling

Trust Scorecard – Quality and Safety Committee

Reporting Month : December 2020

NHS University Hospitals Coventry and Warwickshire NHS Trust

Quality and Safety Scorecard									
Type	Measure	Previous Position	Latest Position	DoT	Current Target	Annual Target	Annual FOT	Executive Lead	Trend
Excellence in patient care and experience									
	Theatres								
	Surgical Safety Checklist - WHO	100.00%	100.00%	⇨	100%	100%	100%	CMO	
	National Quality Requirements								
	Valid NHS Number - Inpatients - Cumulative (2 months in arrears)	99.4%	99.5%	⇧	99%	99%	99%	COO	
	Valid NHS Number - A&E - Cumulative (2 months in arrears)	96.8%	96.8%	⇨	95%	95%	95%	COO	
	Operational Quality Measures								
	12 Hour Trolley Waits in Emergency Care	0	0	⇨	0	0	0	COO	
	Ambulance Handover within 30 Minutes	86.7%	84.0%	⇩	100%	100%	100%	COO	
	Ambulance Handover within 60 Minutes	97.4%	96.6%	⇩	100%	100%	100%	COO	
	Urgent Operations Cancelled for the Second Time	0	0	⇨	0	0	0	COO	
	RTT 52 Week Waits Incomplete (1 month in arrears)	1639	1995	⇩	0	0	0	COO	
Leading research based health care organisation									
	Patients Recruited into NIHR Portfolio-Cumulative (2 months in arrears)	1527	2045	⇧	2455	4261	4261	CMO	
	Performance in Initiating Trials - Quarterly	56.3%	75.0%	⇧	80%	80%	80%	CMO	
	Performance in Delivery of Trials - Quarterly	62.5%	57.1%	⇩	80%	80%	80%	CMO	
	Research Critical Findings and Serious Incidents - Quarterly	0	1	⇩	0	0	0	CQO	
	Peer Reviewed Publications - Calendar Year Cumulative (2 months in arrears)	118	127	⇧	182	246	246	CMO	

Some national submissions have been suspended due to the pandemic. Where possible the KPI remains reported within scorecards.

Target Type
National Target
Regional Target
Local Target

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

DoT	
⇧	Improving
⇨	No change
⇩	Falling

Performance Trends

Improving

(3 months consecutive improvement)

- No indicators have shown a 3 month improvement

Deteriorating

(green indicators worsening)

(3 months consecutive deterioration)

- No indicators achieving target have shown a 3 month deterioration.

Deteriorating

Measure	Target	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020
Reported Harmful Patient Safety Incidents (1 month in arrears)	24.94%	22.4%	22.7%	19.7%	23.7%	22.6%	25.6%	21.2%	25.5%	26.4%	28.3%	29.1%	
RTT 52 Week Waits Incomplete (1 month in arrears)	0	0	0	2	25	92	234	475	742	1150	1639	1995	

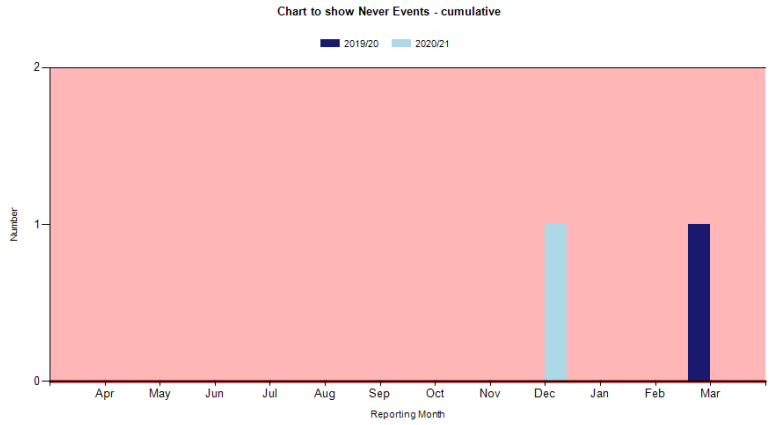
- Reported Harmful Patient Safety Incidents: The indicator reports any incidents where a patient has reported to have come to low, moderate , severe harm or death. November reported zero severe harm incidents and 14 deaths, however each incident has been reviewed by the Patient Safety Response team and all 14 deaths were concluded not as not as a result of the patient safety incident. In addition, all patient deaths are reviewed via the Trusts Mortality Review process to identify if there are any further opportunities for learning. A total number of 12 moderate harm incidents were reported in November, the incidents related to pressure ulcers, falls and infection incidents and an immediate Patient Safety Visit has been held for each incident and immediate learning identified. There was no significant increase in a particular category of incident. Following Root Cause Analysis investigations, learning and actions for each incident will be disseminated at responsible committees such as infection control, falls forum and pressure ulcer forum.
- RTT 52 week waits continue to rise as a result of service changes required in response to Covid-19.

Failed Year End Target

Measure	Target	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020
Never Events - Cumulative	0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0
E. Coli - Trust Acquired - Cumulative	51	51	59	67	5	6	11	17	24	27	38	42	53

- A Never Event has been reported in December against the target of zero.
- In December the Trust breached its local target of no more than 51 incidences of Trust Acquired E.Coli

A never event has been reported in December – Wrong route administration of medication.



A Never Event has been declared in December 2020: Wrong route administration of medication.

The incident relates to a patient who was admitted to UHCW via the Emergency Department (ED) 10th December 2020. The patient was later transferred to the Acute Medicine Unit (AMU1).

Reflective accounts and discussion with the nurse manager identified that the patient was due to be administered morphine. The patient was administered the oral morphine via the subcutaneous route.

The incident resulting in no harm to the patient.

The following actions were taken immediately or within days of the event:

- Chief Medical Officer Safety Message sent: An independent 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
- SBAR (situation, background, assessment, recommendation) form completed and sent to all staff to make them aware that the incident occurred and remind all staff that medications are to be administered in line with the Medicines management policy.

A Serious Incident Investigation is underway to generate learning and develop recommendations. The Root Cause Analysis is in progress and is due for completion by the end of February.

Operational Performance | Headlines December 2020

NHS University Hospitals Coventry and Warwickshire NHS Trust

Operational Summary

Emergency 4 hour wait:
December 2020 - **80.4%**

Latest benchmarked month:
England – December 80.3%
Midlands – December 80.0%

4hr Achievement Overview - as at 15/1/2021

Stream	Last Month	Current Month	Last Year	This Year
Type 1 Majors	49.63%	47.91%	55.03%	66.14%
Type 1 Resus	44.44%	46.22%	52.34%	56.48%
Type 1 Paediatrics	89.99%	95.25%	87.57%	92.51%
Local Health Economy	80.39%	79.48%	82.47%	87.27%

Diagnostic Waiters 6 Weeks and Over

9.59% : 875 breaches across all areas

Imaging	9
Cardiology	81
Endoscopy	205
Neurophysiology	472
Sleep Studies	1
Urology	14
Audiology	93

Summary

Emergency 4 hour wait was 80.4% for December, a deterioration of 1.8% from last month. UHCW was above the benchmarked position for England and for the Midlands.

The cancer 62 day referral to treatment and 31 day subsequent surgery targets were not achieved in November.

The Trust has delivered 15,678 Covid-19 vaccinations (as at 17/01/21)

Ambulance Handover

Within 30 minutes : **84.0%**
Within 60 minutes : **96.6%**

LLOS

Average number of patients with a length of stay 21 days and over **120**

Incomplete RTT pathways

Submitted Position	Inc %	Backlog (Over 18 Weeks)		Latest Benchmarked Month	UHCW	NHS England
Nov 2020	57.9%	12,761		01/11/2020	57.9%	67.9%
Nov 2019	83.0%	5,790		01/11/2019	83.0%	83.8%
YTD UHCW Change	-25.1%	6,971		Benchmark Change	-25.1%	-15.9%

52 Weeks
1995 (November)
Previous month **1639**
Target **0**

Covid-19 Vaccinations

ALL Vaccinations					
Total up to 17/01/2021	Patients 75-79	Patients Over 80	Care Home Staff	UHCW - Healthcare Staff	Other Trust Healthcare Staff
15678	68	821	4399	7522	2868
	0.43%	5.24%	28.06%	47.98%	18.29%

Cancer standards - November

	Mth
TWW:	98.21%
31 day:	96.36%
62 day:	73.98%
31 Day Sub Surg	89.83%

7.5 breaches (9 patients) treated over 104 days

Last minute Non-Clinical Operations – Elective
0.9%
of elective admissions – 50 Patients
Last month – 55 Patients

No 12 hour trolley waits

Reason to Reside
Data Collection compliance for eligible areas: 76% (13/01/2021)

Trust Scorecard – Finance, Resources and Performance Committee

Reporting Month : December 2020

NHS University Hospitals Coventry and Warwickshire NHS Trust

Finance and Workforce Scorecard									
Type	Measure	Previous Position	Latest Position	DoT	Current Target	Annual Target	Annual FOT	Executive Lead	Trend
Excellence in patient care and experience									
	Emergency care								
	Emergency Care 4 Hour Wait	82.2%	80.4%	⇩	95%	95%	95%	COO	
	12 Hour Trolley Waits in Emergency Care	0	0	⇨	0	0	0	COO	
	Ambulance Handover within 30 Minutes	86.7%	84.0%	⇩	100%	100%	100%	COO	
	Ambulance Handover within 60 Minutes	97.4%	96.6%	⇩	100%	100%	100%	COO	
	Delayed Transfers as a Percentage of Admissions	N/A	N/A		3.5%	3.5%	3.5%	COO	
	30 Day Emergency Readmissions (1 month in arrears)	8.6%	9.0%	⇩	7.6%	7.6%	7.6%	COO	
	Number of Medical Outliers - Average per Day	86.5	82.2	⇧	50	50	50	COO	
	Length of Stay Acute - Average	6.5	6.2	⇧	7	6.9	6.9	COO	
	Non emergency care								
	Last Minute Non-clinical Cancelled Operations - Elective	0.9%	0.9%	⇧	0.8%	0.8%	0.8%	COO	
	Breaches of the 28 Day Readmission Guarantee	4	16	⇩	0	0	66	COO	
	Urgent Operations Cancelled for the Second Time	0	0	⇨	0	0	0	COO	
	18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears)	52.6%	57.9%	⇧	92%	92%	92%	COO	
	RTT 52 Week Waits Incomplete (1 month in arrears)	1639	1995	⇩	0	0	0	COO	
	E-referral Appointment Slot Issues – National data (1 month in arrears)	1.5%	1.0%	⇧	4%	4%	4%	COO	
	Diagnostic Waiters - 6 Weeks and Over	8.19%	9.59%	⇩	1%	1%	1%	COO	
	Bed Occupancy Rate - KH03 (3 months in arrears)	79.3%	79.3%	⇨	93%	93%	93%	COO	
	Cancer								
	Cancer 2 Week Wait GP Referral to OP Appointment (1 month in arrears)	90.88%	98.21%	⇧	93%	93%	93%	COO	
	Cancer 2 Week Wait Breast Symptom (1 month in arrears)	100.00%	100.00%	⇨	93%	93%	93%	COO	
	Cancer 31 Day Diagnosis to Treatment (1 month in arrears)	96.59%	96.36%	⇩	96%	96%	96%	COO	
	Cancer 31 Day Subsequent Surgery Standard (1 month in arrears)	95.35%	89.83%	⇩	94%	94%	94%	COO	
	Cancer 31 Day Subsequent Drug Standard (1 month in arrears)	100.00%	100.00%	⇨	98%	98%	98%	COO	
	Cancer 31 Day Subsequent Radiotherapy Standard (1 month in arrears)	97.67%	98.77%	⇧	94%	94%	94%	COO	
	Cancer 62 Day Standard plus 31 Day Rare Cancers (1 month in arrears)	78.54%	73.98%	⇩	85%	85%	85%	COO	
	Cancer 62 Day Screening Standard (1 month in arrears)	64.71%	92.86%	⇧	90%	90%	90%	COO	
	Cancer 62 Day Consultant Upgrades (1 month in arrears)	66.7%	88.1%	⇧	85%	85%	85%	COO	
	Cancer 104+ Day Waits (1 month in arrears)	7.5	7.5	⇨	0	0	0	COO	

Target Type
National Target
Regional Target
Local Target

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

DoT	
⇧	Improving
⇨	No change
⇩	Falling

Trust Scorecard – Finance, Resources and Performance Committee

Reporting Month : December 2020

NHS University Hospitals Coventry and Warwickshire NHS Trust

Finance and Workforce Scorecard									
Type	Measure	Previous Position	Latest Position	DoT	Current Target	Annual Target	Annual FOT	Executive Lead	Trend
Excellence in patient care and experience									
	Theatre Productivity								
	Theatre Efficiency - Main	57.9%	58.0%	⇧	85%	85%	85%	COO	
	Theatre Efficiency - Rugby	66.1%	66.0%	⇩	85%	85%	85%	COO	
	Theatre Efficiency - Day Surgery	53.4%	46.8%	⇩	85%	85%	85%	COO	
	Theatre Utilisation - Main	78.0%	78.3%	⇧	85%	85%	85%	COO	
	Theatre Utilisation - Rugby	76.7%	80.2%	⇧	85%	85%	85%	COO	
	Theatre Utilisation - Day Surgery	67.9%	65.0%	⇩	85%	85%	85%	COO	
	Surgical Safety Checklist - WHO	100.00%	100.00%	⇨	100%	100%	100%	CMO	
	Theatre Lists Started within 15 mins of Start Time	29.0%	22.4%	⇩	75%	75%	75%	COO	
Deliver value for money									
	Capital Service Cover Rating							CFO	
	Liquidity Rating							CFO	
	Income & Expenditure Margin Rating							CFO	
	Variance from Control Total Rating							CFO	
	Forecast Income & Expenditure - £'000	176	1009	⇧	-636	-636	176	CFO	
	Agency Rating							CFO	
	Trust Financial Risk Rating							CFO	
	WRP Delivery - £'000	1228	1841	⇧	1841		3683	CFO	
	YTD Income & Expenditure Trust - £'000	-43	824	⇧	-692	-636	176	CFO	
	Agency Expenditure (£'000)	1987	1841	⇧	1903	1903	1903	CWIO	
Employer of choice									
	Appraisal - Non-Medical	78.89%	79.46%	⇧	90%	90%	90%	CWIO	
	Appraisal - Medical	98.49%	99.31%	⇧	90%	90%	90%	CWIO	
	Mandatory Training Compliance	93.86%	93.92%	⇧	95%	95%	95%	CWIO	
	Sickness Rate	5.94%	6.23%	⇩	3.99%	3.99%	3.99%	CWIO	
	Staff Turnover Rate	8.07%	8.02%	⇧	10%	10%	10%	CWIO	
	Vacancy Rate Compared to Funded Establishment	10.24%	10.33%	⇩	10%	10%	10%	CWIO	
	Staff Survey - Recommending as a Place of Work (Quarterly)	N/A	N/A		70%	70%	70%	CWIO	
Leading research based health care organisation									
	Submitted Research Grant Applications - Quarterly - Cumulative	85	85	⇨	67	134	134	CMO	
	Commercial Income Invoiced £000s - Cumulative (1 month in arrears)	417	434	⇧	600	900	900	CFO	
	NIHR Research Capability Funding (£000s)	266	266	⇨	500	1000	1000	CMO	
	Trial Recruitment Income (£000s)	796	796	⇨	1062.5	2125	2125	CMO	
	All Grant Income (£000s)	1161	1161	⇨	1000	2000	2000	CMO	

Some national submissions have been suspended due to the pandemic. Where possible the KPI remains reported within scorecards.

Target Type
National Target
Regional Target
Local Target

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

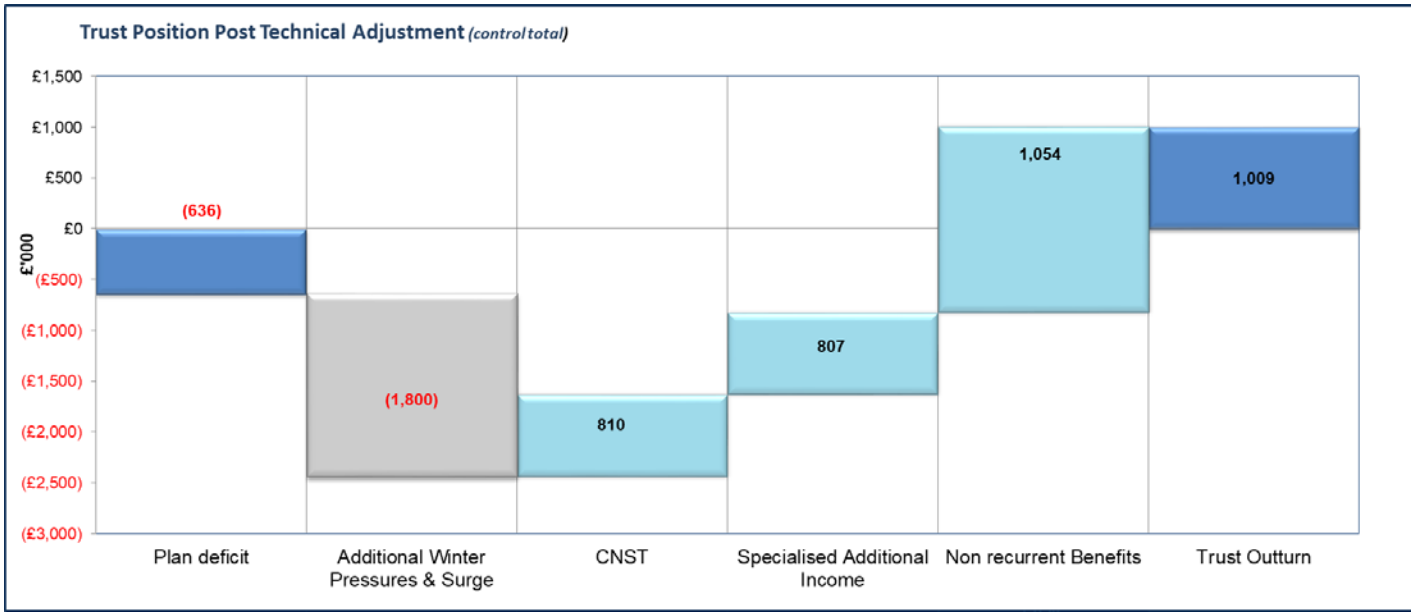
DoT	
⇧	Improving
⇨	No change
⇩	Falling

Integrated Finance Report |Finance Headlines

Reporting Month: December 2020

NHS University Hospitals Coventry and Warwickshire NHS Trust

At Month 9, the Trust reported a £824k favourable position, which is £1.5m favourable compared to plan. The forecast position is £1.0m favourable position, which is £1.6m favourable compared to plan. Additional costs incurred for COVID and loss of Income due to COVID are funded by an additional system top up of income.



Movements on the waterfall show a plan deficit of (£0.6m), an increase in additional winter pressure and critical care surge (£1.8m), non recurrent benefits relating to CNST Maternity Incentive Scheme £0.8m, additional specialised income £0.8m and non recurrent benefits of undertaking less planned care £1.1m, giving a reported forecast position of £1.0m surplus at Month 09.

CONTRACT & ACTIVITY INCOME

£1.5m favourable position reported as at Month 9. £2.4m to cover additional COVID19 costs in respect of laboratory testing

COVID-19 Reimbursement Top Up

COVID-19 Reimbursement Top Up above income plan £2.4m in respect of laboratory testing costs.

Capital

Capital Plan £51.6m

Capital Expenditure of £11.0m at Month 09

YTD £13.2m

AGENCY SPEND

Agency Target £20.8m
December agency expenditure equates to £1.8m, which is an decrease of £0.2m from November.
Year to date expenditure equates to £13.2m
Forecast expenditure equates to £18.7m

Integrated Finance Report |Trust Financial Position

Reporting Month: December 2020

University Hospitals Coventry and Warwickshire NHS Trust

9 Months Ended 31 December 2020	YTD Plan £'000	YTD Actual £'000	Variance to Plan £'000	Forecast Plan £'000	Forecast £'000	Variance to Plan £'000
Total Income From Patient Care Activities	494,269	493,436	(833)	676,623	675,658	(965)
Adjusted Top Up Income	40,460	42,810	2,350	40,460	42,810	2,350
Total Other Operating Income	33,418	33,839	421	45,113	46,156	1,043
Total Operating Income	568,147	570,085	1,938	762,196	764,624	2,428
Total Medical and Dental - Substantive	(89,597)	(88,138)	1,459	(118,057)	(118,294)	(237)
Total Agenda for Change - Substantive	(200,160)	(199,264)	896	(266,502)	(267,578)	(1,076)
Total Medical and Dental - Bank	(7,034)	(9,097)	(2,063)	(11,430)	(13,634)	(2,204)
Total Agenda for Change - Bank	(18,633)	(17,936)	697	(25,030)	(24,026)	1,004
Total Medical and Dental - Agency	(6,159)	(7,234)	(1,075)	(7,832)	(9,960)	(2,128)
Total Agenda for Change - Agency	(4,123)	(5,943)	(1,820)	(5,603)	(8,763)	(3,160)
Other gross staff costs	(1,277)	(1,283)	(6)	(1,705)	(1,711)	(6)
Total Employee Expenses	(326,983)	(328,895)	(1,912)	(436,159)	(443,966)	(7,807)
Total Operating Expenditure excluding Employee Expenditure	(198,596)	(197,880)	716	(269,497)	(263,164)	6,333
Total Operating Expenditure	(525,579)	(526,775)	(1,196)	(705,656)	(707,130)	(1,474)
Operating Surplus/Deficit	42,568	43,310	742	56,540	57,494	954
Total Finance Expense	(40,153)	(40,021)	132	(52,955)	(52,614)	341
PDC dividend expense	(2,397)	(2,397)	0	(3,195)	(2,846)	349
Net Finance Costs	(42,550)	(42,418)	132	(56,150)	(55,460)	690
Surplus/Deficit For The Period	18	892	874	390	2,034	1,644
Control Total adjustments						
Donated assets (income)	(963)	(322)	641	(1,363)	(1,363)	0
Donated assets (depn)	253	254	1	337	338	1
Control Total	(692)	824	1,516	(636)	1,009	1,645

YTD Financial Performance :

Income from Patient Care Activities (including Adj Top Up): £1.5m favourable

- £1.5m NHSE/I income for laboratory testing
- (£0.4m) specialised commissioners devices
- £0.1m injury cost recovery scheme
- £0.1m Private Patients
- £0.1m Other income

Other Operating Income: £0.4m favourable

- (£0.6m) donated assets income
- £0.1m Education & Research Income
- £0.9m salary recharge Income

Expenditure (£1.2m) adverse:

- (£1.9m) pay costs largely driven by bank and agency
- £0.6m Maternity Incentive Scheme
- £0.1m other expenditure

Forecast Financial Performance :

Income from Patient Care Activities (including Adj Top Up): £1.4m favourable

- £1.5m NHSE/I income for laboratory testing
- (£0.8m) specialised commissioners devices
- £0.2m Private Patients
- £0.2m injury cost recovery scheme
- £0.3m income from other NHS Trusts &local authorities

Other Operating Income: £1.0m favourable

- £0.4m Research and Education Income
- £0.6m other Income.

