University Hospitals Coventry and Warwickshire NHS Trust

# PUBLIC TRUST BOARD
# HELD AT 10:00 AM ON THURSDAY 26 MARCH 2020
# BOARDROOM, EXECUTIVE SUITE

## AGENDA

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

**In the light of the current COVID 19 emergency the Trust has tailored this agenda to scale down our normal Board discussions. We want to enable key operational leaders to focus on current pressures but retain proper governance structures and enable the Board formally to focus on COVID19 and other key items**

| Item | General Business | Lead | Format | Action | Time |
|---|---|---|---|---|---|
| 1. | Apologies for Absence - | S Manzie | Verbal | As | 10:00 |
| 2. | Confirmation of Quoracy | S Manzie | Verbal | As | |
| 3. | Declarations of Interest | S Manzie | Verbal | As | |
| 4. | Minutes of last Public Board meeting held on 30 January 2020 | S Manzie | Enclosure | Ap | 10:05 |
| 5. | Action Matrix | S Manzie | Enclosure | As | 10:10 |
| 6. | Matters Arising | S Manzie | Verbal | As | |
| 7. | Chair's Report | S Manzie | Enclosure | As | 10:15 |
| 8. | Chief Executive Officer Update | A Hardy | Enclosure | As | 10:20 |
| **Key Items** | | | | | |
| 9. | COVID-19 | L Crowne | Enclosure / Presentation | As | 10:25 |
| 10. | Integrated Quality, Performance and Finance Monthly Report<br>- Performance<br>- Quality<br>- Finance<br>- Workforce | K Martin | Enclosure | As | 10:55 |
| **For Decision** | | | | | |
| 11. | Changes to Trust Board | G Stokes | Enclosure | Ap | 11:05 |
| **For Noting** | | | | | |
| 12. | CQC Inspection Report | A Hardy | Enclosure | As | 11:20 |
| 13. | Board Assurance Framework and Corporate Risk Register | M Hussain | Enclosure | As | |
| 14. | Serious Incident and Never Event Report | M Hussain | Enclosure | As | |
| 15. | Gender Pay Gap Report | K Martin | Enclosure | As | |
| 16. | Medicines Optimisation Strategy Report | K Patel | Enclosure | As | |
| 17. | Mortality (SHMI and HSMR) Performance Update | K Patel | Enclosure | As | |
| 18. | Medical Education Report | K Patel | Enclosure | As | |
| 19. | Guardian of Safe Working Hours Report | K Martin / K Patel | Enclosure | As | |
| 20. | Caldicott Guardian Annual Report 2019-20 | K Patel | Enclosure | As | |
| 21. | Patient Led Assessments of the Care Environment (PLACE) Annual Report 2019-20 | N Morgan | Enclosure | As | |
| 22. | Finance and Performance Committee Meeting Report | I Buckley | Enclosure | As | |
| 23. | Quality Governance Committee Meeting Report | E Macalister-Smith | Enclosure | As | |
| 24. | Patient Experience (We Care ) Report | M Hussain | Enclosure | I | |

| General | | | | | |
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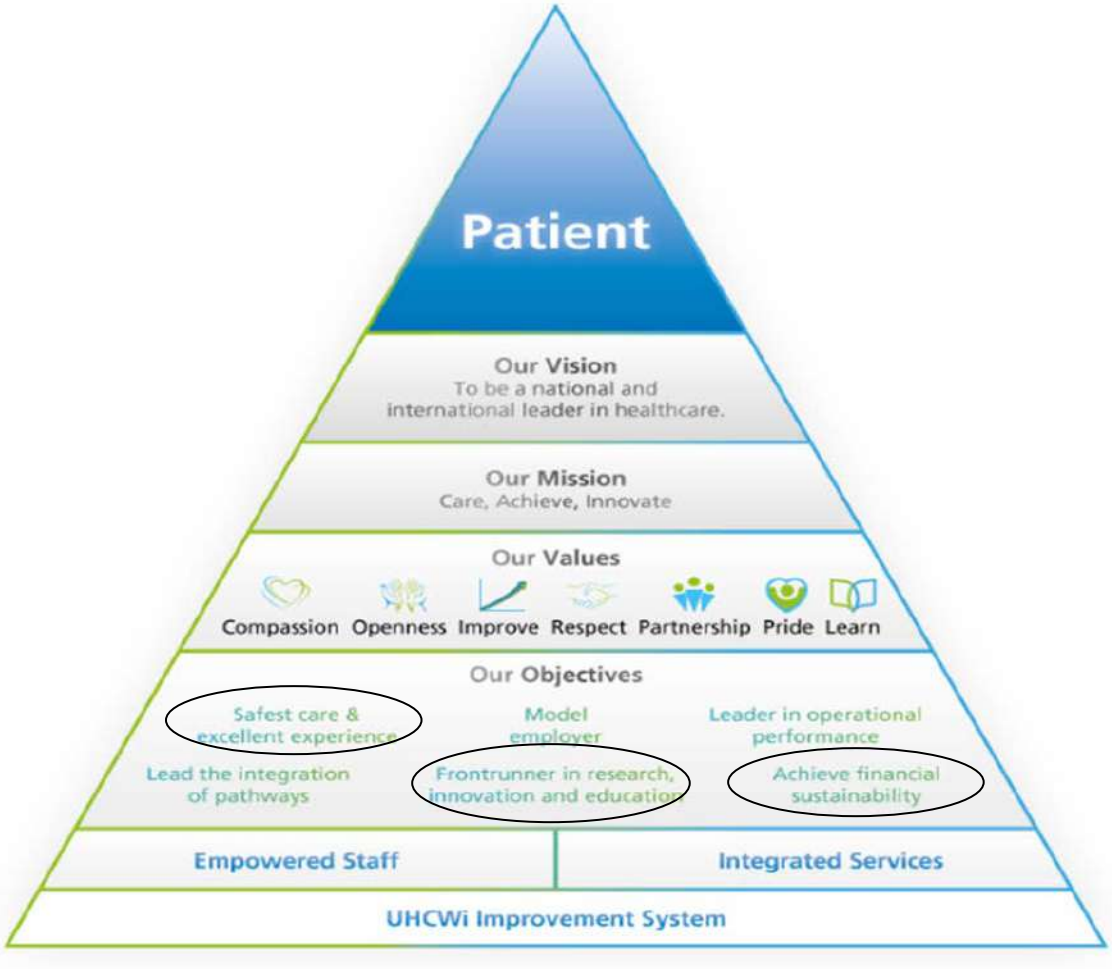
| 25. | Any Other Business | S Manzie | Verbal | D | 11:25 |

**Next Meeting:**
Thursday 28 May 2020 at 10.00am, in the Clinical Sciences Building, University Hospital, Coventry, CV2 2DX

## 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.


Patient
Our Vision
To be a national and international leader in healthcare.
Our Mission
Care, Achieve, Innovate
Our Values
Compassion Openness Improve Respect Partnership Pride Learn
Our Objectives
Safest care & excellent experience
Model employer
Leader in operational performance
Lead the integration of pathways
Frontrunner in research, innovation and education
Achieve financial sustainability
Empowered Staff
Integrated Services
UHCWi Improvement System

# MINUTES OF A MEETING OF THE TRUST BOARD OF UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST HELD ON 30 JANUARY 2020 AT 10:00 IN THE CLINICAL SCIENCES BUILDING, UNIVERSITY HOSPITAL, COVENTRY

| MINUTE REFERENCE | DISCUSSION | ACTION |
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**HTB 20/001** **PRESENT**

Stella Manzie (SM), **Chair**
Ian Buckley (IB), Vice Chair
Laura Crowne (LC), Chief Operating Officer
Guy Daly (GD), Non-Executive Director
Jerry Gould (JG), Non-Executive Director
Andrew Hardy (AH), Chief Executive Officer
Mo Hussain (MH), Chief Quality Officer
Ed Macalister-Smith (EMS), Non-Executive Director
Jenny Mawby-Groom (JMG), Associate Non-Executive Director
Nina Morgan (NM), Chief Nursing Officer
Kiran Patel (KP), Chief Medical Officer
Justine Richards (JR), Chief Strategy Officer
Su Rollason (SR), Chief Finance Officer
Brenda Sheils (BS), Non-Executive Director
Geoff Stokes (GS), Director of Corporate Affairs

**HTB 20/002** **IN ATTENDANCE**

Donna Griffiths (DG), Director of Workforce/Deputy Chief Workforce and Information Officer (representing Karen Martin)
Alex Johnson (AJ), Senior Executive Assistant (Minute Taker)
Jackie Llewellyn-Robinson (JLR), UHCW patient (for item HTB 20/007)
Tracey Fenwick (TF), Modern Matron (for item HTB 20/007)
Sarah Hartley (SH), Group Director of Nursing (for item HTB 20/007)
Paula Lloyd-Knight (PLK), Director of Quality (for item HTB 20/007)
Lorna Shaw (LS), Freedom to Speak Up Guardian (for item HTB 20/019)

**HTB 20/003** **WORLD CLASS COLLEAGUE AWARD**

The RTT Team joined the meeting. AH informed the Board that the team was nominated under the theme of the improvement value, for the support they provide in ensuring that there are no patients waiting over 52 weeks for treatment. This has been the case since November 2018 and AH noted that the Trust stands out for its success in this area. The team received their certificates.

**HTB 20/004** **APOLOGIES FOR ABSENCE**

Sudhesh Kumar (SK), Non-Executive Director
Karen Martin (KM), Chief Workforce and Information Officer/Deputy CEO

| MINUTE REFERENCE | DISCUSSION | ACTION |
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**HTB 20/005** **CONFIRMATION OF QUORACY**

The meeting was quorate.

**HTB 20/006** **DECLARATIONS OF INTEREST**

GD declared his association with Coventry University.

**HTB 20/007** **PATIENT STORY**

JLR, TF, SH and PLK joined the meeting. MH introduced the item and informed the Board that JLR represents the overall patient experience, in that some aspects of her experience were very positive and there are elements which could have been better.

JLR explained her experience to the Board, noting that overall, she received fantastic treatment and care. However on reflection, there were two areas in particular where improvements could be made. Firstly, whilst waiting in the day room, JLR noticed that much of the literature related to palliative/end of life care. JLR was about to have brain surgery and the literature perhaps did not send out the most positive message.

The second point JLR raised related to issues in telephone communications. JLR's husband tried to contact the ward on several occasions via the telephone, however he could not make contact. In addition, when JLR tried to make an outgoing call, the line had been unplugged to allow for staff meetings to take place without interruption. JLR stated that the telephone is a lifeline for patients and their families and the inability to communicate in this way can be very distressing. She suggested that the phone could have been diverted instead of being disconnected.

TF provided feedback regarding telephone communications. She advised that when board rounds take place, they need to be completed in a timely and efficient way. On occasion, telephones can interrupt these rounds. Staff have been asked not to disconnect phone lines and there are now very clear signs in place, stating that phones must not be unplugged and should be diverted instead. Diversion instructions are also available.

SH advised that the day room has recently been decorated and that there will certainly be more thought given to literature placed in the room, whilst still ensuring that all patients have access to the information they need.

SM thanked JLR for attending the Board and presenting a balanced view. SM added that she is aware of the telephone issues and the Trust needs to address this.

JLR, TF, SH and PLK left the meeting.

| MINUTE REFERENCE | DISCUSSION | ACTION |
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| **HTB 20/008** | **MINUTES OF THE PREVIOUS MEETING** | |
| | EMS referred to item HTB19/173 (Emergency Planning Response and Resilience (EPRR) Core Standards). He requested that the minutes of the previous meeting be amended to better reflect EMS' support of Luke Peachey, as the current wording might be construed as a criticism and this was not EMS' intention. | |
| | Subject to this amendment, the minutes were **APPROVED** by the Trust Board. | **GS (AJ)** |
| **HTB 20/009** | **ACTION MATRIX** | |
| | Item HTB 19/140 – The item is ongoing and scheduled to go to QGC in February. | |
| **HTB 20/010** | **MATTERS ARISING** | |
| | JG referred to page 8 of the minutes (item HTB 19/168, Significant Incident Reporting, paragraph 2). He asked if MH had investigated the reasons for the spike in serious incidents every other month. MH believes that this is a presentational issue related to the date the instance occurred, however he will look further into this and provide a full explanation. | **MH** |
| | JG also referenced item HTB19/170 (Guardian of Safe Working Hours Report) and KP confirmed that the issues relating to Allocate login credentials were now resolved. | |
| **HTB 20/011** | **CHAIR'S REPORT** | |
| | SM advised of her ongoing involvement with events/meetings with other health/social care partners and regional chairs' meetings. SM is also involved in the promotion of the British Transplant Games and took part in the Trust's Long Service Awards. | |
| | For accuracy, GD noted that John Latham's title is incorrect in the report. He is Vice-Chancellor of Coventry University. | |
| **HTB 20/012** | **CHIEF EXECUTIVE AND CHIEF OFFICERS' REPORT** | |
| | AH reported that it is a very busy period for both University Hospital and St Cross and he thanked staff for continuing to deliver high quality care in these challenging times. | |
| | AH reported that he has met with the Secretary of State, Matt Hancock. The meeting was held further to a question raised in parliament by local MP, Colleen Fletcher in relation to pressure in ED and possible investment in an additional walk-in centre on site at UHCW. He noted that an Urgent Treatment Centre (UTC) would more appropriately deal with 25% of attendances in ED. AH reported that, there may be some funding available in future for those | |

| MINUTE REFERENCE | DISCUSSION | ACTION |
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| | Emergency Departments in particular need, although there was no guarantee of this from the Secretary of State. AH also discussed treasury reviews on PFI with the Secretary of State and how the PFI is constituted with the Retail Price Index. | |
| | AH also met with Dale Bywater, Regional Director of the Midlands and East region, NHS England/NHS Improvement. Dale congratulated the Trust on sustaining good performance, particularly for RTT (Referral to Treatment) and Cancer. | |
| | The highlight of the month was the opening of the Centre for Care Excellence last week and NM has been awarded a professorship for her contribution to nurse education. | |
| | AH drew attention to the consultant appointments detailed in the report and these were ratified by the Board. | |
| | KP's report was noted and EMS requested a brief report be taken to Remuneration Committee on clinical excellence allowances (CEA). GS and AH suggested that this was not within the remit of the Remuneration Committee however EMS was clear that he wanted to see this. KP said he was happy to share the information. | **KP** |
| | LC's report was noted and she added that the focus is on collaborative system working. | |
| | SR reported that the Trust was visited by the health spend team from the Treasury. They looked at how the money the Trust receives is spent on the front line. SR noted that the KPO (Kaizen Promotion Office) was great in demonstrating the work the Trust has carried out in Operations. | |
| | NM highlighted that Daisy Awards have been presented to three members of staff. NM also attended the launch event for Maggie's Centre and the launch of the Centre of Care Excellence. | |
| | MH updated the Board on the improved status of patient complaints and national safety alert as outlined in the report. | |
| | JR informed that she attended an asset-planning workshop at St Cross. There is an ambition to engage the community, council, and primary care to work together to provide a broader offering to the community and utilise St Cross Hospital to do this. JR/AH will be taking this forward. | |
| | SM noted that she and GS have discussed holding the Trust Board at St Cross at least once a year in future. | |
| | In response to a query from GD, JR advised that the Trust's next strategic board will focus on opportunities for the region's Anchor organisations to work together. | |
| | DG highlighted that the staff flu vaccination rate stands at 81.25%. The target has therefore been met, however the Trust continues to push for improvement. Staff wellbeing continues to be a focus with the recent launch of the Employee Assistance Programme and introduction of Schwartz Rounds. | |
| | The supported internships programme continues and Step in to the | |

| MINUTE REFERENCE | DISCUSSION | ACTION |
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| | NHS programme has also been launched. | |
| **HTB 20/013** | **PATIENT EXPERIENCE (WE CARE) REPORT** | |
| | MH advised that this report shows the quarter two position and is therefore slightly out of date. It is hoped that there will be better alignment for reporting in future. | |
| | MH explained the status of complaints and the recent improvements in response times for both complaints and PALS | |
| | It was noted that the information presented on Board Walk Rounds should contain reports on all walk rounds in order to better understand the issues. MH advised that a paper on the approach to Board Walk Rounds will be brought back to Board. | |
| | MH noted the work being carried out in relation to patient experience and reported that Mystery Shoppers have been recruited to in order to bring fresh eyes to patient navigation. Feedback will be presented to the Board in due course. | |
| | JMG reported that she has been contacted by a patient regarding an issue experienced with car parking. The ANPR system did not recognise the patient's number plate and the patient was subsequently fined. AH noted that ANPR is in excess of 99% accurate. At this time of year, dirty number plates may not be visible or those cars with adapted plates may not be recognised. SM/MH have met with Lincoln Dawkin, Director of Estates on how car parking can be improved. MH requested that this information is useful for building a programme of work for the Mystery Shoppers and asked the Board to advise him if they became aware of any other suggestions. BS noted her support for the Mystery Shopper programme, advising that the targeting of specific areas will be powerful and she looks forward to seeing the report. | |
| | In response to a query from JG, MH advised that the CQC benchmark report on 2018 Children and Young People's Patient Experience Survey has not yet been received. MH will follow this up. | MH |
| | A discussion took place on the lack of response from doctors responding to bleeps, the reasons for this and whether there has been any action/improvement. MH confirmed that he would follow up. | MH |
| | JG stated that communication is a key theme and queried whether the Trust utilises Write to Me, whereby correspondence is sent to patients copying in the doctor, rather than vice versa. KP confirmed that there has been a shift towards this approach. | |
| | SM referred to page 4 of the presentation and requested more clarity on the PALS/Complaints figures contained therein, as her view is that the colours used in the presentation are confusing. | MH |
| | A discussion took place on the use of ward numbers as opposed to ward names, with SM reporting that it's unclear as to which ward deals with which area of health. She noted that this might be confusing for patients too. AH reported that this has been discussed by Trust Board before and there are some challenges with naming wards versus using numbers alone, such as patient confidentiality | |

| MINUTE REFERENCE | DISCUSSION | ACTION |
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and issues which may arise if patients are placed on a ward which is not specific to their medical condition. However GS noted that there is no reason why we shouldn't include this in reports for Board and committees and he will see this is done in future.

SM referred to the improvements in complaint response rates. MH stated that further improvement has been seen since the production of this report. Staffing has increased and a Kaizen event took place to review the process. In August 2019, the response rate (within the 25 working day standard) stood at 47% and there was a backlog of over 100 complaints. The actions taken have now led to 92% response rate and a backlog of 11. The position is therefore very much improved. Fewer complaints tend to be received over the November/December period and this has allowed focus on the backlog.

SM formally requested that communication with patients is a key focus, in particular the issue of answering of telephones on wards.

Trust Board **NOTED** the report.

**HTB 20/014** **SAFEGUARDING ADULTS AND CHILDREN REPORT**

NM provided the Q3 report. She highlighted the status of referrals to social care and that the figures continue to be positive in reflecting that staff are following safeguarding procedures. The primary reason for children being referred is emotional abuse and for adults is neglect. A system-wide approach is being taken.

Training compliance levels were discussed and it was confirmed that level one Safeguarding training can be completed via the Trust's e-learning system.

Audits have identified that the Trust's compliance and consistency in some areas as not achieving the required standard and NM assured that the safeguarding team and midwives are providing support and focus where necessary. Re-auditing is taking place frequently in order to ensure improvements are being made.

In response to a query from BS on agencies working collaboratively across the patch, NM confirmed that multi-agency approach is working more effectively than it has previously. There is a safeguarding hub in place and UHCW has involvement where necessary.

Trust Board **NOTED** the report.

**HTB 20/015** **WORLD CLASS TRANSFORMATION REPORT**

DG reported on the UHCWi and Organisational Development activity as outlined in the report.

AH noted that there is continued external interest in the UHCWi programme and a discussion will take place on how the work continues, post the Virginia Mason collaboration of the past 5 years. AH referenced a recent article in the British Medical Journal on **AH**

| MINUTE REFERENCE | DISCUSSION | ACTION |
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effectiveness of the VMI programme and this will be circulated to the Board.

A discussion took place on the NHS staff survey. SM noted that she felt the 40% response rate was low, however AH informed that this was a good response rate comparative to other NHS organisations. The importance of the results of the staff survey was noted and the CQC take an interest in the results. DG outlined some of the actions taken in previous years to encourage staff to take part in the survey. SM requested that further options are explored in order to encourage wider participation and improve the response rates in future.

**BREAK**

**HTB 20/016** **INTEGRATED QUALITY, PERFORMANCE AND FINANCE REPORT**

**Performance** - LC highlighted the following key messages:

- The trust is not meeting the four-hour national target, nor meeting cancer performance targets, however there have been improvements in these areas since December.
- 52-week wait position remains at zero. This is a result of the good work of the RTT team and governance now in place.
- The Trust is not monitoring deterioration in waiting times, as it is currently taking part in a national pilot.
- The national position on Diagnostics is very challenged, however UHCW continues to deliver to target.

There was a specific item on Long length of Stay and Emergency Department performance later on the agenda. It was suggested that areas where the Trust is an outlier be included in the Executive Summary of the report for clarity.

**Quality and Safety** – it was noted that there were no Never Events. NM reported that cases of C-Diff stood at 10 and the reasons for this increase relate to a new national treatment for haematology patients resulting in more tests being carried out and finding C-Diff, which is an underlying condition in many patients with no ill effects. This rise has also been seen in other Trusts.

KP noted that Hospital Standard Mortality Ratio (HSMR) is reported at 123 cases. There is an issue around coding and there is a need to carefully monitor this.

MH updated the board on the status of overdue Serious Incident reports, advising that the position continues to worsen and is being tackled with urgency. Deterioration is due to an increase in complexity. Actions taken around this issue include the Trust recruiting to more investigator roles, a governance review scheduled to take place in February and learning opportunities identified both internally and externally.

SM referred to the ambulance handover figures on page 10 of the report and queried whether actions could be taken to improve the position. LC explained that the Trust was an outlier in this area last

| MINUTE REFERENCE | DISCUSSION | ACTION |
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year and has since focussed on how to work more collaboratively with West Midlands Ambulance Service. There are some small opportunities to improve in this area. The Trust tends to experience breaches when high volumes of ambulances are received and has on occasion, received 18-20 ambulances within one hour. It is not possible to manage such numbers, however the Trust has instead looked at how quickly it can recover. A system-wide approach has been taken and significant improvements have been made. However, it is apparent that the more the Trust delivers and improves handover, the more ambulances are sent and the Trust is now beginning to see more ambulances from the East Midlands region too. LC advised that this issue is being addressed through the A&E Delivery Board. **LC**

IB suggested that in order to better understand and manage ambulance handovers, it would be useful to carry out a focussed piece of work to monitor the number of ambulances received by the Trust and from what geographical area they originate. LC advised that she would commission this piece of work and provide a report to Finance and Performance Committee.

AH highlighted that UHCW has not experienced any 12-hr trolley waits in almost ten years. He reported that many Trusts see these long waits on a daily basis, therefore the Trust should be proud of this achievement.

**Finance**

SR reported the month 9 position. There is £10m of savings still to be found. However there has been positive movement on this since the previous report to Board. The Trust is forecasting £29.5m of waste reduction (plan is for £36m) and cannot underestimate size of waste reduction achieved to date.

The £10m future savings figure is driven by the shortfall on waste reduction and increased operational pressures. SR is in discussions with CCG regarding an additional contractual payment and is awaiting a decision on this. The capital plan has been accelerated as notification of capital has been received very late in the year.

SM emphasised the importance of the continued focus on removing cost from the organisation and SR agreed that cost reduction is key.

**Workforce**

DG reported that the vacancy rate in November/December had increased slightly.

Absence levels remain above the Trust target; this is a stubborn area and the Trust is not seeing movement. The MSK self-referral programme has been piloted in clinical areas and this has led to a reduction in MSK related absence. The programme is now being rolled out to all staff in a phased way. The Employee Assistance Programme has been launched. Staff can use this service for a wide range of issues and it is hoped that it will contribute to preventing some absences.

The figures for mandatory training remain above the Trust target and

| MINUTE REFERENCE | DISCUSSION | ACTION |
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the position has been maintained despite operational issues.

There has been a small increase in the number of non-medical appraisals. Medical appraisal figures have been maintained.

SM commended the status of appraisal completion and mandatory training. She added that she supports the accelerated MSK programme as she had seen success with this in other settings.

Trust Board **NOTED** the content of the report.

**HTB 20/016** **PROGRESS AGAINST ANNUAL ORGANISATIONAL GOALS**

JR provided the update, advising that steady progress is being made against the goals. A key highlight is the movement on the frailty pathway and the improvements have recently been presented at Trust Delivery Group.

The MSK pathway is also moving forward and constructive discussions are taking place with CWPT in relation to partnership working to deliver improved outcomes.

There has been a delay in the stroke pathway, due to election purdah and the Worcester Partnership issues are still paused. JR will report back to the Board in due course on these matters.

In response to a point made by EMS in relation to ensuring that the MSK pathway is developed in line with the patient point of view, JR gave assurances that this is the case. The pathway is end-to-end and patient centred, with a focus on removing waste and duplication from the system.

SM referred to the bid of £150k to extend the frailty pilot. She noted that it is evident that good outcomes are emerging from the pilot and queried what is required in order to move out of pilot stage to implementation stage. JR advised that this is key priority for Place within the Health and Care Partnership, however there are a number of challenges which need to be addressed with external partners.

BS referred to the development of St Cross Hospital and queried the timescale for this, noting that pace is important. JR advised that the development of theatres is key and that a business case will be completed by March. The plans for St Cross, working in conjunction with other partners, should develop over the next 6-12 months.

In relation to theatres, AH added that consideration will be given to using 3P, a methodology advocated by VMI and how to build with flow and Lean in mind from the outset.

Trust Board **NOTED** the report.

**HTB 20/017** **LONG LENGTH OF STAY (LLOS) AND ED**

LC gave a presentation on the Trust's focus on LLOS and ED.

She explained the LLOS >21 day target and the drive to improve the national position, when 40% reduction targets were set. The targets were set on bed base and at that time, the Trust's LLOS position was

| MINUTE REFERENCE | DISCUSSION | ACTION |
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182. The current target for the Trust is to meet a position of 109 (9% of bed base).

Lots of work has been undertaken in order to improve and LC took the Board through the key actions as detailed within the presentation. These are;

- A Patient Choice Policy
- A frailty pathway pilot and external clinical review
- Development of internal professional standards for discharge
- Deep Dives into specific internal delays;
    - Waiting for tests
    - Decision to admit pathway use
- Pathway reviews and more effective communication
- Promotion and re-launch of pathways available and Integrated Discharge Team (IDT) function versus ward standard work
- Increased governance and process on base 2 patients (patients who are not bedded in optimal areas) specifically on AMU areas
- Standard work on wards through handover and effective information sharing
- Collaborative partnership working using UHCWi methodology – Value Stream Sponsorship Team has been set up and is progressing on complex discharge pathways

There has been increased focus on working closely with the Group Directors of Nursing and AHPs and wards taking more ownership for discharge. There is also opportunity in the IDT who work on complex discharges.

Further work is also being carried out on Discharge to Assess process and identifying which pathway patients fell into. The CCG will carry out an audit on this to identify opportunity.

BS suggested that standardised procedures used by staff could make a big difference to the figures and queried how the Trust is ensuring standard work is in place across the wards. NM explained that a value stream took place for simple discharge and a number of areas were identified which make a difference to the number of discharges. For example, visible boards in place that show which patients are ready to be discharged, TTOs being ready on time and ensuring that scans/blood tests are reviewed early. There are staff in post to facilitate and coordinate these actions. There are also senior meetings scheduled to ensure that there is discipline applied to the process and to provide support.

SM noted that LLOS is an issue for many Trusts but they were managing to improve their position. UHCW is an outlier as its position is worsening and there is a need to understand why this is and focus on changing the position.

JMG referenced the Patient Choice Policy and suggested that the earlier the discharge arrangement discussions take place, the more impact it might have. KP noted that this is part of the focus of the complex discharge value stream and will be looked at in detail. He added that there is also currently no single trusted assessor process in place (which does exist in some other areas) and there is a need to

| MINUTE REFERENCE | DISCUSSION | ACTION |
|---|---|---|

reach that status by agreement with partners. Standard work will then be put in place.

A discussion took place on patients who are being treated at home (UHCW at Home) and it was confirmed that the LLOS figures include those patients. LC advised that the Trust LLOS figures would be on target if those patients could be removed, however it is not possible to do so. KP added that he had challenged NHS England/Improvement on the inclusion of these figures, as they artificially inflate the Trust's position. The Trust is an outlier, but partly for a positive purpose. SM suggested that reference to this is made in response to their escalation letter.

The Board discussed the impact of geography and the stated aim of repatriation of patients within 48 hours. LC advised that an escalation process is in place and this is working effectively. However there is a need to ensure that patients are in the best place to receive the care they need. In response to a query from EMS, LC advised that this Trust must accept patients from outside of the area due to its status as Major Trauma Centre.

LC summarised the status of Emergency performance. There has been improvement in January, however the acuity of patients has increased and Full Capacity Protocol (FPC) has been enacted on two occasions. Recovery from FPC was positive and resilience of staff was demonstrated.

LC explained what the Trust has done differently this year to meet emergency demand, which includes.

- Planned elective activity was reduced with clear governance and daily management
- Frailty pilot
- Reverse boarding policy and protocol in place
- Increased senior management in each Group on site in the evening to support flow
- Standard work in the Site Team and for Managers of the Day for clear discharge management
- Improved electronic governance of Rugby patients and better use of Rugby capacity
- Review of the criteria for escalation areas and the Patient Transit Facility to ensure effective use of resources to manage demand.
- Increased awareness of hot clinic availability to manage demand effectively

In response to a query from SM, she explained the reverse boarding process. This focuses on moving patients who are ready to be discharged into an alternative area in order that their beds can be utilised for incoming patients. This requires increased collaborative working with wards and forces flow in the Trust.

LC explained the graphs relating to the correlation between ED, LOS and bed occupancy, advising that there is no correlation between LLOS and ED performance. 7-day LLOS shows stronger correlation and this is where the biggest opportunity lies.

SM suggested that there may be limited statistical links, however it is

| MINUTE REFERENCE | DISCUSSION | ACTION |
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| | likely that there is a cultural link in the way the Trust manages bed occupancy.<br><br>KP referred to a recent report on ED flow and noted the three areas identified as being statistically significant. They are; the ability to manage surges in capacity, the physical square footage of the ED and the timeliness of senior medical review. KP noted that the footprint of the UHCW ED (i.e. the floor space), is the second lowest in the Midlands and that this needs to be addressed.<br><br>Trust Board **RECEIVED ASSURANCE** from the information presented. SM thanked LC for the presentation and the Board recognised the efforts of the Operations team and focus it has placed on the importance of LLOS. Continued focus is required and although the overview is reported via the Integrated Quality, Performance and Finance Monthly Report, it would be helpful to include further detail on status and regional position for future reports to the Board itself. | |
| **HTB 20/018** | **SEVEN DAY SERVICES**<br><br>KP summarised the content of the report, advising of the focus on timeliness of first consultant review and the process changes in this area. KP referred to the graphs and explained that the audit results are being analysed and there is still some work to do. Job planning will be in place in the next 3-6 months.<br><br>In response to a query from SM, KP confirmed that the standards will not be met by the end of March 2020, however the aspiration is to do so by March 2021. He explained that there are nuances behind the definition of compliance and advised that the Trust is aiming to improve outcomes and is therefore focussing on ensuring the patient sees a specialist consultant.<br><br>SM acknowledged that the decisions taken by the Trust needs to be meaningful, however if that means UHCW will not meet its target in this area, correspondence will need to go to NHS England/Improvement explaining the reasons for this. KP gave a commitment to send such a letter. | **KP** |
| | Trust Board **NOTED** the report and recognised that the clinical standards will not be achieved by March 2020, but took the view that to achieve the real purpose of seven day coverage patients should be seen by the relevant specialist consultant and this means there will be a delay in the Trust achieving compliance with the seven day target. | |
| **HTB 20/019** | **FREEDOM TO SPEAK UP/RAISING CONCERNS BI-ANNUAL REPORT**<br><br>LS joined the meeting and summarised the content of the report. There has been a focus on internal networking to improve triangulation of information, creation of a production board and a new-self assessment tool.<br><br>In response to a query from EMS, LS confirmed that follow-ups are undertaken with staff after 3-6 months. DG added that intelligence | |

| MINUTE REFERENCE | DISCUSSION | ACTION |
|---|---|---|
| | from the staff survey can be utilised to ensure that the speaking up process is effective.<br><br>The self-assessment/improvement tool was discussed. GS advised of the need to ensure that sensitivity is applied and confidential information is not exposed.<br><br>SM stated that on occasion, issues are raised which should be dealt with by line managers and LS ensures that those are managed back to the appropriate area.<br><br>GS advised that there was a presentation to Chief Officer Forum last year on the themes coming out of the queries raised.<br><br>Trust Board **RECEIVED ASSURANCE** from the information provided. | |
| **HTB 20/020** | **FINANCE AND PERFORMANCE COMMITTEE MEETING MONTHLY REPORT**<br><br>Trust Board **RECEIVED ASSURANCE** from the information provided. | |
| **HTB 20/021** | **QUALITY GOVERNANCE COMMITTEE MEETING MONTHLY REPORT**<br><br>EMS reported that changes to the Patient Experience and Engagement Committee Terms of Reference will be finalised in line with the review of the committee terms of reference. GS confirmed he is working on these.<br><br>GD advised that SK was present at the December QGC, however the attendance log does not reflect this. | |
| **HTB 20/022** | **AUDIT COMMITTEE MEETING MONTHLY REPORT**<br><br>JG explained that he has requested that a list of policies and review dates are annually reported to Audit Committee in order to provide assurance that reviews are taking place. | |
| **HTB 20/023** | **QUESTIONS FROM MEMBERS OF THE PUBLIC WHICH RELATED TO MATTERS ON THE AGENDA**<br><br>A question was received from Jean Forbes. She asked if the surgical masks used by the Trust are made in China and if there was a supply chain problem as a result of the outbreak of Coronavirus. SR confirmed that the masks are manufactured in China, however the Trust has alternative suppliers available and there is currently no shortage of masks. GS added that transport restrictions for freight are not currently in place.<br><br>KP provided assurance that the Trust is taking all necessary action in relation to the outbreak and that hourly updates are being received on its prevalence. | |

| MINUTE REFERENCE | DISCUSSION | ACTION |
|---|---|---|
| **HTB 20/024** | **ANY OTHER BUSINESS**<br><br>GS circulated the Fit and Proper Person forms and requested Board members complete and return them to him. | |
| **HTB 20/025** | **NEXT MEETING**<br><br>The next meeting will take place on Thursday 26 March at 10am in the Clinical Sciences Building at UHCW NHS Trust | |

| | |
|---|---|
| **SIGNED** | **…….....** |
| | **CHAIR** |
| **DATE** | **…….....** |

# PUBLIC TRUST BOARD MASTER ACTION MATRIX 2019/20



| Meeting Date | Item | Minute Reference | Action | Lead Officer | Deadline | Update |
|---|---|---|---|---|---|---|
| 30 Jan 2020 | Minutes of the previous meeting | HTB 20/008 | EMS referred to item HTB19/173 (Emergency Planning Response and Resilience (EPRR) Core Standards). He requested that the minutes of the previous meeting be amended to better reflect EMS' support of Luke Peachey, as the current wording might be construed as a criticism and this was not EMS' intention. | Chair/GS | 26 Mar 2020 | 17 Feb - minutes updated, action complete |
| 30 Jan 2020 | Matters Arising | HTB 20/010 | JG referred to page 8 of the minutes (item HTB 19/168, Significant Incident Reporting, paragraph 2). He asked if MH had investigated the reasons for the spike in serious incidents every other month. MH believes that this is a presentational issue related to the date the instance occurred, however he will look further into this and provide a full explanation. | MH | 26 Mar 2020 | 20 Mar - action complete<br>An explanation is provided in the SI report for Board this month. The most recent data shows that reporting has levelled out and whilst there was an increase in reporting in July due to a delay in reporting, measures have been put in place so this does not occur in future. |
| 30 Jan 2020 | Chief Executive and Chief Officer Reports | HTB 20/012 | KP's report was noted and EMS requested a brief report be taken to Remuneration Committee on clinical excellence allowances (CEA). GS and AH suggested that this was not within the remit of the Remuneration Committee however EMS was clear that he wanted to see this. KP said he was happy to share the information. | KP | 26 Mar 2020 | |
| 30 Jan 2020 | Patient Experience (We Care) Report | HTB 20/013 | In response to a query from JG, MH advised that the CQC benchmark report on 2018 Children and Young People's Patient Experience Survey has not yet been received. MH will follow this up. | MH | 26 Mar 2020 | 20 Mar - action complete<br>The Children's and Young People's report has now been received and the results and actions following on from this were discussed at PEEC in February. |
| 30 Jan 2020 | Patient Experience (We Care) Report | HTB 20/013 | A discussion took place on the lack of response from doctors responding to bleeps, the reasons for this and whether there has been any action/improvement. MH confirmed that he would follow up. | MH | 26 Mar 2020 | |
| 30 Jan 2020 | Patient Experience (We Care) Report | HTB 20/013 | SM referred to page 4 of the presentation and requested more clarity is provided in future presentations on the PALS/Complaints figures contained therein, as her view is that the colours are confusing. | MH | 26 Mar 2020 | 20 Mar - action complete<br>Q3 We Care Report has been amended following feedback with notable additions around individuals/board members identified who support the Boardwalks, specialty details of wards when described in the report and a review of colours and arrows so RAG systems are consistent in board reporting. |
| 30 Jan 2020 | World Class Transformation Report | HTB 20/015 | AH referenced a recent article in the British Medical Journal on effectiveness of the VMI programme and this will be circulated to the Board. | AH | 26 Mar 2020 | |
| 30 Jan 2020 | Integrated Quality, Performance and Finance Report | HTB 20/016 | IB suggested that in order to better understand and manage ambulance handovers, it would be useful to carry out a focussed piece of work to monitor the number of ambulances received by the Trust and from what geographical area they originate. LC advised that she would commission this piece of work and provide a report to Finance and Performance Committee. | LC | 26 Mar 2020 | |
| 30 Jan 2020 | Seven Day Services | HTB 20/018 | Letter to be written to NHS England and Improvement explaining that the Trust is currently not meeting its target in this area. | KP | 26 Mar 2020 | |

| Deadline Key: | |
|---|---|
| | Not started |
| | In Progress |
| | Overdue |
| | Completed |

University Hospitals Coventry and Warwickshire NHS Trust

# REPORT TO PUBLIC TRUST BOARD ON 26 MARCH 2020

| | |
|---|---|
| **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

This report outlines a number of activities before the onset of COVID 19. Since the spread of COVID 19, while work has continued in very limited groups and remotely, the flow of normal business has been significantly reduced with cancellation of regional and national events.

However before the arrival of the virus, there have been a number of interesting and useful events. On 4th February the Chair of the Coventry and Warwickshire Partnership Trust and I were briefed by clinical staff on the challenges of dealing with patients with severe mental ill – health in mainstream wards, both within an emergency setting at University Hospital and in the children's ward. The Coventry and Warwickshire Partnership Board and the UHCW Board also met for a "Board to Board" discussion about a range of issues including how to work in collaboration.

I have attended a number of meetings related to the health system across Coventry and Warwickshire. These have included a meeting attended by the Chief Executive and myself hosted by the Leader of Warwickshire County Council, looking at how progress could be made in integrated health services and in particular highlighting the importance of the involvement of the voluntary and community sector. In addition to this I have been at the Health and Care Partnership Advisory Chairs' group, the Partnership Board chaired by Sir Chris Ham and the Joint Place Forum.

Individual events and meetings have included a speaking engagement at the Coventry and Warwickshire Champions meeting, to a group of over a hundred local business and service leaders, where I spoke about the Trust's recent achievement of the "Good" designation, and a meeting of myself and the Chief Executive and Chief Strategy Officer with the Chair of the Coventry and Warwickshire Local Enterprise Partnership about current issues including how to make more links between UHCW research and the work of local businesses – we made a commitment to have more discussions as we go forward. On the 5th March the Chief Medical Officer and I hosted a delegation from NHS Digital and attended a dinner for them at University of Warwick.

Within UHCW, I have met with consultant Andrew Stein and Arts Co-ordinator Emma Linnane to discuss the impact of having arts activity present in the two hospitals of the Trust, I have toured the key plant and boiler room sites in University Hospital and visited the hyperbaric chamber at Hospital of St Cross and as part of the Trust's quality assurance process I have undertaken two board walk rounds, one in Outpatients at St Cross and the other in the Neonatal ward at University Hospital.

As a result of the end of the terms of Ian Buckley and Ed Macalister–Smith I chaired the appointment panel for two new Non–Executive Directors. I also chaired the appointment panel for the Chief Operating Officer which appointed Laura Crowne to the substantive role, to whom, many congratulations.

Dame Stella Manzie

## PREVIOUS DISCUSSIONS HELD

Not applicable

## KEY IMPLICATIONS

| | |
|---|---|
| **Financial** | Not relevant to this item |
| **Patient Safety or Quality** | The board walk rounds mentioned relate to patient experience and safety |
| **Human resources** | Appointment of a) two non - executive directors and b) the Chief Operating Officer are part of the governance arrangements for appointment to the organisation. |
| **Operational** | Not relevant to this item |

University Hospitals Coventry and Warwickshire NHS Trust

# REPORT TO PUBLIC TRUST BOARD

# HELD ON 26 MARCH 2020

| | |
|---|---|
| **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 February and March 2020.

**Professor Andrew Hardy – Chief Executive Officer**

Since the last Board meeting on 30th January 2020 I have been involved in a number of events and meetings.

Firstly, I would like to thank all our staff who have worked so hard to help Trust to achieve its overall rating of 'GOOD' following the latest inspection by the Care Quality Commission. It gave me great pleasure to be able to pass on the good news to staff at both University Hospital and Rugby St Cross prior to the formal announcement. I also had the pleasure of attending a DAISY Award for a member of staff on the Labour Ward – 'daisy awards' offer members of the public an opportunity to thank Nurses and Midwives who have gone above and beyond. I have also continued my usual CEO Direct sessions across both Trust sites.

Other internal commitments have included Group Finance Escalation meetings to ensure each of the Groups are working within their required budgets, an Ideas Den (a 'Dragons Den' type event to encourage staff to pitch their waste reducing / money saving ideas), undertaking the formal recruitment process for the Chief Operating Officer role, attending the Leading Together for Service Leaders 20 (Residential 2 event) and I attended the feedback session following a Quality Assurance visit by the Warwickshire, Solihull and Coventry Breast Screening Unit.

In relation to the System Transformation Plan (STP) I have attended the local monthly Partnership Executive Group meetings, attended the 3rd 'Time Out' session with the STP Chair and partnership agencies, attended the STP and ICS Leaders' Development Day and the Quarterly Coventry and Warwickshire STP System Review meeting with NHSE/I.

In regard to VMI I have attended the local Trust Guiding Team meetings and the formal Transformation Guiding Boards in London where all five participating Trust's engage.

With our commitment to working collaboratively with all our partner agencies we have had a Board to Board meeting with Coventry and Warwickshire Partnership Trust, the Health Partnership Board, attended a Warwickshire Health and Care Roundtable discussion with colleagues from Warwickshire County Council, attend the Coventry and Warwickshire LEP and UHCW meeting,

I have also been required to attend various external meetings which have included the NHS CEO Forum and dinner in London, the Warwick Business School Advisory Board meeting, the Health and Care Leaders Forum (as part of the NHS Confederation's Integrated Care Systems Network) with Niall Dickson, various CIPFA related meeting (The Chartered Institute of Public Finance and Accountancy) along with the CIPFA Midlands Annual General Meeting, the NHS Providers Chairs and Chief Executives Network event in London and Clive Lewis from Globis.

And finally, as part of the "a day in the life of …..", where Chief Officers have the opportunity to experience different roles and services across the Trust, I had the pleasure of spending a couple of hours with the Orthopaedic Therapy Team on Cedar Ward (Rugby St Cross) learning about the service they provide.

**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 | Consultant Position |
|---|---|
| Dr Timothy Davies | Consultant Anaesthetist with an interest in General/Emergency Anaesthesia |
| Dr Charles Pairaudeau | Consultant Anaesthetist with an interest in General/Emergency Anaesthesia |
| Dr Umair Ansari | Consultant Anaesthetist with an interest in Education/Simulation |
| Dr Satyam Kumar | Consultant Gynaecological Oncologist |
| Mr Jeremy Twigg | Consultant Gynaecological Oncologist |
| Dr Nwe Ni Than | Consultant Hepatologist |
| Dr Chander Shekhar | Consultant Gastroenterologist with an interest in therapeutic and interventional endoscopy |
| Dr Ruhina Ahmed | Consultant Gastroenterologist with an interest in Upper GI |
| Mr Muhammad Aslam | Consultant Colorectal Surgeon |
| Ms Abhilasha Patel | Consultant Colorectal Surgeon |

## KEY IMPLICATIONS:

| | |
|---|---|
| **Financial:** | None |
| **Patients Safety or Quality:** | None |
| **Human Resources:** | None |
| **Operational:** | None |

University Hospitals Coventry and Warwickshire NHS Trust

# REPORT TO PUBLIC TRUST BOARD
# HELD ON 26 MARCH 2020

| | |
|---|---|
| **Subject Title** | Trust Response to COVID-19 Pandemic |
| **Executive Sponsor** | Laura Crowne, Chief Operating Officer |
| **Author** | Laura Crowne, Chief Operating Officer |
| **Attachments** | Draft corporate risk – Impact of COVID-19 Epidemic on UHCW<br>(to follow) |
| **Recommendation(s)** | Board is asked to **RECEIVE ASSURANCE** from the attached report |

## EXECUTIVE SUMMARY

This paper addresses the current and anticipated implications of the spread of COVID-19 and seeks to provide assurance where possible about the Trust's preparedness.

Verbal updates will supplement this report as the situation is fast moving and some issues are still being addressed.

## PREVIOUS DISCUSSIONS HELD

Daily silver command meetings

Twice-weekly gold command meetings

## KEY IMPLICATIONS

| | |
|---|---|
| **Financial** | Unknown at this stage but additional costs likely to be covered by NHSI |
| **Patient Safety or Quality** | Impact on patients who succumb to the virus and have to be hospitalized and the knock on implications on the Trust's ability to treat other patients, especially elective activity. |
| **Human resources** | Flexible working practices will be required to address staff shortages and target critical activity at the expense of less important work |
| **Operational** | Operations targeted towards freeing up inpatient capacity, especially to provide critical care |

## 1. INTRODUCTION

1.1 The world-wide pandemic of COVID-19 (also known as Coronavirus) is having massive impact on the country as a whole, the wider NHS and the system. Guidance and instruction is being issued daily by the government and its agencies and this report is by definition a snapshot of the current situation.

1.2 As it is a new virus, the lack of immunity in the population (and the absence as yet of an effective vaccine) means that COVID-19 has the potential to spread extensively. The current data seem to show that we are all susceptible to catching this disease, and thus it also more likely than not that the UK will be significantly affected. Among those who become infected, some will exhibit no symptoms. Early data suggest that of those who develop an illness, the great majority will have a mild-to moderate, but self-limiting illness – similar to seasonal flu.

1.3 It is, however, also clear that a minority of people who get COVID-19 will develop complications severe enough to require hospital care, most often pneumonia. In a small proportion of these, the illness may be severe enough to lead to death. So far the data we have suggest that the risk of severe disease and death increases amongst elderly people and in people with underlying health risk conditions (in the same way as for seasonal flu)

1.4 Illness is less common and usually less severe in younger adults. Children can be infected and can have a severe illness, but based on current data overall illness seems rarer in people under 20 years of age. So far, there has been no obvious sign that pregnant women are more likely to be seriously affected.

## 2. GOVERNANCE AND COMMUNICATION

2.1 'Silver' (operational) meetings are being held daily and 'Gold' (strategic) meetings are being held twice weekly, at present. A situation report is provided to NHSE every day (including weekends) which covers 31 separate data items and also requires an exception report for additional operational challenges.

2.2 There is a detailed standard operating procedure (SOP) for dealing with COVID-19 which is being reviewed and revised as more information and guidance is received. This includes flow charts for dealing with various scenarios of patients presenting at both University Hospital and St Cross and infection control instructions for staff for themselves and to give to patients.

2.3 At this time we have 5 key work streams set up based on the COVID-19 prioritise which are; Business continuity, Patient pathways and Training, Workforce, Communication and Procurement/Supplies. These have changed recently as we move into different phases on COVID-19 management and are reviewed regularly.

2.4 The Chief Medical Officer has also established a Clinical COVID Group to address the clinical implications and decisions needed, especially in light of new clinical guidance issued but also to work through the preparation arrangements that need to be put in place.

2.5 The Chief Operating Officer has also established an incident co-ordination centre in line with national guidance to support transacting key day to day operational management and have clear robust governance of the decisions made in line with major incident protocols.

2.6 Daily bulletins are issued to chief officers, members of 'silver' command and on call managers and executives. This is also been shared with non-executive directors.

2.7 Regular bulletins are being issued to all staff, and managers' guidance is also being sent based on the latest information. Managers are being encouraged to be more visible than usual and to keep themselves aware of current staffing issues and support the Trust's mitigation plans.

2.8 A TrustNav page has been established which has links to internal and external documents and guidance and is accessible to all onsite staff.

## 3. INFRASTRUCTURE AND EQUIPMENT

3.1 Additional testing 'pods' have been established in the WISDEM centre and outside the emergency department. The ED pods are only open when the WISDEM centre is closed (i.e. out of hours) or if referred to by staff at WISDEM pods.

3.2 Personal protective equipment (PPE) is being sourced and managed centrally by the NHS in order to ensure effective distribution. We are aware that nationally there are challenges and have seen some areas raising concerns internally however we are maintain stock levels accordingly.

## 4. PREPARATION AND MITIGATION

4.1 The exponential growth in cases means that we are preparing the Trust for many more patients and will be looking to free up inpatient beds and make more beds capable of acting as critical care beds. We are also preparing to divert staff from non-clinical areas to support clinical or other business critical activities (e.g. procurement) and to divert clinical staff to areas where they can support the anticipated growth in patients. These arrangements also need to be in place to address the anticipated increase in staff absence due to sickness or self-isolation over the coming weeks and months.

4.2 Non-critical meetings are being stood down and those that happen are being shortened and telephone or video technologies are being used where possible. Non-site based staff (including non-executive directors) are being encouraged to only come on site if absolutely necessary in line with NHSE guidance.

4.3 A new corporate risk addressing the impact of COVID-19 has been discussed at Risk Committee which sets out many of the risks and mitigations currently being considered, and a paper describing these is attached for information. This will be kept under constant review and provides a useful summary of the

## 5. CONCLUSION

5.1 Both the spread of COVID-19 and its impact are increasing exponentially so much of the information outlined may change in the coming days and months. Board members will be kept up to date as situations develop and changes to the way the Trust works will be inevitable.

University Hospitals Coventry and Warwickshire NHS Trust

# REPORT TO PUBLIC TRUST BOARD
# HELD ON 26 MARCH 2020

| | |
|---|---|
| **Subject Title** | Integrated Quality, Performance & Finance Report – Month 11 – 2019/20 |
| **Executive Sponsor** | Karen Martin, Chief Workforce and Information Officer |
| **Author** | Daniel Hayes, Director of Performance & Informatics |
| **Attachment(s)** | Integrated Quality, Performance & Finance Report – Reporting period: February 2020 |
| **Recommendations:** | For Noting |
| Trust Board is asked to review and note the contents of the report. | |

## EXECUTIVE SUMMARY

The attached Integrated Quality, Performance & Finance Report covers the reported performance for the period ending 29th February 2020.

The Trust has achieved 16 of the 33 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.

Key indicators in breach are the Trusts performance against:

- 18 Weeks Referral to Treatment Time
- Average Number of Daily Stranded Patients

Key indicators achieving the target include:

- All National Cancer Standards
- Complaints Turnaround
- Mandatory Training Compliance

The Trust delivered performance of 82.0% on the four hour national standard in February, below the national standard of 95%. This is an improvement of 1.1% from last month. UHCW was below the latest available benchmarked positions (February) for England but above benchmarked position for the Midlands.
The RTT incomplete position remains below the 92% national target and stands at 80.8% in January.

The Trust reported no 52 week incomplete pathway breaches in January. This compares to a national average of 9.

In January all eight national cancer standards were achieved. All 31 day standards remain above target for the year to date.

The latest published HSMR is reported at 108.26 which is within Dr Foster's calculated relative risk range.

At month 11, the Trust reported a £4.6m deficit in line with the plan.

| **PREVIOUS DISCUSSIONS HELD** |
|---|
| *Standard monthly report to Trust Board* |

| **KEY IMPLICATIONS** | |
|---|---|
| **Financial** | Deliver value for money and compliance with NHSI |
| **Patients Safety or Quality** | NHSI and other regulatory compliance |
| **Human Resources** | To be an employer of choice |
| **Operational** | Operational performance and regulatory compliance |

NHS
University Hospitals Coventry and Warwickshire NHS Trust

# Integrated Quality, Performance and Finance Reporting Framework

## Reporting period: February 2020

# Contents

NHS
University Hospitals Coventry and Warwickshire NHS Trust

# Executive Summary



## 16 KPIs achieved the target in February

| | Indicators achieved | Indicators in exception | Indicators in watching status | Total indicators |
|---|---|---|---|---|
| Safest care and excellent experience | 6 | 3 | 0 | 9 |
| Leader in operational performance | 5 | 6 | 0 | 11 |
| Model employer | 2 | 1 | 2 | 5 |
| Achieve financial sustainability | 2 | 1 | 0 | 3 |
| Frontrunner in research innovation and education | 1 | 3 | 1 | 5 |
| All domains | **16** | **14** | **3** | **33** |

### KPI Hotspot

**What's Good?**

- All National Cancer Standards Achieved
- Complaints Turnaround
- Mandatory Training Compliance

**What's Not So Good?**

- 18 Weeks Referral to Treatment Time
- Average Number of Daily Stranded Patients

**The Trust has achieved 16 of the 33 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.**

The Trust delivered performance of 82.0% on the four hour national standard in February, below the national standard of 95%. This is an improvement of 3.1% from last month. UHCW was below the latest available benchmarked position for England but above the Midlands.

The RTT incomplete position remains below the 92% national target and stands at 80.8% in January.

The Trust reported no 52 week incomplete pathway breaches in January. This compares to a national average of 9.

All national cancer standards were achieved for January. This is the first time since April 19 that this has been achieved. For a second consecutive month the 62 day referral to treatment target has been achieved.

The latest published HSMR is reported at 108.26 which is within Dr Foster's calculated relative risk range.

C diff has had two cases in February. C diff cases remain below the quarterly ceiling for quarters Q3 and Q4 to date.

At month 11, the Trust reported a £4.6m deficit in line with the plan.