Expenditure (£1.5m) adverse:

- (£7.8m) pay costs, due to COVID, Critical Care and Restoration.
- £5.5m drugs, clinical supplies and other costs
- £0.8m Maternity Incentive Scheme

Integrated Finance Report |Statement of Financial Position

Reporting Month: December 2020

University Coventry and War

Finance Summary

9 months ended 31 December 2020	Full Year			Year To Date		
	Plan (£'000)	Forecast Outturn (£'000)	Variance (£'000)	Plan (£'000)	Actual (£'000)	Variance (£'000)
Non-current assets						
Property, plant and equipment	368,476	362,893	(5,583)	340,343	334,440	(5,903)
Intangible assets	6,459	6,239	(220)	5,866	4,960	(906)
Investment Property	10,010	10,010	0	10,010	10,010	0
Trade and other receivables	30,292	26,655	(3,637)	36,481	32,495	(3,986)
Total non-current assets	**415,237**	**405,797**	**(9,440)**	**392,700**	**381,905**	**(10,795)**
Current assets						
Inventories	14,203	14,203	0	13,918	12,861	(1,057)
Trade and other receivables	54,739	55,983	1,244	46,615	47,359	744
Cash and cash equivalents	18,085	18,085	0	93,695	111,268	17,573
	87,027	**88,271**	**1,244**	**154,228**	**171,488**	**17,260**
Non-current assets held for sale	0	0	0	0	0	0
Total current assets	**87,027**	**88,271**	**1,244**	**154,228**	**171,488**	**17,260**
Total assets	**502,264**	**494,068**	**(8,196)**	**546,928**	**553,393**	**6,465**
Current liabilities						
Trade and other payables	(65,702)	(61,240)	4,462	(128,504)	(143,269)	(14,765)
Borrowings	(7,739)	(7,330)	409	(7,437)	(7,455)	(18)
DH Interim Revenue Support loan	0	0	0	0	0	0
DH Capital loan	(912)	(913)	(1)	(898)	(896)	2
Provisions	(3,853)	(2,908)	945	(2,505)	(2,435)	70
Total current liabilities	**(78,206)**	**(72,391)**	**5,815**	**(139,344)**	**(154,055)**	**(14,711)**
Net current assets/(liabilities)	**8,821**	**15,880**	**7,059**	**14,884**	**17,433**	**2,549**
Total assets less current liabilities	**424,058**	**421,677**	**(2,381)**	**407,584**	**399,338**	**(8,246)**
Non-current liabilities:						
Trade and other payables	0	0	0	0	0	0
Borrowings	(239,020)	(235,995)	3,025	(232,150)	(232,132)	18
DH Interim Revenue Support loan/RWCSF	0	0	0	0	0	0
DH Capital loan	(2,670)	(2,670)	0	(2,670)	(2,670)	0
Provisions	(2,268)	(2,287)	(19)	(2,374)	(2,393)	(19)
Total assets employed	**180,100**	**180,725**	**625**	**170,390**	**162,143**	**(8,247)**
Financed by taxpayers' equity:						
Public dividend capital	191,835	191,119	(716)	189,121	180,000	(9,121)
Retained earnings	(73,563)	(72,222)	1,341	(73,934)	(73,060)	874
Revaluation reserve	61,828	61,828	0	55,203	55,203	0
Total Taxpayers' Equity	**180,100**	**180,725**	**625**	**170,390**	**162,143**	**(8,247)**

The Statement of Financial Position ("SoFP") shows the assets, liabilities and equity held by the Trust and is used to assess the financial soundness of an entity in terms of liquidity, financial , credit and business risks.

The "Plan" figures now reflect that latest submitted version of the Plan and as such include the forecast impact of the Covid-19 pandemic, the change in funding arrangements for 2020/21 with most DH loans now converted to PDC, the finalised 2019/20 outturn position and the deferral of IFRS 16 implementation until April 2021.

Some of the key points to note in this report are:

Year to Date

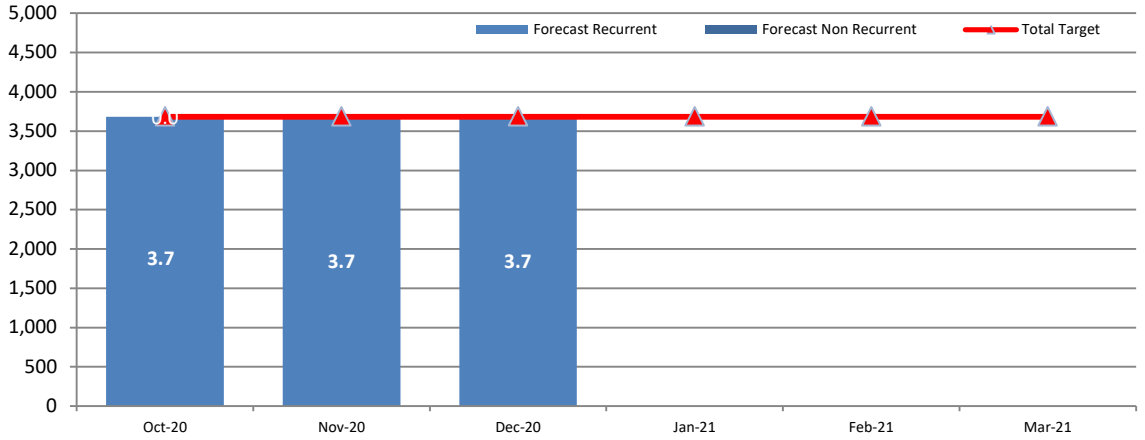
- Spend on property, plant and equipment and also intangibles is lower than Plan due to delays in commencing capital schemes as a result of Covid and time taken to confirm capital resource across the STP;
- Receivables balances reflect the adjustment of the non-current element of the PFI life-cycling prepayment and also the reduction in aged debt ;
- Trade payables balances are higher than expected due to additional Covid funding being paid in advance, increasing deferred income balances and also due to increased accrued expenditure;
- Public Dividend Capital is lower than Plan as cash draws have been deferred in line with delayed capital spend;
- The above movements have resulted in an increased cash balance.

Forecast Outturn

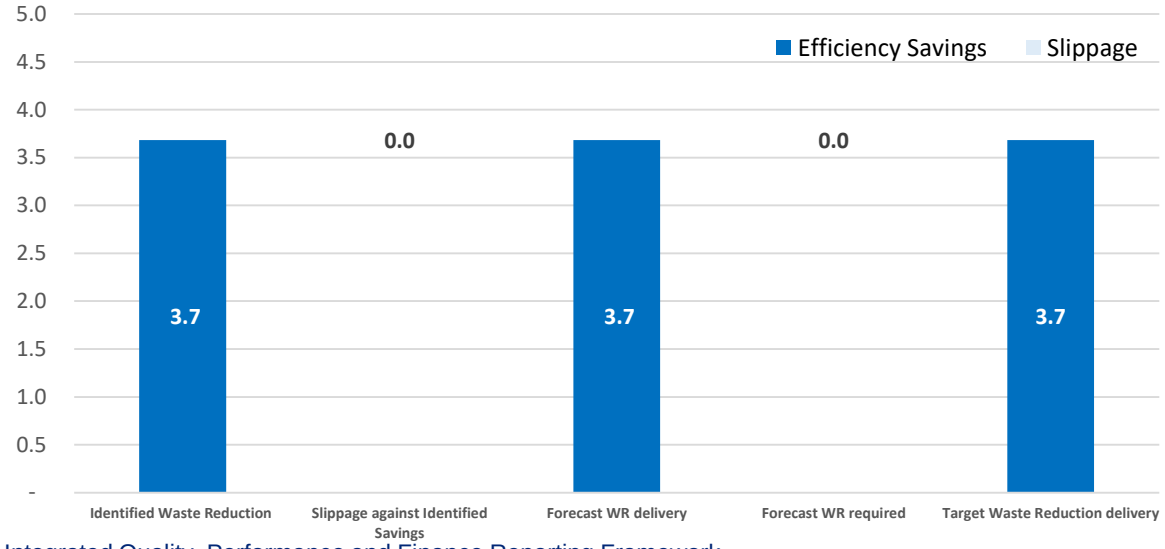
- Property, plant and equipment is lower than Plan due to a revised forecast outturn with several capital schemes slipping into next year;
- Receivables are now forecast to be less than Plan to reflect the improved recovery rate;
- Payables are forecast to reduce further following improved work flows;
- The slippage of the Pathology Analyser scheme reduces the value of finance lease borrowing at the end of the year;
- Retained earnings are forecast to be lower than Plan due to an improved Income and Expenditure position;

University Hospitals Coventry and Warwickshire NHS Trust

Waste Reduction Programme Delivery



Waste Reduction Overview



- **The Trust is forecasting delivery of £3.683m of potential savings.**
- **In line with the required half year target of £3.683m.**

Key Headlines – Waste Reduction Programme

- The Trust has set a recurrent efficiency target of £3.683m in 2020/21 and zero non-recurrent efficiency target.
- The Groups have a recurrent vacancy target of £3.25m effective from 1st October.
- The balance of £433k is held by Core Services.
- This target is planned and expected to be delivered in equal phasing over months 7-12
- As the target is recurrent, it has been removed from group position's as part of the budget setting process for 2020/21.
- As at Month 9 forecast delivery is line with the plan.

Risks

As at month 9

- 100% of the target has been identified
- 100% of the target is forecast to be delivered

Efficiency Savings Delivery by Group

WASTE REDUCTION DELIVERY POSITION AGAINST TARGET						
TOTAL TRUST SUMMARY INFORMATION	Full-Year Target £000	Forecast Delivery £000	Forecast Delivery %	YTD Target £000	YTD Delivery £000	YTD Delivery %
TRUST OVERALL POSITION	3,683	3,683	100%	1,841	1,841	100%
Emergency Medicine	298	298	100%	149	149	100%
Surgical Services	357	357	100%	178	178	100%
Trauma and Neuro Services	385	385	100%	193	193	100%
Womens and Childrens	346	346	100%	173	173	100%
Medicine	704	704	100%	352	352	100%
Clinical Diagnostic Services	189	189	100%	94	94	100%
Clinical Support Services	622	622	100%	311	311	100%
Core Services	433	433	100%	217	217	100%
Corporate Departments	349	349	100%	174	174	100%

Note that target allocations may move between Groups on a monthly basis to reflect joint working on Waste Reduction schemes or budget moves.

- ***See the Trust intranet page for a weekly update on Waste Reduction Programme.***

Workforce Information | Headlines December 2020

NHS
University Hospitals Coventry and Warwickshire NHS Trust

This report provides a summary overview of workforce data. A detailed analysis of this data is provided within the monthly workforce report presented to the Finance, Performance & Resources Committee.

Agency Spend
£1,840,778

Headcount
9350 Headcount
8197.74 WTE
(inclusive of ISS/ROE)

Training
93.84% (Substantive Employees)

Target ≥ 95%

Vacancy Rate
10.33%
906.19 WTE

Target ≤ 10%

Medical
99.31%
(Source RMS – includes dispensation period for Covid)

Non-Medical
79.46%

Target ≥ 90%

Turnover **8.02%**
(12 months rolling average so excludes Covid-19 staff)

Target ≤ 10%

Sickness
6.23%

Target ≤ 4%

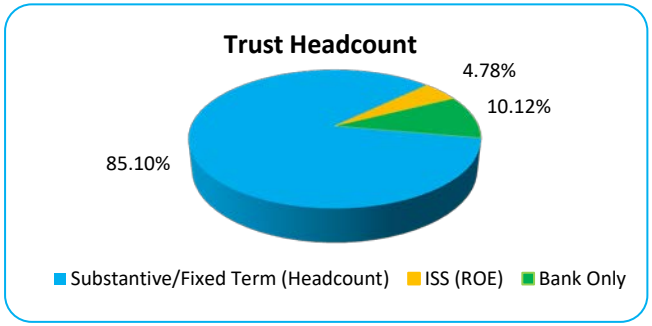
Workforce Information | December 2020

University Hospitals Coventry and Warwickshire NHS Trust

Headcount | WTE

The tables on this page shows the headcount and WTE for staff.

Staff Headcount Breakdown	Oct-20	Nov-20	Dec-20
Substantive/Fixed Term	8767	8712	8871
ISS (ROE)	489	481	479
Trust Total	**9256**	**9193**	**9350**
Bank Only	1014	1001	1018



Staff WTE Breakdown	Oct-20	Nov-20	Dec-20
Substantive/Fixed Term	7760.74	7849.16	7862.34
ISS (ROE)	371.10	365.6	335.40
Trust Total	**8131.84**	**8214.76**	**8197.74**

Staff Group in Post | Monthly Variation

Staff Group Variances (WTE)	Staff in Post Nov-20	Staff in Post Dec-20	Starters in Month	Leavers in Month
Add Professional	286.68	284.93	0.00	5.76
Add Clinical Services	1797.81	1798.48	18.61	10.55
Admin & Clerical	1383.74	1405.40	17.79	4.84
Allied Health Professional	470.34	471.52	0.00	3.55
Estates & Ancillary	2.00	2.00	0.00	0.00
Healthcare Scientists	377.55	380.81	4.00	2.00
Medical & Dental	1085.22	1090.04	51.35	50.82
Nursing & Midwifery	2444.82	2428.17	9.41	15.45
Students	1.00	1.00	0.00	0.00
Total	**7849.16**	**7862.34**	**101.16**	**92.97**

December continues to see an increase in staff (13.18 WTE).

As part of the Trust wide programme to achieve a 0% vacancy rate with HCAs, there are 129 WTE in the pipeline with 51 at offer stage in the recruitment process.

Of the starters in month, 50 percent are in the Additional Clinical Services staff group, with 9.75 WTE HCAs.

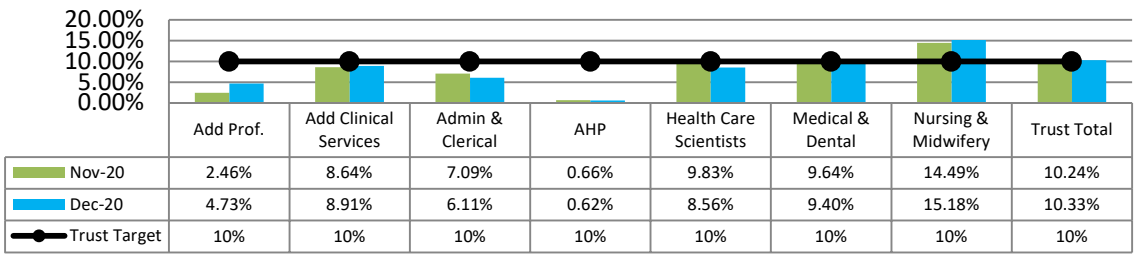
The majority of changes in Medical staff is a result of the rotational doctors, and the welcome of consultants in Care of the Elderly that has previously struggled to recruit to this post.

NB: *Staff in Post data reflects new starters, monthly amendments to the increase and decrease hours and leavers. Therefore, whilst a number of staff may have been recruited in month the overall figure may go down due to the changes in hours and leavers.*

Workforce Information | December 2020

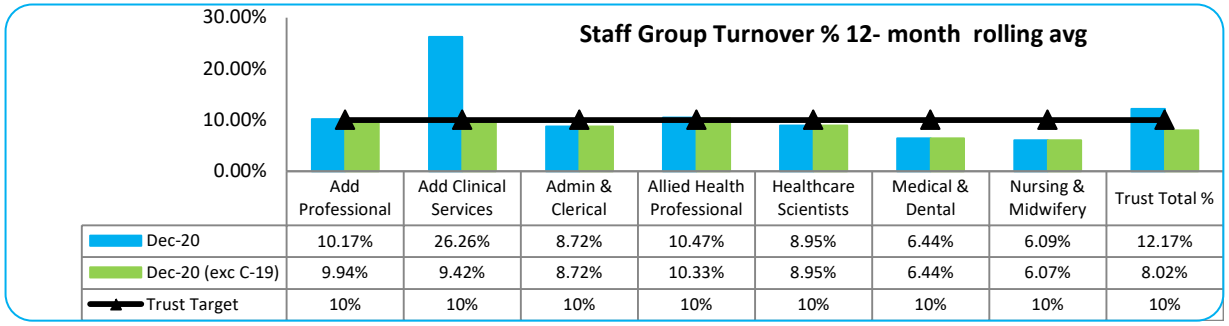
NHS University Hospitals Coventry and Warwickshire NHS Trust

Vacancy | by Staff Group



Staff Group	Nov-20 Funded (WTE)	Nov-20 Staff In Post (WTE)	Nov-20 Funded Vacancies (WTE)	Dec-20 Funded (WTE)	Dec-20 Staff In Post (WTE)	Dec-20 Funded Vacancies (WTE)
Add Prof Scientific and Technic	293.92	286.68	7.24	299.09	284.93	14.16
Additional Clinical Services	1967.89	1797.81	170.08	1974.30	1798.48	175.82
Administrative and Clerical	1489.34	1383.74	105.60	1496.82	1405.40	91.42
Allied Health Professionals	473.46	470.34	3.12	474.46	471.52	2.94
Healthcare Scientists	418.70	377.55	41.15	416.48	380.81	35.67
Medical and Dental	1200.95	1085.22	115.73	1203.10	1090.04	113.06
Nursing and Midwifery Registered	2858.96	2444.82	414.14	2862.87	2428.17	434.70
Grand Total (please note Estates & Students not included in the total)	**8703.22**	**7846.16**	**857.06**	**8727.12**	**7859.35**	**867.77**

The overall Trust vacancy percentage is 10.33% is a slight increase on the previous month of 10.24%. Funded establishment has increased by 23.9 WTE and Staff in Post has increased by 13.19 WTE, which has resulted in an overall increase of (10.71 WTE) on the Trust vacancy figure.



Turnover | by Staff Group

The Trust overall turnover rate (12-months rolling) has decreased by 0.05% from 8.07% in November to 8.02% in December. During the last 12 month period, the Trust has had 827 leavers. In December there were 53 medical staff leavers, of which 84.91% were Rotational Doctors. Nursing and Midwifery turnover continues to be low at 6.09%, which is the same as November's rate. The Group with the highest turnover is Clinical Diagnostics at 11.35%, followed by Core at 8.40%.

Vacancy Trajectory - Strategic Workforce Committee continues to have oversight of workforce modelling, this includes focus on vacancy hotspot areas.

Nursing & Midwifery (Band 6 and above) – There are **73.30 WTE** currently being actively recruited to with 39.56 WTE at pre-employment check stage and 33.74 WTE commencing in January and February. International Recruitment stands at **95 offered** status with 8 appointed in December, with **16 arriving** into the country in December with 10 days isolation to follow.

Nursing & Midwifery (Band 5) – There are **107.43 WTE** at pre-employment check stage with a further 26.46 WTE with confirmed start dates for January and February..

Healthcare Scientists - There are **35.98 WTE** actively being recruited to with 15 WTE at pre-employment check stage and 9.5 WTE with a confirmed start dates for January and February.

Medical & Dental - There are **128 WTE** actively being recruited to with **66 WTE at pre-employment check** stage . There are **18 WTE with a confirmed start** dates for January and February.

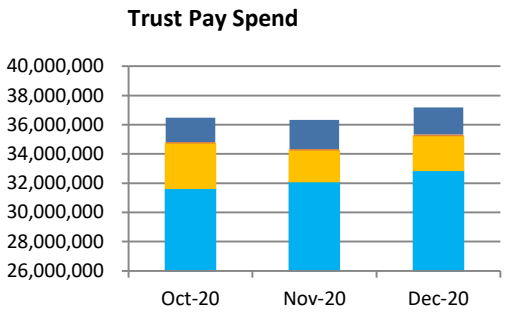
Additional Clinical Services – HCA - As part of the Trust wide programme to achieve a 0% vacancy rate with HCAs, there are **129 WTE** in the pipeline with 51 at offer stage in the recruitment process. **19.81 WTE** have a start date for January / February.

This graph highlights the turnover including and excluding staff employed to support COVID-19.

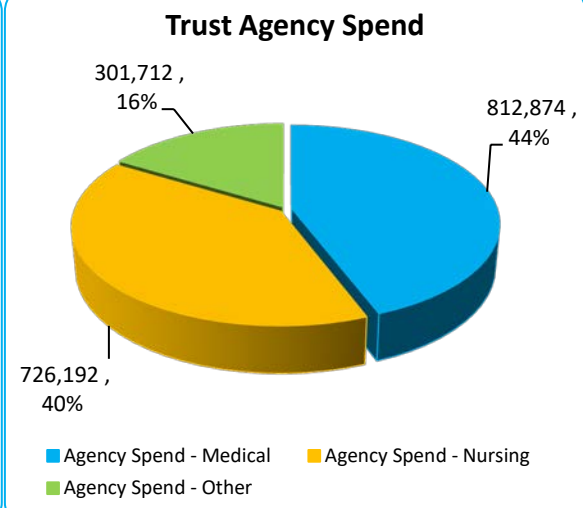
Workforce Information | December 2020

University Hospitals Coventry and Warwickshire NHS Trust

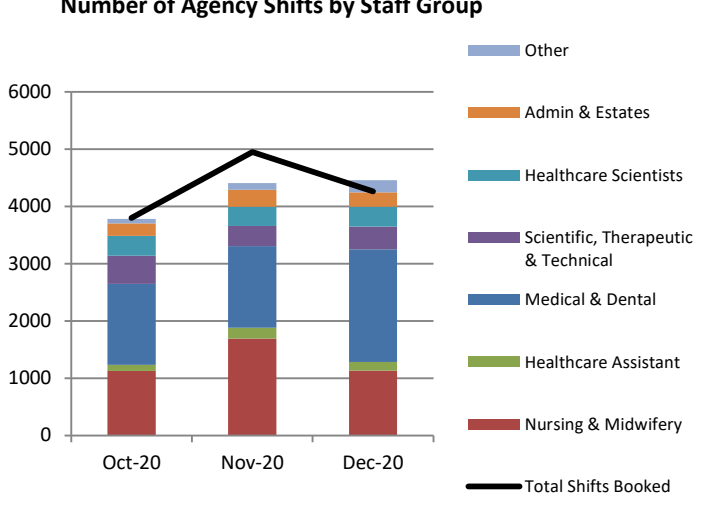
Pay Costs| Provided by Finance



	Oct-20	Nov-20	Dec-20
Total Agency Spend	1,664,913	1,986,981	1,840,778
Overtime Spend	105,869	122,092	125,044
Bank Spend	3,036,681	2,089,318	2,333,693
Substantive Spend	31,666,565	32,135,002	32,887,181



Agency | Number of Shifts Booked



Agency Shifts Booked | Reasons for Shifts Booked

*Reasons	Oct-20	Nov-20	Dec-20
Vacancy	2922	3579	3195
Sickness	141	181	152
Additional Capacity	266	222	188
Other - COVID	265	646	518
Other	207	325	212

Staff Group	Oct-20	Nov-20	Dec-20
Nursing & Midwifery	1129	1690	1133
Healthcare Assistant	106	190	149
Medical & Dental	1430	1972	1781
Scientific, Therapeutic & Technical	494	347	392
Healthcare Scientists	347	337	347
Admin & Estates	217	297	254
Other	78	120	209
Total Shifts Booked	**3801**	**4953**	**4265**

* Reasons categorisation drawn from E-Rostering.

Substantive spend has increased this month on November by £752k, this is mainly due to the increase in substantive WTE. Overall agency spend has decreased by £146.2k. Overtime and Bank Spend has increased by (£247.3k). The main reason recorded for agency use continues to be vacancy (75% of bookings) a 2.8% increase on November. The total number of agency shifts have reduced by 688, the highest reduction is for Nursing which is 557. There has been a decrease of 128 shifts being booked due to Other COVID-19 reasons. Although Sickness for Medical and Nursing has increased by 1% in December the operational movement of staff has resulted in less shifts being booked against this reason.

Workforce Information | December 2020

NHS University Hospitals Coventry and Warwickshire NHS Trust

Absence| by Group

Overview:

COVID ABSENCE:

Groups	Covid -19 Absence % (FTE)	Without Covid Absence
218 Clinical Diagnostics	0.77%	5.36%
218 Clinical Support Services	1.16%	4.95%
218 Core Services	1.12%	4.10%
218 Emergency Medicine	1.48%	5.24%
218 Medicine	2.08%	4.48%
218 Surgical Services	1.99%	4.77%
218 Trauma and Neuro Services	1.60%	4.63%
218 Women and Children	1.21%	5.32%
Grand Total	**1.41%**	**4.82%**

OTHER ABSENCE:

- Sickness Absence in December 2020 has increased (0.29%) from November 2020, to 6.23%. For the same winter period last year we recorded 5.07% Overall WTE sickness days lost have increased by 1,260 this month.

Actions:

Activity to reduce absence continues as per last month see below the Trust also continues to support staff with daily communications which is vital to ensure we are all informed and aware of the support available as Mental Health and Covid remain the two highest contributions to current sickness levels .

1. Additional staff rest areas have been identified as both a core and local offer in critical areas. The Health & Wellbeing Team have promoted these to staff and supported locally through providing literature and posters to remind staff of the offer. Care packages and refreshments are being deployed into areas.
2. The wellbeing offer has been reviewed for Critical Care, Respiratory and Enhanced Care areas; and additional psychological support has been put in place with a plan to embed this for the short and medium term utilising the funds from NHS England & NHS Improvement and NHS Charities.
3. An action plan has been developed and shared with key stakeholders to ensure consistent support is provided .

Group Rolling Sickness Absence Rate %	Oct-20	Nov-20	Dec-20
218 Clinical Diagnostics	6.12%	6.26%	6.13%
218 Clinical Support Services	5.59%	7.11%	6.11%
218 Core Services	4.94%	4.98%	5.22%
218 Emergency Medicine	6.27%	6.36%	6.72%
218 Medicine	4.75%	5.26%	6.56%
218 Surgical Services	5.68%	5.80%	6.76%
218 Trauma and Neuro Services	4.64%	5.58%	6.22%
218 Women and Children	4.41%	5.63%	6.53%
Trust Total %	**5.28%**	**5.94%**	**6.23%**

Absence | Reasons

This table below shows the top 5 absence reasons by Days Lost (WTE) and the percentage Absence.

Absence Reasons Top five	Total WTE Days Lost	Absence %
Infectious diseases (inc Covid-19)	3430.66	22.64%
Mental Health	4035.25	26.63%
Gastrointestinal problems	767.39	5.06%
Cold, Cough, Flu - Influenza	418.35	2.76%
Musculoskeletal	1352.17	8.92%
Overall All Absence Trust Totals	**15,153.17**	100.00%

Workforce Information | December 2020

University Hospitals Coventry and Warwickshire NHS Trust

Mandatory Training |by Group

*This data excludes Employees status – New starters up to six weeks / Maternity & Adoption Leave / External Secondments Career Breaks/ Rotational Doctors / Non Executive Directors / Students/ Honorary Contracts / In-active Bank Staff.

Group Mandatory Training %	Oct-20	Nov-20	Dec-20
Clinical Diagnostics	93.72%	95.77%	96.36%
Clinical Support Services	95.72%	95.77%	96.36%
Core Services	93.84%	93.46%	93.18%
Emergency Medicine	93.27%	92.97%	93.19%
Medicine	93.50%	93.34%	93.01%
Surgical Services	91.28%	90.64%	90.98%
Trauma and Neuro Services	94.48%	94.62%	94.72%
Women & Children	93.09%	92.83%	92.64%
Temporary Staffing Services	94.64%	94.78%	95.04%
Trust Total	93.97%	93.86%	93.92%
Substantive Staff Only	93.92%	93.78%	93.84%
Bank Staff Only	94.64%	94.78%	95.04%

- Mandatory training levels has increased by 0.06% in December 2020, with the same increase for substantive only staff and 0.14% increase for Bank only staff. Performance continues to be monitored at Group Performance Reviews and at Group Management Board meetings. The overall result is still high and we aim to improve results via communications to staff on how to access ESR training from home.

Appraisals |by Group

This data excludes *Employees status – As above

Appraisal % by Group	Non-Medical Appraisals			Medical Appraisals		
	Oct-20	Nov-20	Dec-20	Oct-20	Nov-20	Dec-20
Clinical Diagnostics	70.05%	68.86%	78.65%	92.42%	98.41%	98.48%
Clinical Support Services	83.62%	85.21%	90.73%	93.75%	97.85%	97.96%
Core Services	54.23%	55.50%	60.66%	100.00%	100.00%	100.00%
Emergency Medicine	80.04%	83.52%	81.63%	93.59%	97.62%	98.91%
Medicine	75.43%	79.71%	76.36%	95.27%	97.99%	99.36%
Surgical Services	77.26%	74.58%	75.56%	96.04%	99.04%	100.00%
Trauma and Neuro Services	72.04%	76.47%	80.92%	97.50%	99.18%	100.00%
Women & Children	88.20%	83.60%	85.81%	98.04%	100.00%	100.00%
Temporary Staffing				0.00%	100.00%	0.00%
Trust Total	76.33%	78.89%	79.46%	95.39%	98.49%	99.31%

Non Medical Appraisals

- There has been a 0.57% increase in compliance levels from November 2020, following the 2.56% increase in October. Clinical Support remains the highest performer at over 90%.
- All Groups, as part of the Q3 Quarterly Performance Reviews, have been set a trajectory to achieve 90% by the end of February.

Medical Appraisals

- Appraisals were restarted in Sept 2020 which would explain the steady increase for the last 3 months.
- There has been a 0.81% increase in compliance levels from November 2020.
- All Groups have seen an increase in compliance with four groups now recording 100%.
- Medical appraisals linked to revalidation were paused, but will need to be completed by March 2021. Appraisals have been re-allocated the special dispensation for COVID-19, compliance levels are provided via the RMS system. Communications have been sent to Medical staff to explain the situation.
- Temporary staffing Medical results have fluctuated due to the termination of a number of inactive Locum staff .

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 28 JANUARY 2021

Subject Title	Safeguarding Adults and Children Report
Executive Sponsor	Nina Morgan, Chief Nursing Officer
Author	Clare Baker, Lead Professional for Safeguarding
Attachment(s)	Safeguarding Adults and Children Report
Recommendation(s)	Trust Board is asked to **RECEIVE ASSURANCE** from the Safeguarding Report for Quarter 2 of 2020-2021

EXECUTIVE SUMMARY

The safeguarding report is presented in two parts, Childrens Safeguarding (part 1) and Adult Safeguarding (part 2)

Part 1 – Childrens Safeguarding – Quarter 2.

- The main category of reported abuse remains 'emotional abuse', reflecting the national trend in Childrens mental health.
- Childrens safeguarding training is above 95% compliance for levels 1 / 2 with Level 3 at 90.30% compliance (amber).

Part 2 – Adults Safeguarding – Quarter 2.

- The main categories remain neglect / self-neglect.
- CQC 'Must Do' action – MCA recording within Neuro services – compliance 89% at time of reporting.
- Adult safeguarding training compliance is above 95% for Level 1 and 92.48% for Level 2 (amber).

PREVIOUS DISCUSSIONS HELD

-

KEY IMPLICATIONS	
Financial	Potential need to review resource in relation to the rise in the demand for safeguarding investigations as themes emerge ie. domestic abuse.
Patients Safety or Quality	If staff are not appropriately training and do not adhere to legislation they will not be able to provide optimum care to patients.
Human Resources	Safeguarding supervision requirements are under review, to ensure time allocated sufficient to meet demand and ensure staff are supported in practice (resilience)

Operational	If staff are not supported with relevant training, policy's and guidance they will not be able to offer the optimum care to patients and may feel unsupported, which could impact on staff retention rates.

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

REPORT TO PUBLIC TRUST BOARD

28 JANUARY 2021

Safeguarding Adults & Children Report

1. Introduction

This University Hospitals Coventry and Warwickshire NHS Trust (UHCW) Safeguarding Report is to inform the committee on progress made in delivering the Safeguarding agenda during Quarter 2 2020. This report sets out the work carried out by Coventry University Hospitals NHS Trust adults, children's and midwifery safeguarding team. In addition this report will provide assurance that the Trust meets its statutory responsibilities in relation to safeguarding.

The safeguarding agenda has been steered and monitored internally via the Safeguarding Adults and Children Safeguarding Committee chaired by the Director of Nursing to promote safeguarding and standards of care for children, young people and adults wherever they access services within the Trust.

The Trust's Adult and Child Safeguarding Committee incorporates both the adult and children groups into one forum, which addresses the wider safeguarding agenda.

UHCW is represented at Safeguarding Board meetings in Coventry and Warwickshire by the Associate Director of Nursing for Quality and Patient Safety, and the Group Director of Nursing & Allied Health Professional for Women and Children. UHCW Safeguarding team also attends sub groups, committees and task and finish groups across the system.

The report will be presented in two parts, part 1 Safeguarding Children and part 2 Safeguarding Adults.

2. Part 1 - Safeguarding Children

Children are best protected when professionals are clear about what is required of them individually and how they need to work together. Safeguarding Children is defined in Working Together (2018) as:

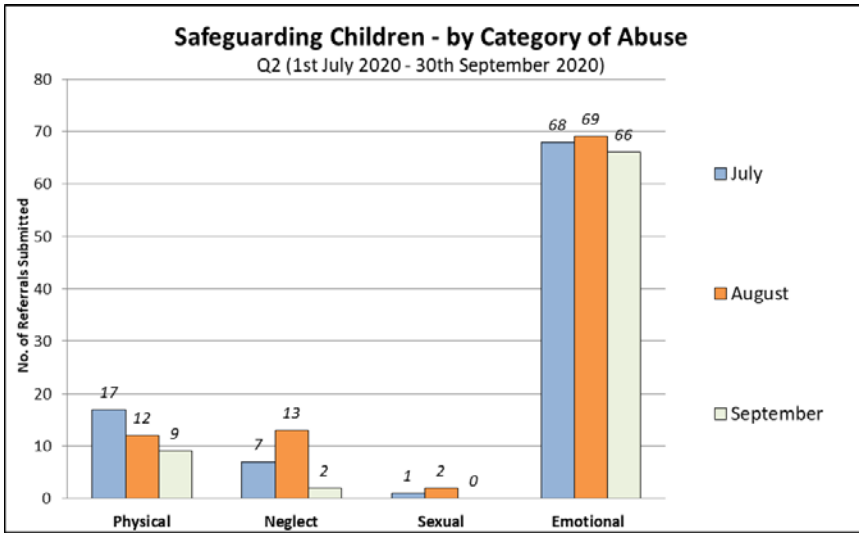
- Protecting children and young people from maltreatment
- Preventing the impairment of children's health and development
- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care
- Taking action to enable all children to have the best outcomes

3. Childrens safeguarding referrals Quarter 2 2020

The category of 'abuse' is the predominant reason for children's safeguarding referrals in Quarter 2 2020 with the main sub-category of 'emotional abuse' (Fig.1). This has been a common trend and has been identified in previous reports.

Emotional abuse is most commonly indicated by the behavioural issues and relates primarily to the large number of children and young people who are admitted to the paediatric wards following self-harm or suicidal ideation. Many of these children and young people are repeat attenders and often remain as an inpatient for a prolonged period due to specialist support being required such as tier 4 mental health placements

The Safeguarding Team regularly liaise with the Lead Nurse for Paediatrics and the Child and Adolescent Mental Health Service to review this cohort of patients and ensure that they are treated in the right place, receiving the right care and that they have appropriate support in the community. Paediatric services continue to escalate to Childrens Acute Mental Health Service using a RAG system to call for additional support when the service is at a peak in demand.



(Fig.1)

3.1 Safeguarding Children Training

During the reporting period Safeguarding Children training was delivered in accordance with the RCPCH Safeguarding Children & Young People Intercollegiate Document (March 2014).

Safeguarding Children training is provided in a number of ways:

- **Level 1** (all staff working in health care settings) is available via an e-learning package and through a workbook. Bespoke sessions are also delivered where required.
- **Level 2** (all non-clinical and clinical staff who have any contact with children/young people and/or their parents/carers) is delivered to all staff on induction and then there is an e- learning package that can be accessed for renewal as well as face to face training.
- **Level 3** (all clinical staff working with children, young people and/or parents/carers). This is delivered every 3 years to a multi-disciplinary group of identified staff cohorts via the local safeguarding board and in house facilitated sessions.

The content of training is under continuous review and currently includes;

- Female Genital Mutilation
- Domestic Violence and Abuse
- Child Sexual Exploitation
- Completion and appropriate use of Child Protection and Early Help referrals
- Parental behaviours - substance misuse, mental health.

The Safeguarding Team aim to facilitate individual training needs by offering a range of training methods as detailed below (Fig.2)

Competency	Training offered via
Safeguarding Children level 1	• Workbook • E-Learning via ESR • UHCW Bespoke face to face
Safeguarding Children level 2	• E-Learning via ESR • UHCA monthly face to face
Safeguarding Children level 3	• UHCW monthly face to face • Local Safeguarding Childrens Partnership training

Overall, compliance is as follows for the reporting period (Fig.3):

	% Compliant
Safeguarding Children level 1	**96.46%**
Safeguarding Children level 2	**95.35%**
Safeguarding Children level 3	**90.30%**

(Fig.3)

It is important to recognise that whilst the Safeguarding children level 3 is below the trust target of 95% the training has remained constant during quarter 2 despite restrictions on numbers for face to face training due to social distancing. Changes within the Children's Safeguarding team have also impacted the ability to deliver face to face training though e-Learning has been actively encouraged. It is expected that the training will return face to face in January 2021 when a new member of staff is in post, compliance remains above the CCG target of 90%.We aim to reach 95% compliance by August 2021.The Safeguarding team will provide information across the groups detailing the eLearning offer for level 3 until face to face can be re-established. Groups will be informed of their compliance and of any outstanding staff who are non-compliant. Staff will be informed individually of their requirement to undertake the training.

3.2 Childrens Safeguarding Practice Review

A Childrens Safeguarding Practice Review (CSPR) is commissioned where abuse or neglect is known or suspected and a child dies, or is seriously harmed and there are concerns about the way organisations or professionals worked together to safeguard the child. The case must meet the criteria set out in Working Together (2018). The table below illustrates the numbers of requests by local authorities to participates in these reviews(Fig.4);

	Scoping	Rapid Review	Serious Case review	Outcome
Warwickshire	10	10	3 Pending	No learning for UHCW NHS Trust
Coventry	5	0	1 Pending	No learning for UHCW NHS Trust

(Fig.4)

UHCW NHS Trust has participated in a total of fifteen scoping requests and attended ten rapid reviews. As a result of this UHCW is currently contributing towards four CSPR's, three are for Warwickshire families and one in Coventry. The Warwickshire cases are progressing and an individual management review has been submitted for one case, further guidance is awaited for the others.

UHCW were part of a review panel with Warwickshire Safeguarding Partnership which have published a report on 4th September 2020 following a serious case review. Below is a brief summary of the report:

Warwickshire Safeguarding Partnership Serious Case Review– 'Alice and Beth.'

The subjects of the review were sisters, Alice and Beth. Both girls attended UHCW Emergency department on different occasions and sadly died within two weeks of each other. The mother to both children is Clare; Clare was arrested and subsequently charged with the murder of both children. Clare was convicted of the murder of both Alice and Beth and is currently serving a term of imprisonment.

Whilst there were no learning recommendations for UHCW, the Safeguarding team have considered and reviewed the nine recommendations outlined in the report. Below are recommendations not to UHCW but are relevant when caring for individuals attending the Trust.

These are:-

- Encourage professionals to adopt an investigative, questioning and professionally curious approach when considering the history of a case

- Raise awareness with agencies that when making referrals to the MASH (Multi-agency Safeguarding Hub), they ensure that the referral accurately fully reflects the concerns of the referrer and that the MASH clarifies any information that is not clear
- Convey to professionals that they should adopt a healthily skeptical approach to developing a hypothesis and considering all alternatives, despite them being 'unthinkable'

The Childrens Safeguarding team provides Safeguarding Childrens training via e-learning and face to face which includes all aspects of the above recommendations. The Safeguarding team monitors referrals to MASH and contact the professionals completing the referral to offer support if this is not detailed enough for the MASH team. The Safeguarding team works very closely with MASH and will follow up any clarifications requested.

Following the COVID-19 pandemic there has been an increase in scoping activity which is predominantly requested by our Warwickshire partners. This is creating an additional workload for the Safeguarding Team. There does not appear to be any themes for this and there has been no learning outcomes specifically for UHCW but there is an expectation that this may continue as society returns to the "new normal" and remains under constant review.

4. Part 2 - Safeguarding Adults

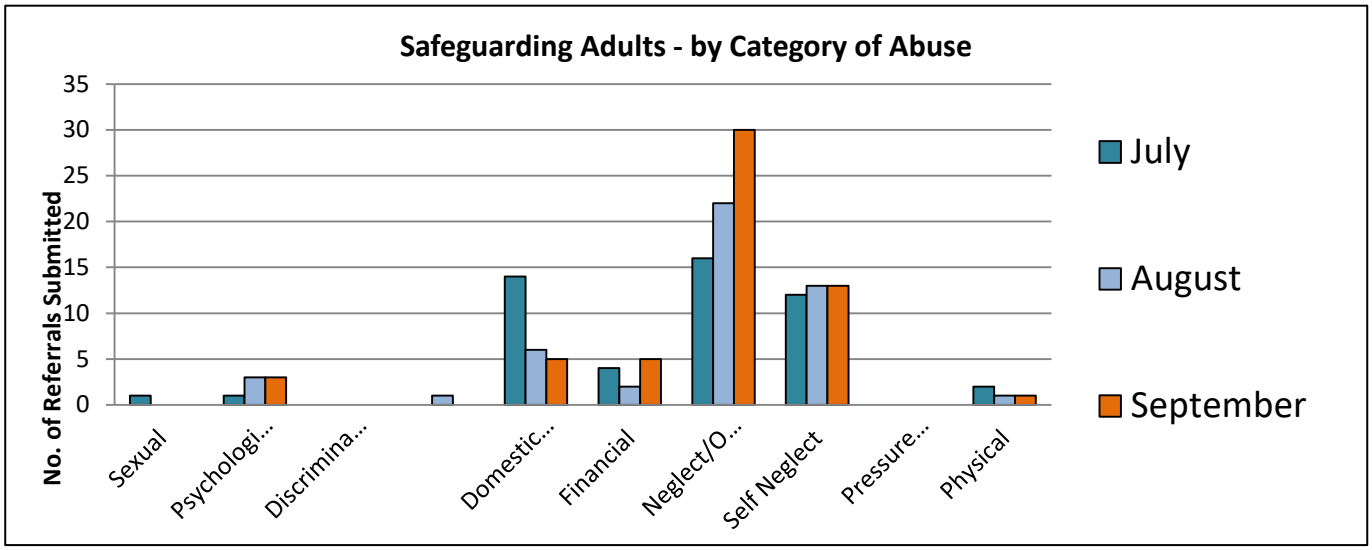
Adult safeguarding means protecting a person's right to live in safety, free from abuse and neglect. Six principles underpin all adult safeguarding work:

- Empowerment - personalisation and the presumption of person-led decisions and informed consent.
- Prevention - it is better to take action before harm occurs.
- Proportionality - proportionate and least intrusive response appropriate to the risk presented.
- Protection - support and representation for those in greatest need.
- Partnership - local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- Accountability - accountability and transparency in delivering safeguarding (*Care Act 2014)*

4.1 Adult Safeguarding Referrals

The predominant reason for UHCW referring to Adults Social Care has been due to concerns regarding both neglect and self-neglect (Fig. 5).

Many of the concerns do not require / trigger a full safeguarding enquiry but are managed as a care concern. Each referral is reviewed by a member of the Adult Safeguarding Team who will in turn seek out further information from the source of the referral in order to ensure the appropriate level of intervention is actioned. In addition to this they will also identify any areas of learning and support the individuals or teams to action this.



(Fig.5)

As these two key areas have been identified as the predominant reason for referral to adult safeguarding, training has provided an opportunity to explore this with UHCW staff. There are a number of strategy's within the hospital to support individuals who self-neglect, these include working closely with external agencies (i.e. Fire service/Age UK) and these more complex cases are used in training as examples of good practice.

Throughout quarter 2 there have been eight safeguarding concerns raised against the trust, 7 of which have been concluded and learning has been disseminated to the ward staff. The referrals were made by social care. When an investigation is indicated, the safeguarding adults lead will work alongside colleagues in social care to ensure the right outcomes are achieved for the patient. If the allegations of abuse relates specifically to care and treatment within the Trust, the safeguarding adults lead will contact the Ward Manager, Modern matron, Group Director of Nursing and Allied Health professionals and Clinical Director informing them of the allegation and supporting them with the investigation and ensure CCG and social care colleagues are updated. The Safeguarding team also attends case conferences with social care and the patient/next of kin present. This gives an opportunity for the patient or next of kin to share the impact on them following the concerns raised. This also allows an opportunity for any questions regarding the report which has been shared with them following an internal investigation. The Safeguarding team alongside ward staff and Modern Matron participate in the conferences to understand impacts on their patients and carers, and share the learning and service changes which have been implemented as a result.