# Trust Scorecard

## Reporting Month February 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 |
| **Safest care and excellent experience** | | | | | | | | |
| | **Infection Control** | | | | | | | |
| | Healthcare associated incidents of Clostridioides difficile - Cumulative | 62 | 64 | ⇩ | 55 | 60 | CNO | |
| | MRSA Bacteremia - Trust Acquired - Cumulative | 0 | 0 | ⇨ | 0 | 0 | CNO | |
| | **Safe Care** | | | | | | | |
| | Never Events - Cumulative | 0.0 | 0.0 | ⇨ | 0 | 0 | CMO | |
| | Serious Incidents - Number | 11 | 10 | ⇧ | 15 | 15 | CQO | |
| | HSMR - Basket of 56 Diagnosis Groups (3 months in arrears) | 89.14 | 108.26 | ⇩ | RR | RR | CMO | |
| | SHMI - Quarterly (6 months in arrears) | 108.71 | 108.78 | ⇩ | RR | RR | CMO | |
| | Average Number of Long Length of Stay Patients | 229 | 210 | ⇧ | 109 | 109 | CNO | |
| | **Patient Experience** | | | | | | | |
| | Friends & Family Test - Recommender Targets Achieved | 1 | 1 | ⇨ | 7 | 7 | CQO | |
| | Complaints Turnaround <= 25 Days (1 month in arrears) | 100% | 100% | ⇨ | 90% | 90% | CQO | |
| **Leader in operational performance** | | | | | | | | |
| | **Patient Flow** | | | | | | | |
| | Emergency Care 4 Hour Wait | 78.9% | 82.0% | ⇧ | 95% | 95% | COO | |
| | Bed Occupancy Rate - KH03 (3 months in arrears) | 97.5% | 99.8% | ⇩ | 93% | 93% | COO | |
| | Delayed Transfers as a Percentage of Admissions | 5.2% | 5.2% | ⇧ | 3.5% | 3.5% | COO | |
| | Breaches of the 28 Day Readmission Guarantee | 23 | 6 | ⇧ | 0 | 0 | COO | |
| | Diagnostic Waiters - 6 Weeks and Over | 0.19% | 0.18% | ⇧ | 1% | 1% | COO | |
| | **RTT** | | | | | | | |
| | 18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears) | 82.3% | 80.8% | ⇩ | 92% | 92% | COO | |
| | RTT 52 Week Waits Incomplete (1 month in arrears) | 0 | 0 | ⇨ | 0 | 0 | COO | |
| | Last Minute Non-clinical Cancelled Operations - Elective | 0.6% | 0.7% | ⇩ | 0.8% | 0.8% | COO | |
| | **Cancer** | | | | | | | |
| | Cancer 62 Day Standard plus 31 Day Rare Cancers (1 month in arrears) | 86.67% | 86.28% | ⇩ | 85% | 85% | COO | |
| | Cancer 104+ Day Waits (1 month in arrears) | 6.5 | 2.0 | ⇧ | 0 | 0 | COO | |
| | National Cancer Standards Achieved (1 month in arrears) | 6 | 8 | ⇧ | 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 February 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 | 95.59% | 95.58% | ⇩ | 95% | 95% | CWIO | |
| | Appraisal - Non-Medical | 85.19% | 86.66% | ⇧ | 90% | 90% | CWIO | |
| | Appraisal - Medical | 97.69% | 95.55% | ⇩ | 90% | 90% | CWIO | |
| | Sickness Rate | 4.80% | 4.43% | ⇧ | 3.99% | 3.99% | CWIO | |
| | Staff Survey - Recommending as a Place of Work (Quarterly) | N/A | 65.30% | | 70% | 70% | CWIO | |
| **Achieve financial sustainability** | | | | | | | | |
| | Income & Expenditure Margin Rating | 3 | 3 | ⇨ | 3 | 2 | CFO | |
| | Forecast Income & Expenditure - £'000 | 0 | 0 | ⇨ | 0 | 0 | CFO | |
| | WRP Delivery - £'000 | 26327 | 28307 | ⇧ | 31057 | 36000 | CFO | |
| **Frontrunner in research innovation and education** | | | | | | | | |
| | Patients Recruited into NIHR Portfolio-Cumulative (2 months in arrears) | 3078 | 3337 | ⇧ | 3062 | 4083 | CMO | |
| | Commercial Income Invoiced £000s - Cumulative (1 month in arrears) | 669 | 730 | ⇧ | 750 | 900 | CFO | |
| | NIHR Research Capability Funding (£000s) | 246 | 246 | ⇨ | 750 | 1000 | CMO | |
| | Trial Recruitment Income (£000s) | 874 | 874 | ⇨ | 2363 | 3150 | CMO | |
| | All Grant Income (£000s) | 1489 | 1489 | ⇨ | 1650 | 2200 | CMO | |

# Trust Heatmap

NHS
University Hospitals Coventry and Warwickshire NHS Trust

Performance Summary

| Reporting Period: | | | | | | | | February 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 | 4 | 26 | 7 | 8 | 0 | | 0 | 64 | 55 |
| MRSA Bacteremia - Trust Acquired - Cumulative | 0 | 0 | 0 | 0 | 0 | | 0 | 0 | 0 |
| Never Events - Cumulative | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | | 0.0 | 0.0 | 0 |
| Serious Incidents - Number | 1 | 2 | 4 | 1 | 0 | 1 | 0 | 10 | 15 |
| HSMR - Basket of 56 Diagnosis Groups (3 months in arrears) | 82.03 | 105.18 | 94.60 | 49.61 | 82.53 | | | 108.26 | 100 |
| Average Number of Long Length of Stay Patients | 5 | 102 | 69 | 26 | 0 | 0 | 8 | 210 | 109 |
| Friends & Family Test - Recommender Targets Achieved | 0 | 0 | 0 | 0 | 1 | 2 | 1 | 1 | 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 | 80.2% | | | 100.0% | 99.4% | | | 82.0% | 95% |
| Breaches of the 28 Day Readmission Guarantee | | 0 | 4 | 2 | 0 | | 0 | 6 | 0 |
| Diagnostic Waiters - 6 Weeks and Over | | 0.98% | 0.18% | 1.71% | | 0.05% | | 0.18% | 1% |
| 18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears) | | 85.0% | 77.9% | 80.0% | 81.4% | 76.7% | 74.5% | 80.8% | 92% |
| RTT 52 Week Waits Incomplete (1 month in arrears) | | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0 |
| Last Minute Non-clinical Cancelled Operations - Elective | 0.0% | 0.0% | 1.7% | 1.9% | 0.7% | 0.0% | 1.2% | 0.7% | 0.8% |
| Cancer 62 Day Standard plus 31 Day Rare Cancers (1 month in arrears) | | 90.41% | N/A | 83.33% | 100.00% | | | 86.28% | 85% |
| Cancer 104+ Day Waits (1 month in arrears) | | 0.0 | 0.0 | 2.0 | 0.0 | | | 2.0 | 0 |
| National Cancer Standards Achieved (1 month in arrears) | | 6 | 5 | 5 | 6 | | | 8 | 8 |
| **Model employer** | | | | | | | | | |
| Mandatory Training Compliance | 93.48% | 95.32% | 93.75% | 94.50% | 94.87% | 95.90% | 97.53% | 95.58% | 95% |
| Appraisal - Non-Medical | 87.41% | 82.64% | 82.02% | 88.14% | 89.25% | 87.92% | 94.43% | 86.66% | 90% |
| Appraisal - Medical | 92.00% | 95.89% | 96.64% | 96.33% | 98.08% | 96.72% | 91.25% | 95.55% | 90% |
| Sickness Rate | | | | | | | | | 3.99% |
| Staff Survey - Recommending as a Place of Work (Quarterly) | | | | | | | | 65.30% | 70% |
| **Achieve financial sustainability** | | | | | | | | | |
| WRP Delivery - £'000 | 1653 | 4560 | 2112 | 2373 | 2748 | 1265 | 4583 | 28307 | 31057 |
| **Frontrunner in research innovation and education** | | | | | | | | | |
| Patients Recruited into NIHR Portfolio-Cumulative (2 months in arrears) | 118 | 922 | 539 | 246 | 1031 | 107 | 374 | 3337 | 3062 |

# Performance Trends



**Improving**

**(3 months consecutive improvement)**

| Measure | Target | Mar 2019 | Apr 2019 | May 2019 | Jun 2019 | Jul 2019 | Aug 2019 | Sep 2019 | Oct 2019 | Nov 2019 | Dec 2019 | Jan 2020 | Feb 2020 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Emergency Care 4 Hour Wait | 95% | 80.9% | 82.9% | 87.6% | 88.1% | 88.8% | 85.2% | 81.6% | 80.6% | 75.5% | 77.3% | 78.9% | 82.0% |

- Emergency Care 4 Hour Wait has shown three months improvement since its low point in November 2019.

**Deteriorating (green indicators worsening)**

**(3 months consecutive deterioration)**

- No achieving KPIs have shown 3 consecutive months deterioration

**Deteriorating (red indicators worsening)**

**(3 months consecutive deterioration)**

| Measure | Target | Mar 2019 | Apr 2019 | May 2019 | Jun 2019 | Jul 2019 | Aug 2019 | Sep 2019 | Oct 2019 | Nov 2019 | Dec 2019 | Jan 2020 | Feb 2020 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears) | 92% | 85.1% | 85.1% | 85.6% | 85.2% | 85.1% | 83.8% | 83.8% | 83.7% | 83.0% | 82.3% | 80.8% | |

- 18 Weeks Referral to Treatment Time – This trend reflects the seasonal expectation associated with winter pressures alongside an increase in referrals to the Trust in late summer.

**Failed Year End Target**

| Measure | Apr 2019 | May 2019 | Jun 2019 | Jul 2019 | Aug 2019 | Sep 2019 | Oct 2019 | Nov 2019 | Dec 2019 | Jan 2020 | Feb 2020 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Healthcare associated incidents of Clostridioides difficile - Cumulative | 9 | 14 | 24 | 33 | 38 | 44 | 45 | 48 | 58 | 62 | 64 |

- In January 2020 the year end target of 60 for Healthcare associated incidents of Clostridioides difficile was breached.

# Quality and Safety | Headlines February 2020

NHS University Hospitals Coventry and Warwickshire NHS Trust

## INFECTION CONTROL

This month 0 MRSA and 2 CDiff cases were reported.

**Infection Rates**
Cumulative

**64** CDiff
55 YTD target
Annual Target 60

**0** MRSA
0 YTD target
Annual Target 0

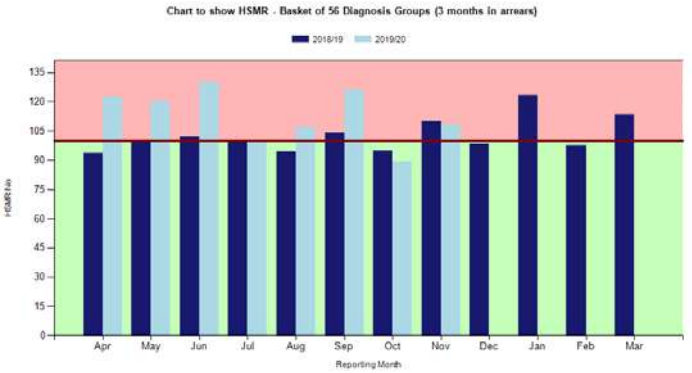
- **CDiff** 48 RCAs complete, 8 agreed lapses in care
- **MRSA** decolonisation: 90.94%
- **MRSA** High Risk Elective Inpatient Screening: 96.3%
- **MRSA** High Risk Emergency Screening: 93.6%

## MEDICINE RELATED SERIOUS INCIDENTS

0 medicine related serious incidents have been reported.

## HSMR

The latest HSMR score reported from Dr Foster is 108.26




## Summary

RIDDOR – There were three reported incidents for February. Two sprains and strains and one disease, all relate to staff.
Complaints turnaround times have achieved 100% for the second consecutive month.
HSMR is reported at 108.26 which is within Dr Foster's calculated relative risk range.

**12** No 12 hour trolley waits

No urgent operations have been cancelled for the second time

## RIDDOR

**3**
Incidents reported for February

**4hr Achievement Overview - as at 16/3/2020**

| Stream | Last Month | Current Month | Last Year | This Year |
|---|---|---|---|---|
| Type 1 Minors | 92.57% | 90.09% | 93.83% | 91.39% |
| Type 1 Majors | 53.93% | 44.67% | 64.81% | 54.77% |
| Type 1 Resus | 58.61% | 48.97% | 59.63% | 51.91% |
| Type 1 Paediatrics | 83.98% | 88.59% | 93.27% | 87.33% |
| Local Health Economy | 82.02% | 78.92% | 86.92% | 82.39% |

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

**Never Events**
0
YTD performance against target of 0

**LLOS**
Average number of patients with a length of stay 21 days and over
210

**Incomplete RTT pathways**
52 Weeks
0 (January)
Previous month 0
Target 0

Integrated Quality, Performance and Finance Reporting Framework

Quality and Safety Summary

# Trust Scorecard – Quality and Governance Committee

## Reporting Month February 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 | 62 | 64 | ⇩ | 55 | 60 | 60 | CNO | |
| | E. Coli - Trust Acquired - Cumulative | 51 | 59 | ⇩ | 57 | 62 | 62 | CNO | |
| | MRSA Decolonisation Score | 71.4% | 90.9% | ⇧ | 100% | 100% | 100% | CNO | |
| | MRSA High Risk Elective Inpatient Screening | 96.9% | 96.3% | ⇩ | 95% | 95% | 95% | CNO | |
| | MRSA High Risk Emergency Screening | 90.8% | 93.6% | ⇧ | 90% | 90% | 90% | CNO | |
| | Serious Incidents - Number | 11 | 10 | ⇧ | 15 | 15 | 15 | CQO | |
| | Serious Incidents - Overdue | 6 | 6 | ⇨ | 0 | 0 | 0 | CQO | |
| | Medicine related serious incidents | 0 | 0 | ⇨ | 0 | 0 | 0 | CQO | |
| | Reported Harmful Patient Safety Incidents (1 month in arrears) | 23.1% | 22.4% | ⇧ | 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) | 7 | 7 | ⇨ | 7 | 10 | 10 | CMO | |
| | Never Events - Cumulative | 0.0 | 0.0 | ⇨ | 0 | 0 | 0 | CMO | |
| | Mixed Sex Accommodation Breaches | 0 | 0 | ⇨ | 0 | 0 | 0 | COO | |
| | HSMR - Basket of 56 Diagnosis Groups (3 months in arrears) | 89.14 | 108.26 | ⇩ | RR | RR | RR | CMO | |
| | SHMI - Quarterly (6 months in arrears) | 108.71 | 108.78 | ⇩ | RR | RR | RR | CMO | |
| | Pressure Ulcers Category 3 - Trust Associated (1 month in arrears) | 1 | 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) | 4 | 2 | ⇧ | 2 | 2 | 2 | CNO | |
| | Falls with Moderate Harm or Above per 1000 Occupied Bed Days | 0.00 | 0.03 | ⇩ | 0.08 | 0.08 | 0.08 | CNO | |
| | Eligible Patients Having VTE Risk Assessment (1 month in arrears) | 97.0% | 97.2% | ⇧ | 95% | 95% | 95% | CNO | |
| | Average Number of Long Length of Stay Patients | 229 | 210 | ⇧ | 109 | 109 | 109 | CNO | |
| | Transfer of Patients at Night (UH to Rugby) | 3 | 3 | ⇨ | 0 | 0 | 0 | COO | |
| | **Patient Experience** | | | | | | | | |
| | Friends & Family Test Inpatient Recommenders (Inc. Day Cases) | 90.5% | 91.4% | ⇧ | 95% | 95% | 95% | CQO | |
| | Friends & Family Test Inpatient Coverage (Inc. Day Cases) | 23.0% | 24.0% | ⇧ | 26% | 26% | 26% | CQO | |
| | Friends & Family Test A&E Recommenders | 76.6% | 78.6% | ⇧ | 87% | 87% | 87% | CQO | |
| | Friends & Family Test A&E Coverage | 13.4% | 12.6% | ⇩ | 15% | 15% | 15% | CQO | |
| | Friends & Family Test Outpatient Recommenders | 91.23% | 91.18% | ⇩ | 95% | 95% | 95% | CQO | |
| | Friends & Family Test Outpatient Coverage | 8.43% | 8.47% | ⇧ | 8% | 8% | 8% | CQO | |
| | Maternity FFT Recommenders - 36 weeks | 91.07% | 97.83% | ⇧ | 97% | 97% | 97% | CQO | |
| | Maternity FFT Recommenders - Labour / Birth | 85.00% | 96.15% | ⇧ | 97% | 97% | 97% | CQO | |
| | Maternity FFT Recommenders - Postnatal Hospital | 90.16% | 94.37% | ⇧ | 97% | 97% | 97% | CQO | |
| | Maternity FFT Recommenders - Postnatal Community | 100.00% | 96.92% | ⇩ | 97% | 97% | 97% | CQO | |
| | Maternity FFT No of Touchpoints Achieving a 15% Response Rate | 1 | 2 | ⇧ | 4 | 4 | 4 | CQO | |
| | Number of Registered Complaints (1 month in arrears) | 40 | 52 | ⇩ | 34 | 34 | 34 | CQO | |
| | Complaints per 1000 Occupied Bed Days (1 month in arrears) | 1.18 | 1.54 | ⇩ | 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 Governance Committee

## Reporting Month February 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) | 99.5% | 99.5% | ⇨ | 99% | 99% | 99% | COO | |
| | Valid NHS Number - A&E - Cumulative (2 months in arrears) | 96.5% | 96.5% | ⇨ | 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 | 88.6% | 92.5% | ⇧ | 100% | 100% | 100% | COO | |
| | Ambulance Handover within 60 Minutes | 97.7% | 98.8% | ⇧ | 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) | 0 | 0 | ⇨ | 0 | 0 | 0 | COO | |
| **Leading research based health care organisation** | | | | | | | | | |
| | | | | | | | | | |
| | Patients Recruited into NIHR Portfolio-Cumulative (2 months in arrears) | 3078 | 3337 | ⇧ | 3062 | 4083 | 4083 | CMO | |
| | Performance in Initiating Trials - Quarterly | 62.5% | 54.2% | ⇩ | 80% | 80% | 80% | CMO | |
| | Performance in Delivery of Trials - Quarterly | 76.5% | 72.7% | ⇩ | 80% | 80% | 80% | CMO | |
| | Research Critical Findings and Serious Incidents - Quarterly | 0 | 0 | ⇨ | 0 | 0 | 0 | CQO | |
| | Peer Reviewed Publications - Calendar Year Cumulative (2 months in arrears) | 175 | 183 | ⇧ | 246 | 246 | 246 | CMO | |

| 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)**

| Measure | Target | Mar 2019 | Apr 2019 | May 2019 | Jun 2019 | Jul 2019 | Aug 2019 | Sep 2019 | Oct 2019 | Nov 2019 | Dec 2019 | Jan 2020 | Feb 2020 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Friends & Family Test Inpatient Coverage (Inc. Day Cases) | 26% | 23.6% | 22.4% | 21.5% | 23.4% | 22.7% | 23.7% | 23.5% | 20.7% | 18.8% | 21.7% | 23.0% | 24.0% |
| Friends & Family Test Outpatient Coverage | 8% | 3.75% | 4.13% | 4.22% | 3.73% | 3.82% | 5.47% | 5.85% | 8.09% | 6.68% | 8.20% | 8.43% | 8.47% |
| Reported Harmful Patient Safety Incidents (1 month in arrears) | 24.94% | 24.9% | 24.2% | 21.7% | 22.0% | 21.2% | 22.2% | 25.9% | 24.3% | 24.2% | 23.1% | 22.4% | |

- Friends & Family Test Inpatient and Outpatient Coverage indicators have both shown a three month trend in improvement. The Trust has increased the number of patients who are being contacted by text to obtain their response and this is reflected in the rates of coverage.
- The proportion of Patient Safety Incidents reported as harmful has reduced for the last three months.

**Deteriorating**

**(green indicators worsening)**

**(3 months consecutive deterioration)**

- No KPIs achieving standard have shown a deterioration for three consecutive months.

**Deteriorating**

- No KPIs failing to achieve the standard have shown a deterioration for three consecutive months.

**Failed Year End Target**

| Measure | Apr 2019 | May 2019 | Jun 2019 | Jul 2019 | Aug 2019 | Sep 2019 | Oct 2019 | Nov 2019 | Dec 2019 | Jan 2020 | Feb 2020 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Healthcare associated incidents of Clostridioides difficile - Cumulative | 9 | 14 | 24 | 33 | 38 | 44 | 45 | 48 | 58 | 62 | 64 |

- In January 2020 the year end target of 60 for Healthcare associated incidents of Clostridioides difficile was breached.

# Ward Staffing Levels





| Ward | February | | | Extract from February 2020 CHPPD reporting |
|---|---|---|---|---|
| | Expected CHPPD | Actual CHPPD | CHPPD Variance (act-exp) | Wards of Note |
| **Surgical Services** | | | | |
| Ward 33 | 6.2 | 7.8 | 1.6 | CHPPD expected variance with HCA due to increase demand for cohorted bays |
| **Trauma and Neuro Services** | | | | |
| Ward 42 | 5.2 | 6.9 | 1.7 | CHPPD expected variance with HCA due to increased demand for cohorted bays and 1:1 care |
| Ward 52 | 5.6 | 7.1 | 1.5 | CHPPD expected variance due to optional duties which will be balanced after rota realignment and increased 1:1 and cohorted bays |
| **Women and Children's Services** | | | | |
| NeoNatal Unit | 14.6 | 11.6 | -3 | CHPPD Variance was due to a combination of acute sickness with safety maintained by flexing capacity by closing 2 cots |

| | Expected | Actual |
|---|---|---|
| **Total February 2020 CHPPD** | **8.1** | **7.8** |

National guidance from NHSE/I changed in September 2018 and safe staffing is now measured using Care Hours per Patient Day (CHPPD) rather than fill rate. This is calculated by dividing the amount of staff 'time' available within a ward area by the numbers of patients on the ward (at midnight) and allows each trust to look at their own trends over time.

In February 2020, the cumulative total CHPPD was 8.1 against demand of 7.8 (-0.3) which comparable with January 2020 was 7.9 against demand of 7.7 care hours (+0.2).

This position remains comparable with peers (8.1) identified within model hospital data and within expected range (national median of 8.0).

For assurance, all staffing gaps are reviewed and mitigated through twice daily safer staffing meetings.

As rosters are re-aligned from April 2020, wards with more specialist beds requiring a higher staff ratio will be separated out, for example, wards with an extended care unit or hyper-acute beds within their bed base (e.g.. ward 22 ECU / ward 41 / ward 43). This will improve the reliability of data and ensure benchmarking is more meaningful however, it will take a number of months to show trends.

# Operational Performance | Headlines February 2020

NHS University Hospitals Coventry and Warwickshire NHS Trust

Operational Summary

Emergency 4 hour wait:
February 2020 - 82.0%

Latest benchmarked month:
UHCW – February 82.0%
England – February 82.8%
Midlands – February 81.5%

4hr Achievement Overview - as at 16/3/2020

| Stream | Last Month | Current Month | Last Year | This Year |
|---|---|---|---|---|
| Type 1 Minors | 92.57% | 90.09% | 93.83% | 91.39% |
| Type 1 Majors | 53.93% | 44.67% | 64.81% | 54.77% |
| Type 1 Resus | 58.61% | 48.97% | 59.63% | 51.91% |
| Type 1 Paediatrics | 83.98% | 88.59% | 93.27% | 87.33% |
| Local Health Economy | 82.02% | 78.92% | 86.92% | 82.39% |

Diagnostic Waiters 6 Weeks and Over

0.18% : 17 breaches
9 Cardiology
3 Imaging
3 Urology
1 Neurophysiology
1 Audiology

## Summary

Emergency 4 hour wait was 82.0% for February. This is an improvement of 3.1% from last month. UHCW was below the benchmarked position for England but above the Midlands.
All national cancer standards were achieved for January. This is the first time since April 19 that this has been achieved. For a second consecutive month the 62 day referral to treatment target has been achieved.
RTT performance has continued to decline and reflects seasonal expectations.

## Incomplete RTT pathways

| Submitted Position | Inc % | Backlog (Over 18 Weeks) |
|---|---|---|
| January 20 | 80.8% | 6,691 |
| January 19 | 84.6% | 4,870 |
| YTD UHCW Change | -3.8% | 1,821 |

| Latest Benchmarked Month | UHCW | NHS England |
|---|---|---|
| December 19 | 82.3% | 83.1% |
| December 18 | 84.6% | 86.2% |
| Benchmark Change | -2.3% | -3.1% |

52 Weeks

0 (January)
Previous month 0
Target 0

Ambulance Handover

Within 30 minutes : 92.5%
Within 60 minutes : 98.8%


No 12 hour trolley waits

LLOS
Average number of patients with a length of stay 21 days and over
210

Cancer standards - January


TWW: 98.39%
31 day: 96.25%
62 day: 86.28%

2 breaches (3 patients) treated over 104 days

**Last minute Non-Clinical Operations – Elective**
0.7%
of elective admissions – 50 patients
Last month – 46 patients

# Trust Scorecard – Finance and Performance Committee

## Reporting Month February 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 | 78.9% | 82.0% | ⇧ | 95% | 95% | 95% | COO | |
| | 12 Hour Trolley Waits in Emergency Care | 0 | 0 | ⇨ | 0 | 0 | 0 | COO | |
| | Ambulance Handover within 30 Minutes | 88.6% | 92.5% | ⇧ | 100% | 100% | 100% | COO | |
| | Ambulance Handover within 60 Minutes | 97.7% | 98.8% | ⇧ | 100% | 100% | 100% | COO | |
| | Delayed Transfers as a Percentage of Admissions | 5.2% | 5.2% | ⇧ | 3.5% | 3.5% | 3.5% | COO | |
| | 30 Day Emergency Readmissions (1 month in arrears) | 7.3% | 7.6% | ⇩ | 7.66% | 7.66% | 7.66% | COO | |
| | Number of Medical Outliers - Average per Day | 96.6 | 77.4 | ⇧ | 50 | 50 | 50 | COO | |
| | Length of Stay Acute - Average | 7.4 | 7.4 | ⇩ | 7.106 | 6.958 | 6.958 | COO | |
| | **Non emergency care** | | | | | | | | |
| | Last Minute Non-clinical Cancelled Operations - Elective | 0.6% | 0.7% | ⇩ | 0.8% | 0.8% | 0.8% | COO | |
| | Breaches of the 28 Day Readmission Guarantee | 23 | 6 | ⇧ | 0 | 0 | 79 | 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) | 82.3% | 80.8% | ⇩ | 92% | 92% | 92% | COO | |
| | RTT 52 Week Waits Incomplete (1 month in arrears) | 0 | 0 | ⇨ | 0 | 0 | 0 | COO | |
| | E-referral Appointment Slot Issues – National data (1 month in arrears) | 4.6% | 2.7% | ⇧ | 4% | 4% | 4% | COO | |
| | Diagnostic Waiters - 6 Weeks and Over | 0.19% | 0.18% | ⇧ | 1% | 1% | 1% | COO | |
| | Bed Occupancy Rate - KH03 (3 months in arrears) | 97.5% | 99.8% | ⇩ | 93% | 93% | 93% | COO | |
| | **Cancer** | | | | | | | | |
| | Cancer 2 Week Wait GP Referral to OP Appointment (1 month in arrears) | 98.18% | 98.39% | ⇧ | 93% | 93% | 93% | COO | |
| | Cancer 2 Week Wait Breast Symptom (1 month in arrears) | 100.00% | 98.32% | ⇩ | 93% | 93% | 93% | COO | |
| | Cancer 31 Day Diagnosis to Treatment (1 month in arrears) | 95.28% | 96.25% | ⇧ | 96% | 96% | 96% | COO | |
| | Cancer 31 Day Subsequent Surgery Standard (1 month in arrears) | 92.31% | 94.87% | ⇧ | 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) | 95.57% | 94.56% | ⇩ | 94% | 94% | 94% | COO | |
| | Cancer 62 Day Standard plus 31 Day Rare Cancers (1 month in arrears) | 86.67% | 86.28% | ⇩ | 85% | 85% | 85% | COO | |
| | Cancer 62 Day Screening Standard (1 month in arrears) | 93.10% | 96.43% | ⇧ | 90% | 90% | 90% | COO | |
| | Cancer 62 Day Consultant Upgrades (1 month in arrears) | 87.5% | 86.0% | ⇩ | 85% | 85% | 85% | COO | |
| | Cancer 104+ Day Waits (1 month in arrears) | 6.5 | 2.0 | ⇧ | 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 |

Integrated Quality, Performance and Finance Reporting Framework

# Trust Scorecard – Finance and Performance Committee

## Reporting Month February 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 | 59.5% | 64.1% | ⇧ | 85% | 85% | 85% | COO | |
| | Theatre Efficiency - Rugby | 71.3% | 72.0% | ⇧ | 85% | 85% | 85% | COO | |
| | Theatre Efficiency - Day Surgery | 58.8% | 59.9% | ⇧ | 85% | 85% | 85% | COO | |
| | Theatre Utilisation - Main | 78.1% | 80.0% | ⇧ | 85% | 85% | 85% | COO | |
| | Theatre Utilisation - Rugby | 82.1% | 84.2% | ⇧ | 85% | 85% | 85% | COO | |
| | Theatre Utilisation - Day Surgery | 74.9% | 76.5% | ⇧ | 70% | 70% | 70% | COO | |
| | Surgical Safety Checklist - WHO | 100.00% | 100.00% | ⇨ | 100% | 100% | 100% | CMO | |
| | Theatre Lists Started within 15 mins of Start Time | 33.7% | 40.1% | ⇧ | 75% | 75% | 75% | COO | |
| **Deliver value for money** | | | | | | | | | |
| | Capital Service Cover Rating | 3 | 3 | ⇨ | 4 | 4 | 3 | CFO | |
| | Liquidity Rating | 4 | 4 | ⇨ | 4 | 4 | 4 | CFO | |
| | Income & Expenditure Margin Rating | 3 | 3 | ⇨ | 3 | 2 | 2 | CFO | |
| | Variance from Control Total Rating | 1 | 1 | ⇨ | 1 | 1 | 1 | CFO | |
| | Forecast Income & Expenditure - £'000 | 0 | 0 | ⇨ | 0 | 0 | 0 | CFO | |
| | Agency Rating | 1 | 1 | ⇨ | 1 | 1 | 1 | CFO | |
| | Trust Financial Risk Rating | 3 | 3 | ⇨ | 3 | 3 | 3 | CFO | |
| | WRP Delivery - £'000 | 26327 | 28307 | ⇧ | 31057 | 36000 | 30531 | CFO | |
| | YTD Income & Expenditure Trust - £'000 | -3283 | -4553 | ⇩ | -2930 | 0 | 0 | CFO | |
| | Agency Expenditure (£'000) | 1544 | 1625 | ⇩ | 1902 | 1902 | 1902 | CWIO | |
| **Employer of choice** | | | | | | | | | |
| | Appraisal - Non-Medical | 85.19% | 86.66% | ⇧ | 90% | 90% | 90% | CWIO | |
| | Appraisal - Medical | 97.69% | 95.55% | ⇩ | 90% | 90% | 90% | CWIO | |
| | Mandatory Training Compliance | 95.59% | 95.58% | ⇩ | 95% | 95% | 95% | CWIO | |
| | Sickness Rate | 4.80% | 4.43% | ⇧ | 3.99% | 3.99% | 3.99% | CWIO | |
| | Staff Turnover Rate | 10.17% | 10.23% | ⇩ | 12% | 12% | 12% | CWIO | |
| | Vacancy Rate Compared to Funded Establishment | 12.02% | 11.49% | ⇧ | 10% | 10% | 10% | CWIO | |
| | Staff Survey - Recommending as a Place of Work (Quarterly) | N/A | 65.30% | | 70% | 70% | 70% | CWIO | |
| **Leading research based health care organisation** | | | | | | | | | |
| | Submitted Research Grant Applications - Quarterly - Cumulative | 103 | 103 | ⇨ | 99 | 132 | 132 | CMO | |
| | Commercial Income Invoiced £000s - Cumulative (1 month in arrears) | 669 | 730 | ⇧ | 750 | 900 | 900 | CFO | |
| | NIHR Research Capability Funding (£000s) | 246 | 246 | ⇨ | 750 | 1000 | 1000 | CMO | |
| | Trial Recruitment Income (£000s) | 874 | 874 | ⇨ | 2363 | 3150 | 3150 | CMO | |
| | All Grant Income (£000s) | 1489 | 1489 | ⇨ | 1650 | 2200 | 2200 | CMO | |

| 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 |

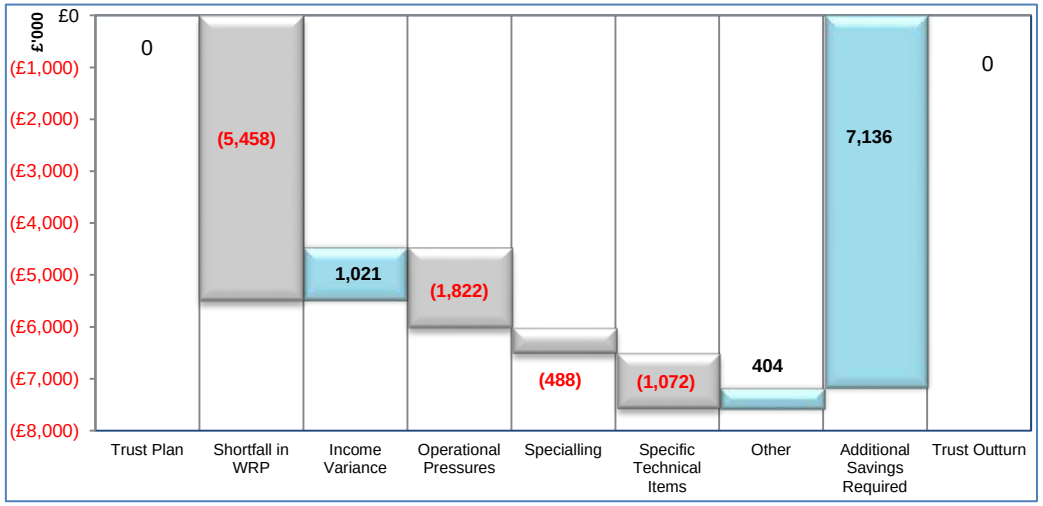
# Integrated Finance Report |Finance Headlines

## Reporting Month: February 2020

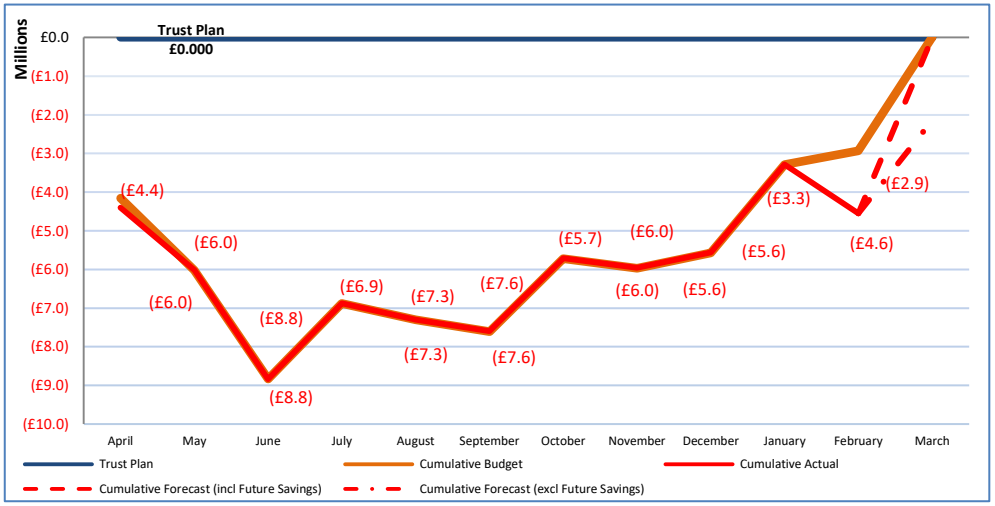
University Hospitals Coventry and Warwickshire NHS Trust

At month 11, the Trust reported a £4.6m deficit , compared to a £2.9m defiit plan. The forecast position for the year remains at break even, which is in line with plan.