The investigation of these cases has found that concerns raised relate to discharge and communication with family/care homes on discharge. UHCW has developed a Patient Flow Liaison officer role. Within this role the officer contacts the care home the day after discharge to discuss the discharge plan and confirm that this was actioned without any concerns. UHCW participates in a meeting twice weekly with CCG to discuss any concerns that care homes have raised in relation to discharge.
All direct learning is undertaken by clinical areas, who are accountable for monitoring their improvement against action plans, these actions are monitored by the Safeguarding team to ensure they are completed with oversight through the Safeguarding Committee.

4.2 Adult Safeguarding Training Compliance

Overall Safeguarding training compliance (Fig. 6) for the reporting period is as follows:

Safeguarding Adults level 1	**96.65%**
Safeguarding Adults level 2	**92.48%**

(Fig.6)

Training continues on e-learning currently and face to face training has been re-established though the team has had to decrease numbers due to social distancing. Safeguarding Adults level 2 meets the CCG target of 90% but is below the Trust target of 95%. This competence has the smallest cohort of staff and targeted work is being undertaken to address the compliance.

National Guidance from 2018 produced within Adult Safeguarding stipulated the requirement to introduce Safeguarding Adults level 3. To achieve compliance they are required to complete Adult Safeguarding Training Level 2, PREVENT and Mental Capacity Act (MCA) Training. The aim is to have achieved 90% by March 2021. Face to face MCA training has recommenced, a workbook has been developed by the adult safeguarding team and instruction on how to access e-learning has also been distributed. Due to limited access to rooms MCA training is also being offered via Microsoft teams, uptake for this training has been minimal but feedback is positive.

4.3 PREVENT Training

Prevent is one of the arms of the government's anti-terrorism strategy, it addresses the need for staff to raise their concerns about individuals being drawn towards radicalisation. Prevent training at UHCW forms part of the wider safeguarding agenda and encourages staff to view an individual's vulnerability as they would any other safeguarding issue. The training has been developed in accordance with the Prevent Training and Competencies Framework (2015). All staff groups require basic Prevent and all clinical staff are required to attend Workshops to Raise Awareness of Prevent (WRAP). This is being undertaken in a phased approach with agreement from the CCG.

During the reporting period the Trust worked towards achieving 95% compliance for all levels of Safeguarding training (Fig. 7). Each department and group is responsible for monitoring and maintaining training compliance for their staff groups. Training compliance is readily accessible for individual staff and managers to view by the electronic ESR reporting system.

PREVENT Awareness	**96.67%**
PREVENT WRAP	**97.63%**

(Fig.7)

4.4 Safeguarding Link worker Day

The Safeguarding team organised two Safeguarding link worker days, staff were invited from all wards to allocate an individual who has an interest in safeguarding. The agenda covered various aspects of safeguarding including hidden harm, mental capacity and alcohol and drug misuse. Speciality teams were invited to present on the day and feedback from evaluation forms found that the staff valued the information given to them from the Alcohol Liaison Team and St. Giles Trust. The St Giles Trust Intervention Service aims to support children and young people presenting to UHCW as a result of youth violence, exploitation, gang and/or county line related activities. Feedback from the day was very positive; the Lead Professional for Safeguarding alongside the Named Nurse for Safeguarding Adults attended the day to introduce themselves. The Safeguarding link workers were asked to audit their areas on a monthly basis to identify one patient on the ward whom there was reason to doubt capacity and review the notes to ascertain if documentation was completed correctly. They were then asked to feed this back to the Safeguarding team and their line manager so any themes could be discussed and action plans implemented. The Safeguarding team have also agreed to meet with the Safeguarding link workers in their work areas monthly for a supportive discussion.

4.5 Serious Adult Reviews

A Serious Adult Review is commissioned when an adult experiencing abuse or neglect dies, or when there has been a serious incident, or in circumstances involving the abuse or neglect of one or more adults.

The purpose of an SAR is to:

- Learn from cases where there are clear concerns that agencies have not worked as well together as they might; and which demonstrate areas of practice that could have been delivered more effectively and additionally
- Consider whether or not serious harm experienced by an adult, or group of adults at risk of abuse or neglect, could have been predicted or prevented, and use that consideration to develop learning that enables agencies to improve its services and prevent abuse and neglect in the future
- Agree how this learning will be acted on, and what is expected to change as a result
- Identify any issues for multi or single agency policies and procedures

There are currently no serious adult reviews for Coventry Safeguarding Adult Board but UHCW are contributing towards one review being co-ordinated by Warwickshire Safeguarding Partnership. Initial scoping has been submitted for all of the cases and two rapid reviews have taken place. There are no learning points that have been highlighted for UHCW.

The table below illustrates the numbers of requests by local authorities to participate in these reviews (Fig.8);

	Scoping	Rapid Review	Serious Case review	Outcome
Warwickshire	5	1	0	No learning for UHCW NHS Trust
Coventry	N/A	N/A	N/A	N/A

(Fig.8)

UHCW were part of a review panel with Warwickshire Safeguarding Partnership which have published a report in September 2020 following a SAR, this case is historical dating back to 2018. Below is a brief summary of the report :-

Warwickshire Safeguarding Partnership Serious Adult Review– 'Peter'

Peter suffered from a complex series of conditions contributing to poor overall health coupled with self-neglect which can be difficult to manage. Peter's family would describe him as an alcoholic and he had been like this for as long as they could remember. Peter was also an Insulin dependent diabetic who was known not to take his insulin on occasions.

In April of 2018 Peter was admitted to UHCW and treated for Chronic Pancreatitis. Following the acute treatment for his condition he was transferred to Rugby St. Cross for further care and discharge planning.

He was discharged from Rugby St. Cross on the 6th June to temporary accommodation; the room in the temporary accommodation had no fridge or cooking facilities. On 23rd June Peter's son could not gain access to his room, he sought the assistance of the hotel staff and sadly found that Peter had passed away.

There were three learning recommendations outlined in the report specifically for UHCW, the Safeguarding team have considered and reviewed these:-

- University Hospital Coventry and Warwickshire NHS Trust should review their discharge procedure to ensure that all relevant health professionals are involved in the discharge plan and that the patient, and if relevant families and carers, are aware of the plan and support to be provided or available.
- University Hospital Coventry and Warwickshire NHS Trust should review the process for allocation of district nursing support to ensure that where this is required it is delivered and the request is appropriately recorded
- University Hospital Coventry and Warwickshire NHS Trust should ensure that where intervention is given for alcohol misuse, that on discharge support services are identified in the community.

The Intergrated Discharge Team shared learning across the organisation during board rounds and timely referrals to district nursing services was highlighted as a priority when planning discharge. A seven minute guide was disseminated to staff which provided information and guidance when considering discharge of a patient who is known to self-neglect.

There is a greater understanding between the hospital team and social care in regards to referral of patients with needs who have an alcohol dependency. Since this case no such referrals to social care have been declined.

There is now an allocated housing officer from the local authority for patients at Rugby St Cross who works closely with the discharge team, an holistic assessment is undertaken to ensure that the patients' needs are identified and suitable accommodation found. Patients with alcohol dependence are offered referral to the community alcohol service

4.6 Domestic Homicide Reviews

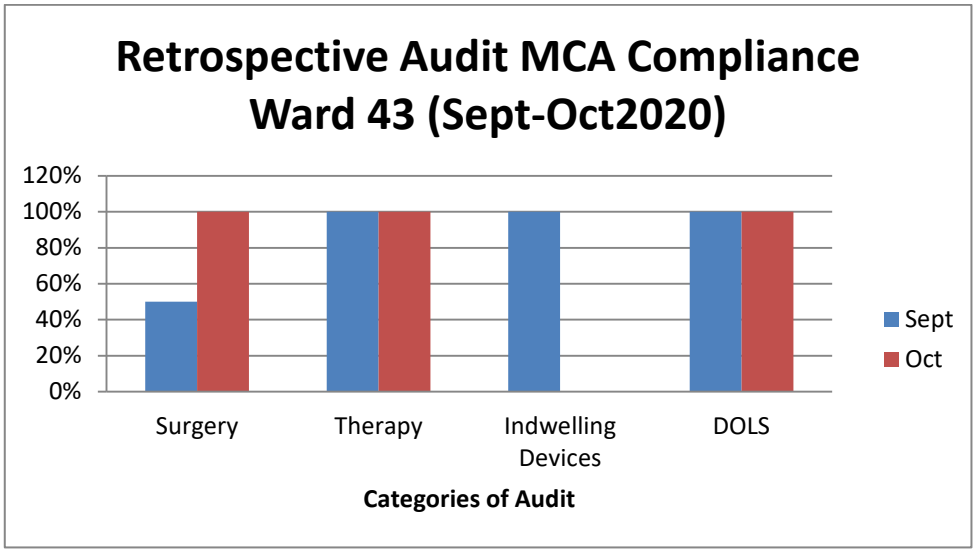
UHCW have received a request to participate in the scoping of one domestic homicide review during the period reported.

4.7 UHCW CQC Report (Feb 2020) – 'must do' action

Following a CQC inspection at UHCW the Neurosurgery group were given 'must do' actions. "*The service must ensure all patients who may lack capacity to consent to routine care and/ or treatment are appropriately assessed in all instances, and that this assessment is recorded within patient records*"

Retrospective monthly audits have been established by the Safeguarding team on ward 43. The Safeguarding team publish the results to the triumvirate; they are also shared with the therapists as one of the categories directly relates to them. This audit reviews if mental capacity assessments are completed and documented correctly. It is divided into 6 separate categories which are audited, ResPect forms, surgery, invasive procedures, indwelling devices, therapy and DoLs.

Below (Fig.9) is a graph displaying the results of the retrospective audits for September and October 2020:-



(Fig.9)

The results of the audits are shared with the triumvirate as well as professionals with lead roles within Neurosurgery. The results are also discussed at the ward safety huddles and production board which is led by the ward manager. Consent for surgery was 50% in September, on previous audits this was not a usual finding within this category. The Safeguarding team provided further training at board rounds regarding use of documentation when obtaining consent of a patient for surgery. The audit in October found this had improved to 100%. The safeguarding team has implemented monthly supportive sessions on ward 43 to meet with staff members to discuss effective and relevant use of mental capacity assessments.

Conclusion

The Safeguarding Team continues to raise the profile of safeguarding through visibility in the clinical areas and campaigns such as domestic abuse awareness. Some challenges persist in relation to training compliance; this has been impacted due to restricted face to face training due to COVID. The report overall this month is positive with three of the five safeguarding training competences meeting the Trust target of 95% and all achieving the CCG target. Work regarding the understanding and adherence to the Mental Capacity Act trust wide continues.

Author: Clare Baker
Title: Lead Professional for Safeguarding
Date: 29.12.2020

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 28 JANUARY 2021

Subject Title	Integrated Care System Update
Executive Sponsor	Justine Richards, Chief Strategy Officer
Author	Jamie Deas, Director of Strategy and Integration
Attachments	Integrated Care System Update
Recommendations	Trust Board is asked to **RECEIVE ASSURANCE** from the report

EXECUTIVE SUMMARY

- This paper focuses on the NHSEI paper "Integrating Care: Next Steps to Building strong and effective integrated care systems across England" that sets out the strategic and operational direction of system working, underpinned by detailed policy and legislative proposals.
- The paper is positioned to open up a discussion about how ICSs could be embedded in legislation or guidance and for this to be implemented from April 2022.
- The key components of the future model of ICSs are place-based partnerships, provider collaboratives, clinical and professional leadership, good governance and accountability, a robust financial framework, supportive regulation and oversight from the centre and a radically transformed approach to commissioning.
- The above areas are explored in more detail in this report.
- The paper proposes two options for how to ICSs could be enshrined in legislation these being a statutory ICS board/joint committee with an accountable officer (AO) or a statutory ICS body.
- In terms of the two proposed legislative options outlined in the document the Trust believes that Option 2 is the preferred option and has responded to the online survey conducted by NHSEI around this matter accordingly.
- In relation to the establishment of the ICS for Coventry and Warwickshire, the Coventry and Warwickshire Health Care partnership (HCP) submitted an ICS designation application to NHSEI in December for approval.
- This document sets out the HCPs self-assessment of readiness to operate as an ICS, the key priorities for the ICS, the governance arrangements and how it will be organised.

  The application will be considered by both the regional and national teams in Late January/Early February prior to a decision to enable the establishment of the ICS by April 2021.

PREVIOUS DISCUSSIONS HELD

- ICS development is regularly covered in the Strategy and Partnerships Board Report.

KEY IMPLICATIONS

Financial	In the proposed ICS models, finances will be system and place based
Patients Safety or Quality	All new proposed pathway redesigns will be clinically led with patient safety and quality as the primary focus
Human Resources	All new proposed pathways will require detailed workforce plans
Operational	All new proposed pathway redesigns will require detailed operational delivery plans

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

REPORT TO PUBLIC TRUST BOARD

Integrated Care System Update

1. BACKGROUND

1.1 On 26 November 2020, NHS England and NHS Improvement (NHSEI) set out guiding principles for the future of integrated care systems (ICSs) in England and outlined two proposals for how ICSs could be embedded in legislation by April 2022, subject to parliamentary decision.

1.2 This paper summarises these principles and proposals, what they might mean to the Trust and provides an update on progress made by the Coventry and Warwickshire Healthcare Partnership in its preparation for ICS status.

2. INTEGRATING CARE: NEXT STEPS TO BUILDING STRONG AND EFFECTIVE INTEGRATED CARE SYSTEMS ACROSS ENGLAND

2.1 The NHSEI paper "Integrating Care: Next Steps to Building strong and effective integrated care systems across England" sets out the strategic and operational direction of system working, underpinned by detailed policy and legislative proposals. The paper is positioned to open up a discussion about how ICSs could be embedded in legislation or guidance and for this to be implemented from April 2022.

2.2 NHSEI states that its proposals on the future of ICSs are designed to serve four fundamental purposes:

- Improving population health and healthcare;
- Tackling unequal outcomes and access;
- Enhancing productivity and value for money;
- Helping the NHS to support broader social and economic development.

2.3 This will be achieved by embracing three principles taken from the NHS Long Term Plan: decisions taken closer to communities; collaboration between partners at place; and collaboration between providers.

2.4 The following section outlines the key components of the proposals and what this may mean for the Trust.

2.5 **Place-based partnerships.**

2.6 The paper introduces a key role at Place it describes as the "Place Leader". The place leader will work with partners such as the local authority and voluntary sector in an inclusive, transparent and collaborative way. Their four main roles will be to: support and develop primary care networks (PCNs); simplify, modernise and join up health and care; use population health management and other methods to identify at-risk communities; and coordinate the local contribution to health, social and economic development. The exact division of responsibilities between system and place should be based on the principle of subsidiarity.

2.7 We have been explicit with partners and commissioners that we see UHCW as the lead provider for Coventry and Rugby place and as such would have a key leadership role for both Places. This would enable us to more effectively vertically integrate our long term condition pathways such as diabetes, COPD, Heart Failure etc. through alignment to Primary Care Networks via Out of Hospital services (currently sitting with CWPT); and to build on our position as an anchor organisation within Coventry and Warwickshire.

2.8 **Provider Collaboratives**

2.9 Providers will play an active and strong leadership role, joining up the provision of services within and between places. All NHS provider trusts will be expected to be part of a provider collaborative. Further guidance on provider collaborative models will be published in early 2021.

2.10 We are keen to understand further the role that the Provider Collaborative will play and the form it will take in the ICS and look forward to NHSEIs guidance in this. Ensuring we play a leading role in shaping the work of the provider collaborative is critical to delivering our horizontal integration and tertiary strategies.

2.11 **Clinical and professional leadership.**

2.12 Primary care clinical leadership will be expressed at neighbourhood (PCN) level, at place, and there will be a primary care perspective at ICS level. Specialist clinical leadership will be present in both ICSs and horizontal provider collaboratives. At ICS and collaborative level, clinical networks should be able to undertake clinical service reviews and develop recommendations for the ICS and collaborative. The Clinical Forum has a key role here to form the clinical system voice that transcends organisational boundaries and is a key enabler to inform a clinically led view of transformation for the system.

2.13 **Governance and accountability**

2.14 The document commits to mutually agreed governance arrangements, including the partnership board. The NHS, local government and other partners will have collective responsibility and decision-making in assurance, planning and improvement and financial governance. The system must also define leadership, governance and accountability arrangements for place, which should involve: “at a minimum primary care providers leadership, local authorities, including the Director of Public Health and providers of community and mental health services and Healthwatch; agreed decision-making arrangements with local government; and representation on the ICS board.”

2.15 **Financial framework**.

2.16 NHSEI will increasingly organise the finances of the NHS at ICS level and put allocative decisions in the hands of local leaders. A ‘single pot’ will be created, bringing together different funding streams, including current CCG commissioning budgets, primary care budgets, the majority of specialised commissioning spend, central support or sustainability funding and nationally-held transformation funding allocated to systems. “Decisions about the use of all these budgets will usually be made at the lowest possible level, closest to the communities they serve and in partnership with their local authority”. Increasingly, funding will focus more on outcomes than activity.

2.17 **Regulation and oversight**.

2.18 NHSEI recognises that regulation needs to adapt, with more support from national regulators for systems and the individual organisations within them, and a shift in emphasis to reflect the importance of partnership working. Practical steps it can take to support systems include issuing guidance under the NHS provider licence that good governance for providers includes a duty to collaborate; and ensuring foundation trust directors’ and governors’ duties to the public support system working.

2.19 This will provide incentives for greater collaboration between NHS providers and is an enabler to the realisation of our strategy.

2.20 **How commissioning will change.**

2.21 The activities, capacity and resources for commissioning will change in three significant ways in the future. First, there will be a single, system-wide approach to undertaking strategic commissioning. Second, provider organisations and others (through partnerships at place and in provider collaboratives) will become a principal engine of transformation. And third, there will be a greater focus on population health and outcomes in contracts and the collective system ownership of the financial envelope.

2.22 This will require us to expedite our approach to the utilisation Public Health Management Informatics and focus more on the prevention agenda.

2.23 To facilitate these changes the paper outlines two options to enshrine ICSs in legislation:

2.24 **Option 1:** a statutory ICS board/joint committee with an accountable officer (AO). This would establish a mandatory, rather than voluntary, statutory ICS board through the mechanism of a joint committee and enable NHS commissioners, providers and local authorities to take decisions collectively. An AO would not replace individual organisation AOs/chief executives but would be recognised in legislation and would have duties in relation to delivery of the board's functions. One aligned CCG per ICS footprint and new powers would allow that CCGs are able to delegate many of their population health functions to providers.

2.25 **Option 2:** a statutory ICS body. ICSs established as NHS bodies partly by "re-purposing" CCGs, taking on the commissioning functions of CCGs. CCG governing body and GP membership model would be replaced by a board consisting of representatives from system partners. As a minimum, this would include representatives of NHS providers, primary care and local government alongside a chair, a chief executive and a chief financial officer. The power of individual organisational veto would be removed and the ICS chief executive would be a full-time AO role.

2.26 From a UHCW perspective Option 1 being essentially the "as is" model but with a provider or CCG CEO/AO lead as the system Accountable Officer does not go far enough in providing the levers or incentives to achieve system change .

2.27 This is because the retention of individual organisational duties and autonomy presents a barrier to achieving true integration in that the power of individual organisational veto would remain. The reliance on collective responsibility to deliver the transformation required to achieve population health outcomes is a significant risk in a developing partnership. There is also the risk in this option that with one individual holding the role of AO for the system and retaining their own lead role for their organisation, that there is a real or perceived conflict of interest that will impede progress – either with UHCW or another organisation in this role.

2.28 Option 2 however enables a provider agnostic model with all NHS providers (with a primary care representative as an equal partner rather than the governing body) and local authorities being represented on the statutory board with a full time independent CEO, Chair and CFO.

2.29 In this model the ICS can delegate responsibility for the organisation and delivery of services to providers, thus removing competition, and creating greater scope and incentives for provider collaboration to use whole-population budgets to drive care pathway transformation, system integration and promote the prevention agenda.

2.30 In terms of the two proposed legislative options outlined in the document we agree with NHSEI that Option 2 is the preferred option and have responded to the online survey conducted by NHSEI around this matter accordingly.

2.31 There is an expectation that all STP areas in England will become ICSs as from April 2021.

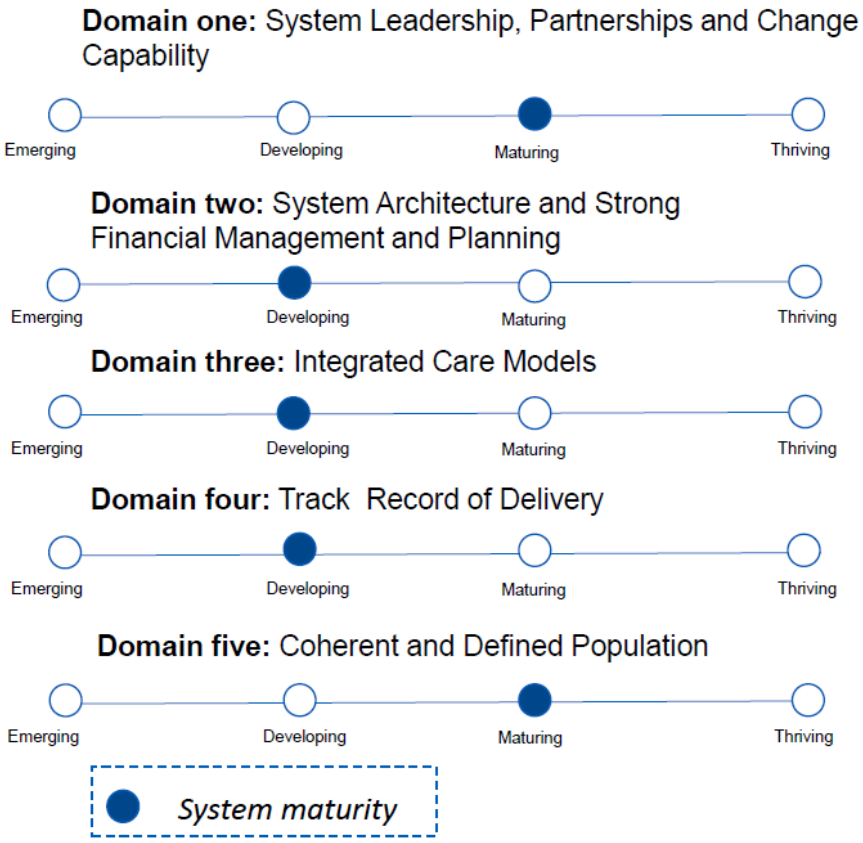
3. COVENTRY AND WARWICKSHIRE INTEGRATED CARE SYSTEM

3.1 SUBMISSION

3.2 As set out in the NHS Long Term Plan, there is a requirement for all systems to become Integrated Care Systems by April 2021. All systems were required to undertake an assessment of their readiness for ICS designation and to apply for ICS designation to enable STPs to begin operating as ICSs in line with the LTP requirement.

3.3 In December 2020 the Coventry and Warwickshire Health Care Partnership (HCP) submitted its ICS designation application to NHSEI. This will be considered by NHSEI at both regional and national level to determine suitability for ICS designation and the level of support required to facilitate the transition.

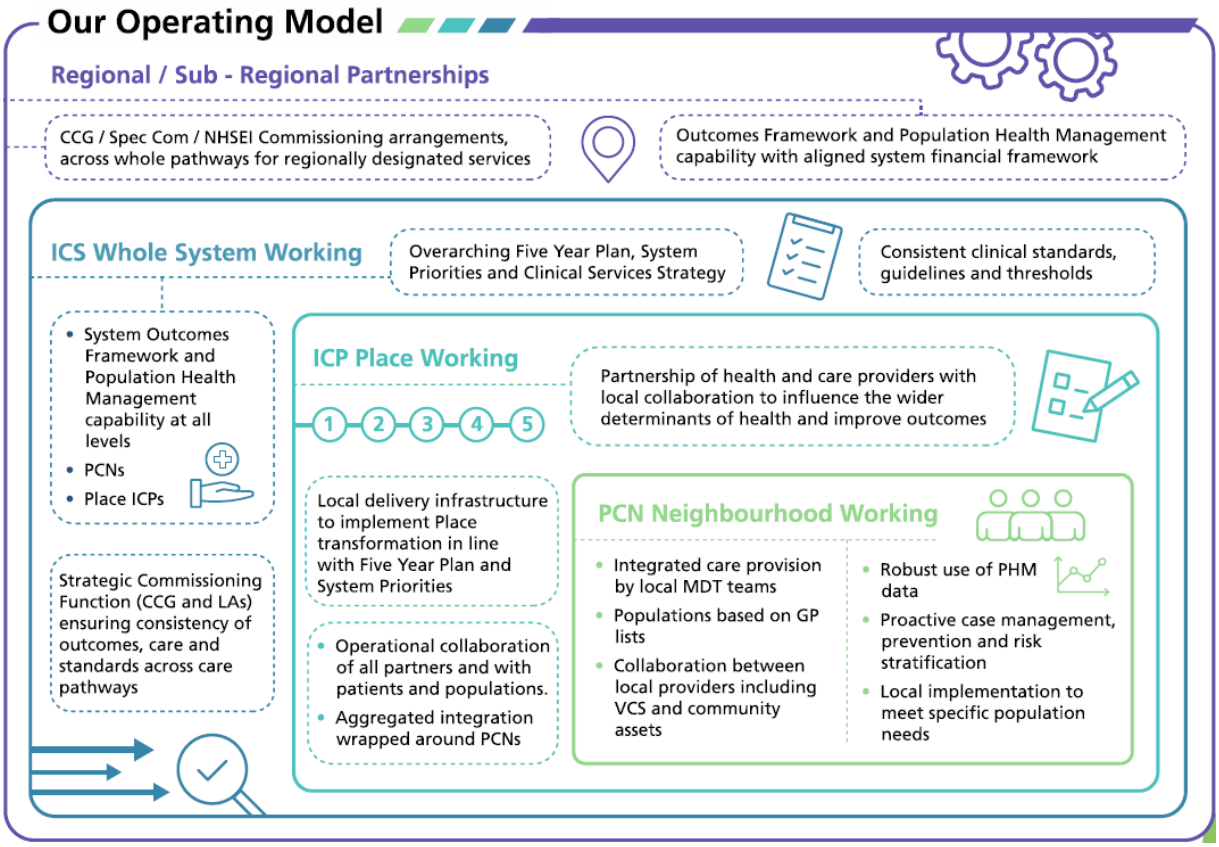
3.4 The HCPs self-assessment of readiness to operate as an ICS is based around five core domains utilising a maturity matrix that defined system maturity for each domain as emerging, developing, maturing or thriving. The graphic below shows the HCP assessment for each domain:



3.5 The application outlined the key priorities of the HCP as follows:

- To accelerate preventative programmes and activities that target those at greatest risk, e.g. pre rehabilitation, mental health programmes
- To work together, as partners, at system and Place to identify and address health inequalities and variations in health and care provision
- To protect the most vulnerable, ensuring inclusivity runs though everything we do
- To focus our delivery on Place based care, supported by strong, well developed PCNs
- To successfully manage urgent emergency care (UEC), particularly winter pressures (including Flu) alongside managing a second Covid 19 surge (including Covid 19 vaccination and mass testing)
- To restore elective care to 'better than' pre Covid levels, with particular focus on long waiters, cancer and diagnostics
- To care for and develop our workforce ensuring they continue to have the resilience and support to deliver the best care to our patients and communities particularly our
- BAME employees
- To maximise all enablers that support us deliver our Five Year Plan commitments e.g. digitally enabled care
- To 'live within our means' and become financially sustainable

3.6 To deliver the priorities outlined above The diagram below illustrates the four levels of the ICS operating model from Primary Care Network neighbourhood level, to place, to system and up to the regional level for specialist pathways and services:



3.7 The application will be considered by both the regional and national teams in Late January/Early February prior to a decision to enable the establishment of the ICS by April 2021.

4. RECOMMENDATION

4.1 The Trust Board is asked to **RECEIVE ASSURANCE** from the report

Author Name: Jamie Deas

Author Role: Director of Strategy and Integration

Date report written: 18 January 2021

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
28 JANUARY 2021

Subject Title	Patient Experience and Engagement: We Care Patient Experience Report Quarter 3 (2020 - 2021)
Executive Sponsor	Mo Hussain, Chief Quality Officer
Author	Sam Caton, Head of Patient Relations
Attachments	Patient Experience and Engagement: We Care Patient Experience Report Quarter 3 (2020 - 2021)
Recommendation (s)	Trust Board is asked to **RECEIVE ASSURANCE** from the quarterly report

EXECUTIVE SUMMARY

Patient Experience and Engagement (2020-2021) Quarter 3 Report

Improving the experience of each individual patient is at the centre of the NHS Constitution. Obtaining feedback from patients and taking account of their views and priorities are vital for the delivery of high quality services and for driving real service improvements. This summary provides an overview of progress on the Patient Experience and Engagement objectives for University Hospitals Coventry and Warwickshire NHS Trust as part of the current Quality Strategy 2016 – 2021.

Objective one
(Improve the way we listen, respond and use patient feedback to support improvements)

To support the delivery of this objective the Trust employs a Patient Advice and Liaison Service (PALS), Complaints Team and feedback mechanisms facilitated by the Patient Insight and Engagement Team.

Thinking of You: Changes in visiting due to COVID 19 resulted in many relatives and visitors unable to contact their loved ones, and vice versa. Recognising the importance for patients to stay in touch with friends and family outside of hospital they were invited to send a letter and photos to loved ones on our wards via 'Thinking of You' by completing a simple form on the Trust's website. To date we have processed 2,263 individual 'Thinking of You' requests an increase of 359 from Quarter 2.

Patient Connect: In light of restrictions to visiting put in place during Covid-19 Virtual Visiting was introduced. This enhances the opportunity for communication enabling families to keep in touch virtually with loved ones via ipads**.**

Complaints: The Trust received 101 complaints in Quarter 3 (99 in Quarter 2) and responded to 100% within 25 working days. The performance indicator is 90% within 25 working days.

In Quarter 3 the Trust received 14 requests for further resolution of complaints (FLR) (21 received in Quarter 2 2020-21 a reduction of 34%). The Trust received an average of 32 requests for further resolution of complaints in 2019-2020. The Trust received 7 Parliamentary and Health Service Ombudsman (PHSO) cases in Quarter 3, a rise of 1 from Quarter 2.

Primary themes: Of complaints received in Quarter 3, communication, specifically communication with the patient relatives and carers remains the primary theme of all complaints received. An

example of which, *'communication, I can't emphasise the importance of this enough. Each day, twice a day, my mother called. Most days the communication she got was minimal, occasionally she'd speak to one of the 'nice nurses' or a physio would have more to say. I phoned once and spoke to an ITU consultant. She was very good and explained things in detail but that was the one and only medical call we received. Most hand overs were 'he's not eating much' and that'd be it. The communication was very poor overall. In a time of no visiting it was unbearable. I can only hope that now we are entering the second lockdown this communication has improved through feedback'.*

Learning: As a result of the complaint the Ward Sister has spoken with her Team and used this feedback as an example of the importance of communication. During the first Covid-19 lockdown the use of Ipads for Facetime were sourced enabling communication channels to be kept open between patients and their relatives.

Visiting has been introduced in the Cardiothoracic Critical Care Unit for long term patients. This has to be limited to one family member and once a week. Consultants now make a point of telephoning family members at home to give updates. If there are more sensitive issues to discuss then arrangements are made for a family member to attend so a more personal conversation can be held. One of the overnight rooms that are off the unit has been adapted into a relative's room to support the improvement of communication.

Values and behaviour, specifically attitude of medical and nursing/midwifery has re-entered the top 5 themes. Admissions, discharges and transfers have entered the top 5 themes, specifically discharge arrangements, including lack of, or poor planning. Attitude of Nursing And Midwifery staff also entered the top 5 which should be seen alongside communication issues identified above.

How do we communicate themes: Complaint Officers meet group representatives weekly and themes and escalations of concerns are shared. Themes are also communicated to groups via monthly Quality Improvement Patient Safety meetings (QIPS) and other committees, such as the Nursing and Midwifery Committee and the Hospital of St Cross Quality meeting. Emerging and or immediate action themes are escalated in real time.

Responsiveness in action: Through the Patient Advice and Liaison Service and Complaints Team an emerging theme of patient property issues was identified. This was quantified and escalated to key stakeholders. Following escalation, the Head of Patient Relations in partnership with the Kaizen Promotion Office (KPO) have begun an improvement project with support from stakeholders involved throughout the patient journey.

Patient Advice and Liaison: The Patient Advice and Liaison Service processed 830 enquiries in Quarter 3, managing 90% of enquiries within 5 working days. The performance indicator is 90% within 5 working days.

Primary themes: Enquiry themes remain static from Quarter 2. Communication, specifically communication with patients and their relatives, remains the top subject for PALS enquiries from the previous Quarter and mirrors primary complaint themes. Appointments remain the second highest theme, specifically appointment delay and availability. Trust administration, specifically general administration issues, access to health records and complaint handling is the third most enquired about theme followed by facilities, specifically parking and cleanliness. Values and behaviour of staff remains static at number 5.

Compliments and Thanks: 248 Compliments and Thanks were received in respect of Trust services in Quarter 3, an increase of 35% from Quarter 2. Of particular note were 107 positive comments received for the Bowel Cancer Screening Service based at the Hospital of St Cross, which was mirrored in both Quarter 1 and 2 data. Ward 43 – Neurosurgery received the second highest number of compliments and thanks (24). Speciality Groups are able to view their compliments via Datix dashboards and monthly QIP reports.

Objective two
(Improve the way we develop and manage patient information leaflets)

The Trust utilises a Patient Virtual Panel which consists of over 150 people within the local community who are available to comment and provide feedback on information created for patients.

During Quarter 3, 131 leaflets were updated and 38 new leaflets were uploaded. The Trust achieved 98.0% compliance for all Patient Information leaflets. 425 queries were received and responded to during Quarter 3. This information is available live on 'Insite' (workforce and information metrics).

Objective three
(Ensure our staff place Trust values at the centre of care improvements)

To support the delivery of this objective patient feedback from the National Survey Programme provides an insight into how our staff are living the Trust values. Surveys allow patients the opportunity to give area specific feedback to outside parties who then provide recommendations to the Trust.

Adult Inpatient 2019 Survey: the Trust drew a sample in December 2020 and fieldwork commenced in January 2021, which will end in May 2021.

The Urgent and Emergency Care Survey: the Trust drew samples in October 2020 and fieldwork has been underway since October 2020 and will continue to March 2021.

The Children and Young People's Patient Experience Survey: the Trust will draw samples in January 2021 with proposed fieldwork commencing February 2021 – June 2021.

Objective four
(Ensure that patient voice is at the centre of care improvements)

Involvement hubs: The system wide response to Covid-19 has resulted in altered delivery of patient involvement activity. The involvement kiosks at University Hospital were switched off to minimise the spread of infection from touch screen use. A kiosk at the Hospital of St Cross will be installed within the Outpatients Department when the restriction on use is lifted.

Patient partners: During Quarter 3 much of the Patient Partner Activity was stood down although some activity continued virtually. The second Patient Partner Forum meeting for this financial year took place virtually on 28 October 2020. The meeting discussed how to progress the work plan and how Patient Partner roles will differ from Volunteers. The Patient Partner Programme is currently in the process of restructuring with new activities and recruitment planned in the coming months, once detail of the role has been confirmed and approved.

Friends and Family Tests (FFT): In Quarter 3 the Trust received 12,339 responses, 89% were positive remaining static from Quarter 2.

Objective five
(Improve the patient care environment)

Board Walk Rounds were reinstated in Quarter 3, which took place virtually in Quarter 3. A virtual walk round of the Mortuary took place on 16 November 2020 and Ophthalmology Clinic 9 on 3 December 2020.

Tackling Racial Inequality: The Patient Insight and Involvement Team will engage the public in relation to the Trust's commitment to tackle racial inequality. Plans are being put in place to engage

with our communities around this issue.

PREVIOUS DISCUSSIONS HELD

KEY IMPLICATIONS

Financial	Delivery of value for money
Patients Safety or Quality	To create a high quality patient experience
Human Resources	None
Operational	Operational performance

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

REPORT TO PUBLIC TRUST BOARD HELD ON

28 JANUARY 2021

WE CARE: PATIENT EXPERIENCE AND ENGAGEMENT REPORT QUARTER 3 2020 - 2021

JANUARY 2021

1.0 Background

Improving the experience of each individual patient is at the centre of the NHS Constitution. Obtaining feedback from patients and taking account of their views and priorities are vital for the delivery of high quality services and for driving real service improvements. This report will provide an overview of progress on the Patient Experience and Engagement objectives for University Hospitals Coventry and Warwickshire NHS Trust.

For context, as a result of the National and Trust response to COVID-19 aspects of the Patient Experience and Engagement objectives of improvement have been altered, and are identified within the report, where applicable.

2.0 Objective One: Improve the way we listen, respond and use patient feedback to support improvements.

To support the delivery of this objective the Trust employs a Patient Advice and Liaison Service (PALS), Complaints Team and feedback mechanisms facilitated by the Patient Insight and Engagement Team.

2.1 **Thinking of You:** Changes in visiting due to COVID 19 resulted in many relatives and visitors unable to contact their loved ones, and vice versa. Recognising the importance for patients to stay in touch with friends and family outside of hospital they were invited to send a letter and photos to loved ones on our wards via ‘Thinking of You’ by completing a simple form on the Trust’s website. To date we have processed 2,263 individual ‘Thinking of You’ requests an increase of 359 from Quarter 2 although the number received each week is reducing.

2.2 **Patient Connect:** Trust virtual visiting was introduced following changes to patient visiting to further enhance the opportunity for communication, providing comfort to those whose loved ones are no longer able to visit our hospitals.

The initiative has been implemented with support from University Hospitals Coventry and Warwickshire NHS Trust Charity to ensure that two dedicated iPads were delivered to each of our wards. FaceTime, Skype and Microsoft Teams were set up on each device.

2.3 **Complaints:** The Trust received 101 complaints in Quarter 3 (99 in Quarter 2) and responded to 100% within 25 working days. The performance indicator is 90% within 25 working days.

In Quarter 3 the Trust received 14 requests for further resolution of complaints (FLR) (21 received in Quarter 2 2020-21 a reduction of 34%). The Trust received an average of 32 requests for further resolution of complaints in 2019-2020. The Trust received 7 Parliamentary and Health Service Ombudsman (PHSO) cases in Quarter 3, a rise of 1 from Quarter 2.

Primary themes: Of complaints received in Quarter 3, communication, specifically communication with the patient relatives and carers remains the primary theme of all complaints received. Clinical treatment within the Surgical and Medicine Groups, specifically delays in treatment remain the second and third most complained about subjects. Values and behaviour, specifically attitude of medical and nursing/midwifery has re-entered the top 5 themes. Admissions, discharges and transfers have entered the top 5 themes, specifically discharge arrangements, including lack of, or poor planning.

2.4

	Top 5 Primary themes for Complaint Cases received in quarter 3	Top 3 themes for quarter 3 as a breakdown of primary theme	Position of subjects in Q2 2020-21
1st	Communications	Communication with patient	1st
		Communication with relatives/carers	
		Delay or failure in treatment or procedure	
2nd	Clinical Treatment - General Medicine Group	Delay in treatment	2nd
		Delay or failure to diagnose (inc e.g. missed fracture)	
		Delay or failure to follow up	
3rd	Clinical Treatment - Surgical Group	Delay or failure in treatment or procedure	3rd
		Other - Clinical Treatment	
		Delay or failure to follow up	
4th	Values and Behaviours (staff)	Attitude of Medical Staff	Did not appear
		Attitude of Nursing Staff/midwives	
		Other - Values & Behaviours	
5th	Admissions, Discharges & Transfers (excl delayed discharge due to absence of care package - see Integrated care)	Discharge Arrangements (inc lack of or poor planning)	Did not appear
		Delay in discharge awaiting medication	
		Discharged too early	

2.5 **Complaint example (Communication failure)**: *'My father was admitted on X for a valve repair. My mother visited him for one hour on 21st and then lockdown started and no one saw him again until the day before he died when he was unconscious'.* The complainant explained, *'communication, I can't emphasise the importance of this enough. Each day, twice a day, my mother called. Most days the communication she got was minimal, occasionally she'd speak to one of the 'nice nurses' or a physio would have more to say. I phoned once and spoke to an ITU consultant. She was very good and explained things in detail but that was the one and only medical call we received. Most hand overs were 'he's not eating much' and that'd be it. The communication was very poor overall. In a time of no visiting it was unbearable…"*

To respond to the needs of patients and meet the demands on the service there was an increased number of patients admitted to the Cardiothoracic Critical Care Unit

(CTCC). Staff assumed the night shift had contacted the family and asked them to come in which was not the case.

Actions/Learning:

A) As a result of the complaint the Ward Sister has spoken with her Team and used this feedback as an example of the importance of communication.

B) During the first Covid-19 lockdown the use of Ipad's for Facetime were sourced enabling communication channels to be kept open between patients and their relatives.

C) Visiting has been introduced for the CTCC long term patients. This has to be limited to one family member and once a week.

D) Consultants now make a point of telephoning family members at home to give updates. If there are more sensitive issues to discuss then arrangements are made for a family member to attend so a more personal conversation can be held. One of the overnight rooms that are off the unit has been adapted into a relative's room to support the improvement of communication.

2.6 **How do we communicate themes:** Complaint Officers meet group representatives weekly and themes and escalations of concerns are shared. Themes are also communicated to groups via monthly Quality Improvement Patient Safety meetings (QIPS)and other committees, such as the Nursing and Midwifery Committee and the Hospital of St Cross Quality meeting. Emerging and or immediate action themes are escalated in real time.

2.7 **Responsiveness in action:** Through the Patient Advice and Liaison Service and Complaints Team an emerging theme of patient property issues was identified. This was quantified and escalated to key stakeholders. Following escalation, the Head of Patient Relations in partnership with the Kaizen Promotion Office (KPO) have begun an improvement project with support from stakeholders involved throughout the patient journey.

2.8 **Patient Advice and Liaison:** The Patient Advice and Liaison Service processed 830 enquiries in Quarter 3 (a reduction of 20 from Quarter 2), managing 90% of enquiries within 5 working days. The performance indicator is 90% within 5 working days.

The PALS Team have worked hard to improve the quality of the experience using their service. This is reflected in liaise and respond activity continuing to increase per quarter (489 cases). Liaise and respond involves PALS acting on behalf of a patient/carer when dealing with a service or group before providing feedback to the enquirer. This has seen a continued fall per quarter of cases being referred directly to a speciality to respond (923 cases in Quarter 4 2019-2020 compared with 196 cases in Quarter 2 2020-2021 and 143 in quarter 3).

	Quarter 4 2019-20	Quarter 1 2020-21	Quarter 2 2020-21	Quarter 3 2020-21
PALS Enquires	**1129**	**529**	**850**	**830**
Signposting	21	22	52	57
Immediate Response	146	67	162	140
Liaise and Respond	37	186	435	489
Refer to Specialty	923	252	196	143
On-going support	2	2	5	1
% of PALS enquires resolved or referred in 5 working days	1109 (98%)	474 (90%)	679 (80%)	749 (90%)

2.9 **Primary themes:** Enquiry themes remain static from Quarter 2. Communication, specifically communication with patients and their relatives, remains the top subject for PALS enquiries from the previous Quarter and mirrors primary complaint themes. Appointments remain the second highest theme, specifically appointment delay and availability. Trust administration, specifically general administration issues, access to health records and complaint handling is the third most enquired about theme followed by facilities, specifically parking and cleanliness. Values and behaviour of staff remains static at number 5.

2.10

Top 5 Primary PALS Enquiries received in quarter 3	Top 3 Themes identified in quarter 3 as a breakdown of the primary enquiry	Position of subjects in Q2 2020-21
Communications	Communication with relatives/carers	1st
	Communication with patient	
	Other - Communications	
Appointments	Appointment - availability (inc urgent)	2nd
	Appointment delay (inc length of wait)	
	Other - Appointments incl delays / cancellations	
Trust Admin / Policies / Procedures incl Pt record management	Access to health records	3rd
	Other - Trust Admin issues	
	Accuracy of health records (e.g. errors, omissions, other patient's records in file)	
Facilities	Car parking - management (including fines/clamping etc)	4th
	Other - Facilities services	
	Car parking - payment methods/facilities (e.g. cash only, no change)	
Values and Behaviours (staff)	Attitude of Nursing Staff/midwives	5th
	Attitude of Medical Staff	
	Attitude of Admin & Clerical Staff	

248 Compliments and Thanks were received in respect of Trust services in Quarter 3, an increase of 35% from the previous Quarter, which is encouraging. Of particular note were 107 positive comments received for the Bowel Cancer Screening Service based at the Hospital of St Cross, which was mirrored in both Quarter 1 and 2 data. Encouragingly, Ward 43 – Neurosurgery received the second highest number of compliments and thanks (24). Speciality Groups are able to view their compliments via Datix dashboards and monthly QIP reports.

3.0 Objective Two: Improve the way we develop and manage patient information leaflets

To support the delivery of this objective the Trust is consistently working to improve the way we develop and manage patient information leaflets, along with plans to

improve access to patient information on the Trust website. The Trust utilises a Patient Virtual Panel which consists of over 150 people within the local community who are available to comment and provide feedback on information created for patients.