### Trust Position Post Technical Adjustment *(control total)*




### Surplus / (Deficit) position *(control total)*




### Updates on Control Total

Movements within the control total include an under performance of (0.2%) on contract income, other income (1.4% favourable to plan) and expenditure overspends (1.1%) adverse to plan). The Trust reported a forecast break even position at month 11.

### Updates on Surplus/(Deficit) position

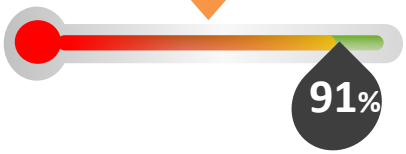
The forecast position is break even, in line with the plan. The forecast position assumes £7.1m future savings are identified and delivered in full.

### CONTRACT & ACTIVITY INCOME

**0.2%** Forecast Under performance

Forecast contract income from activities reports an adverse variance of (£1.0m) against a plan of £593.9m.

Year-to-date adverse variance (£1.3m) against a plan of £543.1m




**Waste Reduction Programme** forecast delivery is £30.5m against a target of £36.0m.

Year-to-date delivery £28.3m against a target of £31.1m

### PSF/FRF/MRET

The Trust has PSF/FRF.MRET targets of £25.4m.

£22.5m reported at Month 11 in line with plan.
Forecast is £25.4m.

### Capital

Original Plan £44.7m,, Revised to £31.8m in July

Forecast £25.4m

Capital Expenditure of £12.8m at Month 11.

### £19.3m AGENCY SPEND

Forecast position of £19.3m against an internal target of £18.0m and a NHSI agency ceiling of £22.8m.

£17.7m actual spend year-to-date on agency against an internal target of £16.5m.

# Integrated Finance Report |Trust Financial Position

## Reporting Month: February 2020

University Hospitals Coventry and Warwickshire NHS Trust

## Statement of Comprehensive Income

| 11 months ended 29 February 2020 | Plan | Full Year | | Variance to plan | | Year to date | | Variance to plan | |
|---|---|---|---|---|---|---|---|---|---|
| | £'000 | Budget (£'000) | Forecast (£'000) | £'000 | % | Budget (£'000) | Actual (£'000) | £'000 | % |
| Contract income from activities | 593,355 | 593,886 | 592,846 | (1,040) | (0.2%) | 543,064 | 541,796 | (1,268) | (0.2%) |
| Other income from activities | 11,135 | 12,071 | 11,176 | (895) | (7.4%) | 11,074 | 10,242 | (832) | (7.5%) |
| Other Operating Income | 96,698 | 101,995 | 104,951 | 2,956 | 2.9% | 92,865 | 95,378 | 2,513 | 2.7% |
| Settlement of prior year contracts | | (9,465) | (9,465) | 0 | 0.0% | (9,465) | (9,398) | 67 | 0.7% |
| **Total Income** | **701,188** | **698,487** | **699,508** | **1,021** | **0.1%** | **637,538** | **638,018** | **480** | **0.1%** |
| Pay costs | (385,842) | (399,495) | (409,937) | (10,442) | (2.6%) | (366,577) | (374,851) | (8,274) | (2.3%) |
| Other operating expenses | (263,500) | (256,725) | (253,372) | 3,353 | 1.3% | (235,216) | (231,775) | 3,441 | 1.5% |
| Additional savings required | | | 7,136 | 7,136 | | | 0 | 0 | |
| Settlement of prior year contracts | | 9,537 | 9,552 | 15 | | 9,728 | 11,177 | 1,449 | |
| Reserves | 0 | (997) | (1,899) | (902) | (90.5%) | (1,632) | (665) | 967 | 59.3% |
| **Total Operating Expenses** | **(649,342)** | **(647,680)** | **(648,520)** | **(840)** | (0.1%) | **(593,697)** | **(596,114)** | **(2,417)** | **(0.4%)** |
| **EBITDA** | **51,846** | **50,807** | **50,988** | **181** | **0.4%** | **43,841** | **41,904** | **(1,937)** | **(4.4%)** |
| Depreciation | (23,629) | (22,590) | (22,590) | 0 | | (20,903) | (20,707) | 196 | |
| Interest Receivable | 100 | 100 | 250 | 150 | | 91 | 248 | 157 | |
| Interest Charges | (1,638) | (1,638) | (1,638) | 0 | | (1,486) | (1,412) | 74 | |
| Financing Costs | (25,902) | (25,902) | (25,903) | (1) | | (23,709) | (23,699) | 10 | |
| Unwinding Discount | (10) | (10) | (7) | 3 | | (10) | (7) | 3 | |
| PDC Dividend | (374) | (374) | (475) | (101) | | (342) | (435) | (93) | |
| Profit / loss on asset disposals | 0 | 0 | 0 | 0 | | 0 | 0 | 0 | |
| **Net Surplus/(Deficit)** | **393** | **393** | **625** | **232** | **59.0%** | **(2,518)** | **(4,108)** | **(1,590)** | **(63.1%)** |
| EBITDA % | 7.4% | 7.3% | 7.3% | | | 6.9% | 6.6% | | |
| Net Surplus % | 0.1% | 0.1% | 0.1% | | | (0.4%) | (0.6%) | | |
| Technical Adjustments: | | | | | | | | | |
| Donated/Government grant assets adjustment | (393) | (393) | 1 | 394 | 100.3% | (418) | 181 | 599 | 143.3% |
| 18/19 PSF Reallocation | | 0 | (626) | (626) | | 0 | (626) | (626) | |
| **Trust Position Post Technical Adjustment (Control total)** | **0** | **0** | **0** | **0** | **0.0%** | **(2,936)** | **(4,553)** | **(1,617)** | **(55.1%)** |

**The Trust reports a break even forecast in line with its planned control total.**

**Year to Date** - Surplus / (Deficit) position: The Trust is reporting a £4.6m deficit at Month 11.

- Contract income is £1.3m adverse to budget.
- Non-contract income is £1.7m favourable to budget.
- Total operating expenditure is £2.4m adverse to budget, driven by overspends on pay, offset by underspends on non-pay, a benefit from settlement of contracts and reserves.
- Settlement of prior year contract agreements with Commissioners is reflected in both income and expenditure for accounting purposes, and amounts to a £1.4m benefit.

**Outturn** - Surplus / (Deficit) position: The forecast position at Month 11 is break even in line with plan.

- Contract income is forecast at £592.8m, £1.0m adverse to plan, driven by performance against activity targets. This is explained in the income section on page 7.
- Non-contract income is forecast at £116.1m, which is £2.1m favourable to budget .
- Total operating expenditure is forecast at £648.5m, which is £1.0m adverse to budget. This is driven by adverse performance on pay and non-delivery of corporate waste reduction target, less unallocated reserves, income provisions release and assumed additional savings.

**Non-Operating Expenditure** is forecast in line with plan.

**Reserves** – The forecast reserves position at Month 11 is £1.0m adverse to budget, due to £4.1m corporate led waste reduction schemes not yet achieving offset by unallocated reserves and income provisions.

# Integrated Finance Report |Statement of Financial Position

## Reporting Month: February 2020

University Hospitals Coventry and Warwickshire NHS Trust

| 11 months ended 29 February 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 | 367,888 | 349,991 | (17,897) | 352,175 | 335,169 | (17,006) |
| Intangible assets | 8,776 | 7,191 | (1,585) | 8,269 | 4,432 | (3,837) |
| Investment Property | 8,575 | 9,695 | 1,120 | 8,575 | 9,695 | 1,120 |
| Trade and other receivables | 34,529 | 33,362 | (1,167) | 38,011 | 36,300 | (1,711) |
| **Total non-current assets** | **419,768** | **400,239** | **(19,529)** | **407,030** | **385,596** | **(21,434)** |
| **Current assets** | | | | | | |
| Inventories | 14,171 | 14,680 | 509 | 14,171 | 14,611 | 440 |
| Trade and other receivables | 61,949 | 58,413 | (3,536) | 69,163 | 55,525 | (13,638) |
| Cash and cash equivalents | 1,000 | 1,000 | 0 | 1,550 | 21,077 | 19,527 |
| | **77,120** | **74,093** | **(3,027)** | **84,884** | **91,213** | **6,329** |
| Non-current assets held for sale | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total current assets** | **77,120** | **74,093** | **(3,027)** | **84,884** | **91,213** | **6,329** |
| **Total assets** | **496,888** | **474,332** | **(22,556)** | **491,914** | **476,809** | **(15,105)** |
| **Current liabilities** | | | | | | |
| Trade and other payables | (66,212) | (54,304) | 11,908 | (84,689) | (72,034) | 12,655 |
| Borrowings | (10,294) | (9,347) | 947 | (8,939) | (8,931) | 8 |
| DH Interim Revenue Support loan | (28,785) | (43,089) | (14,304) | (20,733) | (43,175) | (22,442) |
| DH Capital loan | (4,410) | (3,542) | 868 | (2,604) | (3,414) | (810) |
| Provisions | (8,715) | (2,555) | 6,160 | (8,515) | (685) | 7,830 |
| **Net current assets/(liabilities)** | **(41,296)** | **(38,744)** | **2,552** | **(40,596)** | **(37,026)** | **3,570** |
| **Total assets less current liabilities** | **378,472** | **361,495** | **(16,977)** | **366,434** | **348,570** | **(17,864)** |
| **Non-current liabilities:** | | | | | | |
| Trade and other payables | 0 | 0 | 0 | 0 | 0 | 0 |
| Borrowings | (245,703) | (237,283) | 8,420 | (241,273) | (237,705) | 3,568 |
| DH Interim Revenue Support loan/RWCSF | (57,471) | (49,534) | 7,937 | (59,247) | (49,534) | 9,713 |
| DH Capital loan | (29,077) | (21,116) | 7,961 | (29,023) | (19,511) | 9,512 |
| Provisions | (1,997) | (2,113) | (116) | (2,197) | (2,344) | (147) |
| **Total assets employed** | **44,224** | **51,449** | **7,225** | **34,694** | **39,476** | **4,782** |
| **Financed by taxpayers' equity:** | | | | | | |
| Public dividend capital | 66,359 | 67,224 | 865 | 66,359 | 66,608 | 249 |
| Retained earnings | (76,530) | (71,295) | 5,235 | (79,435) | (76,027) | 3,408 |
| Revaluation reserve | 54,395 | 55,520 | 1,125 | 47,770 | 48,895 | 1,125 |
| **Total Taxpayers' Equity** | **44,224** | **51,449** | **7,225** | **34,694** | **39,476** | **4,782** |

**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.**

## Year to date

A number of variances in the year to date position are due to the current 2019/20 plan being based on a forecast 2018/19 outturn rather than the actual outturn. After excluding these, some of the key variances are:

- Property plant and equipment balances are significantly less than plan due to the reduced current year capital programme and delays in commencing schemes pending the approval of loan applications;
- Cash balances are higher than plan due to the receipt of the final allocation of PSF funding for 2018/19, revenue loans drawn to fund the YTD deficit and a significant reduction in prior year debt;
- Revenue loans are above plan due to drawing loans prior to receiving the final 2018/19 PSF funding and also the delay in receiving Q2 PSF income;
- Provisions carried over from 2018/19 have now been released following the resolution of most prior year over-performance debts;
- Capital loans are less than plan due to the reduced capital programme and the delayed receipt of loan funding and;
- Retained earnings reserve are more favourable than plan due to the final 2018/19 PSF allocation of approx. £6m being notified late in April, offset by the shortfall in 2018/19 of £1m of funding for the pay award related to PFI staff (both being accounted for in 2018/19).

## Forecast

The outturn SoFP is in line with Plan as at year end with the exception of:

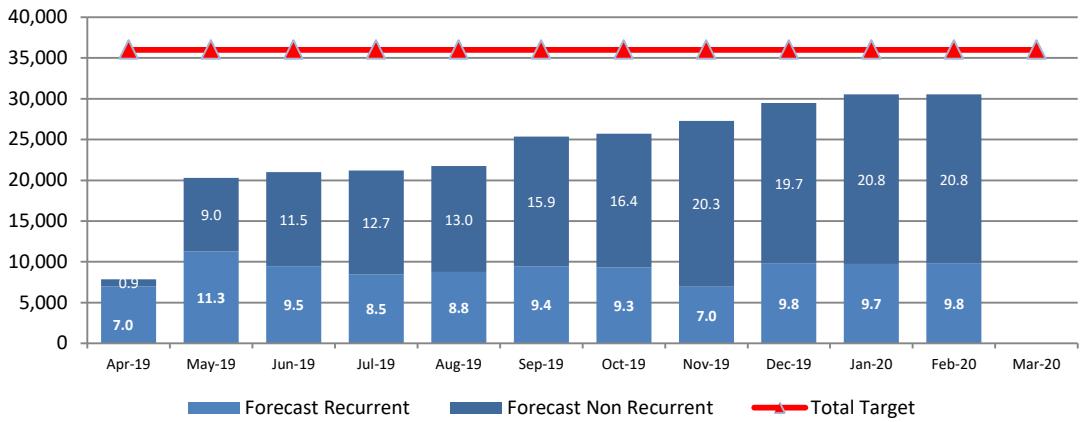
- A significant variance in property plant and equipment balances due to the downward revision of expected capital spend due to the limited loan funding available and the further slippage of finance lease schemes. This is offset by a reduction in the amount of capital loan and finance lease borrowing required;
- A favourable movement in retained earnings due to the final 2018/19 PSF allocation and shortfall in ROE pay award funding;
- An increase in the revaluation reserve as a result of the 2018/19 revaluation exercise; and
- Movements in receivables and payables which offset the above improvements in reserves.

# Integrated Finance Report |Waste Reduction Programme

## Reporting Month: February 2020

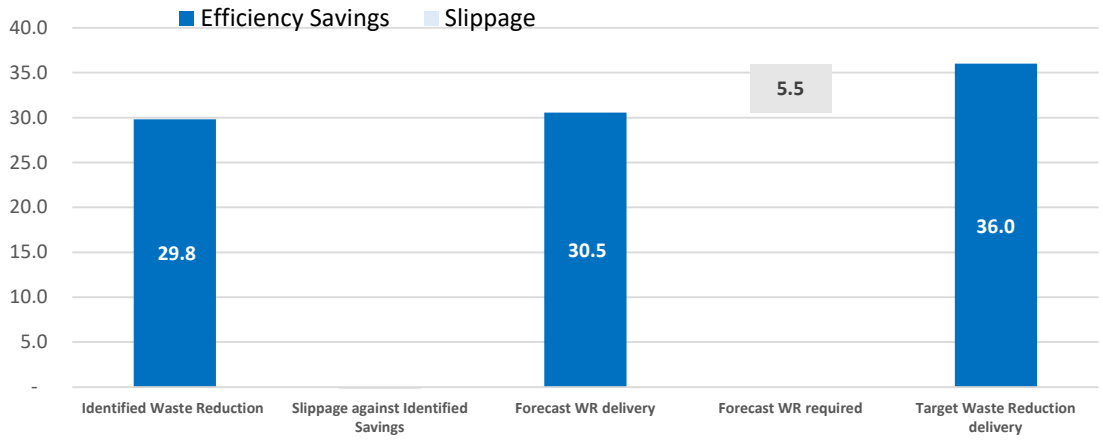
University Hospitals Coventry and Warwickshire NHS Trust

### Waste Reduction Programme Delivery




**The Trust is forecasting delivery of £30.5m of potential savings:**
**£5.5m below the required target of £36m. This is the same reported position as Month 10**

### Waste Reduction Overview




### Key Headlines – Waste Reduction Programme

- The Trust has set a recurrent efficiency target of £26m in 2019/20 and a non-recurrent efficiency target of £10m.
- The non recurrent forecast is £10.8m greater than target and remains unchanged since month 10
- The Trust Wide schemes are a net total of £6.7m of the total plan
- As at Month 11 forecast delivery is £739k greater than planned, which is largely attributed to the Outpatients scheme.

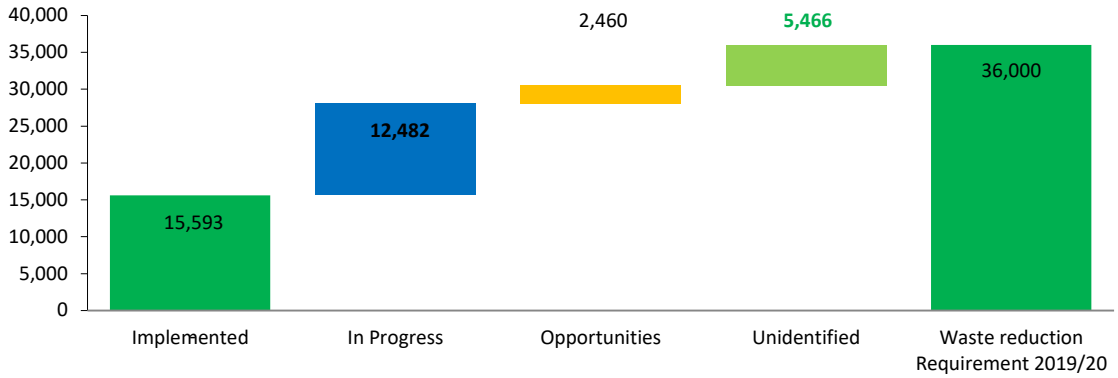
### Risks

As at month 11

- 83% of the target has been identified ( an increase of 1% since Month 10 )
- 85% of the target is forecast to be delivered (no change since Month 10)

University Hospitals Coventry and Warwickshire NHS Trust

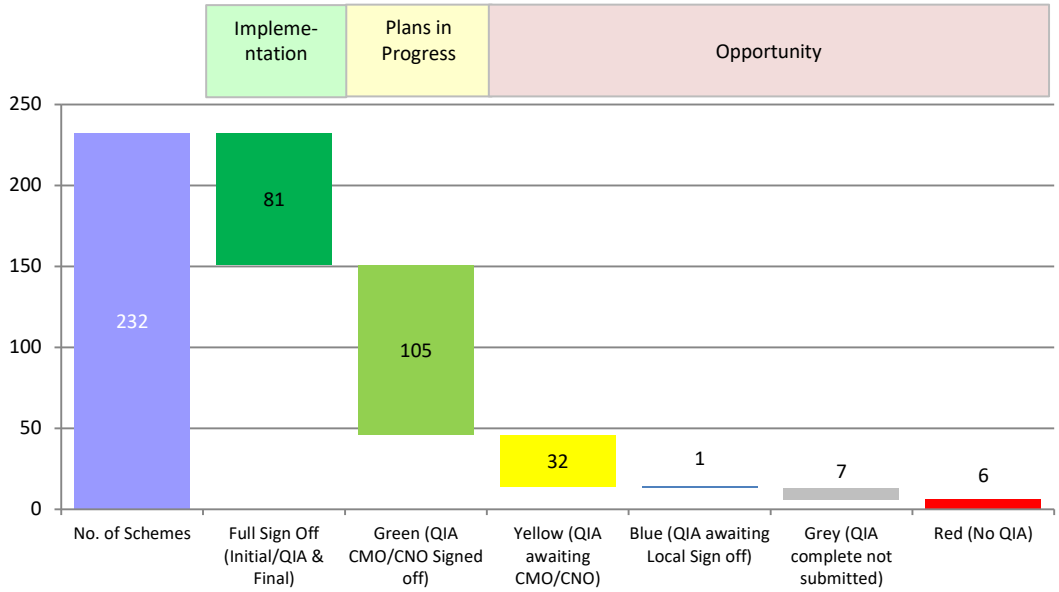
## Waste Reduction by Category – ( Forecast Delivery £k)




### Waste reduction Categories

- As at month 11 92% of forecast delivery is now Plans in Progress or Fully implemented status
- An increase from Month 10 of 1%

## Assessment *(QIA & Initial & Final Sign-off)*




**The Assessment process includes a Quality Impact Assessment and Operational & Finance review of all assessments completed at Group level.**

- A QIA is required for all Waste Reduction schemes regardless of the value.
- The chart shows the completion status of the WRP Sign off status
- The Assessment process drives the status (Opportunity, Plan in Progress, and Implementation) on each scheme which informs how Trust Waste Reduction position is reported – internally and externally.

**Quality Impact Assessment:**

- As at Month 11, 214 of the 220 (97%) group schemes now have a completed QIA
- 175 (81%) of the 216 local schemes with QIAs have been fully signed off (last month 177 schemes / 82%)
- 11 (92%) of the 12 Trustwide programmes have had QIAs fully signed off (last month 11 / 92%)

**Full WRP Sign Off:**

- 81 schemes are fully signed off – i.e. have initial Finance & Operational approval, QIA & Final Financial Approval (last month 66)
- Continued push to drive up QIA completions and Sign offs within the groups

# Workforce Information | Headlines February

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 and Performance Committee.

Agency Spend
**£1,544,183**

**HEADCOUNT**
**8634 (7675.72WTE)**
(*exclusive of ISS/ROE)


**Training 95.54% (Substantive Employees)**

**Target ≥ 95%**


**Vacancy Rate 11.49%**

**Target ≤ 10%**

**Sickness 4.43%**

**Target ≤ 4%**


**Turnover 10.23%**
**(Headcount %)**

**Target ≤ 10%**


**Medical 95.55%**

**Non-Medical 86.66%**

**Target ≥ 90%**

*unable to include ISS Headcount Workforce information this month

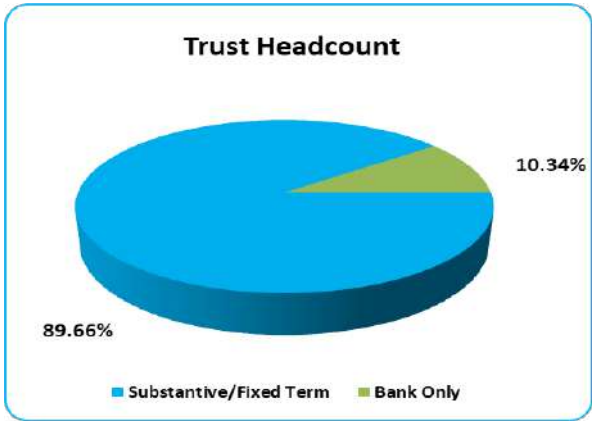
# Workforce Information | February 2020

University Hospitals Coventry and Warwickshire NHS Trust

## Headcount | WTE

| Staff Headcount Breakdown | Dec-19 | Jan-20 | Feb-20 |
|---|---|---|---|
| Substantive/Fixed Term | 8574 | 8627 | 8634 |
| ISS (ROE) | 519 | 515 | 0 |
| **Trust Total** | **9093** | **9142** | **8634** |
| Bank Only | 958 | 955 | 996 |

Total Trust Headcount excluding ROE (ISS) staff is **8634**. Bank headcount has increased by **41**.




| Staf in Post WTE | Dec-19 | Jan-20 | Feb-20 |
|---|---|---|---|
| **Staff in Post Actual (excluding ROE (ISS), Bank Workers)** | **7589.43** | **7633.19** | **7675.72** |

Overall, WTE has increased by 42.53 WTE (which includes existing staff increasing or decreasing their hours).

## Staff Group in Post | Monthly Variation

| Staff Group WTE Variances | Jan-20 | Feb-20 | Variance (WTE) | % Variance |
|---|---|---|---|---|
| Add Prof | 271.50 | 269.86 | -1.64 | -0.61% |
| Add Clinical | 1740.91 | 1758.30 | 17.39 | 0.99% |
| Admin & Clerical | 1334.03 | 1346.25 | 12.22 | 0.91% |
| AHP | 438.49 | 439.90 | 1.41 | 0.32% |
| Estates & Ancillary | 3.67 | 2.00 | -1.67 | -83.50% |
| Healthcare Scientists | 357.35 | 356.87 | -0.48 | -0.13% |
| Medical & Dental | 1040.91 | 1043.12 | 2.21 | 0.21% |
| Nursing & Midwifery | 2436.41 | 2449.50 | 13.09 | 0.53% |
| Students | 9.92 | 9.92 | 0.00 | 0.00% |
| **Total** | **7633.19** | **7675.72** | **42.53** | **0.55%** |
| ISS/ROE | 393.60 | N/A | N/A | N/A |

Overall between January and February 2020 there has been an increase of staff in post of **42.53 WTE**.

The staff groups with increases in post:

- Additional Clinical (17.39 WTE)
- Nursing & Midwifery (13.09 WTE)
- Administration & Clerical (12.22 WTE)
- Medical and Dental (2.21 WTE)
- Allied Health Professionals (1.41 WTE)

The staff group with decreases in post:

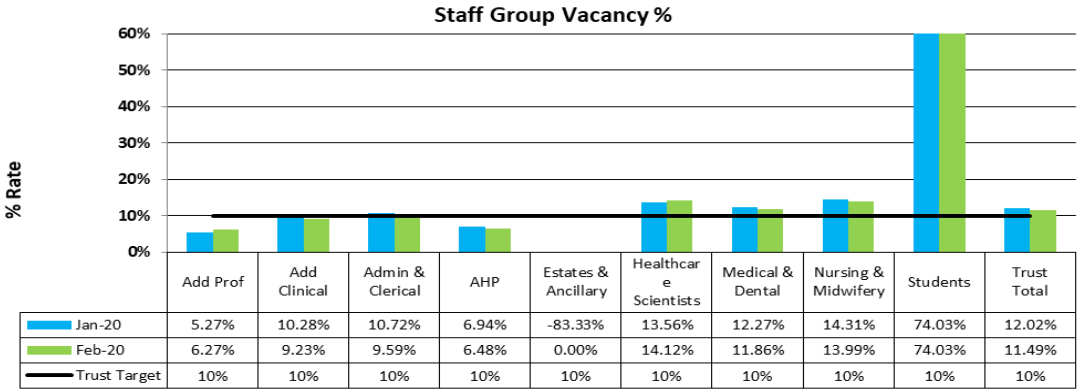
- Add Prof Scientific & Technic (1.64 WTE)
- Healthcare Scientists (0.48 WTE)
- Estates & Ancillary(1.67 WTE)

***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 | February 2020

NHS University Hospitals Coventry and Warwickshire NHS Trust

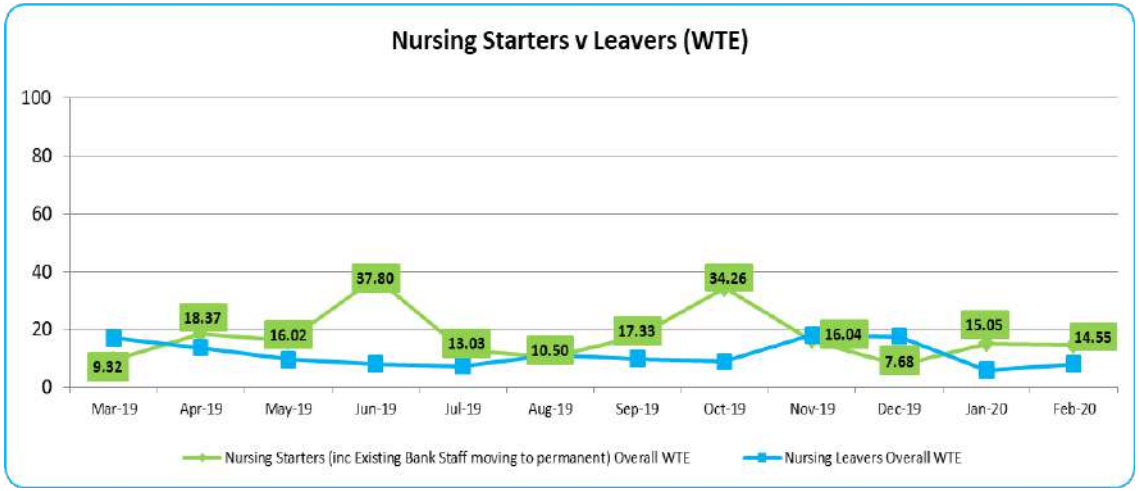
## Vacancy | by Staff Group




| | Add Prof | Add Clinical | Admin & Clerical | AHP | Estates & Ancillary | Healthcare Scientists | Medical & Dental | Nursing & Midwifery | Students | Trust Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Jan-20 | 5.27% | 10.28% | 10.72% | 6.94% | -83.33% | 13.56% | 12.27% | 14.31% | 74.03% | 12.02% |
| Feb-20 | 6.27% | 9.23% | 9.59% | 6.48% | 0.00% | 14.12% | 11.86% | 13.99% | 74.03% | 11.49% |
| Trust Target | 10% | 10% | 10% | 10% | 10% | 10% | 10% | 10% | 10% | 10% |

The overall vacancy rate is **11.49% a 0.53%** decrease on the previous month. The largest proportion of vacancies by staff groups is Healthcare Scientists **(14.12%, 58.65 WTE)** Nursing & Midwifery **(13.99%, 398.53 WTE),** and Medical & Dental **(11.86%, 140.40 WTE).**

The forecast of new starters in March for Nursing & Midwifery is **25** (Source: Resourcing Department).

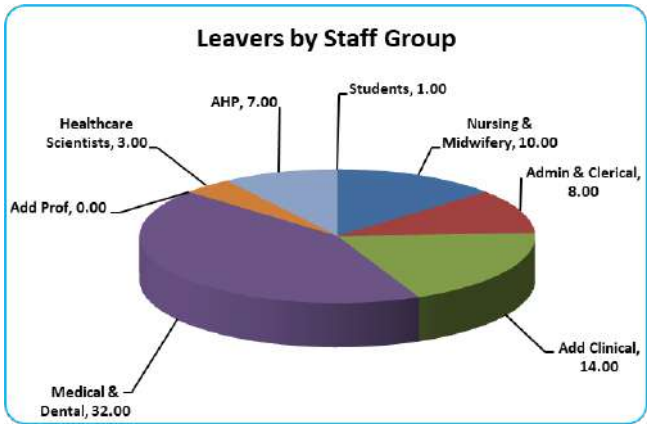



## Turnover | by Staff Group (includes Bank)

The Trust overall turnover rate (12 - months rolling) has increased **0.06%** to **10.23%** from **10.17%** in January.

The highest headcount of the leavers in staff groups, **Medical & Dental (32), Additional Clinical Services (14), Nursing & Midwifery (10)** and **Administrative & Clerical (8)**
(The above does not include Bank staff).

We have a dedicated Recruitment and Retention Group in place, led by the Lead Nurse - Workforce and Head of Employment Services. The group is taking forward a recruitment plan, which reports progress actions into the Recruitment Forum on a monthly basis. One specific area of work is around Flexible Working Options, in order to boost retention rates.



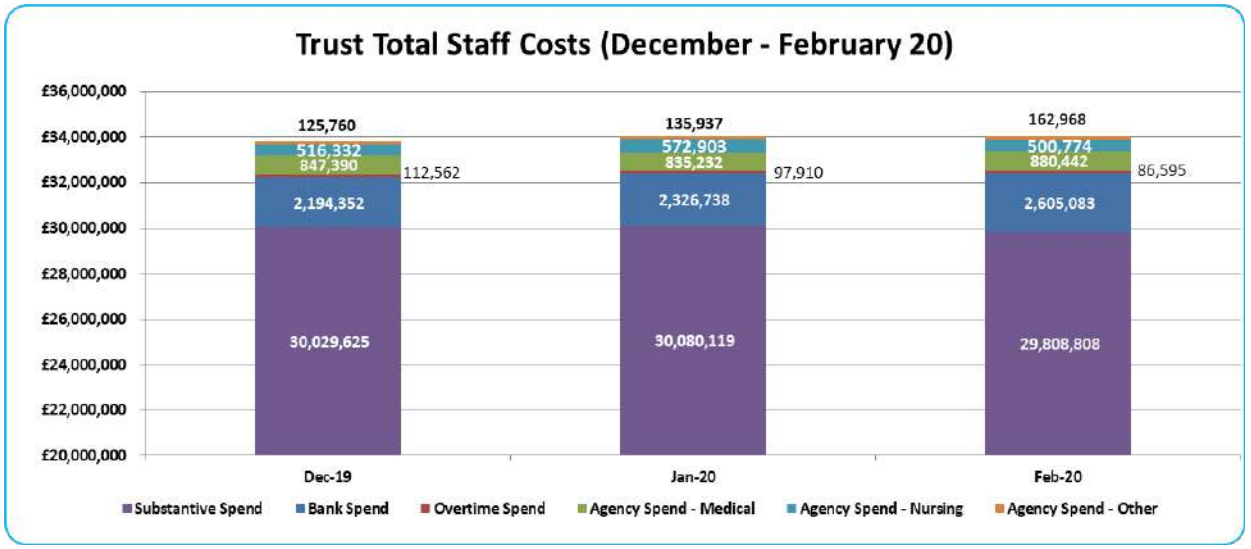

***It is important to note that Medical and Dental leavers will be significantly higher within peak doctor rotation months which include August, September, December, February, March and April.**

# Workforce Information | February 2020

University Hospitals Coventry and Warwickshire NHS Trust

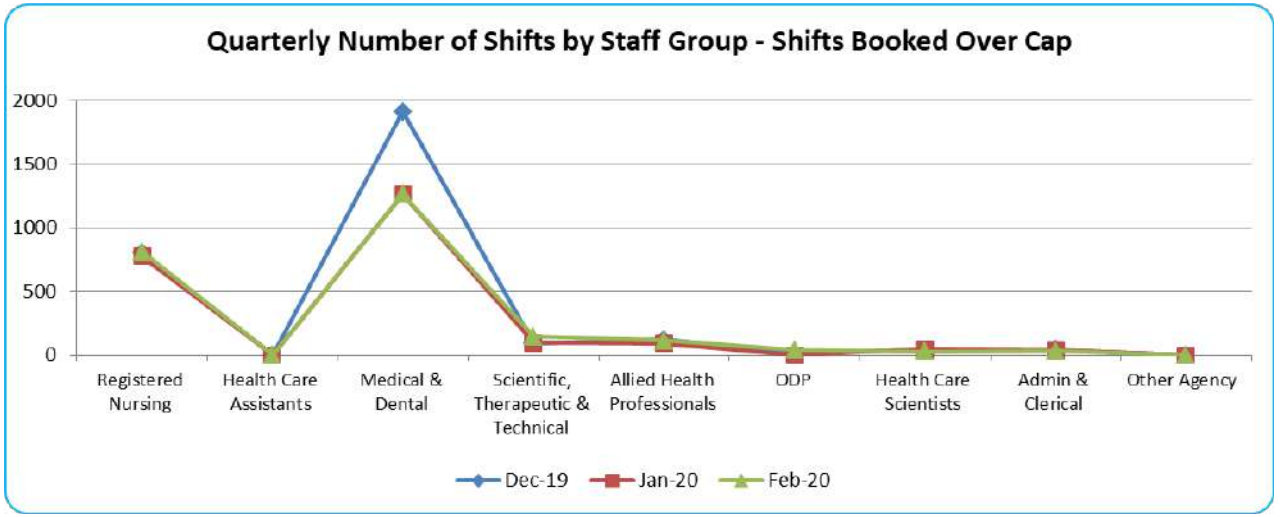


## Pay Costs| Provided by Finance




- The overall pay bill for February 2020 decreased by £4,169 (0.01%) from January.
- Temporary costs equate to 12.44% of the Trusts total pay bill (£34,044,669), this is an increase of 0.78% on January 2020, which was 11.66%.
- Agency costs against total costs has increased 0.01% from 4.53% to 4.54%. There has been an overall increase in total agency spend of £111 to £1,544,183 against January 2020.
- Overall Bank (£2,605,083) spend has increased by £278,345.

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




- The percentage of medical shifts above agency cap rates has remained consistently at 100%.
- Nursing shifts over cap rates has increased throughout February, ranging between 57.68% and 59.24%.
- AHP over price cap has also increased throughout February ranging from 31.40% and 41.18%.
- Healthcare Scientists over price cap ranges from 12.24% to 14.06%, which is an decrease compared to January's information.

# Workforce Information | February 2020

University Hospitals Coventry and Warwickshire NHS Trust



## Absence| by Group

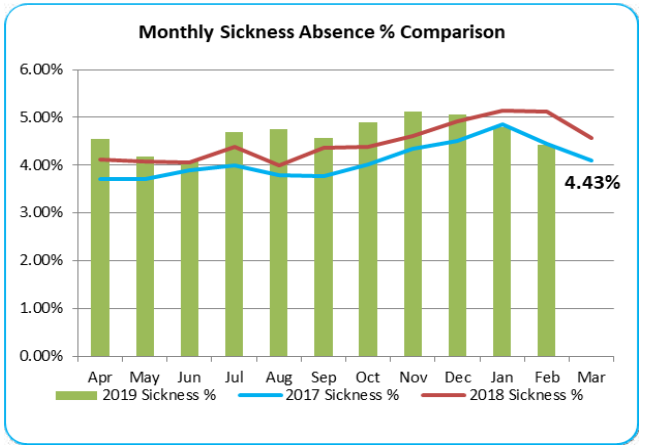
The overall Trust sickness absence rate in February has decreased by **0.37%** to **4.43%**, which is above the current Trust 4.00% target.

In relation to overall time lost due to absence, the highest reason for absence was Gastrointestinal problems **203 episodes** (**16.65%** of overall sickness).

There is one group (Core Services) that meets the 4% target during February, but all other Clinical Groups have not achieved the target. Managers are being reminded of the detail of the Policy and the number of managing attendance training sessions has been increased to capture more delegates.

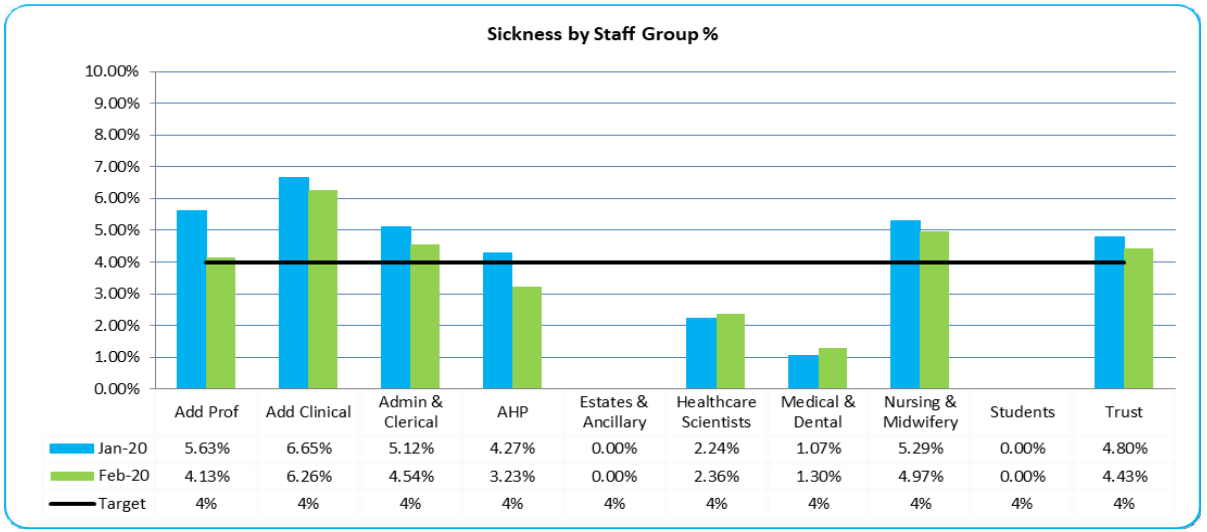
| Group Rolling Sickness Absence Rate % | Dec-19 | Jan-20 | Feb-20 |
|---|---|---|---|
| 218 Clinical Diagnostics | 5.04% | 4.54% | 4.89% |
| 218 Clinical Support Services | 6.11% | 5.83% | 5.32% |
| 218 Core Services | 3.60% | 3.72% | 3.17% |
| 218 Emergency Medicine | 5.58% | 5.00% | 4.76% |
| 218 Medicine | 4.40% | 4.44% | 4.22% |
| 218 Surgical Services | 5.28% | 4.60% | 4.03% |
| 218 Trauma and Neuro Services | 4.56% | 4.14% | 4.12% |
| 218 Women and Children | 5.98% | 5.60% | 4.38% |
| **Trust Total%** | **5.07%** | **4.80%** | **4.43%** |

## Absence | by Month/Year




The sickness rate for February 2020 is lower in comparison to the same period in 2017 and 2018.

## Absence | by Staff Group




| | Add Prof | Add Clinical | Admin & Clerical | AHP | Estates & Ancillary | Healthcare Scientists | Medical & Dental | Nursing & Midwifery | Students | Trust |
|---|---|---|---|---|---|---|---|---|---|---|
| Jan-20 | 5.63% | 6.65% | 5.12% | 4.27% | 0.00% | 2.24% | 1.07% | 5.29% | 0.00% | 4.80% |
| Feb-20 | 4.13% | 6.26% | 4.54% | 3.23% | 0.00% | 2.36% | 1.30% | 4.97% | 0.00% | 4.43% |
| Target | 4% | 4% | 4% | 4% | 4% | 4% | 4% | 4% | 4% | 4% |

# Workforce Information | February 2020

University Hospitals Coventry and Warwickshire NHS Trust

## Mandatory Training |by Group


| Group Mandatory Training % | Dec-19 | Jan-20 | Feb-20 |
|---|---|---|---|
| Clinical Diagnostics | 95.72% | 95.96% | 95.90% |
| Clinical Support Services | 97.23% | 97.36% | 97.53% |
| Core Services | 96.35% | 96.21% | 96.07% |
| Emergency Medicine | 93.82% | 93.64% | 93.48% |
| Trauma and Neuro Services | 94.07% | 93.65% | 93.75% |
| Medicine | 95.47% | 95.58% | 95.32% |
| Surgical Services | 93.87% | 94.00% | 94.50% |
| Women & Children | 94.82% | 95.01% | 94.87% |
| Temporary Staffing Services | 96.23% | 96.08% | 96.07% |
| **Trust Total** | **95.57%** | **95.59%** | **95.58%** |
| **Substantive Staff Only** | **95.57%** | **95.55%** | **95.54%** |
| **Bank Staff Only** | **96.19%** | **95.99%** | **95.95%** |

- Mandatory Training compliance for all staff has decreased by **0.01%** from **95.59%** in January to **95.58%** in February, and is still above the Trust target of **95%.**
- Bank only staff compliance has decreased this month by **0.4%** to **95.95%.**
- Continued support and challenge is provided to Groups through monthly accountability meetings to maintain focus on increasing/maintaining their compliance rates.
- We continue to focus on making improvements to topics under 90% compliant with targeted actions monitored via our Training, Education & Learning Committee to ensure we are providing sufficient capacity and a range of opportunities for staff to undertake their mandatory training.

## Appraisals |by Group


Non-medical appraisal compliance has increased **1.46%** on last month from **85.20%** to **86.66%**, against a target of **90%**.

Medical appraisal is aligned to revalidation dates and is at **95.55%** a decrease **2.14%** from last month. The Trust have an agreed process for validating the information each month between RMS and ESR. The CMO is contacting individuals who remain non-compliant.

| | Non-Medical Appraisals | | | Medical Appraisals | | |
|---|---|---|---|---|---|---|
| Appraisal % by Group | Dec-19 | Jan-20 | Feb-20 | Dec-19 | Jan-20 | Feb-20 |
| Clinical Diagnostics | 88.57% | 92.81% | 87.92% | 94.92% | 98.31% | 96.72% |
| Clinical Support Services | 93.80% | 92.81% | 94.43% | 94.19% | 95.12% | 91.25% |
| Core Services | 76.58% | 75.39% | 77.56% | 100.00% | 100.00% | 90.91% |
| Emergency Medicine | 84.15% | 82.96% | 87.41% | 96.05% | 97.26% | 92.00% |
| Honorary Contracts & ESR Admin | | | | 100.00% | 100.00% | 100.00% |
| Trauma and Neuro Services | 83.57% | 81.38% | 82.02% | 96.64% | 100.00% | 96.64% |
| Medicine | 84.58% | 81.60% | 82.64% | 94.78% | 99.15% | 95.89% |
| Surgical Services | 87.07% | 88.42% | 88.14% | 97.06% | 99.30% | 96.33% |
| Women & Children | 88.57% | 86.83% | 89.25% | 95.92% | 96.33% | 98.08% |
| Temporary Staffing | | | | 98.55% | 97.56% | 97.50% |
| **Trust Total** | **86.60%** | **85.20%** | **86.66%** | **96.08%** | **97.69%** | **95.55%** |

University Hospitals Coventry and Warwickshire NHS Trust

**REPORT TO PUBLIC TRUST BOARD**
**HELD ON 26 MARCH 2020**

| | |
|---|---|
| **Subject Title** | Changes to Trust Board |
| **Executive Sponsor** | Dame Stella Manzie, Chair |
| **Author** | Geoff Stokes, Director of Corporate Affairs |
| **Attachment(s)** | None |
| **Recommendation(s)** | Trust Board is asked to;<br>• **NOTE** the appointments by NHS England and NHS Improvement of two new non-executive directors<br>• **APPROVE** changes to Committee chairs shown at 3.1<br>• **DELEGATE** authority to the Chair and Chief Executive to agree the proposed temporary changes to membership of committees set out in section 3.3 (to follow)<br>• **APPROVE** the appointment of as Vice-Chair as shown at 4.1<br>• **APPROVE** the temporary changes to Standing Orders set out in section 5.4<br>• **APPROVE** the appointment of Mark Easter, Clinical Director for Clinical Support Services as UHCW nominated trustee for UHCW Charity to replace Ian Buckley |

## EXECUTIVE SUMMARY

This paper sets out some planned changes to the Board and addresses some short to medium term issues to be addressed as a result of the current COVID-19 crisis.

Following interviews on 6 March 2020, NHS England and NHS Improvement appointed two new non-executive directors to the Trust Board; Afzal Ismail and Carole Mills. These appointments are to replace Ed Macalister-Smith and Ian Buckley whose terms of office finish on 31 March 2020, and whose contributions to the development of the Trust over the past six and a half years are much appreciated.

The planned changes to terms of reference of committees have been deferred due to the current crisis, but some changes are necessary, to appoint new chairs and re-balance committee attendance and to make some short term arrangements for Board governance over the coming months.

The departure of Ian Buckley also means a replacement Vice Chair is required.

## PREVIOUS DISCUSSIONS HELD

| |
|---|
| |

| **KEY IMPLICATIONS** | |
|---|---|
| **Financial** | None directly relating to this report |
| **Patients Safety or Quality** | None directly relating to this report |
| **Human Resources** | None directly relating to this report |
| **Operational** | None directly relating to this report |

# Changes to Trust Board

## 1. INTRODUCTION

1.1 This paper sets out some planned changes to the Board and addresses some short to medium term issues as a result of the current COVID-19 crisis.

## 2. NEW NON-EXECUTIVE DIRECTORS

2.1 The terms of office of Ed Macalister-Smith (EMS) and Ian Buckley (IB) come to an end on 31 March 2020, and their efforts over the past six and a half years are much appreciated by the Board and the Trust.

2.2 Two new NEDs have been appointed following by NHS England and NHS Improvement and they will start their three-year terms of office on 1 April 2020. They are, Afzal Ismail, Group Director of Corporate Services at a large housing association and Carole Mills, an experienced former local authority Chief Executive. Both NEDs have nonexecutive experience.

## 3. CHANGES TO COMMITTEE CHAIRS

3.1 The departure of EMS and IB means some reconfiguration of committee chairs is required. Following discussions with available Board members, the following changes are proposed;

| Committee | Current | Proposed |
|---|---|---|
| Audit Committee | Jerry Gould | Afzal Ismail |
| Finance and Performance Committee | Ian Buckley | Jerry Gould |
| Quality Governance Committee | Ed Macalister-Smith | Sudhesh Kumar |

3.2 Chief officer leads for the committees are as follows;

- Audit Committee — Chief Finance Officer
- Finance and Performance Committee — Chief Finance Officer
- Quality Governance Committee — Chief Quality Officer
- Remuneration Committee — Chief Workforce and Information Officer

3.3 Over the past few months consultation has been carried out about changes to committee terms of reference and these were due to be presented to this meeting of the Board for approval, but given the current crisis, this has been deferred. However, there are some changes to membership that need to be made to take account of the imminent changes and recent Board appointments. These proposals will be discussed with Board members and Trust Board is asked to delegate authority to the Chair and Chief Executive to agree committee membership in the short-term.

3.4 If approved, the existing terms of reference will be amended accordingly.

## 4. APPOINTMENT OF VICE-CHAIR

4.1 As the current term of office of the current Vice-Chair (Ian Buckley) finishes on 31 March 2020, a new Vice Chair needs to be appointed. Following discussion by the Chair with other members of the Board, Jerry Gould is proposed as Vice Chair.

## 5. TEMPORARY CHANGES TO GOVERNANCE ARRANGEMENTS

5.1 The current crisis requires some temporary change to the way the board and its committees operate over the coming months, and the following are proposed as emergency measures.

5.2 Due to non-Trust based individuals being encouraged not to attend Trust premises unless unavoidable, Trust Board meetings will be held 'virtually' using telephony or video technology until further notice.

5.3 National guidance on social distancing means it is currently not possible to enable public access to the Board meetings. However technological solutions are being explored to allow members of the public to observe meetings taking place in the future as is done in a number of other settings, but we have been unable to enable members of the public to observe this meeting and this has been publicised on our website. We are hopeful that by the time of the next planned Board meeting on 28 May 2020, facilities will be available to broadcast the meeting, live or in a recording.

5.4 Agendas will focus on business critical and regulatory issues (where regulators are still requiring those latter issues to be addressed) and will be kept as short as possible. Any other items will either be deferred or cancelled altogether. Where it is possible for reports to be drafted, then these may be circulated outside of formal meetings, for information and assurance.

5.5 Committee meeting agendas should be reviewed to ensure they only include business-critical items and there may be more pressure on getting papers out six days before meetings, as stated in standing orders. Where necessary, meetings may be stood down, but this will only be done in discussion with the Committee Chair, Trust Chair and lead chief officer.

5.6 Two changes to Standing Orders are being proposed to reflect the points above, to take effect immediately, until revoked or confirmed in a new set of Standing Orders (changes shown in red);

**3.11 Quorum**

No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and members (including at least one member who is also a chief officer of the Trust and one member who is not) is present (for this purpose 'present' includes those members using telephonic or video technology to join the meeting).

**3.17 Admission of public and the press**

i.) Admission and exclusion on grounds of confidentiality of business to be transacted

The public and representatives of the press may attend all meetings of the Trust (where this does not contradict national advice relating to social distancing).

## 6. APPOINTMENT OF UHCW TRUSTEE - UNIVERSITY HOSPITAL CHARITY

6.1 Following Ian Buckley's term of office coming to an end on 31 March 2020 a replacement UHCW nominated Trustee is required.

6.2 The Trust has four nominees on the Charity Board, the others being;

- Brenda Shiels, Non-Executive Director
- Nina Morgan, Chief Nursing Officer
- Lincoln Dawkin, Director of Estates and Facilities

6.3 The Charity Board wishes to strengthen the clinical and operational expertise available to the Board and following some canvassing of interest, , it is proposed that Mark Easter, Clinical Director for Clinical Support Services is nominated for a term of three years, until 31 March 2023.

University Hospitals Coventry and Warwickshire NHS Trust

# REPORT TO PUBLIC TRUST BOARD HELD ON 26 MARCH 2020

| | |
|---|---|
| **Subject Title** | CQC Inspection Report |
| **Executive Sponsor** | Andy Hardy, Chief Executive Officer |
| **Author** | Sharron Oulds, Associate Director of Quality Effectiveness and Assurance |
| **Attachment(s)** | CQC Must Do Action plan V5 FINAL 20200503<br>UHCW response to CQC inspection report Must Do actions 2020 FINAL letter |
| **Recommendation(s)** | Trust Board is asked to **NOTE** the report |

## EXECUTIVE SUMMARY

### CQC Inspection Report

The Trust received the CQC Inspection Report on 6th February 2020 with an overall rating of 'Good'. This rating has changed from 'Requires Improvement' from the previous inspection. The rating for the domain of Safe achieved 'Good'. The rating for Effective, Caring and Well led remained at 'Good' with the Responsive rating remaining the same as previously as 'Requires Improvement.'

The Use of Resources Report was rated as 'Requires Improvement'

Please see Ratings Table below:

University Hospital

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services | Good ↑ Feb 2020 | Good →← Feb 2020 | Good →← Feb 2020 | Good ↑ Feb 2020 | Good →← Feb 2020 | Good ↑ Feb 2020 |
| Medical care (including older people's care) | Good →← Feb 2020 | Good →← Feb 2020 | Good →← Feb 2020 | Good →← Feb 2020 | Good →← Feb 2020 | Good →← Feb 2020 |
| Surgery | Good →← Aug 2018 | Good →← Aug 2018 | Good →← Aug 2018 | Requires improvement →← Aug 2018 | Good →← Aug 2018 | Good →← Aug 2018 |
| Critical care | Good →← Feb 2020 | Good ↑ Feb 2020 | Good →← Feb 2020 | Good →← Feb 2020 | Good ↑ Feb 2020 | Good ↑ Feb 2020 |
| Maternity | Good ↑ Feb 2020 | Good →← Feb 2020 | Good →← Feb 2020 | Good →← Feb 2020 | Good →← Feb 2020 | Good →← Feb 2020 |
| Services for children and young people | Good →← Aug 2018 | Good →← Aug 2018 | Good →← Aug 2018 | Good →← Aug 2018 | Good →← Aug 2018 | Good →← Aug 2018 |
| End of life care | Good →← Aug 2018 | Good →← Aug 2018 | Outstanding →← Aug 2018 | Good →← Aug 2018 | Good →← Aug 2018 | Good →← Aug 2018 |
| Outpatients | Good →← Aug 2018 | Not rated | Good →← Aug 2018 | Requires improvement →← Aug 2018 | Good →← Aug 2018 | Good →← Jul 2018 |
| Diagnostic imaging | Good →← Aug 2018 | Not rated | Good →← Aug 2018 | Good →← Aug 2018 | Good →← Aug 2018 | Good →← Aug 2018 |
| Neurosurgery | Requires improvement →← Feb 2020 | Requires improvement →← Feb 2020 | Good →← Feb 2020 | Requires improvement →← Feb 2020 | Requires improvement →← Feb 2020 | Requires improvement →← Feb 2020 |
| **Overall*** | Good ↑ Feb 2020 | Good →← Feb 2020 | Good →← Feb 2020 | Requires improvement →← Feb 2020 | Good →← Feb 2020 | Good →← Feb 2020 |

Hospital of St Cross

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services | Good →← Aug 2018 | Good →← Aug 2018 | Good →← Aug 2018 | Good →← Aug 2018 | Requires improvement →← Aug 2018 | Good →← Aug 2018 |
| Medical care (including older people's care) | Good →← Aug 2018 | Good →← Aug 2018 | Good →← Aug 2018 | Good →← Aug 2018 | Good →← Aug 2018 | Good →← Aug 2018 |
| Surgery | Good →← Aug 2018 | Good →← Aug 2018 | Good →← Aug 2018 | Requires improvement →← Aug 2018 | Good →← Aug 2018 | Good →← Aug 2018 |
| Outpatients | Good →← Feb 2020 | Not rated | Good →← Feb 2020 | Good →← Feb 2020 | Good ↑ Feb 2020 | Good →← Feb 2020 |
| **Overall*** | Good →← Feb 2020 | Good →← Feb 2020 | Good →← Feb 2020 | Good →← Feb 2020 | Good ↑ Feb 2020 | Good →← Feb 2020 |

The Trust received 30 actions, of which 4 are 'must dos' and 26 are 'should dos'

Must Do Actions
The 'must do' actions relate to the Core Service Neurosurgery and are detailed below.

- 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.

  Breach of Regulation 11: Need to consent.

- The service must ensure that consultants work in line with best practice and national guidelines.

  Breach of Regulation 17: Good Governance.

- The service must operate effective governance procedures; particularly throughout theatres, to ensure quality, risk management and performance is accurately recorded and reviewed.

  Breach of Regulation 17: Good Governance.

- The service must address nurse staffing to ensure all patients are kept safe.

  Breach of Regulation 18: Staffing.

The Trust had 28 days to respond to the CQC with a Must do action plan, with a deadline of 5th March 2020. Meetings were held with the Triumvirate for Neurosurgery and Clinical Support Services to identify the steps to meet the regulatory requirements and an action plan was developed and submitted to the CQC. The Trust responded to the CQC with the Must Do action plan (appendix 1).

**Action Planning**
Initial meetings post report publication have taken place with leadership of the clinical groups inspected to commence the process of action planning for 'should do' actions. This process will use a framework of identifying measurable Key Performance Indicators, processes to achieve actions and assurance through evidence to ensure the recommendations in the report are addressed.