During Quarter 3, 131 leaflets were updated and 38 new leaflets were uploaded. The Trust achieved 98.0% compliance for all Patient Information leaflets. 425 queries were received and responded to during Quarter 3. This information is available live on 'Insite' (workforce and information metrics).

All information produced within the Trust on conditions, treatments, procedures or services must meet UHCW's Patient Information Standard and go through an approval process including the virtual panel described above.

4.0 Objective Three: Ensure our staff place Trust values at the centre of care improvements

The NHS National Patient Survey Programme is part of the government's commitment to ensure hospital patient feedback informs continued development and improvement. CQC publishes patient experience surveys in secondary care under their National Patient Survey Programme. This includes surveys for Outpatients, Inpatients, Accident & Emergency, Maternity and Children & Young People. In addition, NHS England publishes the Cancer Patient Experience Survey. The results from these surveys help the CQC assess NHS performance and other regulatory activities such as registration, monitoring ongoing compliance and reviews.

To support the delivery of this objective patient feedback from the National Survey Programme provides an insight into how our staff are living the Trust values. Surveys allow patients the opportunity to give area specific feedback to outside parties who then provide recommendations to the Trust. It should be noted that the CQC, following consultation with NHS England/Improvement made the decision to cancel the fieldwork for the 2020 Maternity Survey due to the COVID-19 outbreak. The CQC will continue to monitor the proposed schedule for the NHS Patient Survey Programme in response to the ongoing Covid-19 pandemic.

Adult Inpatient 2019 Survey: the Trust drew a sample in December 2020 and fieldwork commenced in January 2021, which will end in May 2021.

The Urgent and Emergency Care Survey: the Trust drew samples in October 2020 and fieldwork has been underway since October 2020 and will continue to March 2021.

The Children and Young People's Patient Experience Survey: the Trust will draw samples in January 2021 with proposed fieldwork commencing February 2021 – June 2021.

5.0 Objective Four: Ensure that patient voice is at the centre of care improvements

5.1 **Involvement hubs:** The system wide response to Covid-19 altered delivery of patient involvement activity. The involvement kiosks at University Hospital and the Hospital of St Cross were switched off to minimise the spread of infection from touch screen use. The company who supplied the kiosks are developing touchless devices and have extended the Trust's contract free of charge until October 2021.

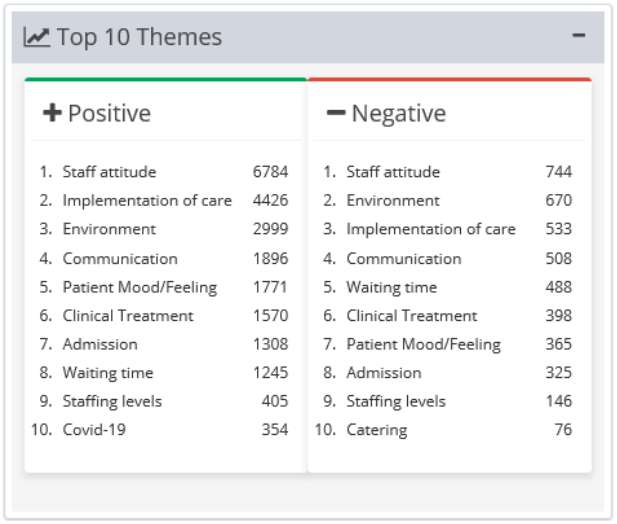
5.2 **Patient partners:** During Quarter 3 much of the Patient Partner Activity was stood down. The second Patient Partner Forum meeting for this financial year took place virtually on 28 October 2020. The meeting discussed how to progress the work plan and how Patient Partner roles will differ from Volunteers. The Patient Partner Programme is currently in the process of restructuring with new activities and recruitment planned in the coming months, once detail of the role has been confirmed and approved.

5.3 **Friends and Family Tests (FFT):** NHS England and Improvement temporarily suspended the submission of FFT data to NHS England/Improvement from all settings in April 2020. The Trust resumed submitting FFT data in January 2021.

In Quarter 3 the Trust received 12,339 responses, 89% were positive remaining static from Quarter 2. Below is a breakdown of themes and words both positive and negative.

Top 10 Words

+ Positive		− Negative	
1. Staff	3542	1. Staff	299
2. Care	1858	2. Hours	253
3. Good	1549	3. Time	220
4. Friendly	1222	4. Waiting	201
5. Received	1088	5. Doctor	186
6. Excellent	1011	6. Appointment	179
7. Helpful	988	7. Wait	168
8. Service	931	8. Ward	149
9. Time	851	9. Pain	146
10. Professional	846	10. Nurse	139



Top 10 Themes

+ Positive		− Negative	
1. Staff attitude	6784	1. Staff attitude	744
2. Implementation of care	4426	2. Environment	670
3. Environment	2999	3. Implementation of care	533
4. Communication	1896	4. Communication	508
5. Patient Mood/Feeling	1771	5. Waiting time	488
6. Clinical Treatment	1570	6. Clinical Treatment	398
7. Admission	1308	7. Patient Mood/Feeling	365
8. Waiting time	1245	8. Admission	325
9. Staffing levels	405	9. Staffing levels	146
10. Covid-19	354	10. Catering	76

6.0 Objective Five: Improve the patient care environment

6.1 **Board Walk Rounds:** Board Walk Rounds were reinstated in Quarter 3, which took place virtually in Quarter 3. A virtual walk round of the Mortuary took place on 16 November 2020 and Ophthalmology Clinic 9 on 3 December 2020.

Date	Location and Facilitators	Key Findings
16 November 2020	Mortuary (virtual) Jerry Gould, Non-Executive Director. Donna Griffiths, Chief People Officer.	**What works well?** • Covid response – at a time when team is being formed with a new management structure being put into place. • Service delivered to patient families in particular, paediatric patient families. • Forensic services – highly commended by number of police forces. **What requires improvement?** • Capacity – challenges across UHCW (although support in place at Warwick Hospital if needed) – caused by delays in collections from funeral directors. • Processes of tracking in mortuary – paper based and subject to error (cross

		cover with Bereavement Services). • Noise pollution in paediatric Chapel of Rest due to location alongside facilities corridor.
3 December 2020	Ophthalmology/clinic 9 Stella Manzie, Chair. Mo Hussain, Chief Quality Officer.	**What works well?** • Timed appointments • Triage with consultants before appointment. • Little queuing. • Innovations such as working with RNIB on welfare calls to check if people(often elderly) who do not want to come into the hospital are not isolated or in need. • The UHCWi process pre lockdown proposed a number of major changes to arrangements on site. COVID has sped these up and made the changes more radical. • Social distancing had to be observed strictly as most patients were accompanied by another individual. **What requires improvement?** • Innovative discussions taking place about the possibility of 7 day and /or some evening working to facilitate access by patients. • Reference to automating the registration system to remove paper which would make things much more efficient. • There is a need for improvement to the current staff room. Facilities were said to be too far away to be much use during a break with limited time.

		• Transfers of patients from other wards to ophthalmology when other disciplines e.g. Surgical, Neuro, and Trauma want advice on possible eye injuries. • Guidance needs to be issued about the importance of patients being accompanied.

6.2 **Tackling Racial Inequality:** The Patient Insight and Involvement Team will engage the public in relation to the Trust's commitment to tackle racial inequality. Plans are being put in place to engage with our communities around this issue.

MINUTES OF THE AUDIT AND RISK ASSURANCE COMMITTEE MEETING HELD ON THURSDAY 15 OCTOBER 2020 AT 9:30AM VIA MICROSOFT TEAMS

ITEM	DISCUSSION	ACTION

ARAC/20/99 PRESENT

Afzal Ismail, Non-Executive Director (AI) – **Chair**
Guy Daly, Non-Executive Director (GD)
Jerry Gould, Non-Executive Director (JG)

ARAC/20/100 IN ATTENDANCE

Sarah Brown, KPMG (SB)
Paul Capener, Interim Consortium Director CW Audit Services (PC)
Rubina Chaudary, Counter Fraud, CW Audit Services (RuC)
Alex Johnson, Senior Executive Assistant – **minutes**
Harjit Matharu, Head of Information Governance (HM) *for item ARAC/20/115*
Lisa O'Brien, Audit Manager, CW Audit Services (LO'B)
Susan Rollason, Chief Finance Officer (SR)
Derek Stewart, Associate Director of Finance (DS)
Geoff Stokes, Director of Corporate Affairs (GS)
Sarah Swan, CW Audit Services (SS)
Richard Walton, KPMG (RW)

ARAC/20/101 APOLOGIES FOR ABSENCE

Sudhesh Kumar, Non-Executive Director (SK)

ARAC/20/102 CONFIRMATION OF QUORACY

The meeting was declared quorate.

ARAC/20/103 DECLARATIONS OF INTEREST

There were no declarations of interest.

ARAC/20/104 MINUTES OF THE AUDIT AND RISK ASSURANCE COMMITTEE (ARAC) MEETINGS HELD ON 19 JUNE 2020 AND 16 JULY 2020

The minutes of the extraordinary Audit and Risk Committee Assurance meeting held on 19 June 2020 were **APPROVED** as a true and accurate record.

SS requested her name be added to the attendance of the ARAC meeting minutes of 16 July 2020 and noted that PC's job title needs to be updated. JG referred to page 8, paragraph 4 of the minutes and advised that the wording should be amended to reflect the point made was in relation to the avoidance of conflicting recommendations being provided to the Board, rather than the avoidance of conflicting opinions.

Subject to the above amends, the minutes of the Audit and Risk Committee meeting held on 16 July 2020 were **APPROVED**.

ITEM	DISCUSSION	ACTION

ARAC/20/105 ACTION MATRIX

AI advised that all items on the action matrix are complete and can be closed.

ARAC/20/106 MATTERS ARISING

There were no matters arising.

ARAC/20/107 INTERNAL AUDIT RECOMMENDATIONS UPDATE

LO'B summarised the content of the report, advising that following the last ARAC meeting, CW Audit has carried out work on the internal recommendations and discussions have taken place with DS with a view to closing duplicate recommendations or those that are no longer applicable.

JG noted a discrepancy in the number of deferrals contained within the report; the cover sheet refers to 6 deferrals, however the table states there are 7. JG added that it would be helpful to be clear on dates recommendations were originally made, in order that the Committee can be clear on the length of time a recommendation has been open for.

AI queried the level of confidence in meeting the revised implementation dates. DS advised that he is confident that all recommendations will be resolved by the next ARAC meeting in January. DS provided a summary of each of the recommendations and actions being taken around them.

It was noted that DS will soon be leaving the Trust and he confirmed that other team members are involved in the internal audit recommendations and any outstanding actions will be taken forward in his absence.

Audit and Risk Assurance Committee **NOTED** the report and **APPROVED** the revised implementation dates.

ARAC/20/108 INTERNAL AUDIT PROGRESS REPORT

LO'B informed that although quarter 1 was quiet due to the pandemic, work has now increased significantly. Two reviews have been completed on financial governance and the Innovate Grant expenditure claims. Planned and ongoing work taking place includes DSPT compliance toolkit, RTT data quality, charitable funds and EPR. The key developments are outlined in the report.

The Committee **NOTED** the report.

ARAC/20/109 2019/20 PERFORMANCE OUTCOME MEASURES AND KPI REPORT

PC informed the Committee that internal audit has demonstrated strong compliance with the measures and is delivering an effective service. He noted that there has been a slight increase in time taken by managers to respond to draft audit reports and this will be

ITEM	DISCUSSION	ACTION

monitored.

AI noted that it would be useful for the report to include details of timings from when the audit began, to the production of the report.

The Committee **NOTED** the report.

ARAC/20/110 FINANCIAL GOVERNANCE ARRANGEMENTS DURING COVID-19

SS informed the Committee that significant assurance could be provided on the controls and processes in place. This is a positive outcome for the Trust.

SR added that when the pandemic first began to impact, guidance was received from NHS England and NHS Improvement (NHSE/I) on the financial requirements and the checklist included was reviewed to ensure all the points were covered. Internal audit has been very helpful and there will be an external audit in future. SR acknowledged the level of assurance provided, however there are some areas for improvement and these will be addressed prior to the external audit.

GD referred to the recommendation rated amber on page 9 of the report and sought clarification on its meaning. SS advised that it relates to ensuring claims are being made in the correct way and the level of evidence required to support those claims.

The Committee **NOTED** the report.

ARAC/20/111 CUSTOMER SATISFACTION SURVEY 2019/20

PC advised that excellent feedback has been received from customers and he is very proud of this, in particular the “added value” score which is very good.

PC outlined the themes for improvement as included in the executive summary of the report. He added that there would be a focus on developments in line with Covid, such as the cyber risk during that period, along with a national benchmarking report.

PC noted that George Eliot Hospital NHS Trust (GEH) is the only organisation in the STP footprint that CW Audit is not currently working with. SR confirmed that GEH has been encouraged to do so, and that she will continue to press for this.

The Committee **NOTED** the report.

ARAC/20/112 INNOVATE UK GRANT – INDEPENDENT ASSURANCE REPORT (FINAL)

LO’B advised that an independent reasonable assurance review has taken place in relation to the PathLAKE project, for which the Trust has been awarded a grant of almost £2m. As part of the terms and conditions of the grant, an internal assessment of expenditure must

ITEM	DISCUSSION	ACTION
	take place. CW Audit will carry out four reports over the duration of the project. This report is the second of those.	
	In response to a query from GD, LO'B confirmed that the £90k expenditure during this reporting period is for claims between January – March 2020.	
	SR explained that the PathLAKE project relates to the digitalisation of pathology and histology reporting, and includes PathLAKE plus which is focussed on artificial intelligence and algorithms.	
	ACTION: SR to circulate a short explanatory brief to the Committee that explains the project further.	**SR**
	In response to a query from JG, LO'B confirmed that the key managers involved in the project, along with SR, have sight of the internal audit recommendations report prior to it being provided to Innovate.	
	SS outlined the claims process, advising that the Trust submits claims regularly and once Innovate is satisfied, they will release funds. SS added that CW Audit does not review every claim submitted.	
	SR noted that the project is significant from both a strategic and financial point of view.	
	The Committee **NOTED** the report.	
ARAC/20/113	**COUNTER FRAUD PROGRESS REPORT**	
	RC provided an update on investigations, sanctions and redress.	
	There have been two new cases since the last Audit and Risk Assurance Committee. One of the cases relates to an employee who had amended a sick note. The appropriate actions have been taken and the case is now closed subject to HR disciplinary procedures taking place	
	Operational Lynx – ongoing actions are taking place in relation to this national investigation, as outlined in the report. RS is awaiting further information from ID Medical and will update the Committee in due course.	
	Employee working during trust time – case closed as CWPT and CWPS have confirmed that there is no employee working at those organisations of the name in question.	
	Allegation of unnecessary overtime – GS advised that it was the Freedom to Speak Up Guardian (not the Freedom of Information Officer) who was contacted in the first instance regarding this allegation.	
	RC outlined the proactive plan of work (completed) which includes: - Counter fraud information to be posted on Trust Nav	

ITEM	DISCUSSION	ACTION

- Working with Learning and Development in relation to new starters receiving counter fraud material
- NFI submissions have now been made
- Staff notified of NFI requirements via September payslips
- Privacy notice signed off on compliance declaration
- Summer newsletter issued

Planned work includes virtual induction arrangements, preparation of TOR for proactive work on pre-employment/identity checks and the completion of the previous NFI exercise.

SR confirmed that interviews will be taking place to replace DS and the role and responsibilities will be reviewed/allocated accordingly.

AI referred to organised crime in some sectors and he queried how robust the Trust processes are for new employee checks, particularly in relation to references, qualifications and eligibility to work in the UK. RC confirmed that there are processes in place as part of the pre-employment checks and RC will check the asylum and immigration checks that are carried out in order to provide assurance around this matter. **RC**

ARAC/20/114 Q1 BENCHMARKING REPORT

SB explained that she is taking over AB's role and that RW will take on the senior manager role.

RW noted that this report contains unaudited data and is for information rather than assurance. Due to the pandemic, the reporting to NHSE/I has changed. Information relates to many more clients than usual (not just Midlands trusts). More trusts will be added in future, and this will help provide more comparative data.

RW outlined the content of the graphs, in particular noting the Trust's position for EBITDA (earnings before interest, taxes, depreciation and amortisation), agency spend, capital expenditure and Covid expenditure.

SR added that debtors are a particular area of focus and this has been discussed at Finance, Resource and Performance Committee. In relation to Covid spend, SR noted that UHCW is the regional hub for testing and as such, makes claims for pathology for the whole region which will distort the figures for UHCW.

The Committee discussed the capital expenditure data (page 7) and GD noted it would be useful to better understand the actual/forecast and whether there is any particular associated risk. SR acknowledged that the capital expenditure programme is significant. It is taken through Finance, Resource and Performance Committee and a risk is going to be added to the risk register regarding the Trust's ability to spend the capital. It is important to understand that there are some limitations on spend due to PFI arrangements and the Trust is also receiving more capital than was originally planned. The focus is now on rapid delivery of the capital expenditure programme. DS added that the STP plan was not approved until July 2020, which is a further reason why the Trust is behind on its capital

ITEM	DISCUSSION	ACTION

expenditure plan.

The Committee **NOTED** the report.

ARAC/20/115 INFORMATION GOVERNANCE UPDATE

HM joined the meeting. GS advised that this is the first report of this kind to the Committee and aims to provide an overview of the information governance function and priorities. The report will be provided twice a year and any comments on the format and information provided are welcomed.

HM provided the key points from the report:

- Data Security and Protection Toolkit (DSPT) has been submitted.
- 95% standard met for mandatory information governance training.
- Ongoing work being undertaken on data protection and GDPR compliance.

One particular area of concern is Subject Access Requests (SAR). The compliance rate is less than 50%. One reason for this is the increased complexity of requests being received. A new electronic system is being implemented and this should help improve compliance rates. GS added that SAR is a challenge for many Trusts. Chief Officers are aware that the standard is not being met, however the challenges are being tackled and there is a balance of risk in place. Cases that relate to policeor child protection are prioritised.

SS added that she would review actions taken for other clients on SAR compliance and advise if anything can be done more efficiently. **SS**

JG queried the reasons why some groups (Surgical Services, Trauma and Neuro, Medicine and Emergency) consistently fall below the target for information governance mandatory training and queried whether any further action could be taken to improve the rates in these areas. ACTION: GS to consider whether targeted activity to groups who consistently fall below the information governance training targets would be beneficial. **GS**

The Committee **NOTED** the challenges on SAR. AI added that although the report is lengthy, it is important for the Committee to have sight of this level of detail. For future reports, he requested the Executive Summary include detail of the top 3 incidents and the improvements being implemented in those areas.

HM left the meeting.

ARAC/20/116 REVIEW OF CLINICAL AUDIT EFFECTIVENESS

GS informed the Committee that Sharron Oulds, Associate Director of Quality, would normally attend ARAC to present this report, however she is unavailable on this occasion. GS will take the item and refer any questions back to Sharron.

JG noted the very detailed information contained within the report.

ITEM	DISCUSSION	ACTION

He suggested that as clinical audit is covered in depth at the Quality and Safety Committee meeting, it might be unnecessary for ARAC to review such detail. In order for ARAC to provide assurance to Trust Board, an alternative may be for the report to ARAC to contain only those items rated red or amber and for assurance to be provided on actions being taken for those items. AI agreed that a more bespoke report including key findings and areas for improvement would be sufficient for ARAC.

The Committee **NOTED** the report.

ARAC/20/117 REVIEW OF BOARD ASSURANCE FRAMEWORK (BAF)

GS introduced the report, advising that the review is ongoing. The working group set up to review the BAF has met once to date and a further meeting is being arranged. The BAF working group terms of reference are included with the report, along with a diagram that sets out the relationship structure of the BAF and corporate risks.

JG suggested that it would be useful to clarify within the terms of reference, the difference between corporate risks and the BAF.

JG also referenced the 'top 5-10 risks that will stop us' (as shown on appendix 2). A discussion followed on the appropriate number of risks to be referenced. Consideration should be given to the manageability and practicality of having too many risks.

The Committee **NOTED** the update of the review.

ARAC/20/118 BOARD ASSURANCE FRAMEWORK (BAF)

GS referred to the current Board Assurance Framework attached to the report and informed the Committee that this is due to go to Trust Board in November.

GS drew attention to risk 4 (financial stability) on the BAF and informed the Committee that at Chief Officer's Group on Tuesday, the scoring of this risk was discussed. The view is that the current scoring against this risk is too high. Up until now, the risk has been treated as financial, however it is felt that it is more of a reputational and regulatory risk. GS proposed to the Committee that the score should be lower than the current rating of 5 and added that this Committee is required to recommend a score to the Trust Board. GS referred to the Risk Management Policy, which he shared with the Committee on screen via MS Teams.

SR agreed that the risk should be assessed from a regulatory point of view, taking into account the national media challenge and reputational consequence of failing to manage the risk.

It was proposed that the scoring is revised to 4 for the consequence and 3 for the likelihood. The Committee **AGREED** the revised score.

GD also noted that there is a level of concern in relation to risk 2 scoring (operational performance) and that this may be revisited due to Covid.

ITEM	DISCUSSION	ACTION

Al requested that when the BAF is taken to the Trust Board, the executive summary should outline the amendment to the scoring and reason for doing so. The executive summary should also provide assurance around the management of the 6 BAF risks.

The committee **NOTED** the report.

ARAC/20/119 RISK MANAGEMENT REPORT

GS introduced the report and outlined the three risks for the Committee to focus on:

- Potential breaches of confidentiality
- Unauthorised use of Trust systems (access by Trust staff)
- Raising concerns

The focus for today's discussion is on the unauthorised use of Trust systems by Trust staff. GS noted that misuse of access to Trust systems is usually carried out by staff that have access to clinical systems and use this access to check information they are not permitted to view. The severity of misuse can range from a staff member checking a relative's appointment time on behalf of that relative, to more malicious types of misuse.

GS explained that when the Trust becomes aware of such instances, the audit processes work effectively and the appropriate action can be taken. However, there are a number of challenges. The current system does not differentiate between legitimate and non-legitimate access. Access is generic, e.g. a staff member in gynaecology will also have access to geriatric records and although in some instances wider access is required, particularly for ED, in many cases it is unnecessary. Although there is a balance to be met to ensure that barriers are not put in place that stop individuals carrying out their role.

One possible solution is a piece of software that is known to highlight where possible breaches have taken place. There would be a cost to purchase the software, as well as an administrative cost and it is not yet known how many false positives it would produce.

The ambition is to be able to confidently state to the organisation that if a staff member accesses records when they should not, they will be caught, disciplined and if appropriate, dismissed. If staff believe this is the case, it may result in a behaviour change.