Furthermore, discussions are taking place regarding the journey to achieving 'Outstanding' which will form a separate action plan and planning piece across the organisation.

Regular engagement meetings between clinical groups and the assurance and compliance manager will commence to review progress on the action plan, discuss potential CQC relationship meeting programme content and review the CQC insight report where appropriate.

- Finalise Should Do Trustwide Action Plan
- CQC Action Plan to be approved at Trust Board
- Monitor plan and assurance of delivery at QGC
- Progress CQC Relationship Manager meeting programme
- Progress regular engagement meetings with clinical groups
- Commence development of towards outstanding action plan

| **PREVIOUS DISCUSSIONS HELD** |
|---|
| Trust Delivery Group February 2020<br>Quality Governance Committee 20 February 2020 |

| **KEY IMPLICATIONS** | |
|---|---|
| **Financial** | The implementation of improvements from CQC recommendations may have financial implications |
| **Patients Safety or Quality** | Regulatory breaches impact on the quality of patient care. The implementation of actions to address the Must Do actions will improve patient safety and quality of care |
| **Human Resources** | The implementation of improvements from CQC recommendations may have an impact on staff within services and recruitment implications for services |
| **Operational** | The implementation of improvements from CQC recommendations may have implications for the delivery of services. |

# UHCW CQC Must Do Action Plan Inspection Report February 2020

| UHCW CQC IMPROVEMENT ACTION PLAN | |
|---|---|
| **CORE SERVICE:** | Neurosurgery |
| **GROUP:** | Neurosurgery, Clinical Support Services |
| **Triumvirate:** | Neurosurgery: Jonathan Young Clinical Director, Gabrielle Harris Group Director of Operations, Sarah Hartley Group Director of Nursing and Allied Health Professionals<br>Clinical Support Services: Mark Easter Clinical Director, Martin Robinson Group Director of Operations, Joan Goodbody Group Director of nursing and Allied Health Professionals |
| **Date Action Plan Implemented: 12 February 2020** | |

| NO | Key Performance Indicator | Process | | | | |
|---|---|---|---|---|---|---|
| | AREAS FOR IMPROVEMENT CQC MUST DO RECOMMENDATIONS | ACTION | Person Responsible | Due Date | STATUS (RAG rated ) | Executive Lead |
| 1 | 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.<br><br>Breach of Regulation 11: Need to consent. | Develop a bespoke package of training for the Multidisciplinary Team on Ward 43 to include Mental Capacity Assessment and documentation in partnership with the Safeguarding Team. | Claire Baker Safeguarding Lead | 31/3/2020 | In Progress | Nina Morgan (CNO) |
| | | All staff on Ward 43 to attend MCA training, including registered and unregistered staff. | Steve Hodgson Group Manager | 30/06/2020 | In Progress | |
| | | Implement dedicated weekly audits on MCA compliance for W43 Neurosurgery. | Claire Baker Safeguarding Lead | 31/03/2020 | In Progress | |
| | | Implement recurrent monthly spot check case record review of x3 Ward 43 patients to monitor compliance with MCA/ DoLs policy through the patients journey and identify early hot spots | Claire Baker Safeguarding Lead | 30/04/2020 | In Progress | |
| | | Complete pilot of local MCA guidance sheet to be added to induction checklist for all temporary staff on Ward 43. | Sarah Hartley<br>Group Director of Nursing and Allied Health Professionals | 30/06/2020 | In Progress | |

# UHCW CQC Must Do Action Plan Inspection Report February 2020

| NO | Key Performance Indicator | Process | | | | |
|---|---|---|---|---|---|---|
| | AREAS FOR IMPROVEMENT<br>CQC MUST DO RECOMMENDATIONS | ACTION | Person Responsible | Due Date | STATUS (RAG rated ) | Executive Lead |
| 2 | The service must ensure that consultants work in line with best practice and national guidelines.<br><br>Breach of<br>Regulation 17: Good Governance. | Amend Consultant of the day (COD) model guidance to reflect subspeciality specific concerns discussed daily with respective consultant and decisions about all neurosurgical patients on a daily basis | Krunal Patel<br>Consultant Neurosurgeon | 28/02/2020 | Completed | |
| | | Amend Consultant of the day (COD) model/guidance to include mandatory requirement for the COD to see all patients admitted within the last 24 hours | Krunal Patel<br>Consultant Neurosurgeon | 28/02/2020 | Completed | |
| | | Ensure all substantive or long term agency medical staff are provided with stamps to ensure that all records are legible and appropriately signed. | Steve Hodgson<br>Group Manager Neurosciences | 31/03/2020 | In Progress | |
| | | Circulate and present monthly compliance reports regarding completion of the British Association of Spine Surgeons database at the monthly departmental meeting. | Krunal Patel<br>Consultant Neurosurgeon | 31/03/2020 | In Progress | Kiran Patel (CMO) |
| | | Implement process of additional consultant agreement to all decisions to recategorise patients from elective to emergency admission on the day of surgery. | Krunal Patel<br>Consultant Neurosurgeon | 28/02/2020 | Completed | |
| | | Develop an escalation process for the recategorisation of elective to emergency surgery to ensure MDT approach to planning and additional consultant agreement on the day of surgery | Jonathan Young<br>Group Clinical Director<br>Neurosciences | 30/04/2020 | Not started | |

# UHCW CQC Must Do Action Plan Inspection Report February 2020

| NO | Key Performance Indicator | Process | | | | |
|---|---|---|---|---|---|---|
| | AREAS FOR IMPROVEMENT CQC MUST DO RECOMMENDATIONS | ACTION | Person Responsible | Due Date | STATUS (RAG rated ) | Executive Lead |
| 3 | The service must operate effective governance procedures; particularly throughout theatres, to ensure quality, risk management and performance is accurately recorded and reviewed.<br><br>Breach of Regulation 17: Good Governance. | Implement formal weekly theatre management walk around by Modern Matron. Standard work for walk around to be reviewed to include compliance monitoring; including environmental clutter, theatre shoes and adherence to surgical instrument checklists. | Carolyn Bradshaw Modern Matron- Theatres | 30/04/2020 | In Progress | Mo Hussain (CQO) |
| | | Undertake an evaluation of access to emergency theatres including NCEPOD compliance for Neurosurgery and plan improvements from findings. | Soorly Sreevathsa<br>Consultant - Anaesthetics | 31/05/2020 | Not started | |
| | | Review all Standard Operating Procedures regarding access to emergency theatres for Neurosurgery patients in collaboration with anaesthetics and Neurosurgery | Krunal Patel<br>Consultant Neurosurgeon | 30/06/2020 | In Progress | |
| | | Complete WHO Safer Surgical Checklist audit for 19/20, agree date(s) for 20/21. | Carolyn Bradshaw<br>Modern Matron- Theatres | 31/03/2020 | In Progress | |
| | | All theatre staff to receive updated information on current theatre lines of responsibility, accountability and reporting. | Carolyn Bradshaw<br>Modern Matron- Theatres | 31/03/2020 | In Progress | |
| | | Theatre Management job descriptions for Neurosurgery to include responsibilities for quality governance and monitoring e.g audit leads, safety lead, QIPS lead | Carolyn Bradshaw<br>Modern Matron- Theatres | 31/03/2020 | In Progress | |
| | | Revise local induction package for new theatre staff to include clear information about roles and responsibilities within the department to support the PDR process. | Carolyn Bradshaw<br>Modern Matron- Theatres | 31/05/2020 | In Progress | |
| | | Promote the trustwide process for raising concerns with the freedom to speak up guardian and its importance to all Theatres staff using a variety of communication methods. | Carolyn Bradshaw<br>Modern Matron- Theatres | 31/03/2020 | In Progress | |

# UHCW CQC Must Do Action Plan Inspection Report February 2020

| NO | Key Performance Indicator | Process | | | | |
|---|---|---|---|---|---|---|
| | AREAS FOR IMPROVEMENT CQC MUST DO RECOMMENDATIONS | ACTION | Person Responsible | Due Date | STATUS (RAG rated ) | Executive Lead |
| | | Update all Anaesthetic Staff on Controlled Drug signing process for Theatres in accordance to Trust policy. | Soorly Sreevathsa<br>Consultant - Anaesthetics | 30/03/2020 | Not started | |
| 4 | The service must address nurse staffing to ensure all patients are kept safe.<br><br>Breach of Regulation 18: Staffing. | Send shifts not covered to agency 6wks ahead to maximise fill. Review options to increase fill on Ward 43. | Tracey Fenwick - Modern Matron | 28/02/2020 | Completed | |
| | | Implement escalation for corporate support to ensure a minimum number of staff on shift is protected for both Ward 43 and NECU. | Sarah Hartley<br>Group Director of Nursing and Allied Health Professionals | 30/06/2020 | In Progress | |
| | | Complete recruitment of 12 Overseas qualified nurses to support vacancy rate. | Sarah Hartley<br>Group Director of Nursing and Allied Health Professionals | 01/06/2020 | In Progress | |
| | | Complete recruitment of band 3 posts to support Neurosurgery Enhanced Care Unit | Tracey Fenwick<br>Modern Matron Cardiac Services | 01/06/2020 | In Progress | Nina Morgan (CNO) |
| | | Develop a focused work plan on retention of staff in this area to include clinical education lead and health and wellbeing actions | Sarah Hartley<br>Group Director of Nursing and Allied Health Professionals | 01/06/2020 | Not started | |
| | | Progress formal separation of Neurosurgery Enhanced Care Unit (NECU)from ward beds on W43 to allow wider scope of recruitment and increase leadership of both areas. | Tracey Fenwick<br>Modern Matron Cardiac Services | 31/07/2020 | In Progress | |

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5 March 2020

Professor Ted Baker
Chief Inspector of Hospitals
Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

**Reference:** CQC_ENFORCEMENT_NUMBER INS2-5747323761

Dear Professor Baker

**Re: Care Quality Commission Health and Social Care Act 2008 Inspection report and Use of Resources report University Hospitals Coventry and Warwickshire NHS Trust. Action to take against must do requirements**

I would like to thank you for the report following the recent inspection of our services (inspection report on 11 February). As you know, UHCW continuously strives to improve its services to deliver high quality care for all its patients and we take very seriously the regulatory requirements you have identified. I have therefore enclosed an action plan identifying the steps the Trust will take to meet the regulatory requirements outlined as Must Do actions in the report.

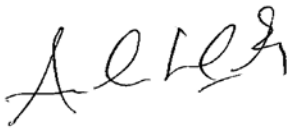
These actions will address the regulatory breaches of:

- Regulation 11 HSCA (RA) Regulations 14 Need for consent
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

I would like to confirm that I will respond in writing as per your requirements when actions are completed. However, beyond this, the Trust is in the process of developing a more detailed action plan on behalf of the Board which together with the Must Do actions includes the Should Do actions identified in your report. All actions and evidence of progress/completion will be monitored through our Quality Governance Committee (a subcommittee of our Board) and will be reported to our Board. We will also ensure that as part of our regular/monthly relationships meetings with your regional team, we update them on progress against the above.

I hope the attached action plan on the Must Do actions provides you with the level of assurance around the work that is underway to prioritise their resolution. Should you have any further questions about any of the actions identified, please do feel free contact me on the details above.

Yours sincerely



**Professor Andrew Hardy**
**Chief Executive Officer**

Cc: Nina Morgan – Chief Nursing Officer
Mo Hussain - Chief Quality Officer
Jenny Gardiner - Director of Quality
Phil Terry - Inspection Manager
HSCA_Compliance@cqc.org.uk

University Hospitals Coventry and Warwickshire NHS Trust

# REPORT TO TRUST BOARD
# HELD ON 26 MARCH 2020

| | |
|---|---|
| **Subject Title** | Board Assurance Framework and Corporate Risk Register |
| **Executive Sponsor** | Mo Hussain, Chief Quality Officer |
| **Author** | Geoff Stokes, Director of Corporate Affairs |
| **Attachments** | Appendix 1 Board Assurance Framework<br>Appendix 2 Corporate Risk Register (to be updated) |
| **Recommendation(s)** | Risk Committee is asked to receive **ASSURANCE** from the report |

## EXECUTIVE SUMMARY

The attached Board Assurance Framework (BAF) has been updated by operational leads on behalf of relevant chief officer sponsors. This update was discussed at Risk Committee on 16 March 2020 and includes the addition of related corporate risks, following a recommendation from the Audit Committee.

A change in rating has been recommended for BAF risk 4 - Financial Sustainability. It is recommended to reduce the likelihood of this risk from 5 to 4 to signify a greater level of confidence in achieving the 2019/20 control total.

Following discussion at Board, a review is being carried out by CW Audit of the BAF process and this may result in a different approach being adopted in future. Therefore at present no changes of substance to the BAF have been proposed.

The Risk Committee was dominated by a discussion about the impact on COVID-19 (Coronavirus) and a new corporate risk has been added to address the multiple aspects of the pandemic. Elsewhere on the agenda that risk is detailed and will be updated onto the Datix risk system in due course. Therefore the corporate risk register attached as appendix 2 does not include that risk.

Given the speed and growth of the virus and its impact on the activities of the whole Trust and wider society, there will be constant updates and reviews of this risk and it will inevitably overlap and overtake other risks on the coming weeks and months.

The key corporate risks with scores of 20 or above are shown below.

| Risk ID | Risk Description | Risk Score |
|---|---|---|
| 3540 | Impact of COVID-19 Pandemic on UHCW NHS Trust | 20 |
| 2769 | Delays to admission to a Mental health Unit for patients with serious mental health problems | 20 |
| 3346 | UHCW NHS Trust Lack of CT Scan Capacity for ED, Major Trauma and Urgent In-Patient Referrals | 20 |
| 2067 | Overcrowding in ED (ED 4hr wait) | 20 |
| 2237 | Severe shortage of permanent storage capacity in mortuary at UHCW | 20 |

| |
|---|
| |

## PREVIOUS DISCUSSIONS HELD

| |
|---|
| Trust Board 28 November 2019 |

## KEY IMPLICATIONS

| | |
|---|---|
| **Financial** | Financial risks are included in the BAF |
| **Patients Safety or Quality** | Risks to patient safety or quality are included in the BAF |
| **Human Resources** | Human resources risks are included in the BAF |
| **Operational** | Operational risks are included in the BAF |

# Board Assurance Framework

| DATIX REF | RISK NUMBER | CQC DOMAIN | STRATEGIC OBJECTIVE | RISK TITLE | RISK DESCRPTION | EXEC LEAD | MANAGEMENT LEAD | COMMITTEE | INITIAL | | | PREVIOUS | | | PROPOSED | | | CHANGE | TARGET | | | LAST REVIEW | NEXT REVIEW |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | LIKELIHOOD | CONSEQUENCE | RISK RATING | LIKELIHOOD | CONSEQUENCE | RISK RATING | LIKELIHOOD | CONSEQUENCE | RISK RATING | | LIKELIHOOD | CONSEQUENCE | RISK RATING | | |
| 3061 | 1 | Safe | To deliver the safest care and excellence in patient experience | Safety metrics | IF our patient safety and patient experience metrics deteriorate THEN the Trust may become an outlier RESULTING IN poor patient care and experience, reputational damage (including a negative impact on our CQC rating) and potential regulatory sanctions. | Mo Hussain, Chief Quality Officer | Jenny Gardiner, Director of Quality | Quality Governance Committee | 4 | 4 | 16 | 3 | 4 | 12 | 3 | 4 | 12 | ⇔ | 2 | 3 | 6 | 3 Mar 2020 | 31 Mar 2020 |
| 3062 | 2 | Responsive | To be a leader in operational performance | Operational Performance | IF we fail to meet the national operational targets THEN it will have an impact on patient safety and experience RESULTING IN potential patient harm, reputational damage and potential regulatory sanctions. | Laura Crowne, Chief Operating Officer | Martin Robinson. Deputy Chief Operating Officer | Finance and Performance Committee | 5 | 4 | 20 | 4 | 4 | 16 | 4 | 4 | 16 | ⇔ | 2 | 2 | 4 | 3 Mar 2020 | 30 Jun 2020 |
| 3063 | 3 | Well Led | To be a model employer | Effective workforce | IF our staff are not satisfied and report a poor experience as reflected in opinion surveys THEN it may affect our recruitment and retention RESULTING IN a negative impact on organisational performance and reputational damage. | Karen Martin, Chief Workforce & Information Officer/Deputy CEO | Donna Griffiths, Director of Workforce / Deputy Chief Workforce and Information Officer | Quality Governance Committee | 4 | 3 | 12 | 2 | 3 | 6 | 2 | 3 | 6 | ⇔ | 2 | 3 | 6 | 3 Mar 2020 | 30 Jun 2020 |
| 3064 | 4 | Well Led | To achieve financial sustainability | Financial Sustainability | IF we do not achieve financial balance consistently THEN we will not be able to make improvements to the infrastructure, support operational and clinical developments RESULTING in poor patient experience and regulatory sanction. | Su Rollason, Chief Financial Officer | Antony Hobbs, Director of Operational Finance | Finance and Performance Committee | 5 | 5 | 25 | 5 | 5 | 25 | 4 | 5 | 20 | ⇩ | 2 | 4 | 8 | 3 Mar 2020 | 30 Jun 2020 |
| 3065 | 5 | Effective | To be a frontrunner in research, innovation and education | Research and Development | IF we fail to increase our output and participation in research and innovation and are unable to develop our students and trainees THEN it will have a negative impact on recruitment and quality of care for our patients RESULTING in reputational damage. | Kiran Patel, Chief Medical Officer | Ceri Jones, Head of Research and Development | Quality Governance Committee | 4 | 3 | 12 | 2 | 3 | 6 | 2 | 3 | 6 | ⇔ | 2 | 3 | 6 | 3 Mar 2020 | 30 Jun 2020 |
| 3066 | 6 | Well Led | To lead the integration of care pathways for the population we serve | Integrated care | IF we do not work collaboratively with our partners and lead integrated service developments across the local system THEN we will be unable to achieve our ambition to provide outstanding care, excellent patient outcomes and sustainable services RESULTING IN fragmented care across for the populations we serve. | Justine Richards, Chief Strategy Officer | Jamie Deas, Director of Strategy and Integration | Board | 3 | 4 | 12 | 2 | 4 | 8 | 2 | 4 | 8 | ⇔ | 2 | 2 | 4 | 3 Mar 2020 | 30 Jun 2020 |

# Board Assurance Framework



| | | | | | |
|---|---|---|---|---|---|
| **BAF RISK REFERENCE** | 1 | Safety metrics | | **DATE OF REVIEW** | 3 Mar 2020 |
| **DATIX REF** | 3061 | **RELATED** | 107, 1102, 1864, 2067, 2136, 2195, 2237, 2255, 2264, 2279, 2416, 2533, | **NEXT REVIEW DATE** | 31 Mar 2020 |
| | | **CORPORATE** | 2537, 2540, 2546, 2633, 2646, 2664, 2656, 2716, 2769, 2792, 2832, 2911, | | |
| | | **RISKS** | 3051, 3074, 3086, 3128, 3133, 3198, 3222, 3265, 3285, 3312, 3334, 3346 | | |

**RISK DETAILS**

| RISK DESCRIPTION | RATING | L | C | R |
|---|---|---|---|---|
| IF our patient safety and patient experience metrics deteriorate | **INITIAL** | 4 | 4 | 16 |
| THEN the Trust may become an outlier | **TARGET** | 2 | 3 | 6 |
| RESULTING IN poor patient care and experience, reputational damage (including a negative impact on our CQC rating) and | **PREVIOUS** | 3 | 4 | 12 |
| potential regulatory sanctions. | **CURRENT** | 3 | 4 | 12 |

**CONTEXT**

| | | | |
|---|---|---|---|
| **STRATEGIC OBJECTIVE** | To deliver the safest care and excellence in patient | **CHIEF OFFICER LEAD** | Mo Hussain, Chief Quality Officer |
| **ANNUAL GOAL(S)** | | **MANAGEMENT LEAD** | Jenny Gardiner, Director of Quality |
| | | | |
| | | | |
| **CQC DOMAIN** | Safe | **COMMITTEE** | Quality Governance Committee |

**CONTROLS AND ASSURANCE**

| REF | CONTROL | SOURCE OF ASSURANCE | LEVEL |
|---|---|---|---|
| 1 | Serious incident process in place, including Patient Safety Response team | Serious Incidents and Never Events Report to Board | 2 |
| 2 | Mortality review process | Mortality Update report to Board | 2 |
| 3 | Patient Partners Forum established | Patient Experience and Engagement Committee | 1 |
| 4 | Infection control process is robust and results in low infection | Infection Prevention and Control report to Board | 2 |
| 5 | Safe staffing of ward areas | Safer Staffing report to Board | 2 |
| | | | |

**ACTIONS**

| REF | GAP | ACTION | BY WHEN | PROGRESS |
|---|---|---|---|---|
| 1 | Assurance regarding NATSSips and LOCSSips | Programme to be undertaken to introduce national standards to surgical specialities | 31 Dec 2019 | Programme passed to Groups to develop for specialties |

# Board Assurance Framework

**ACTIONS**

| REF | GAP | ACTION | BY WHEN | PROGRESS |
|---|---|---|---|---|
| 2 | Further develop patient experience and engagement | Patient experience delivery plan to be implemented | 31 Dec 2021 | A series of actions and target dates are included in the delivery plan which is monitored and progress on the delivery plan reported to PEEC. The target date represents the completion of all actions, but many will be completed before this date. |
| 3 | Method for assessing quality standards across the Trust | Introduce an assessment process to test quality standards across the Trust (at ward level) to enable greater oversight and engagement. Baseline assessments in core wards to take place | 31 Aug 2020 | World Class Wards accreditation system launched 27 September 2019 as part of Pathway to Excellence programme |

# Board Assurance Framework



| | | | | | |
|---|---|---|---|---|---|
| **BAF RISK REFERENCE** | 2 | Operational Performance | | **DATE OF REVIEW** | 3 Mar 2020 |
| **DATIX REF** | 3062 | **RELATED CORPORATE RISKS** | 2067, 2162, 2195, 2316, 2472, 2533, 2537, 2633, 2644, 2716, 2769, 2784, 2785, 3020, 3051, 3222, 3265, 3285, 3324, 3312, 3346, 3366 | **NEXT REVIEW DATE** | 30 Jun 2020 |

**RISK DETAILS**

| RISK DESCRIPTION | RATING | L | C | R |
|---|---|---|---|---|
| IF we fail to meet the national operational targets<br>THEN it will have an impact on patient safety and experience<br>RESULTING IN potential patient harm, reputational damage and potential regulatory sanctions. | **INITIAL** | 5 | 4 | 20 |
| | **TARGET** | 2 | 2 | 4 |
| | **PREVIOUS** | 4 | 4 | 16 |
| | **CURRENT** | 4 | 4 | 16 |

**CONTEXT**

| | | **ACCOUNTABILITY** | |
|---|---|---|---|
| **STRATEGIC OBJECTIVE** | To be a leader in operational performance | **CHIEF OFFICER LEAD** | Laura Crowne, Chief Operating Officer |
| **ANNUAL GOAL(S)** | Support improvements in planned care through the development of St Cross Hospital | **MANAGEMENT LEAD** | Martin Robinson. Deputy Chief Operating Officer |
| | Expand our diagnostic services in CT and MRI | | |
| | | | |
| **CQC DOMAIN** | Responsive | **COMMITTEE** | Finance and Performance Committee |

**CONTROLS AND ASSURANCE**

| REF | CONTROL | SOURCE OF ASSURANCE | LEVEL |
|---|---|---|---|
| 1 | Rapid access and triage (RAT) space reducing ambulance handover times. | Local/STP A&E Delivery Board | 3 |
| 2 | Clear priorities identified and incorporated into Integrated Emergency Care | Weekly progress meetings | 0 |
| | Improvement Plan, includes work streams in minors, streaming, RATing and all national standards for ED timed pathways. | Integrated Urgent Care Improvement Plan monitored through Emergency Care Improvement Board and Local A&E Delivery Boards | 3 |
| 3 | Daily activity reporting for A&E performance, weekly analysis against agreed | Health economy A&E Delivery Board | 3 |
| | timed pathways with actions agreed at daily huddles in operations centre and ED | Monitoring of Integrated Urgent Care Improvement Plan at 2 weekly Emergency Care Improvement Board. | 3 |
| 4 | Cancer software implemented to ensure enhanced tracking | Weekly Access meeting with relevant groups, Cancer Access Board | 0 |
| 5 | Investment to enhance ED staffing model agreed and temporary staff in post pending permanent appointments | Weekly meeting with relevant groups, oversight at Emergency Care Improvement Board | 0 |

# Board Assurance Framework

| REF | CONTROL | SOURCE OF ASSURANCE | LEVEL |
|---|---|---|---|
| 6 | Review of stranded patients, Patient Flow work stream with dedicated support to deliver improvement | Formal reporting mechanism for Delayed Transfers of Care to NHSI | 3 |
| 7 | Red 2 Green and SAFER initiatives | Supported as part of the Patient Flow Work stream, monitored at CDG/ TDG | 1 |
| 8 | Demand and capacity modelling carried out to identify recovery trajectories for all elective specialties | Performance monitored via Board (IPR) and Finance & Performance Committee | 2 |
| 9 | Senior management focus on RTT and micro-management to prevent 52 week breaches | Performance monitored via Board (IPR) and Finance & Performance Committee | 2 |

**ACTIONS**

| REF | GAP | ACTION | BY WHEN | PROGRESS |
|---|---|---|---|---|
| 1 | Specific plan for seasonal fluctuations | Ensure robust Winter Plan to support Winter Demand via A&E with review at the end to inform 2020/21 planning. | 1 Jun 2020 | Winter plan in place. Review to be scheduled |
| 2 | | Cancelation of activity in advance to ensure bed capacity in Dec 19/ Jan 20. Groups to design year activity plan for 20/21 to improve forward | 1 May 2020 | Initial period complete. ODP process underway |
| 3 | Emergency care pathway design | Use of UHCWi approach on elements of emergency care pathways | 1 Jun 2020 | Focus on children's ED, then minors from 4 April |
| 4 | Trust is outlier on stranded patients with long LOS | Detailed LOS work programme including Quarter 4 focus on reducing long lengths of stays. | 30 Jun 2020 | Action plan in place and progressing. |
| 5 | External Flow improvement initiatives | Use of MADE (Multi Agency Discharge Event) periodically to improve hospital flow. Once quarterly to be agreed - Nov/Dec, Feb/Mar, | 30 Jun 2020 | Two completed. First Dec 19, Second Feb 20 |
| 6 | Standardised work across the Trust in response to OPEL hospital status changes | Consolidate existing documentation into new OPEL action cards for use across the hospital | 31 May 2020 | Draft document completed |
| 7 | Deputy COO with dedicated senior Manager oversight of Unplanned care | Appoint Deputy Chief Operating Officer with remit for emergency and unplanned. | 31 Jul 2020 | Interviews due 5 March 2020 |

# Board Assurance Framework



| | | | | | |
|---|---|---|---|---|---|
| **BAF RISK REFERENCE** | 3 | Effective workforce | | **DATE OF REVIEW** | 3 Mar 2020 |
| **DATIX REF** | 3063 | **RELATED CORPORATE RISKS** | 1898, 2279, 2783, 2911, 3030, 3193, 3222, 3366 | **NEXT REVIEW DATE** | 30 Jun 2020 |

**RISK DETAILS**

| RISK DESCRIPTION | RATING | L | C | R |
|---|---|---|---|---|
| IF our staff are not satisfied and report a poor experience as reflected in opinion surveys<br>THEN it may affect our recruitment and retention<br>RESULTING IN a negative impact on organisational performance and reputational damage. | **INITIAL** | 4 | 3 | 12 |
| | **TARGET** | 2 | 3 | 6 |
| | **PREVIOUS** | 2 | 3 | 6 |
| | **CURRENT** | 2 | 3 | 6 |

**CONTEXT**

| | | | |
|---|---|---|---|
| **STRATEGIC OBJECTIVE** | To be a model employer | **CHIEF OFFICER LEAD** | Karen Martin, Chief Workforce & Information Officer/Deputy |
| **ANNUAL GOAL(S)** | Address the gaps in the general medicine workforce and eliminate base 2 beds | **MANAGEMENT LEAD** | Donna Griffiths, Director of Workforce / Deputy Chief Workforce and Information Officer |
| **CQC DOMAIN** | Well Led | **COMMITTEE** | Quality Governance Committee |

**CONTROLS AND ASSURANCE**

| REF | CONTROL | SOURCE OF ASSURANCE | LEVEL |
|---|---|---|---|
| 1 | Access to a range of health & wellbeing initiatives (e. g. NHS health checks, outdoor gyms, occupational health service) | Workplace Wellbeing Charter accreditation<br>Updates to Strategic Workfroce Committee | 3 |
| 2 | Employee Engagement Officer in post | Strategic Workforce Committee | 1 |
| 3 | Access to development opportunities and career pathways | Strategic Workforce Committee | 1 |
| 4 | UHCW Improvement System enables staff to contribute to improvements in patient care | Trust Guiding Team | 1 |
| 5 | Line Manager support (manager toolkit, leadership programme, etc.) | Strategic Workforce Committee | 1 |
| 6 | Trust Values | Trust Guiding Team | 1 |
| 7 | Appraisal and talent management process | Strategic Workforce Committee | 1 |
| 8 | Freedom to Speak up Guardian appointed Sept 2018 and confidential contacts in place | Twice annual report to Board | 2 |
| 9 | Guardian of Safe Working | Twice annual report to Board | 2 |
| 10 | Organisational Development, Workforce & Innovation Strategy 2018-2021 | Strategic Workforce Committee | 1 |
| 11 | Statistically significant improvement in 2018 Staff Engagement Score | 2018 NHS National Staff Survey | 3 |

# Board Assurance Framework

**ACTIONS**

| REF | GAP | ACTION | BY WHEN | PROGRESS |
|---|---|---|---|---|
| 1 | Inconsistent line manager support/engagement with staff | Spread of UHCW*i* management system and increased numbers of managers attending Lean for Leaders programme | 31 Mar 2020 | Additional activity planned to ensure a Kaizen event per week takes place across the organisation to increase awareness and spread. Work with P&I to report Lean for Leader trained staff via Insite will be live in March to enable Groups to fully support them to utilise their UHCWi knowledge and skills |
| 3 | | Active recruitment campaign to close gaps in our change maker cover to support CQC campaign and support increased engagement overall. | 31 Mar 2020 | 152 active changemakers and reruitment continues to attain our vision of a change maker in every team/department. Changemakers activity is supported and co-ordinated through the Employee Engagement Officer. They are currently involved in the planning for Blooming with Pride 2020 |
| 4 | Variable levels of leadership throughout the organisation | Continued access to Leading Together programme. Access to Aspirant Leaders programme and BAME Stepping Up Programme. | 31 Mar 2020 | Current cohorts running for Leading Together and Lean for Leaders. Nominations out for the Aspirant Leader programme. Next cohort of the BAME Stepping Up programme commenced. New manager welcome pack developed. UHCW*i* tools available. |
| 5 | | Development of Coaching Academy | 30 Jun 2020 | Coaching Development Programme commenced and will see a further 20 staff trained as interna coaches. Manager as a Coach programme available from April 2020. |

# Board Assurance Framework

| REF | GAP | ACTION | BY WHEN | PROGRESS |
|---|---|---|---|---|
| 6 | Limited spread of UHCWi methodologies | Refresh self-assessment for cultural transformation continuum to assess spread of UHCWi | 30 Nov 2020 | 2019 self assessment undertaken on . Agreed focus continues on 3 areas - Standard Work, Daily Management and Visible Leaders. This focus is being realised through Lean for Leaders training and Leader Rounding from an Exec level down. All Lean for Leaders are trained in making visible their own leader standard work and daily management will be embedded using rounding. TGT monitors progress. |
| 6 | Staff do not always feel listened to | Promote role of Change Maker as an enabler for improved engagment | 31 Mar 2020 | Employee Engagement Officer developing Change Maker role as a virtual engagement team. Recruitment of additional changemakers in progress. Currently have 152 active change |
| 7 | | Bringing people together campaign (including the development of a feedback friendly culture) | 31 May 2020 | Campaign scoped and focus areas agreed at SWC with ongoing oversight from OD Committee. Communicaiton and engagement campaign being finalised in March. |
| 8 | | Analysis and sharing of initial results of the 2019 staff Survey. Agree corporate actions to be taken. | 1 Aug 2020 | Final and Benchmarked results shared across organisation (COG, COF, TDG, SWC, all staff). OD Committee developing corporate action plan from a workshop held on 18 February. Clinical Groups have their benchmarked data and HRBPs are supporting the development of local action plans. Individual teams will have access to their data via Insite during March. Progress will be presented at COF i August. |
| 9 | Communication channels not reaching all staff | A range of clinically-led professional monthly bulletins are being introduced to engage staff on issues affecting the profession - CMOBulletin launched November 2019, AHP Bulletin commenced jan 2020 and Nursing one in development; all are being evaluated and | 31 Mar 2020 | CMO Bulletin launched October 2019 with excellent initial feedback. Learning from that, AHP Bulletin launched January 2020 and nursing scheduled Feb 2020 |

| REF | GAP | ACTION | BY WHEN | PROGRESS |
|---|---|---|---|---|
| | | Dedicated social media channel, probably facebook, being explored for messages for staff, to support operational messaging; | 31 Mar 2020 | Other NHS Trusts approach being reviewed to look at options before implementation; |

# Board Assurance Framework

| | | | | | |
|---|---|---|---|---|---|
| **BAF RISK REFERENCE** | 4 | Financial Sustainability | | **DATE OF REVIEW** | 3 Mar 2020 |
| **DATIX REF** | 3064 | **RELATED CORPORATE RISKS** | 2264, 2783, 2784, 2785, 3155, 3285 | **NEXT REVIEW DATE** | 30 Jun 2020 |

**RISK DETAILS**

| RISK DESCRIPTION | RATING | L | C | R |
|---|---|---|---|---|
| IF we do not achieve financial balance consistently<br>THEN we will not be able to make improvements to the infrastructure, support operational and clinical developments<br>RESULTING in poor patient experience and regulatory sanction. | **INITIAL** | 5 | 5 | 25 |
| | **TARGET** | 2 | 4 | 8 |
| | **PREVIOUS** | 5 | 5 | 25 |
| | **CURRENT** | 4 | 5 | 20 |

**CONTEXT**

| | | | |
|---|---|---|---|
| **STRATEGIC OBJECTIVE** | To achieve financial sustainability | **CHIEF OFFICER LEAD** | Su Rollason, Chief Financial Officer |
| **ANNUAL GOAL(S)** | Deliver our Waste Reduction programme using our UHCWi management system. | **MANAGEMENT LEAD** | Antony Hobbs, Director of Operational Finance |
| **CQC DOMAIN** | Well Led | **COMMITTEE** | Finance and Performance Committee |

**CONTROLS AND ASSURANCE**

| REF | CONTROL | SOURCE OF ASSURANCE | LEVEL |
|---|---|---|---|
| 1 | Agency authorisation process in place and agency spending monitored against threshold | Finance & Performance Committee | 2 |
| 2 | Programme Delivery Office (PDO) monitoring delivery of Waste Reduction Programme | Waste Reduction Board | 1 |
| 3 | Year to date and forecast outturn is reviewed monthly | NHSI | 3 |
| 4 | Budget setting process is robust | Budget setting internal audit review (significant assurance for 2018/19) | 3 |

# Board Assurance Framework

**ACTIONS**

| REF | GAP | ACTION | BY WHEN | PROGRESS |
|---|---|---|---|---|
| 1 | Agency Expenditure | Review Agency spend | 31 Mar 2020 | |
| 2 | Waste Reduction Programme Delivery (Previously known as CIP) | Focus on Waste Reduction delivery | 2 Feb 2020 | Waste Reduction Programme launched for 2019/20, to create one single programme of transformation/waste reductions<br>Monthly Waste Reduction events have been held through 19/20 to support new idea generation, support programme development and Delivery. |
| 3 | Waste Reduction Programme Delivery | Focus on Waste Reduction delivery | 31 Mar 2020 | |
| 4 | Long-term financial sustainability | Service Line Review | 31 Mar 2020 | A piece of analysis was commissioned to look at service line performance over time a five year period, which resulted in service level deep-dives into four specialty areas in quarter 3 (Urology, Trauma and Orthopaedics, Gastroenterology and Neurosurgery). Deep-Dives into Neonatal and Nephrology are scheduled for quarter 4 |
| 5 | Financial Recovery | Focus on run rate improvement | 31 Mar 2020 | Escalation meetings with Group triumvirates chaired by the CEO, alongside the CFO and COO have been established and have continue to run monthly from August 2019. |

# Board Assurance Framework

| BAF RISK REFERENCE | 5 | Research and Development | DATE OF REVIEW | 3 Mar 2020 |
|---|---|---|---|---|
| DATIX REF | 3065 | RELATED CORPORATE RISKS | NEXT REVIEW DATE | 30 Jun 2020 |

**RISK DETAILS**

| RISK DESCRIPTION | RATING | L | C | R |
|---|---|---|---|---|
| IF we fail to increase our output and participation in research and innovation and are unable to develop our students and trainees<br>THEN it will have a negative impact on recruitment and quality of care for our patients<br>RESULTING in reputational damage. | INITIAL | 4 | 3 | 12 |
| | TARGET | 2 | 3 | 6 |
| | PREVIOUS | 2 | 3 | 6 |
| | CURRENT | 2 | 3 | 6 |

**CONTEXT** / **ACCOUNTABILITY**

| | | | |
|---|---|---|---|
| STRATEGIC OBJECTIVE | To be a frontrunner in research, innovation and education | CHIEF OFFICER LEAD | Kiran Patel, Chief Medical Officer |
| ANNUAL GOAL(S) | | MANAGEMENT LEAD | Ceri Jones, Head of Research and Development |
| CQC DOMAIN | Effective | COMMITTEE | Quality Governance Committee |

**CONTROLS AND ASSURANCE**

| REF | CONTROL | SOURCE OF ASSURANCE | LEVEL |
|---|---|---|---|
| 1 | KPIs used to track; resources (applications for resources , research income, research set-up and delivery times and grants submitted) and performance (number of patients recruited) | KPIs monitored at Board via Integrated Performance Report | 2 |
| 2 | Check and challenge of the wider research issues needed to support research (e.g. resource, space, culture etc.) | Regular report to the Board | 2 |
| 3 | Check and challenge of financial implications of research | Research and grant income reported twice yearly to Finance and Performance Committee | 2 |
| 4 | All surveys have associated action plans | Reports to MERC, PSC and SWC and Trust Board | 1 |
| 5 | Assess the desirability, viability and feasibility of new product innovations; inclusive of intellectual property rights and new product innovation approval | Reported to Director of Corporate Affairs & Subsequent boards (TDG or CDG) for approval. | 1 |

# Board Assurance Framework

**ACTIONS**

| REF | GAP | ACTION | BY WHEN | PROGRESS |
|---|---|---|---|---|
| 1 | Opportunities to free up staff time for research (e.g. 3 of 8 fellowships not taken up, 4 examples of failure to release staff for INCA) | Review of Fellowships underway<br>Association of UK University Hospitals (AUKUH) producing national data to enable comparison for NMAHPs. | 30 Jun 2020 | iCAhRE (interdisciplinary Clinical Academic health Research Excellence) Programme in place to support NMAHP and Scientist careers. Centre for Care Excellence launch Jan 2020. Consultant Fellowships to be revised in 2020. |
| 2 | Service gaps at junior doctor level | International appointments | 31 Oct 2019 | MOU signed with Manipal University and Amrita Health Institute.<br>Advertised posts June 2019, recruitment autumn 2019 |
| 3 | Implement robust process for managing and developing new Innovation Ideas | Develop a more process driven approach to managing new innovation ideas, from idea to implementation | 31 Dec 2019 | Robust process in place for managing all new Innovation Ideas including a rigorous process of assessing new ideas and PM approved Innovations. |

# Board Assurance Framework



| | | | | | |
|---|---|---|---|---|---|
| **BAF RISK REFERENCE** | 6 | Integrated care | | **DATE OF REVIEW** | 3 Mar 2020 |
| **DATIX REF** | 3066 | **RELATED CORPORATE RISKS** | 2264 | **NEXT REVIEW DATE** | 30 Jun 2020 |

**RISK DETAILS**

| RISK DESCRIPTION | RATING | L | C | R |
|---|---|---|---|---|
| IF we do not work collaboratively with our partners and lead integrated service developments across the local system | **INITIAL** | 3 | 4 | 12 |
| THEN we will be unable to achieve our ambition to provide outstanding care, excellent patient outcomes and sustainable services | **TARGET** | 2 | 2 | 4 |
| RESULTING IN fragmented care across for the populations we serve. | **PREVIOUS** | 2 | 4 | 8 |
| | **CURRENT** | 2 | 4 | 8 |

**CONTEXT**

**ACCOUNTABILITY**

| | | | |
|---|---|---|---|
| **STRATEGIC OBJECTIVE** | To lead the integration of care pathways for the population we serve | **CHIEF OFFICER LEAD** | Justine Richards, Chief Strategy Officer |
| **ANNUAL GOAL(S)** | Work with Worcester to develop a clinical network for Urology and Oncology | **MANAGEMENT LEAD** | Jamie Deas, Director of Strategy and Integration |
| | Introduce a front door frailty service that improves outcomes | | |
| **CQC DOMAIN** | Well Led | **COMMITTEE** | Board |

**CONTROLS AND ASSURANCE**

| REF | CONTROL | SOURCE OF ASSURANCE | LEVEL |
|---|---|---|---|
| 1 | Coventry and Warwickshire Health and Care Partnership Board in place with membership from all health and local authority partners | NHSI &NHSE | 3 |
| 2 | Coventry and Warwickshire health and Care Partnership Programme Groups in place with senior representation from UHCW | Chief Officer Group | 1 |
| 3 | Worcester Acute Hospital Trust/UHCW Partnership Board in place to develop specialist services | Chief Officer Group | 1 |
| 4 | UHCW, GEH and SWFT acute network collaborative agreement document approved by all parties | Trust Board | 2 |
| 5 | PLACE Partnership Executive Groups established for Coventry & Rugby | Coventry and Warwickshire Health and Care Partnership Board/TDG | 3 |
| 6 | Coventry and Warwickshire Provider Alliance established | Coventry and Warwickshire Health and Care Partnership | 3 |
| 7 | Group Strategy Development Process | Trust Board | 2 |

# Board Assurance Framework

**ACTIONS**

| REF | GAP | ACTION | BY WHEN | PROGRESS |
|---|---|---|---|---|
| 1 | Improve acute network collaboration to support effective and efficient care | Agree partnership working principles, MOU and SLA's | 14 Apr 2020 | Operational workshop to progress agreed work programme scheduled for 2nd Aprils and Exec to Exec meeting with GEH set for 14th April 2020.<br>15 of the 19 SLAs in place between UHCW and GEH have now been agreed. |
| 2 | Specialist Commissioner support for UHCW/WAHT Partnership | Establish regular senior meeting to build relationships with specialist commissioners | 1 Apr 2020 | Initial meeting between Coventry and Warwickshire Providers scheduled for March to establish Urology Area Network in response to NHSE Specialist Commissioning request. This work will be overseen by the Coventry and Warwickshire Provider Alliance |
| 3 | Integrated care system roadmap | Provider Alliance to be established across C&W | Various | • CWPA established in the summer of 2018 with agreed MOU and Terms of Reference in place.<br>• The alliance is co-chaired by the UHCW CTO and SWFT Managing Director<br>• CWPA has been approached by the joint strategic commissioners to develop a range of proposals to redesign Maternity, Children and Young Peoples services which is in progress. Regular gateway reviews and discussion workshops are taking place between CWPA and commissioners as part of this process<br>• CWPA has recently refreshed its MOU to reflect the changes in the governance of the CWHCP including reporting directly to the CWHCP Partnership Executive Group and is working closely with the newly established Clinical Forum in developing clinical pathways and new operating models.<br>Monthly update progress reports to PEG scheduled (SRO Andy Hardy) |
| 4 | Delayed conclusion to Worcester Acute Hospital Trust review of preferred single | UHCW has set out our position to be the preferred partner and intent to give three months notice should Worcester's decision be to partner with another Trust | 29 Feb 2020 | The Trust is still waiting to hear from Worcester as to its decision on future arrangements. A withdrawal plan is in the process of being drawn up should Worcester choose |

# Board Assurance Framework

**ACTIONS**

| REF | GAP | ACTION | BY WHEN | PROGRESS |
|---|---|---|---|---|
| 5 | Establishment of Coventry and Rugby Place Executive Boards | UHCW is playing a leading role in the establishment of an Executive Place Board for Coventry and Rugby and in the development of the programme of transformation | Ongoing | Coventry Place Executive Group well established with detailed transformation plan including programmes for MSK, Frailty, Ophthalmology pathways in progress and a workstream focussed on demand management.<br>Rugby Place group emerging with several meetings/workshops held to agree delivery programme<br>Programme Director (hosted via UHCW) in place since July 2019 |
| 6 | Formal reporting arrangements for Internal Integrated Steering Group | Develop formal reporting process into TDG | 28 Feb 2020 | Overarching Trust strategic plan ws presented to the Strategic Board in February. It was recommended that the plan should be endorsed at the Trust Board in March.<br>Work is in train to develop the detailed delivery plans for the associated tactical projects. Assurance will be provided through quarterly reviews at TDG and to bi-annually to Trust Board. |
| 7 | Group Strategy Development Process | Establish regular senior meeting to develop shared programme between the trust and CWPT | 1 Dec 2019 | A board to board session was held with CWPT and followed up with the establishment of Partnership Forum that met on 25th November 2019 with senior members from both Trusts in attendance. A joint programme will be established between the two trusts including the development of an integrated MSK pathway for Coventry in the initial tranche of work. |

# Corporate Risk Register

| ID | Date Identified | Date Risk logged on Datix | Title | Risk Type | Risk Subtype | Specialty | Specialty Group | Description | Risk level (initial) | Executive Lead | Person Accountable | Person Responsible | Current controls | Risk level (current) | Gaps in controls | Likelihood (current) | Consequence (current) | Rating (current) | Risk level (Target) | Rating (Target) | Next review date | Assurance | Gaps in assurance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2067 | 24-Apr-2015 | 24/04/2014 | Overcrowding in ED (ED 4hr wait) | Corporate | Operational | Emergency Department | Emergency Medicine | Increasing activity in ED and high aggregated patient delay waiting for a bed (>450 mins), > 98 % bed occupancy results in overcrowding and use of corridor which leads to patient safety risks and prevents the attainment of the Constitutional 4 Hour Standard for A&E. | HIGH | Laura Crowne | Laura Crowne | Dr Robert Simpson | Current Controls: □<br>1. Streaming effectively to MDU , incorporating short stay beds, AEC and MDU. Vertical streaming to MDU (&AEC) now operational. AEC opened 5 April 18. Increasing availability of AMU1 beds allows for improved flow - need to work on earlier availability. Requirement to use corridor markedly reduced as a result. Improved quality/safety with new RAT function.□<br>2.Frailty Pilot Sept 19 to reduce length of stay and admission avoid.□<br>3.SAU project in progress□<br>4.The introduction of a Trigger system within ED to provide early alerts to enhance breach avoidance. Trackers moved under ops team from Sept19 □<br>5.Turnaround pathways >1000 pts per/yr□<br>6.Patient Flow work stream monitored through ECIB. Simple Discharge programme, governance and oversight through the Waste Reduction Programme, CNO SRO for Simple Discharge.□<br>7. Front door timed pathways monitored through ECIB &EM Group production board□<br>8. Staffing review on MDU Mar19 which reduced primary assessment time □<br>9. Aug 19. Monitoring aggregated patient delay for ED and MDU at ECIB as a quality measure. NHSi review of Urgent care and action plan in place monitored at ECIB. □<br>-Patient safety checklist and NEWS2 escalation procedure implemented as a result of learning from safety events□<br>-Attended Pt safety committee in Aug 19□ | HIGH | Clinical engagement and resources<br>Lack of 7 day working<br>Development of staff | Expected to occur at least Daily | Major | 20 | LOW | 6 | 28-Feb-2020 | Hourly monitoring<br>Process & o/c indicators<br>Mortality<br>KPIs - FREED metrics | Complex patient pathways with large numbers of patients affected.<br>Capacity is reliant upon external partnerships, and community pathways being updated<br>limited capacity forces short term plans to deal with constraints |

# Corporate Risk Register

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2237 | 1-Apr-2016 | 05/01/2015 | Severe shortage of permanent storage capacity in mortuary at UHCW | Corporate | Operational | Mortuary | Clinical Diagnostic Services | Severely limited storage across the network during times of high death rates and bank holidays particularly during the winter period. This has the potential to lead to reputational damage, stress & upset to relatives. | HIGH | Nina Morgan | Mr Malcolm Hunter | Miss Harriet Tunstall | 17.12.19 - continued issues with Bereavement services not supplying funeral company details so mortuary unable to chase when clear. 12 patients clear however cannot inform anyone. Also still experiencing delays in clinicians completing cremation papers in a timely manner. 9 patients who passed away over a week ago still have no completed paperwork. Mortuary team continue to ask bereavement to provide this info and chase Drs.□<br>21.01.20 - mortuary capacity at UH reaching limit - utilising STX although have seen an increased in number of deaths there also. Mortuary team working hard to move clear patients back to their jurisdiction or be collected by their FDs when information known. Problems still in obtaining this info from bereavement services and coroners office. Daily update email to Trust and Senior Management regarding occupancy status and actions where applicable. □<br>□<br>19.02.20 Storage capacity to be impacted further by introduction of Medical Examiner. based on previous winter trends the number of deaths will exceed the number of patients cleared by the ME leading to a significant delay in the turnaround times of paperwork completion. Trust informed of this. CWPS had no input in the business case. | HIGH | Human Tissue Authority inspection took place August 2016, HTA have highlighted current temporary storage solution in report and require assurance that a permanent storage solution is in progressive. Re-location of surgical training school approximately 12 months. | Expected to occur at least Daily | Major | 20 | LOW | 6 | 20-Mar-2020 | Regular review, updates to Chief Officers<br>Pathology Director of Operations to prepare paper for COG<br>Monthly review of red risks at Pathology Clinical Governance meeting | None identified |

# Corporate Risk Register

| ID | Date Identified | Date Risk logged on Datix | Title | Risk Type | Risk Subtype | Specialty | Specialty Group | Description | Risk level (initial) | Executive Lead | Person Accountable | Person Responsible | Current controls | Risk level (current) | Gaps in controls | Likelihood (current) | Consequence (current) | Rating (current) | Risk level (Target) | Rating (Target) | Next review date | Assurance | Gaps in assurance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2769 | 24-May-2017 | 24/05/2017 | Delays to admission to a Mental health Unit for patients with seious mental health problems | Corporate | Safety - Clinical | Emergency Department | Emergency Medicine | Delay in Admission to Mental Health Units □ CQC inspection report August 2018 highlighted should do action requiring UHCW to work with local mental health trust to reduce delays in admission to a mental health unit for patients with serious mental health problems. (ADULT)□ 23.7.19: Numbers of patient with a mental health diagnosis are increasing by from 17/18 to 18/19. | HIGH | Nina Morgan | Dr Robert Simpson | Sr Rosslyn Young | 09.2019 Update □ 1. Enhanced care team will support level 4 pt requiring 121. We request additional staff and undertake a full risk assessment of the patients needs. □ 2. Security accompany all patients detained under an MCA or MHA.□ 3. Organisational decision to bed these patients on obs ward pending psych bed rather than keep in ED □ 4.RMN on each shift- currently covered by agency but advertised again Aug 19 remains cost pressure □ 5. Commenced Mental Health training review and Ligature training for Clinical Staff across group. (ACP leading) □ 6. Engaged with STP Acute and crisis care workstream Feb 19 onwards (GDNA and ED Consultant)31/01/19□ 7. CWPT local working group - ED clinical lead and Matron□ 8. Reported progress to group board Nov 19□ 9. MH activity on obs ward to be shared with STP Aug 19 onwards□ 10.Daily escalation calls with CWPT via ED team. Site team no longer do calls from Aug 19 leaving organisational risk . □ 11. LOS had reduced to avg 1.8 days but increased Oct 19 to 2.0 days. □ 12. Compassionatre Community MH Volunters recruited and trained Aug 19 x 23- further cohort recruited and trained Oct 19. Further recruitment drive pre christmas with no success.Will do further recruitment drive Feb 20. □ 13. Reviewing AMHAT SOP from CWPT (Jan 20)to | HIGH | Registered Mental Health Nurse not yet recruited - no response from Unit | Expected to occur at least Daily | Major | 20 | LOW | 4 | 28-Feb-2020 | Two MH assistnat RMS on Observation ward. RMN 24/7 cover via Agency to support obs | RMN not commenced covered Agency at all times |

# Corporate Risk Register

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3346 | 1-Apr-2019 | 24/05/2019 | UHCW NHS Trust Lack of CT Scan Capacity for ED, Major Trauma and Urgent In Patient Referrals | Corporate | Safety - Clinical | Radiology | Clinical Diagnostic Services | UHCW has two CT scanners on the UHC site. One scanner located in the ED X-ray department on 1st floor ('EDCT'), and the 2nd located in the ground floor CT department within Radiology (Ground Floor Scanner). There is a third scanner on the Rugby St Cross site (StX CT)□<br>The EDCT scanner provides a service for all ED patients requiring scans and supports the CT service to the rest of the hospital for ward based patients. The ground floor scanner provides a service for the wards during corps hours Monday to Friday, in addition to providing an elective outpatient service to meet 31/62 and RTT targets. The StX CT supports the OPD CT services and ward patients from St Cross.□<br>The demand placed upon the ED CT scanner exceeds the time and capacity for safe usage of one scanner. The additional requirement for major trauma scans to be turned around within 30 minutes is placed at risk of delay if a ward patient is already on the scanner. □<br>Currently performance on the Major Trauma Dashboard measure of time to CT scan for major trauma cases is in bottom quartile of all major trauma centres.□<br>The demand upon the | HIGH | Laura Crowne | Dr Neil Anderson | Mrs Lowella Wilson | 3/2/2020. Final costs for the East Wing CT scanner building alterations have been submitted. These costs will need to be agreed before work can commence. □<br>The location of the discharge lounge is under review by the UHCW estates team - to date there has been no indication that a new site for the discharge lounge has been decided on.□<br>The ODP for 2020/21 will probably not be agreed this year in order to □<br>mitigate the risk of running all of the CT scanners at UHCW at over 100% capacity. (This is already the case and any further growth in demand will put the department at risk of not meeting the national KPI's for CT scan waiting times.) | HIGH | Weekend lists at St Cross resourced through overtime and subject to risks inherent with an overtime service - Additional cost / staff may not always be availble.<br>19 Sept 2019 Provisional date for the start of the install of 4th addition CT scanner has been further delayed - awaiting update<br>Arden CT scanner is not built for high risk unstable trauma patients. There has been incident when both CT scanners at UH have been down due to mechanical error leaving this as only available scanner<br>Arden CT scanner is remotely situated from wards and unstable patients are at risk during transfer<br>Reliance on overtime to catch up following services is subject to staff availability to undertake overime | Expected to occur at least Daily | Major | 20 | MOD | 8 | 6-Apr-2020 | Risk is currently reviewed at QIPS, Imaging Board Meeting and Risk Oversight Meeting Risk to be submitted to corporate risk register | Risk not on corporate risk register |

# Corporate Risk Register

| ID | Date Identified | Date Risk logged on Datix | Title | Risk Type | Risk Subtype | Specialty | Specialty Group | Description | Risk level (initial) | Executive Lead | Person Accountable | Person Responsible | Current controls | Risk level (current) | Gaps in controls | Likelihood (current) | Consequence (current) | Rating (current) | Risk level (Target) | Rating (Target) | Next review date | Assurance | Gaps in assurance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2264 | 1-Apr-2018 | 13/02/2015 | Interventional Radiology Service | Corporate | Safety - Clinical | Radiology | Clinical Diagnostic Services | The service currently has 4.6 wte IR consultant radiologists in post. Royal College of Radiologist guidance recommends at least a 1 in 6 rota and a 1 in 8 rota for populations of more than one million. □<br>□<br>Unfortunately the risk remains that the Interventional Radiology Service will be unable to provide a full interventional radiology service due to shortages in Consultant staff and failure to complete the necessary building works to the IR Suite in a timely manner.<br>□<br>□<br>From May 2019 onwards there are now a significant number of gaps in the IR rota during weekday nights and weekends□<br>□<br>If we are unable to provide a full interventional radiology service , then there is the risk that access targets will not be achieved, patients may come to avoidable harm and the Trust may lose its Major Trauma Centre status. This could result in poor outcomes for patients, loss of income, loss of reputation and the ability to recruit staff, and potentially the loss of our standing as a Teaching hospital.□<br>□<br>Update March 2020.□<br>Despite a keen recruitment drive and | HIGH | Kiran Patel | Dr Neil Anderson | Mr David White | March 2020□<br>Locum IR consultant appointed in January 2020. Will not start until Autumn 2020. Will need to be supported to gain CESR registration.□<br>□<br>Part time bank IR consultant currently supporting term time IR lists.□<br>□<br>□<br>□<br>□<br>□ | HIGH | March 2020. IR locum consultant will not start until Autumn 2020. Will need to be supported to gain CESR registration.<br>Radiographers recruited from the existing rotation cannot fully start in IR due to departmental staffing issues.<br>March 2020. Further delays to the IR build continue the ongoing risks to service delivery<br>IR staffing(nurse/radiographer/support & admin)<br>business case not yet approved<br>Building works restart delayed further - no restart date available. Current old equipment overdue lifecycle replacement by 6 and 3 years respectively<br>Reduction in consultant (5.8 to 4.8) WTE from May due to resignation and reduction in hours<br>Unfilled gaps in IR consultant rota apparent from April onwards. Up to 5 weekday and 1 weekend gap in May and June and more excessive gaps apparent through July and August 2019<br>Update 8 May 2019. An IR consultant has left her post at the end of April and the consultant vacancies are further compounded by another IR consultant reduce his IR Pas following job plan review.<br>9 July 2019 At TDG is was recognised that the market for recruiting | Expected to occur at least Weekly | Major | 16 | LOW | 4 | 27-Apr-2020 | 5th consultant has been appointed and will take up post (August 2017)<br>1st year 6 IR fellow has been appointed<br>Recruitment drive underway with several trainees having visited and indicated an interest in a career at UHCW<br>Programme of pre-emptive planned maintenance in place to reduce the risk of equipment failure and arrangements in place for an enhanced level of response in the event of breakdown.<br>6th Consultant appointed - 5.6 WTE<br>6th consultant in post (5.6 WTE)<br>IR build has completed 2 new IR capable rooms, giving a total of 3 IR capable rooms currently available for use(within current capacity for IR and OP fluoroscopy)<br>Regular equipment quality assurance reviews | No immediate solutions to recruitment which is a national challenge. |