In response to queries from the Committee, GS confirmed that the numbers of instances of misuse that result in disciplinary/dismissal are publicised to staff and that the information governance training includes questions on inappropriate access of Trust systems.

JG suggested that messaging be added to the system which asks staff if they are authorised to view the particular record. This would serve as constant reminder. GS advised that the benefit of such messaging could work if done intermittently, however most staff who have access to the systems are looking at several records every day and they may soon just click through without consideration to the

ITEM	DISCUSSION	ACTION

message.

GS added that the CRSS system currently used is becoming out of date and that there may be more sophisticated options in relation to types of patient/cases and EPR may assist in this respect.

GS advised that work would be undertaken to review the ideas discussed today.

AI noted the importance of this report for the Committee and added that it would be useful to see anonomised case studies for the three focussed risks, in order to have a better understanding of the types of cases and provide the opportunity for the Committee to ask further questions. **GS**

The risk report was reviewed and in response to a query, GS explained the purpose of the "gaps in control" column should be to provide a description of the gap and action being taken. GS added that the data comes from Datix and acknowledged that the data input does not always meet the level of compliance that it should.

AI requested a short presentation on cyber infrastructure/security be provided to a future ARAC. This should outline the number of cyber security attempts per day, software in place, day-to-day activity and volume.

The Committee **NOTED** the report.

ARAC/20/120 POLICIES UPDATE

GS advised that the Committee requested this report at July's meeting and it provides an update on actions taken on the measures taken to increase the Trust's compliance of reviewing policies, procedures and strategies (PPS).

In response to a query from JG, GS confirmed that the review period is driven by the level of perceived risk of the particular PPS.

AI referred to overdue PPSs and requested more information be provided in future on what is being done to resolve these and the timeline for doing so. He also requested that the report be provided to ARAC once or twice a year in order for assurance to be provided. **GS**

The Committee **NOTED** the report.

ARAC/20/121 LOSSES AND SPECIAL PAYMENTS

The Committee **NOTED** and **APPROVED** the losses and special payments.

ARAC/20/122 DEBT WRITE OFFS

The report was **NOTED** and the recommendations **APPROVED**.

ITEM	DISCUSSION	ACTION
ARAC/20/123	**WAIVERS OF SOs/SFIs/SoRD**	
	JG noted that one supplier (Mast Diagnostics) appears three times in the table related to 'high value requests' and he queried whether any action could be taken around this to achieve a more favourable price. SR advised that the particular supplier provides reagent and testing kits for Covid and is therefore a new aspect of this report. She added that this is a transition period and that there is a national supply chain being put in place for these types of supplies.	
	The Committee **NOTED** the report.	
ARAC/20/124	**ANY OTHER BUSINESS**	
	AI thanked the Committee for their work. In particular, he thanked DS for his contribution and wished him well for the future.	
ARAC/20/125	**DRAFT AGENDA FOR THE NEXT MEETING**	
	AI suggested clinical audit be added to the standard ARAC agenda. GS confirmed it is on the work plan, however it is not brought to every Committee meeting, as it is covered in full under Quality and Safety Committee.	
	ACTION: AI and GS to discuss most effective way of reporting clinical audit at ARAC, to ensure the appropriate assurance is provided, without any duplication between ARAC/QSC.	**GS/AI**
ARAC/20/126	**CHAIR'S REPORT TO TRUST BOARD**	
	AI will agree the summary report with GS	
ARAC/20/127	**MEETING REFLECTIONS**	
	AI noted that the high quality and content of the papers and the positive discussions held. GS added that it would be useful for future agendas to state where visitors are expected in order that the chair is aware.	

University Hospitals Coventry and Warwickshire NHS Trust

MINUTES OF THE MEETING OF THE FINANCE, RESOURCES AND PERFORMANCE COMMITTEE HELD AT 1.30PM ON THURSDAY 22 OCTOBER 2020 VIA MICROSOFT TEAMS

MINUTE REFERENCE	DISCUSSION	ACTION

FRPC/20/147 PRESENT

Jerry Gould, Non-Executive Director (JG) - **Chair**
Donna Griffiths, Chief People Officer (DG)
Jenny Mawby-Groom, Associate Non-Executive Director – (JMG)
Carole Mills, Non-Executive Director (CM)
Brenda Sheils, Non-Executive Director (BS)
Susan Rollason, Chief Finance Officer (SR)

FRPC/20/148 IN ATTENDANCE

Abrar Agil, Service Manager (AA) - Observer
Amar Bhagwan, Director of Procurement (AB), item FRPC/20/156
Sandra Cotter, Group Director of Operations (SC) , item FRPC/20/163
Andrea Gordon, Director of Operational Quality (AG) , item FRPC/20/162 and FRPC/20/164
Barbara Hay, Head of Diversity (BH) , item FRPC/20/158
Mark Kemp, Head of Strategy & Development (MK), item FRPC/20/166
Kuldip Manota, Executive Assistant (KM) – minute taker
Clive Robinson, Sustainability Development Manager (CR), item FRPC/20/165

FRPC/20/149 APOLOGIES FOR ABSENCE

Laura Crowne, Chief Operating Officer (LC)

FRPC/20/150 CONFIRMATION OF QUORACY

The meeting was confirmed as quorate.

FRPC/20/151 DECLARATIONS OF INTEREST

There were no declarations of interest.

FRPC/20/152 REVIEW OF MINUTES OF THE PREVIOUS MEETING HELD ON 17 SEPTEMBER 2020

There were 2 corrections:

- Page 2 ‘miss classification’ should read ‘mis-classification’
- Page 6 – there was an typographical error in the word ‘throughout’

With the above amendments the minutes were **APPROVED** as an accurate record of the discussions held.

MINUTE REFERENCE	DISCUSSION	ACTION

FRPC/20/153 ACTION MATRIX

Action matrix was discussed and actions closed except FRPC/20/139 which will be picked up on LCs return

Action FRPC/20/138 can be closed but flu jabs had not been administered as the board development day was held virtually. DG clarified that if NEDs have had flu jabs elsewhere, that can be recorded.

DG also took the opportunity to note that 35% of front line healthcare workers have had a flu jab and 31% if staff overall.

FRPC/20/154 INTEGRATED FINANCE REPORT (Month 06)

SR introduced the Integrated Finance Report and highlighted the following points

- Month 6 financial position was breakeven.
- This was the last month of the Emergency COVID regime.
- Additional COVID-19 costs for September were £2.1m (year to date £21.3m).
- Almost £27m of top up funds have been received to date to compensate for loss of income.
- SR reported that we have received positive feedback on our COVID-19 returns, except the claim for PFI Soft Services; ISS claim (£4m) will come under a different category.

JMG asked what the key difference for the figures in August and the September bottom line were. SR stated there was no difference to the bottom line just a different route in how to claim it back. JMG sought to understand the changes in the cost base and SR explained that the largest part of the difference will be accounted for by restoration of services. The costs for direct access pathways will make a difference from month 7 onwards.

Agency spend for September has increased by £1.6m, the highest level to date this financial year. Whilst this is still under the notional ceiling set by NHSI, the figure is increasing.

JG commented that the report states that student costs will continue to decrease over the next few months as will the actual numbers. DG stated that nursing and medical students were in paid placements to undertake support during COVID-19; they have now gone back to education and will be retained and work on the bank.

Aged Debtors at the end of the reporting period was £12.8m, of which £9.0m (70%) was overdue. The Trust has received significant payments from South Warwickshire £3.2m and Derby and Burton £0.9m.
CM asked if the NHS is required to pay small businesses within a certain timescale. SR stated that national guidance during COVID-19 requires prompt payment; within 7 days.

MINUTE REFERENCE	DISCUSSION	ACTION
	JMG asked what is happening with creditors of over 6 months. SR responded that we are working through these, but unsure what the reasons are for delay, JMG asked for a breakdown as some are quite large.	**SR**
	JG asked what made up the £2.4m favourable reduction in establishment expenses; SR to find out.	**SR**
	JMG was interested to know why we are struggling to restore services – was it because patients aren't presenting or that the Trust hasn't got the capacity to treat them. SR explained that previously it was because patients weren't being referred but she was unsure of the current position.	
	The Committee received and **NOTED** the Month 06 financial position for 2020/21	
FRPC/20/155	**HOSPITAL PHARMACY TRANSFORMATION PLAN (HPTP)** SR presented the Hospital Pharmacy Transformation Plan which relates to the configuration of hospital pharmacy teams promoted by the Carter review.	
	There has been an understandable delay in the last six months or so as the Chief Pharmacist is also the clinical director covering theatres and critical care so has had to focus on those areas.	
	JMG asked if there were any risks to the collaboration between Trusts given the changes in the relationship with Worcester etc. SR explained that UHCW is still working with Worcester on a number of services, even though they are moving away from our relationship on oncology services.	
	JG asked if there were any financial costs attached to the risks; SR stated that the risk was around the allocation of resources. The financial impact may be in missing opportunities to make savings although costs in this area currently benchmark well.	
	The Committee **NOTED** the progress of the HPTP across the G3 and the G5	
FRPC/20/156	**PROCUREMENT UPDATE** AB presented the Procurement update noting that much of the previously planned procurement development has paused as efforts have been focussed on COVID-related procurement.	
	A Trust collaborative is being discussed with a small group of trusts on how we work together to increase our 'spend cube' to drive better pricing. BS asked how the current grouping of trusts has come together. AB explained that the other trusts contacted UHCW as they see us as a way of defending their position.	
	The software for a contracts register was installed December 2019, but	

MINUTE REFERENCE	DISCUSSION	ACTION

has been put on hold due to COVID-19. This is a central database which will hold all our contracts.

JG asked about the bulk store and an alternative site. AB explained that the bulk store is still being used for COVID related PPE but there is a Portakabin used as a hub for consumables. There is a potential for changing our inventory management system which may enable more 'just in time' procurement. There may be a small amount of additional funding required to implement this system.

JG also asked about a cost pressure on the funding model. AB clarified that the category towers are under review as the base contract does lead to anomalies in pricing

The Committee received and **NOTED** the progress to date of the Procurement Transformation Plan

FRPC/20/157 FINANCE PLAN UPDATE

SR presented the Finance Plan update.

The new financial regime arrangement will be set from October to March 2021 with a deficit of £24m across the seven NHS organisations in Coventry and Warwickshire, of which the UHCW planned deficit is £1.9m. As system finance lead, SR has been meeting all the other finance directors individually prior to sign off by the Partnership Executive Group. This position was then shared with NHSE/I. Subsequent to this the final position has been agreed with NHSI/E of £15m deficit across the system and £0.6m deficit for UHCW.

There was a brief discussion about why UHCW isn't planning to breakeven, given the small value of the deficit being planned. SR explained that in meeting the system envelope there are other considerations of equity across the system but she expects to aim to exceed the planned forecast.

In response to a query from JMG, SR explained that the forecast has been based on a line by line assessment to better anticipate expenditure.

BS queried the value of the Waste Reduction Programme which was reinstated Oct- March, SR explained that this equates to £3.6m which has already been achieved, due to vacancies.

The Committee received and **NOTED** the position of the Financial Plan update and the relationship with the system

FRPC/20/158 EQUALITY AND DIVERSITY REPORT/WRES AND WDES REPORT

DG introduced the item by explaining that this is the first year that the Trust has been able to engage with staff networks to enable the development of the actions.

MINUTE REFERENCE	DISCUSSION	ACTION

BH highlighted the key issues from the WRES and WDES report which highlighted areas of discrimination affecting both BAME staff and those with disabilities. One area that needs further review is non-mandatory training, as along with other organisations, there is no standard way of capturing this.

In relation to the WRES, clear links need to be made to the Black Lives Matter/reducing racial inequalities work that has been undertaken. There will be some co-development groups established in the near future to develop some actions.

The WDES has been produced for the second year so comparisons are possible but may not be representative. The issue of staff with disabilities being taken through a capability process will need to be reviewed with the Workforce team to determine if there are any underlying issues.

CM commented on the high number of cases related to bullying/harassment abuse from colleagues; which is a fifth of all staff but a quarter of BME staff which she felt was very high. BH advised that through the recent listening events, we are trying to differentiate between inappropriate behaviour and bullying or harassment. Work will commence with managers on how best to equip them with the skills and knowledge and also to ensure staff understand the difference between inappropriate behaviour as opposed to racial discrimination, bullying or harassment.

DG explained that, unfortunately, the responses for UHCW are in line with the results from staff survey results across the NHS but are much higher than the reported cases.

JMG asked about where staff are shortlisted but then not appointed and if there anything in place to monitor this. BH explained that the system does not accurately record data, however, through the BME network we are trying to unpack the current situation and to see if there is any movement. DG explained that we are doing some deep dives in certain areas, such as nursing, but need to do a bit more segmented breakdown at staff group level, so a comparison can be made. It was acknowledged that our current systems make it difficult to track the data and to make comparisons.

The Committee **NOTED** and **AGREED** to sign off the actions ahead of publication.

FRPC/20/159 APPRENTICESHIP LEVY REPORT

DG presented the Apprenticeship Levy report.

There was a 56% increase in spend in the rolling year from 2018/19 to 2019/20.

JG asked what the financial benefits would be if the Trust were a provider; DG said we would get a sub-contracted income when the apprenticeships are delivered.

MINUTE REFERENCE	DISCUSSION	ACTION

JG asked why the application was rejected, DG stated that feedback was sought and further detail was required in quality assurance, which will be incorporated when the second application is submitted.

The Committee **RECEIVED ASSURANCE** from the report.

FRPC/20/160 PERFORMANCE BENCHMARKING

DG presented the performance benchmarking report and highlighted this is being shared and utilised by particular groups to understand how the Trust can improve and learn from others.

JMG commented that there appeared to be an anomaly in the diagnostic testing target which may be due to it being wrongly titled. She also commented that there appears under-performance compared to other trusts.

The Committee reviewed and **NOTED** the contents of the report.

FRPC/20/161 INTEGRATED, QUALITY, PERFORMANCE AND FINANCE REPORT

DG introduced the Integrated Quality, Performance and Finance Report.

Workforce

There has been a decrease in vacancies from last month. Funding has been secured to recruit 75 international nurses by January 2021, a further funding bid has also been submitted.

Sickness absence has increased by 0.39% this month. This continues to be tracked closely in terms of both staff group and service area.

Appraisal data is being validated. Medical appraisals have been suspended nationally until March 2021, but the Trust chose to reinstate them in September.

JMG enquired about the increases in agency costs for scientific, therapeutic and technically which has increased, but when looking at the number of shifts booked it looks like its falling. DG responded that this was largely due to the vacancies in radiologists and pathology where there is a high demand. JMG wondered if it would be worth over-establishing and filling vacancies rather than go to agency. SR explained that the Trust does look to over-recruit where that is possible in areas where there are shortages. DG stated it was due to a national shortage but the Trust is using agency more efficiently by block booking, so getting value for money.

CM asked if there was a process of continual recruitment and DG confirmed this is the case, especially for band 5 nurses and health care assistants.

The Committee **NOTED** the content of the report.

MINUTE REFERENCE	DISCUSSION	ACTION

FRPC/20/162 ELECTIVE RESTORATION UPDATE

AG presented the Elective Restoration update. There are specific targets that the Trust is expected to meet compared with pre-COVID levels for outpatients, elective and day case procedures and there are challenges in meeting those targets. AG explained that she chairs silver command and has been focussed on driving up performance to report to gold command. Chief officers are meeting with specific groups to ensure there are plans in place for as many patients as possible.
Plans for dealing with surges in COVID patients have been developed to determine when elective work will need to be stood down to create capacity.

JG asked why the head/neck cancer figures were higher. AG responded that this was an issue regionally, due to capacity and workforce limitations but Trusts are working more collaboratively to limit the issue. Also dental referrals come under head/neck, and there is a backlog due to COVID-19

CM asked how cancer patients are being prioritised during restoration and the levels of cancellation. AG stated that the groups are looking to prioritise these cases and going forward, the independent sector will continue to be used for cancer work.

JMG noted that the figures for surgery/day case were not on target. AG stated that clinical services group have been asked to go away and look at day cases and options to increase capacity.

JG queried issues with radiology as they are unable to support a number of restoration requests, and asked if this is due to capacity, equipment or space. AG stated it was all three as there are challenges in staffing, particularly for radiologists.

The Committee **NOTED** the current position

FRPC/20/163 EMERGENCY CARE UPDATE

SC presented the Emergency Care update.

It was reported that the Trust delivered a four-hour performance of 84.89% for September against the national standard of 95%. This represents a decline from 91.03% in August.

JG noted that the report states that some of the wait times are inferred due to increased bed occupancy and long length of stay and wondered how much of this is accurate. SC explained that at the beginning of COVID-19, bed occupancy was at 80%, which made it easier in managing the flow, as the normal demand was not there, however as we are still trying to maintain services, bed occupancy will continue to be an issue and it is currently at 96%.

Committee **NOTED** the report.

FRPC/20/164 BOARD ASSURANCE FRAMEWORK AND CORPORATE RISKS

AG presented the Board Assurance Framework (BAF) and highlighted

MINUTE REFERENCE	DISCUSSION	ACTION

there were 18 open risks, none rated as highest and none overdue and invited the Committee to focus on the five risks highlighted

JG commented that the columns needed to be reviewed as the data was out of date and needs to be updated in line with the risk management policy. Similarly, the risk descriptions in many cases does not reflect the approach set out in the risk management policy. This will be fed back to the relevant risk owners.

JG mentioned the working group that has been set up by the Audit and Risk Assurance Committee looking at the Board Assurance Framework and its relationship with the risk management arrangements across the Trust.

The Committee **REVIEWED** current risks within the portfolio and **RECEIVED ASSURANCE** on the current controls to mitigate the risk.

FRPC/20/165 SUSTAINABILITY DEVELOPMENT UPDATE

CR presented the Sustainability Development update for the last quarter. Governance arrangements are in transition at the moment towards a 'green plan' which must be in the public domain and have targets which are monitored. Future building and refurbishment works should be carbon neutral and all NHS buildings should have LED lighting and solar panels.

Waste systems need to be more agile and support is being sought from the Infection Prevention and Control team on this. Green travel plans will incorporate an increase in cycle routes being developed by Coventry City Council.

The combined heat and power plant is due to go live from February. The building management system is being replaced at Rugby St Cross which should go live at the end of November.

The EU Exit will mean that a new carbon pricing scheme is due to be implemented which could see an uplift in carbon tariffs.

JG queried whether change in the carbon scheme has been incorporated in the risk register due to an increase in costs. SR stated that we do not have it on the register, and will look to see if it is included in the EU Exit Risk. **SR**

The Committee **NOTED** the progress in relation to sustainable development.

FRPC/20/166 DRAFT HYBRID THEATRE

SR outlined the business case for the Hybrid Theatre and made the following points, supported by MK who joined for this item. The scheme is above the £15m capital limit which will require formal approval from NHSE/I via a full business case (FBC).

A hybrid facility includes imaging facilities too and although such facilities exist in the catheterisation laboratory and the interventional

MINUTE REFERENCE	DISCUSSION	ACTION

radiology suite, these are for specific and less complex procedures. The plan has been part of the Trust and the system strategy and is largely an investment in quality. Although there may be financial opportunities moving forwards. As a major trauma centre it is a key requirement to improve patient outcomes.

Through the early investigations, there is only one practical configuration available.

MK added that work is still underway to determine the extent to which the hybrid theatre will help with cost avoidance which may be added to the business case before it goes for approval.

JG enquired whether agreement for the £15.2m has already been received, or is the business case key to persuading others to provide the funding in which case there were some presentational improvements he considered were probably worth incorporating. SR stated that this is not like the ED case and the business case is critical to achieving the funding. JG agreed to forward his annotated copy of the business case to MK for his proposed changes to be incorporated where appropriate.

JMG queried from where the expansion of trans-catheter aortic valve implantation (TAVI) procedures, mentioned in the case, has arisen. MK explained that growing volume for TAVI is an ambition by specialist commissioners which will allow consultants to develop expertise and this will need c150 procedures per year. Specialist commissioners would fund these procedures which would be more suitable for patients who are too unwell for other procedures.

JMG asked about the plans for mothballing two theatres, yet modular theatres are being proposed at Rugby. SR explained this was partly due to balancing capacity and maximising the use of Rugby St Cross for elective work. SR added that there was also a timing issue with the different schemes. JMG also noted an apparent mismatch on table 12 relating to the number of sessions which MK will review.

JG suggested that the business case needs to emphasise that the PBR-related income will come from specialised commissioners and is therefore outside of the fixed income block for the local system.

JG commented that it would be helpful if the any summarised content in the earlier part of the document including that in some of the tables was cross-referenced to the detail in later sections and appendices so information can be found more easily. Also, the links between the objectives of the project and the case for change needs to be made clearer. He also commented that the key risks identified also do not align with those in the risk log later in the document, neither do the mitigations. He also challenged whether it is appropriate to identify mitigations against capital funding not being received as persuading others to approve the allocation of system capital resources for the project was the whole point of the business case. .

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CM stated it would be helpful to get clarity of powers between the committee and Board. SR said that the Board had authority over £1m to confirm any business case and the committee was responsible to review and help inform that decision.

The Committee **NOTED** the content of the Hybrid Theatre outline business case and **RECOMMENDED** it be presented to Trust Board for approval after taking into account the comments made.

FRPC/20/167 DRAFT AGENDA FRPC 19 NOVEMBER 2020

DG stated that the title for the workforce information report needs to be changed to workforce quarterly report.

JMG asked about the reference cost return and when the Committee will receive a briefing on that. SR explained that it is due for November but is not time critical. JMG asked if that briefing could be cross-referenced with, for example, the Model Hospital data for context.

JG commented that he had spoken with Mo Hussain, Chief Quality Officer, about the potential for reducing the frequency of committee meetings over the winter until the end of March 2021 whilst the Trust deals with the second wave of COVID and the pressures of winter. Members of the committee were supportive of the proposal.

FRPC/20/168 ANY OTHER BUSINESS

JG suggested it may be helpful if NEDs had a session on the operational targets the Trust has, what they mean, how they are measured, and any issues around them. DG

JG queried how much clinicians understand about the financial arrangements in health, the move to system working in the future following the government experience of managing the health service through COVID-19. His experience of chairing consultant interview panels suggested many were still very focused on financing improvements and achieving waste reduction through increasing PBR income. SR commented that for senior clinicians (e.g. clinical directors and clinical leads), financial arrangements and their consequences are presented regularly through the Chief Officers Forum (a monthly briefing session or the senior leadership across the Trust). She acknowledged that other clinicians may not be so sighted on financial arrangements, but acknowledged that the framework is changing so that the future of the payment by results (PBR) mechanism is uncertain. Due to this uncertainty, the Trust is not drafting any business cases based on increase in income under a PBR basis

SR reported that there is a risk of under-delivery against the capital programme due to the low level of spend to date against the capital programme, approval for which has only just been released. JMG wondered if the FT status in the system could be used to mitigate some of the risks of under-delivery.

JG requested that if between now and March 2021 the committee meetings are to be bi-monthly, arrangements could be made on the

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alternate months for the committee be kept updated on key issues. This could perhaps be accommodated by adding items to the monthly CEO/NED meetings.

FRPC/20/169 CHAIRS REPORT TO TRUST BOARD

It was agreed the following would be included in the Chair's report to the Board;

- Integrated finance report
- Hospital pharmacy transformation plan
- Elective update
- Hybrid theatre business case

FRPC/20/170 MEETING REFLECTIONS

SR and DG commented that the right representation was not in attendance at the meeting for the operational issues, however will ensure this happens going forward.

FRPC/20/171 DATE OF NEXT MEETING

17 December 2020 (1.30 pm – 4.00 pm)

MINUTES OF THE QUALITY AND SAFETY COMMITTEE MEETING HELD ON THURSDAY 22 OCTOBER 2020 AT 09:30 – 11:30 VIA MICROSOFT TEAMS

MINUTE REFERENCE	DISCUSSION	ACTION
QSC/20/105	**PRESENT** Prof. Sudhesh Kumar, Non-Executive Director (SK) **Chair** Prof. Guy Daly, Non-Executive Director (GD) Mo Hussain, Chief Quality Officer (MH) Carole Mills, Non-Executive Director (CM) Brenda Sheils, Non-Executive Director (BS)	
QSC/20/106	**IN ATTENDANCE** Abrar Agil, Service Manager (AA) - Observer Richard de Boer, Deputy Chief Medical Officer (RdB) *deputising for Prof. Kiran Patel* Andrea Gordon, Director of Operational Quality (AG) – Item QSC/20/118 Esperance Makiese, Executive Assistant (EM) – minute taker Julie Molloy, Performance Information Manager (JM) item QSC/20/117 Duncan Watson, Deputy Chief Medical Officer (DW) – Item QSC/20/115 Vicky Williams, Associate Director of Nursing (VW) –items QSC/20/113, QSC/20/114 and QSC/20/119	
QSC/20/107	**APOLOGIES FOR ABSENCE** Prof. Nina Morgan, Chief Nursing Officer (NM) Prof. Kiran Patel, Chief Medical Officer and Acting CEO (KP)	
QSC/20/108	**CONFIRMATION OF QUORACY** The meeting was confirmed as quorate.	
QSC/20/109	**DECLARATIONS OF INTEREST** None.	
QSC/20/110	**MINUTES OF THE PREVIOUS MEETING** The minutes of the meeting of 17 September 2020 were approved as an accurate record of the meeting and for submission to the Trust Board.	
QSC/20/111	**ACTION MATRIX** The Committee **NOTED** the actions and **APPROVED** those suggested for closure.	
QSC/20/112	**MATTERS ARISING** **Impact of Children's Emergency Department (CED) attendance following re-opening of schools.** • Emergency Department attendance MH reported that the data received proved inconclusive. ED and Children's Emergency Department (CED) attendance has increased as in previous years but not by as much as last year. It	

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is therefore difficult to draw firm conclusions. The data follows the seasonal trend.

- Alcohol presentation
  MH stated that attendance due to alcohol related matters dipped in February and April 2020. It is difficult to link this to pubs closing and reopening.

GD observed that it would have been useful to have the slides from last year for alcohol presentation to compare to. MH confirmed that these could be obtained and circulated. **MH**

RdB confirmed that ED has been monitored as part of the direct pathway work. The attendance figures for ED may be related to social distancing and the reluctance to come to ED. This does not show where ophthalmology attendance has reduced due to virtual appointments. Some patients are sent to the Medical Assessments Unit (MDU) and Surgical Assessment Unit (SAU).

BS noted that MDU and SAU attendance is increasing and therefore will make it hard to compare. The information provided does not show the full picture. MH agreed and pointed out that the question was whether ED and CED attendance had increased due to schools reopening. The information provided confirmed that there was no resulting increase. BS stated that there is a lot of shifting of the pathways in ED. It may be useful to see an impact of the changes in pathways in ED in November and December 2020.

QSC/20/113 **INTEGRATED QUALITY, PERFORMANCE AND FINANCE REPORT (IQPFR)**

[VW joined the meeting]

MH presented the IQPFR and highlighted the following key areas:

- CDiff cases are at 40. Tracking and reviewing is done using the processes in place.
- Doctor Foster data shows a drop in HSMR and is now at 92. This is a good achievement given the previous position.
- RTT pathways data shows the number of patients waiting for over 52 weeks and the harm review process was referenced for tehse patients.
- The final slides show benchmarking against Royal Stoke University Hospital, University Hospitals Birmingham and Nottingham University Hospitals. This is based on quarterly data until the end of August 2020. The data shows the Trust is tracking well.

VW provided the following update regarding long length of stay:

- A process is in place for weekly reviews. 81% of patients are not medically stable or fit for discharge. This percentage is higher for patients in intensive care.
- There are more patients with higher acuity than usual.
- Patients determined not fit for discharge are reviewed to determine when they can be discharged.
- A tool went live yesterday to assist with efficient discharge. It

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is available to all system partners.

SK asked how the benchmarking data can be used given that it is quarterly. He noted that the trend in HSMR is reassuring.

GD thanked MH and VW for the update and stated that the benchmarking in terms of RTT is good but the context is complicated.

SK asked for a breakdown of the reasons for the long length of stay. VW stated that there has been a change in what is normally seen and 81% is a high figure. RdB added that the reasons are unknown although there has been a general rise in comorbidities. DW confirmed that this is an issue that is being worked on.

The Committee **RECEIVED ASSURANCE** from the report.

QSC/20/114 NURSING AND MEDICAL STUDENTS UPDATE

VW presented the Nursing and Medical Students Update. It was reported that in June, clinical placements were paused and the students were redeployed. Supernumery status was paused and normal clinical placements were suspended.

All first year nursing students' placements were also suspended but their supernumery status has been reinstated and they are now in transition standards as per the Nursing and Midwifery Council (NMC) guidelines. COVID helped the trust to respond to managing larger groups of students. They had peer learning support and good positive feedback was received and no complaints were received. There is however, a backlog of first year students requiring placements and risk assessments and processes are in place to deal with this.

Allied Health Professionals (AHP) placements were also suspended and in higher numbers due to the AHP infrastructure being profession-led. A multi-professional forum was set up to manage this.

With regard to medical students, placements were suspended in March 2020 and Year 2 recommenced in July 2020, with years 3 and 4 clinical placements recommencing in June 2020. Work is underway to re-establish teaching and develop new ways to deliver teaching where there are safety concerns.

VW stated that some students have had an issue accessing the flu jab and this may have an impact on COVID reporting and student capacity.

SK observed that the report was encouraging and UHCW as a trust dealt with COVID better than some other trusts. He asked how Personal Protective Equipment (PPE), flu jabs and risk assessments are being dealt with. VW confirmed that a fraction of the students have had COVID. This is being monitored through the monthly Education Group.

BS stated that the report was helpful and expressed some concern

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for the students and their studies. Reassurance was received that no student in the medium term will be disadvantaged. The curriculum is being redefined as a result of the interruption to their education and training. BS expressed an interest in the lessons learned from this.

VW confirmed that NMC approval has been received for blended learning as an option. Nursing students will still have their placements but the number of learners has increased.

In response to BS, VW stated that student nurses are back on supernumery status but it is unlikely that they will go back to being redeployed. RdB further confirmed that medical students are now back to their medical students status. Tim Robbins (Specialist Registrar in Endocrinology) had a paper accepted in the Clinical Medicine Journal which shows how well the work was accepted. VW added that some of the medical students have asked to remain on the Trust staff bank as they valued their work.

SK reported that some electives may be cancelled in the next two years. The curriculum for Years 2-3 in Warwick Medical School is very dense and any time lost may mean that they cannot meet their learning outcomes. The University is trying to be as innovative and creative as possible. However, the impact will be felt for years to come.

GD stated that Coventry City Council has plans to open a test centre in Coventry city centre near Coventry University. In addition to that Coventry is going into Tier 2 soon. The number of people who test positive for COVID may increase and this may therefore have an impact on placements.

GD asked for clarification with regard to AHP students. VW confirmed that AHPs are supplied to the Trust by different institutions and they are more service level driven. The Associate Director of Allied Health Professions is working on getting it to become professions-led. Work is underway to liaise with strategic partners, learning groups and the Trust. A Practice Education Lead has been appointed to develop a governance process.

CM asked what mitigations are in place for students for COVID waves 2 and potentially 3. VW confirmed that plans have been put in place by Health Education England and other education providers to try and minimse the impact. Coventry University is also working to put a plan in place with regard to learning and placements. The Trust is confident that it can continue to provide placements in line with national guidance.

The Committee **RECEIVED ASSURANCE** from the report.

[VW left the meeting]

QSC/20/115 MORTALITY (SHMI AND HSMR) UPDATE

DW presented the Mortality (SHMI and HSMR) Update and highlighted the following:

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- An ongoing workstream is in place which was presented two months ago to the Trust Board.
- Work is underway to get coding more accurate. A nice schematic has been produced to provide guidance on the information that needs to be recorded.
- The Medical Examiner role is functioning and the extension of the COVID-19 Act means that will continue with a single sign-off for the cremation forms and other processes.
- Work is being done to transition to the Royal College of Physicians (RCP) Structured Review Process (SJR). Currently a flow diagram is used which shows how reviews take place. The Quality Department is supporting the work to move towards the DATIX Cloud IQ system. This will be a way to deliver and improve the Trust's processes.
- Changes are being made on CRRS to mirror SJR 1-5 instead of NCEPOD A-E and bringing in the idea of preventable harm.

Over the next six months the Trust is working with a new colleague in Dr Foster. The information being provided by her is making the team work in a different way. The Neurosurgical team is looking at their vascular aneurismal surgery review and learning from that. The team has looked closely at the trauma figures and comparators and performance has improved. The reasons for this are not yet clear but the headline groups are being reviewed. All deaths are being reviewed and there have been no errors since March 2020.The palliative care team were very supportive through COVID. Their improvement of the referral for palliative care has been a significant change. The Trust is looking to combine the ED and mortality review processes.

The Committee **RECEIVED ASSURANCE** from the report.

QSC/20/116 QUALITY IMPACT ASSESSMENT

MH presented the Quality Impact Assessment (QIA) update and reported that it is an update report in terms of the QIA process which has historically been based around the waste reduction programme. The process is currently being reviewed.

During COVID the QIA process was amended and moved towards a more risk based approach and assessing the changes being made. The objective is to build on that. A separate process is in place for an Equality Impact Assessments (EIA). This reviews activities around the protected characteristics. During previous Trust Board discussions it was determined to bring the processes around Waste Reduction, QIA and EIA together.

The QIA process also looks at the benefits associated with any initiative. At the moment the Trust process is risk-focussed. The objective is to capture both for balance.

SK stated that it will be good to see the impact of the change in a few months. It will also be good see an impact on the data.

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BS pointed out that the QIA process has been risk focussed in the past and incorporating other processes such as the EIA will be good. She asked for assurance that the rigour in the level of escalations will not be lost. MH confirmed that the new process will build on what is already in place. Health inequalities will also be considered and the Trust's responsibilities around prevention. It may not be more streamlined but it will be more rigorous and robust.

The Committee **RECEIVED ASSURANCE** from the report.

QSC/20/117 QUALITY STRATEGY UPDATE

MH presented the Quality Strategy Update and reported that the new Quality Strategy is being drafted. A virtual workshop will be arranged to assist with the process. An intern who is currently studying for a Masters has been recruited to drive this process in the next six months.

The workshops will take place in November and December 2020 to collate information and determine the measurable. The draft strategy will be sent out to system partners for consultation before being brought back to the Committee in March 2021 and then on to the Trust Board in April 2021.

SK asked how Non-Executive Directors can helpfully engage in the process of the Quality Strategy development. MH responded that all the Non-Executive Directors will be invited to the workshops.

The Committee **NOTED** the update.

QSC/20/118 QUALITY SCHEDULE

[JM joined the meeting]

MH presented the Quality Schedule and reported that it is a timetabled agenda item as part of the acute contract. The Trust reports to the CCG on a monthly basis. The Quality Schedule is still monitored but the CCG is not actively enforcing it due to the current climate.

JM added that the data is one month behind and the information provided is for the Committee's awareness.

SK enquired as to the reason behind the delay in clinical letters. RdB responded that there are many different methods available to send out the clinical letters. An admin review is underway to determine the reasons for the delay.

BS queried the figures for stroke and asked whether there is anything that can be done about this. RdB responded that there are challenges related to the current configuration of ED. Work is underway to ensure 24 hour cover for the stroke pathway. It is a standard operational issue of which the team is aware and is being

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worked on. Appropriate senior medical support is being sought to ensure they get relevant support when required.

SK agreed with RdB for Outpatients to be added to the Board Walk Rounds list. **EM**

The Committee **NOTED** the update.

[JM left the meeting]

QSC/20/119 BOARD ASSURANCE FRAMEWORK AND CORPORATE RISKS

[VW joined the meeting]

AG presented the Board Assurance Framework (BAF) and Corporate Risks report and reported that the three risks rated at 20 have not changed. An outstanding review and update is due with regard to patients lost in outpatients as this could result in potential harm. The Quality team escalated this risk but no update has yet been received.

AG confirmed endorsement of Board Walk Rounds in a way that tests areas for assurance.

The risks are reviewed monthly at the Risk Committee.

The Committee **NOTED** the update.

[VW left the meeting]

QSC/20/120 CQC UPDATE

MH presented the CQC Update, reporting that the CQC released a draft strategy. This flagged a change on how they will carry out interventions.

AG confirmed that the CQC is due to visit the Trust next week and will speak to key staff in ED to gain winter assurance.

BS observed that the CQC draft strategy is timely to drive the Trust Quality Strategy. However, it can leave the organisation more exposed to interventions. She asked how the Trust will deal with it. SK added that the CQC will change from detailed visits to a system where the Trust needs to be ready anytime. The Committee may need to change to have the data the CQC will use.

MH responded to say that the Trust should be CQC ready at any given time. The CQC usually request Provider Information Return (PIR) in advance. Now they are requesting the data on a bi-monthly basis. The teams need to work with Simon Pitt, the new CQC Relationship Manager, to determine how the data is used. The objective is to be process focussed and CQC ready. ED will be an area of focus due to winter assurance. AG added that Maternity also needs to be considered.

The Committee **NOTED** and **RECEIVED ASSURANCE** from the

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update.

QSC/20/121 DRAFT QSC AGENDA

None.

QSC/20/122 ANY OTHER BUSINESS

Board Walk Rounds

SK reported that the Board Walk Rounds are a useful addition to system assurance. The question is how to bring them back and ensure they do not get in the way of the staff.

MH confirmed that it was agreed in August for the Board Walk Rounds to restart in a virtual format first to avoid risk. A data pack will be shared in advance of each Board Walk Round.

CM suggested that there should be a questionnaire and a pre-recorded patient video included. SK added that a selection of staff not in management should be invited to participate. The virtual Board Walk Rounds should be tried for three months then reviewed.

Flow of Quality and Safety Committee meetings

MH reported that in response to the second COVID wave and the pressure on the Trust, there is a proposal to move the Committee meetings to take place bi-monthly with circulation of any relevant papers in between.

CM expressed support for the motivation behind. The idea of a short meeting followed by a longer meeting would be good.

MH stated that the Trust Board will continue to take place every two months and therefore quality information will be shared monthly. The idea is to stand down meetings and functions that report into the Quality and Safety Committee.

SK reported that at NHS Digital a similar structure was implemented and there was increased staff productivity as a result.

BS agreed with the bi-monthly meetings proposal and pointed out that the length of the papers can be reduced. The Trust Board needs to be used to provide assurance in between, being mindful not to overload the agenda. There is also the Board Walk Rounds for assurance as well as the monthly Non-Executive Directors, Chief Medical Officer and Chief Nursing Officer meetings.

GD agreed with BS and stated that the Trust Board agenda is already overloaded. Informal catch ups between meetings could be the way forward.

CM also echoed BS and stated that the Trust Board agenda is already dense. She suggested that the bi-monthly meeting format

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should be tried to free up colleagues to do their work.

SK summarised that the Committee **AGREED** to move to a bi-monthly meeting structure for the Committee until March 2021. It was also **AGREED** for the meeting in November to be stood down. MH and SK will meet to agree the agenda for all meetings. The Integrated Quality, Performance and Finance Report will still be discussed each month via the Trust Board or Committee meetings. MH/SK

Meeting Observer

AA introduced herself to the Committee and confirmed that she is a Programme Manager on her second year on the NHS Graduate Scheme. Laura Crowne, Chief Operating Officer, is her mentor. She confirmed that she was attending the meeting as an observer.

Mock CQC Inspection

MH reported that the Mock CQC Inspection has been completed and a draft report has been produced. This will be circulated and a 30 minute session set up to enable the NEDs to discuss it.

QSC/20/123 CHAIR'S REPORT TO BOARD

SK summarised the following points to be highlighted to the Trust Board at their next meeting:

- HSMR and SHMI update
- Nursing and Medical students update
- Change in meeting frequency
- Reinstated Board Walk Rounds
- The CQC's shift in inspections

The Committee **RECEIVED ASSURANCE from** the Report.

QSC/20/124 MEETING REFLECTIONS

The Committee expressed the following reflections:

- Good discussions took place.
- It was a helpful meeting.
- It is easier to have discussions in smaller committee meetings.
- A lot of material was covered and the meeting still concluded in time.

The meeting ended at 11.54am.

QSC/20/125 DATE OF NEXT MEETING

The next meeting will take place at 09:30 – 12:00 on 17 December 2020 via MS Teams.

DRAFT
PUBLIC TRUST BOARD AGENDA

25 MARCH 2021

MEETING	MEETING DATE	ITEM NO.	HEADING	ITEM	GUEST	LEAD	AUTHOR	FORMAT	ACTION	TIME	DUR.
PUBLIC	25 Mar 2021	1	General Business	World Class Colleague Award		Andy Hardy	Lynda Scott	Verbal	Note	10:00	00:00
PUBLIC	25 Mar 2021	2.1	General Business	Patient Story		Mo Hussain	Andrea Gordon	Enclosure	Note	10:00	00:10
PUBLIC	25 Mar 2021	2.2	General Business	Apologies for Absence		Chair		Verbal	Assurance	10:10	00:00
PUBLIC	25 Mar 2021	2.3	General Business	Confirmation of Quoracy		Chair		Verbal	Assurance	10:10	00:00
PUBLIC	25 Mar 2021	2.4	General Business	Declarations of Interest		Chair		Verbal	Assurance	10:10	00:00
PUBLIC	25 Mar 2021	3.1	General Business	Minutes of previous meeting		Chair		Enclosure	Approve	10:10	00:05
PUBLIC	25 Mar 2021	3.2	General Business	Action Matrix		Chair		Enclosure	Assurance	10:15	00:05
PUBLIC	25 Mar 2021	3.3	General Business	Matters Arising		Chair		Verbal	Assurance	10:20	00:00
PUBLIC	25 Mar 2021	4	General Business	Chair's Report		Chair		Enclosure	Assurance	10:20	00:10
PUBLIC	25 Mar 2021	5	General Business	Chief Executive Officer Update		Andy Hardy		Enclosure	Assurance	10:30	00:15
PUBLIC	25 Mar 2021	6	Performance Reports	Integrated Quality, Performance and Finance Report • Operations • Quality • Finance		Donna Griffiths	Dan Hayes	Enclosure	Assurance	10:45	00:15
PUBLIC	25 Mar 2021	7	Performance Reports	NHS Staff Survey		Donna Griffiths	Michelle Brookhouse	Enclosure	Note	11:00	00:10
PUBLIC	25 Mar 2021	8	Governance Reports	Data Security and Protection Tookit Annual Submission		Mo Hussain	Harjit Matharu	Enclosure	Approve	11:10	00:05
PUBLIC	25 Mar 2021	9	Governance Reports	Annual Goals		Justine Richards	Jamie Deas	Enclosure	Approve	11:15	00:15
PUBLIC	25 Mar 2021	10	Governance Reports	Fit and Proper Persons Test		Mo Hussain	Geoff Stokes	Enclosure	Assurance	11:30	00:00
PUBLIC	25 Mar 2021	10.1		BREAK						11:30	00:05
PUBLIC	25 Mar 2021	11	Assurance Reports	Board Assurance Framework and Corporate Risks		Mo Hussain	Geoff Stokes	Enclosure	Assurance	11:35	00:10
PUBLIC	25 Mar 2021	12	Assurance Reports	Mortality (SHMI and HSMR) Update		Kiran Patel	Sharron Oulds	Enclosure	Assurance	11:45	00:10
PUBLIC	25 Mar 2021	13	Assurance Reports	Medical Education Report		Kiran Patel	Sailesh Sankar	Enclosure	Assurance	11:55	00:10
PUBLIC	25 Mar 2021	14	Assurance Reports	Serious Incident Report		Mo Hussain	Chelsea Gilsenan	Enclosure	Assurance	12:05	00:10
PUBLIC	25 Mar 2021	15	Assurance Reports	Caldicott Guardian Report		Kiran Patel	Andrea Gordon	Enclosure	Assurance	12:15	00:05
PUBLIC	25 Mar 2021	16	Assurance Reports	Research and Development Update		Kiran Patel	Ceri Jones	Enclosure	Assurance	12:20	00:10
PUBLIC	25 Mar 2021	17	Assurance Reports	Medicines Optimisation Committee Annual Report		Kiran Patel	Mark Easter	Enclosure	Assurance	12:30	00:00
PUBLIC	25 Mar 2021	18	Feedback from Key Meetings	Finance, Resources and Performance Committee Approved Minutes and Report		Jerry Gould	Geoff Stokes	Enclosure	Assurance	12:30	00:05
PUBLIC	25 Mar 2021	19	Feedback from Key Meetings	Quality and Safety Committee Approved Minutes and Report		Sudhesh Kumar	Geoff Stokes	Enclosure	Assurance	12:35	00:05
PUBLIC	25 Mar 2021	20.1	Administrative Matters	Forward Work Programme		Chair	Geoff Stokes	Enclosure	Approve	12:40	00:10
PUBLIC	25 Mar 2021	20.2	Administrative Matters	Draft Agenda for next meeting		Chqir		Enclosure	Approve	12:50	00:05
PUBLIC	25 Mar 2021	20.3	Administrative Matters	Meeting Reflections		Chair		Verbal	Discuss	12:55	00:05
PUBLIC	25 Mar 2021	21	Administrative Matters	Questions from the public		Chair	Geoff Stokes	Enclosure	Note	13:00	00:05
PUBLIC	25 Mar 2021	21.1		BREAK						13:05	00:25