# Corporate Risk Register

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2716 | 3-Apr-2017 | 06/03/2017 | Inability to achieve Gynaecological Oncology 31/62 Standard | Corporate | Safety - Clinical | Gynaecology | Women & Children's Services | The Gynaecological Oncology referral to treatment target has 31 and 62 day parameters from the point of referral to diagnosis to treatment, as an indicator of high quality patient care. Inability to achieve this in a sustainable way is a risk both from a service and patient experience perspective as well as carrying financial penalties.□<br>□<br>From 1st November 2019, there will be 1.0wte gynaecological oncologist in post against a funded establishment of 3.0wte. | HIGH | Laura Crowne | Ms Kara Marshall | Ms Laura Brough | 2.0wte consultant posts are out to advert with a closing date of 30th November 2019. Any interested candidates have been met with by the senior team with executive support.□<br>□<br>The senior clinical fellow post (1.0wte) is also out to advert with obstetric on call commitments removed to enhance dedicated cover to the gynae oncology service.□<br>□<br>Additional theatre lists for the remaining gynae oncologist are being prioritised to minimise breaches of the gynae oncology pathway.□<br>□<br>Robotic training being prioritised alongside securing robotic sessions to attract new candidates.□<br>□<br>All SLAs with neighbouring Trusts have been reviewed to determine level of service provision that can be provided.□<br>□<br>There continues to be a risk to major surgery, diagnostics, TWW and follow up pathways which are currently being managed via waiting list initiatives whilst we address the backlog of patients. External consultant providing supporting to TWW and outpatient diagnostic services.□<br>□<br>Referrals being manually triaged into appropriate clinics to ensure patients who require hysteroscopy can be treated in a one stop appointment. Where referrals are not appropriate, these are being rejected back to GP's for more clinical information | HIGH | Inability to sustain current level of extra sessions with increasing referrals amongst current consultant workforce.<br>Inability to recruit to consultant and clinical fellow vacancies<br>Inability to progress robotic service to attract suitable candidates | Expected to occur at least Weekly | Major | 16 | LOW | 6 | 27-May-2020 | Interested candidates have visited the unit ahead of applying for the advertised posts | Retention of staff based on current workforce vacancies |
| 2785 | 1-Apr-2018 | | Waste Reduction Programme (Previously CIP) | Corporate | Financial | Finance Department | Core Services | Failure to fully identify and deliver the Waste Reduction Programme | HIGH | Susan Rollason | Mr Antony Hobbs | Mr Antony Hobbs | 1) Waste Reduction (CIP)targets allocated as part of budget setting process.□<br>2) Waste Reduction (CIP) system used to record/monitor progress.□<br>3) Waste reduction Board established to oversee the Waste reduction. programme. □<br>4) Waste Reduction (CIP) Steering Group reviews progress.□ | HIGH | None identified | Expected to occur at least Weekly | Major | 16 | LOW | 6 | 30-Mar-2020 | Monthly through Finance Report's to TDG and Waste Reduction Board Monthly through Intergrated Finance Report | None identified |
| 3504 | 28-Jan-2020 | 28/01/2020 | Financial Delivery within Budget and WRP delivery | Corporate | Financial | | Medicine | Medicine Group Financial position deteriorated due to lack of delivery on WRPs, whilst holding high agency spend, over performance on some activity that is not funded, coupled with management gaps over the first 3 quarters of 19/20 financial year. | HIGH | Susan Rollason | Dr Pijush Ray | Dr Pijush Ray | Wrp unmet target agreed for rollover into 2020□<br>vacancy control panel put in place to reduce risk of over recruitment and financial scrutiny. □<br>Reduction of agency spends through GIM rota plus MB2 cover at weekends managed differently. □<br>Removal of Agency GDO spend□<br>winter pressure monies to cover elements of winter escalation□ | HIGH | | Expected to occur at least Weekly | Major | 16 | MOD | 9 | 31-Mar-2020 | | |

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| 2533 | 18-May-2016 | 18/05/2016 | Trust Piped Oxygen Supply lack of Back Up System | Corporate | Safety - Clinical | | All Groups | During meetings of the Medical Gas Committee it had been assumed that at UHCW there was the provision of a backup manifold system for piped oxygen - where banks of large J sized cylinders would provide an automatic backup for the piped oxygen supply. □ □ It has been ascertained that at present there is no back up process in place to support the system and the loss of oxygen supply would have catastrophic clinical consequences in the absence of effective emergency planning.□ | HIGH | Nina Morgan | Mr Lincoln Dawkin | Mr David Simms | The Chief Operating Officer commissioned an audit to be undertaken of the piped oxygen supply system at UHC in order to quantify the level of system risk. This was undertaken on 23.06.2016 by Vinci's external medical gas consulting engineer. The audit provided an opportunity to inspect the existing twin tank delivery system at UHC, including the single pipe point of entry configuration, and also key elements of the site layout with respect to possible implementation of a configuration with an increased level of resilience. □ □ □ An audit of oxygen utilisation across the Trust was undertaken on 05.07.2016 to facilitate emergency planning. While some areas showed adequate reserves of supply, an initial assessment indicated that there are over 100 at risk patients on piped oxygen and where significant additional cylinder supplies at UHC would be required to maintain patient oxygen saturation within a window period of 6 hours for failure of the piped oxygen supply in all areas. For high flow rate demand patients - e.g. 10 litres/minute and above, use would be made of HX and ZX cylinder sizes. In undertaking this audit as a review across the UHC site as a whole, the audit also indicates local requirements for local contingency in the event of loss of piped oxygen supply to specific clinical locations. □ □ | HIGH | No effective Trust contingency in place to deal with loss of oxygen supply. There is a need for immediate contingency planning - e.g. coping with cylinder only supply. It has been shown that at best UHC has only around 2 hours supply with loss of VIE system. | Expected to occur at least Monthly | Catastrophic | 15 | VLOW | 3 | 31-Mar-2020 | The risk handler is not aware of any effective actions to deal with loss of Trust oxygen supply at UHC site as discussed at Risk Committee. The handler is not aware that the Risk Committee has responded apprpriately to the multi-faceted nature of the identified risk | EFA/2011/003 Issued: 17 October 2011 has been identified which directly addrsses this issue - but which has not been actioned. Gaps in assurance of risk of loss of oxygen supply have been identified by the handler. |

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| 2540 | 1-Apr-2017 | 19/05/2016 | Potential Risk of Major Fire Incident | Corporate | Health and Safety / Environment | Estates & Facilities | Core Services | IF the Trust does not deliver the fire compartmentation remediation plan and maintain our current high levels of control and risk mitigation □<br>THEN the risk of a fire incident developing might increase. □<br>RESULTING IN potential patient harm and/or consequent risks to the Trust's ability to deliver effective and safe services □ | HIGH | Nina Morgan | Mr Lincoln Dawkin | Mr David Black | Full range of measures implemented aimed at preventing fire and dealing with fire, should one break out.□<br>Agreement signed with Project Co and funders to complete remediation work and provide decant space□<br>Phase 1 remediation work complete□<br>On-going risk assessment and dialogue with WM Fire Service□<br>de-escalatedfrom BAF July 2018□<br>07/08/2018 TFSM added - a programme of remediation continues and good progress is being made in this regard.□<br>14/12/2018 - the risk remains the same until we are at the end of the fire stopping programme and we have had it confirmed back to us from Project Co that the hospital is now safe. (Updated for D Black).□<br>31/01/2019 (D Black) Work continues to make good the breaches found in the fire compartment walls. Phase 1 of the fire stopping work (the primary fire lines) is 98% complete. This has achieved its aim of fire separating each of the individual towers from each other. Work continues on phase 2 of the scheme. It is anticipated that the work will be completed towards the end of 2019 and the risk level will remain the same until this work is complete.□<br>21/05/2019 - Remedial work still on progress as per the agreed programme.□<br>19/06/2019 - Good progress being made and work continues as per the agreed programme. Discussion being had with regard to the fire compartment sizes within ED.□ | HIGH | Some beds will need to be taken out of use for a short period to accommodate some of the work that is required; the plan for doing this has been agreed with the Operational/Clinical Teams. It is evident that phase 2 works cannot be completed without significant clinical impact on the Trust and discussions remain on-going with Project Co to agree a way forward. | Expected to occur at least Monthly | Catastrophic | 15 | MOD | 8 | 8-Jun-2020 | West Midlands Fire Service review Board<br>Fully assessed by independent fire safety expert and verified by a further independent expert. To Health & Safety Committee as part of Fire Safety Officer's report | First phase of work will now not be completed by the end of July 2017 because of the clinical/operational impact and requirement to identify and implement a decant facility.<br>Lack of solution for remedial works in the Emergency Department |

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| 2633 | 26-Oct-2016 | 26/10/2016 | UHCW Failure of the pod system for pathology sample delivery | Corporate | Safety - Clinical | Specimen Reception | Clinical Diagnostic Services | The regular failures of the pod system which is the primary way that blood samples (particularly urgent samples), are transported to Pathology for testing. As has recently happened, the continuous failure of the system has led to numerous blood samples being trapped in the system for days, impacting on patient care pathways and aiding discharge. On 12th October, a pod with no lid attached arrived in Pathology covered in blood where the pod had broken and the samples had leaked in transit. The system had to be completely decontaminated which too almost a week when no one could use it. During this time, there were insufficient porters to ensure that all urgent samples were delivered from ED, and turnaround times suffered as a result with samples being sent up in batches. Around 50 pods containing specimens that were several days old were then delivered to Pathology in a wheelie bin, as they had all been found lost somewhere in the system. All of these patient samples had to be rebled. On 26th October, another incident occurred where a damaged/worn pod from ED was found in the system, again with a broken sample inside, and | MOD | Laura Crowne | Dr Neil Anderson | Ms Joanne Nicholson | 21/01/20 - Emergency planning steering committee meeting held 08/01/20, and pod risk discussed. It was raised that Estates should be the owners of this risk, and that actually as the pod system has been replaced with porters whilst Project Co continue to check all joints in the system, the delivery of specimens to Pathology has improved. A suggestion was made by the chair of the meeting that replacing the pod system permanently with porters would be a safer and more cost effective option. | HIGH | There is so far no-one taking direct ownership of the system, and therefore we are unable to hold anyone directly to account when the system fails | Expected to occur at least Daily | Moderate | 15 | LOW | 6 | 31-Mar-2020 | There have so far been two meetings of the 'Pod Capability Group' on 14th July and 12th September 2016. A further meeting has not been planned currently. | No further Air Tube capability meetings have been arranged currently |

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| 2832 | 3-Jul-2017 | 09/08/2017 | Patients lost to follow up | Corporate | Operational | | All Groups | If patients are lost to follow up then their care could be delayed and this could result in clinical harm.□<br>□<br>March 2018 - to date 11 x cases of harm identified. Risk to be updated by Clinical Harm Review group with details of current controls. □<br>□<br>Stream 3 validation has now brought the total down to 4,088 and the focus has moved to Stream 4 (see graph above) – these are patients with an Outcome of Follow up but no follow up appointment can be seen.□<br>A new monitoring report is being developed to ensure that the reduction remains in place, and we do not see a repeat growth after the project completes. Specialties are now receiving validated patient data for clinical review and provide feedback within deadlines and clinical reviews are being identified and sent to consultants to complete where necessary.□<br>□<br>Stream 4 is now down to 9,982 with 9,864 reviewed and cleared.□ | HIGH | Laura Crowne | Ms Clare Pheasant | Mr Martin Robinson | New report developed to split patient identified potential lost to follow-up into cohorts black (unknown outcome), red (overdue)□<br>□<br>Project team reviewing potential additional cohorts ie. cancelled appointments □<br>□<br>Specialities have provided clearance plans with trajectories progress reporting to Elective Care Board□<br>□<br>Enhancement implemented to CRRS 13/2/19 to improve capture of outcomes□<br>□<br>Clinical engagement and communications underway in February to understand issues preventing outcome capture□<br>□<br>Current validation is supporting future process development in line with findings from previous follow-up reviews.□<br>□<br>Contacting Trusts to identify best practice processes □<br>□<br>Updated March 2019: "CRRS change implemented 13/2/19 - now highlights un-outcomed appointments on clinician worklists□<br>"Trustwide communication sent regarding suspended outcomes to highlight issue□<br>"CRRS Clinic Outcome compliance report in development for management teams □<br>"Audits in Central Outpatients to understand compliance issues which has identified;□<br>"Training issues - resulting in development of quick guides. | HIGH | None identified | Expected to occur at least Daily | Moderate | 15 | LOW | 6 | 30-May-2020 | Regular review and update at COG DG Chief Officers and NEDs have been briefed. Weekly task and finish group commenced. PPMO developing reports for managers to validate the backlog. New SOP being developed to reduce risk going forwards. | None identified |
| 3128 | 2-Apr-2018 | 29/06/2018 | Lack of capacity in Clinical Microbiology to support Infection Control | Corporate | Safety - Clinical | Microbiology (excl Virology) | Clinical Diagnostic Services | Inadequate clinical staffing in microbiology means that if a single member of staff goes off long term such as maternity leave and mandatory holidays are to be accommodated as well, then there is not enough staff to cover basic clinical microbiology needs across three sites. As a result there is a risk of making clinical errors or not providing adequate clinical cover resulting in poor clinical outcomes.□ | HIGH | Kiran Patel | Dr Neil Anderson | Mrs Dipa Parekh | 06.11.19 - Discussions with JT/NA and CP are ongoing on how best to support infection control.( Last meeting was 05.11.19).□<br>14.11.19 - Inadequate funding for demand. Review undertaken and paper shared with Stakeholder board on 14.11.19. Weekly rota produced and distributed to GEH and SWFT so they know who will be onsite on which day and who to contact at UHCW if there is no site presence. | HIGH | No Gaps in controls. | Expected to occur at least Daily | Moderate | 15 | HIGH | 15 | 1-May-2020 | 2 posts out to adversisment. Locum cover being sought. Enquiries with other Trusts for support | No Gaps in assurance. |

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| 3222 | 20-Nov-2018 | 23/11/2018 | Medical staffing does not meet GPICS standard on merged GCC and CTCC | Corporate | Workforce (HR) | | Clinical Support Services | Insufficient 24/7 medical staffing (below GPICS standard) could lead to suboptimal patient care in Cardio Thoracic Critical Care (CTCC) resulting in potential patient harm, longer lengths of stay and poor CQC rating □ □ | HIGH | Kiran Patel | Mr Mark Easter | Dr Soorly Sreevathsa | 30/05/2019 (IK) There is a single Modern Matron in charge of the two units. Each unit continue to care for the same case load of patients. Staff from both units are moved across to cover daily shortfalls in staffing or sort skill mix issues. Nurse to patient staffing meets the recommended GPICS standard in both units. CTCC has a Consultant Intensivist cover for 8 hours daily Monday to Friday. After hour cover is provided by the GCC consultant Intensivist and middle grade Critical Care trainee on call. In addition CTCC is covered daily by cardiothoracic trainees□ The group continues with the recruitment of ACCPs and medical personnel.□ 29/09/2019: Recently one new intensivist has been recruited and provision have been made to increase the middle grade support for both the units (Plans to recruit fellowship candidates for Cardiothoracic and Clinical fellows with 50:50 educational activity is in place) A new business paper is in draft stage awaiting final consultations makes the case for additional staffing within Critical Care to meet national guidelines for Provision of Intensive Care Services to GPICS standards | HIGH | | Expected to occur at least Daily | Moderate | 15 | VLOW | 2 | 28-Feb-2020 | | |

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| 3312 | 1-Feb-2019 | 20/03/2019 | WIC- Failure to clinically assess patient in 15 min | Corporate | Safety - Clinical | Emergency Department | Emergency Medicine | Coroner recommendation not implemented in WIC to undertake clinical assessment in 15 mins on all pts. □<br>WIC fail to clinically assess pt in 15 min leading to potential failure identify sick and or deteriorating patients resulting in clinical deterioration or death. □<br>There have been two cases at WIC resulting in patient death and the coroner has made recommendation for improvement. | HIGH | Kiran Patel | Mr Kiran Patel | Dr Robert Simpson | WIC is operational managed by Virgin and from a clinical governance perspective managed by Acute and Emergency Med Group. Contract KPIs are not clear relating to 15 min assessment. □<br>Quarterly Clinical and Operational Governance review in place with WIC and Emergency Med.□<br>Contract team reviewing contract compliance □<br>Escalated to legal and Med Director for Executive support and direction. □<br>May 2019 update: 2 performance notices sent to Virgin healthcare end April 2019, contract extended pending UTC designation Dec 2019. □<br>18.7.19 - WIC contract meeting held with Virgin. Limited assurance provided of progress with clinical triage <15mins. Review meeting in Aug 19 planned □<br>Oct 19- Dec 19 Update □<br>Monthly meetings with WIC continue. Triage running now and full implementation by Jan 19. Contract team reissued enforcment letter. RS esclated to KP medical director and RY esclated to CNO.□<br>Contract letter sent from UHCW to Virgin from CMD. Response recieved. Awaiting direction on next steps. Continue monthly governance meeting with WIC . □<br>UTC designation 1st Jan. fully operational by 1st Feb 20 (except PILS training full compliance by 1st April)□<br>04.02.2020 - Triage implemented 01/02. GO live 01/02. Process in place. Median triage target not yet consistently met but | HIGH | | Expected to occur at least Daily | Moderate | 15 | LOW | 6 | 25-Mar-2020 | | |
| 3524 | 13-Feb-2020 | 13/02/2020 | delay in MRI reporting for Cancer patient | Corporate | Safety - Clinical | Radiology | Clinical Diagnostic Services | delay in MRI / CT reporting is delaying cancer treatment decisions , leading to risks in patients staying on ineffective treatment and inappropriate prescription of sometimes very expensive medication, □ or delays in starting / changing treatment | HIGH | Kiran Patel | | Dr Manpreet S Dhillon | escalation of scans for reporting desk | HIGH | | Expected to occur at least Daily | Moderate | 15 | LOW | 4 | 1-Jun-2020 | | |

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| 107 | 1-Apr-2014 | 04/06/2009 | Storage on Hospital Corridors | Corporate | Health and Safety / Environment | Estates & Facilities | Core Services | Fire Implications - Beds, mattresses, cages of linen, waste trolleys etc, are temporarily stored in back corridors. This can impede or slow down an evacuation from a fire that occurs in another area. There are also legal implications for the Trust from the Fire Authority regarding storage of beds and other items in hospital corridors. The risk rating refects both safety and legal aspects of this risk.□<br>□<br>Security Implications - When valuable equipment and supplies are left on hospital corridors then there is the potential for theft. Any theft can have financial implications for the Trust and could disrupt the medical service.□<br>□<br>Clinical Risk Implications - When medical equipment and supplies are left on hospital corridors there is the risk that this equipment and/or the supplies could be tampered with. This could have serious consequences for the Trust. | HIGH | Nina Morgan | Mr Lincoln Dawkin | Mr David Black | 15/08/2018 - Risk remains stubborn - Bed storage management group established and monitoring situation. Agreed action plan to reduce the frequency of issues. Regular walkabout reviews with immediate actions where necessary, resulting in better control of this risk and causes.(D Lord HSM) □<br>28/03/2019 - part solution may have been found, in so much that the uniform exchange rooms on the HUB corridors could be cleared and utilised for the storage of broken items, mattresses and other items normally left on the hospital corridors. This is currently being trailed on the 4th floor HUB corridor and will be reviewed at the next Storage Group meeting. If successful then consideration will be given to this being rolled out across the UH site. (D Black TFSM)□<br>3/9/2019 Update - Work continues to find a solution to the storage of items on hospital corridors. The trial of using the uniform exchange rooms being monitored to see if this is helping. Ongoing□<br>23/01/2020 Update - The issue of equipment and storage on the hospitals corridors continues to be a concern. A number of inititives have been put in place by the Dir of Estates & Facilities to resolve the issue. however the 'Hospital Storage Working Group' will continue to look at ways to address this issue. Further meetings of the group are planned. □ | MOD | None identified | Expected to occur at least Monthly | Major | 12 | LOW | 4 | 8-Jun-2020 | Discussed at NCRM committee and Risk Committee<br>clear Instruction has been given to all teams that NO beds are to be stored on the front street.<br>Regular monitoring in place and breaches addressed<br>Working group established to oversee management of this topic<br>Review to explore possibility of procuring TNT store room to facilitate moving short term maintenance and repair furniture and other items to that store<br>Review to explore possibility of providing a portacabin modular unit to provide additional stroage space for bed awaiting repair/replacement<br>GE to review and improve furniture repairs and replacement procedure<br>NMC forum to identify a nurse manager representative for the stroage group | None identified<br>Limited assurance that the continued storage of items along the rear corridors is controlled sufficiently to enable safe evacuation along this route if necessary<br>Linited assurance that the trust is compliant with relevant Health and Safety and Fire Safety legislation whilst this situation exists |

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| 2162 | 9-Sep-2014 | 22/09/2014 | The EPR Procurement timetable must be adhered to in order to replace key clinical systems before their contracts end. | Corporate | Operational | Transformation / EPR Team | Core Services | Diminishing timescales associated with current contract end dates and National mandates (Lord Carter) to implement critical systems means the Trust risk being in a position where key Departments such as Maternity (contract end now agreed until June 2021, originally this had been Dec 2020) with a much reduced support model from the supplier, a further extension beyond 2021 is highly unlikely and is liekly to have further major implications on the support arrangements) and Pharmacy (ePrescribing) have no electronic system in place.□<br>□<br>This places the safety of Trust patients and compliance with specific targets around Maternity services and prescribing at risk.□<br>□<br>Other systems such as PAS are old and also at risk of becoming non compliant with specific targets and unsupportable.□<br>□<br>This places the safety of Trust patients and compliance with specific targets around Maternity services and prescribing at risk□<br>□ | MOD | Nina Morgan | Mrs Beverley Thompson | Mr Nathan Stratton | The procurement has completed the BAFO stage and a preferred supplier has been choosen. The process of agreeing exact scope, contracts and plans is underway.□<br>The Trust is out to procurement for an EPR solution that includes maternity, PAS and ePrescribing<br>EPR Programme Board provide regular□<br>updates to Chief Officers Group and Trust Board.□<br>Current Maternity system provider has agreed to extend existing contract until June 2021. | MOD | Any delay to make a decision will impact on delivery timescales. | Expected to occur at least Monthly | Major | 12 | LOW | 4 | 31-Mar-2020 | This will be managed by the EPR Programme Board with regular updates to Planning Unit and Chief Officers Group. | None noted. |

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| 2195 | 29-Mar-2016 | 20/11/2014 | HPB- compliance with IOG guidelines | Corporate | Strategy | Upper Gastrointestinal (GI) & Hepatobiliary (HPB)Surgery | Surgical Services | If we do not serve a population of 2 million people we are not able to continue to provide the service according to the recent peer review. | HIGH | Justine Richards | Mr Alex Monahan | Mrs Helen West | 26.9.16□<br>Specialised commissioners have confirmed their intent to support a combined UHBFT and UHCW HPB service from 01.04.2017.□<br>A guiding principles document is in circulation to confirm legal and governance responsibilities and discussions are expected to agree a proposed model of clinical delivery by Dec 2016 □<br>Regular meetings underway□<br>UHCW are working with UHB to amalgamate the 2 HPB services to create a West Midlands HPB service via UHB. A business case should be presented to both Trust Boards and Specialised Commissioners during the summer of 2017 detailing how the service will meet the requirements coming from the Senate review - DM 03.04.2017□<br>□<br>2.5.17□<br>Meetings now underway between UHB and UHCW□<br>To be reviewed with Group Management January 2018. □<br>□<br>16.1.17□<br>Discussions underway with neighbouring Trusts to increase the population served□<br>□<br>28.06.18□<br>Discussions ongoing with neighbouring Trusts to increase the population served.□<br>□<br>31st May 2019□<br>Population base is still not fully resolved. UHCW services now incorporate Sandwell patients. Strategic discussions continue with CEO's regarding links to Worcester and UHB□<br>□ | MOD | Delays to meetings going ahead<br>Clinical model yet to be agreed | Expected to occur at least Monthly | Major | 12 | LOW | 6 | 31-Mar-2020 | Additional management resource - one day a week<br>Agreed pathways and governance ensuring on-going service at UH | Delays during the process as a result of cancelled meetings |

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| 2279 | 1-Apr-2016 | 04/03/2015 | Nursing and Midwifery vacancies are a risk to high quality, safe and effective patient care. | Corporate | Workforce (HR) | | All Groups | Update 24.01.2020 □<br>□<br>For December the RN&M Vacancy is 13.92% 395.00. WTE compared to November's figures of 13.4% 379.58 there is minimal increase in month (0.52% 15.42 wte) this is based on the assumption that newly qualified starters commencement period is staggered mainly during October – December and this is reflected in the figures.<br>□<br>□<br>Taking into consideration the predicted leavers of 54 and the 97 provisional starters this puts the Trust in a good position to meet if not exceed the year-end target for March 2020. □<br>□<br>Recruitment events are ongoing which now captures successes from these events to understand the added value and to help inform future decision making and choice of which event the Trust attends □<br>Over the next three months the recruitment team have visits planned to a number of Universities, Schools and Colleges. There are also plans with the learning and development youth UHCW career event. For UHCW staff we will be holding work life balance sessions on the last Thursday of each month | HIGH | Nina Morgan | Nina Morgan | Ms Rhonda Pickering | Retention (cohort 4) work with NHSi continues (looking at flexible working, transfers, retire and returns, 25-34 year old leavers, and career clinics for all). Trustwide programme to reduce turnover. □<br>□<br>Targeted International nurses in progress□<br>□<br>Recruitment strategy plan includes recruitment events, golden hellos, incentive payments, social media campaigns.□<br>□<br>24.02.2020 RN&M Vacancy is 13.92% 395.00□<br>□<br>09/12/19 figures 13.53%, recruitment strategy near completion - aiming for 10% vacancy in year. □<br>□<br>31/10/2019 International recruitment proposal approved by Trust Development Group (TDG) to recruit 12 RNs into Neuro only □<br>□<br>Controls include;□<br>Taking part in the national Retention Collaborative (2019/20) with NHSI. □<br>A comprehensive programme of recruitment events. □<br>Excellent and well-invested relationship with HEI to maximise nurse graduate recruits.□<br>Conditional job offers ahead of NMC registration. □<br>Strong preceptorship and career development opportunities. □<br>Focus on staff well-being and support. □<br>Acquisition of further funding for additional (20+) student placements to current numbers | MOD | Timescale from advert to staff on site has improved but ongoing work to streamline this and reduce further to no longer than 3 months<br>Agreement to employ greater number of newly qualiifed staff ( work to look at support required for this) as experienced B5 staff not avaialble to match current vacancy levels.<br>Lack of robust national nursing workforce planning.<br>Highly competitive market. Increasing complexity and demand on staff - human factors and work life balance.<br>Junior workforce - leadership experience gap.<br>Professional bodies slow to publish regulatory frameworks for new roles and skill mix.<br>Local quality and timeliness of ESR / vacancy data - to ensure repsonsive plan.<br>Vacancy data is challenged by workforce leaders as inaccurate.<br>ESR review underway<br>Lack of agreed process to agree N&M budgets/Reoster annually. | Expected to occur at least Weekly | Moderate | 12 | LOW | 6 | 27-Mar-2020 | Nursing Fill rate reviewed monthly at Board level. This is moving to CHPPD from Sept 2018<br>Recruitment plan in place for N&M workfoorce to aim to 10% vacancy by March 2019<br>Carter Nursing Workforce metrics and performance management since 2017 Reviewed March 18.<br>Turnover for RN= 6%,HCA = 8%, below Trust target of 10%<br>Reduced external agencies to all framework , better quality assurance.<br>Enhanced Care Team commenced Oct 2015. Review of this workforce underway Q2 2018-19<br>Monitored at COG, F&P Committee, NMC and quarterly Performance Reviews<br>Bi annual review of risk assessment at Nursing and Midwifery Committee<br>Twice yearly Safer Staffing report to Trust Board and to NMC<br>HCSW recruitment excellent and vacancy numbers reduced to below 30 across Trust | Vacancy rate remains high despite active recruitment activities<br>Agency spend reduced from £16M spend 2016/17 to <£9M 2017/18, but over cap shifts remain 45-60%<br>RN vacancy reduced from 20% to 17%.March 18<br>Nurse agency spend above trajectory @M3 2018-19<br>More staff may leave if we fail to recruit due to demands of work<br>Agency reduction target may not be achieved due to continued service pressures despite controls.<br>We may fail to recruit HEI nurse / midwifery graduates in the numbers identified as they seek jobs closer to home.<br>Plan assumes bank availability and no additional workforce growth ie Business Cases |
| 2416 | 4-May-2016 | 02/10/2015 | Potential Breaches of Confidentiality | Corporate | Information Governance | | All Groups | If documents containing highly sensitive and confidential information are not disposed of correctly breaches of confidentiality may occur. This gives rise to the risk of reportable breaches with a potential fine from the ICO, consequent reputation damage and a loss of trust and confidence in the organisation. | HIGH | Geoff Stokes | Mr Geoff Stokes | Ms Harjit Matharu | 1. There are policies and procedures in place that deal with the safe disposal of person identifiable information.□<br>2. An audit has previously been undertaken to establish that there are adequate confidential waste bins around the Trust.□<br>3. There is signage around the organisation (on wards) reminding staff that they must not take any patient information with them and must dispose of any printed information in confidential waste bins before they leave clinical areas.□<br>4. A Human Factors report has been considered, where all recommendations have been responded to (most have been actioned, with a couple that were not feasible due to cost). | MOD | Unable at present to prevent handover and other notes from being printed (due to operational considerations)<br>Ward staff to be engaged in ideas for improving compliance (following human factors report)<br>Lack of follow up for missing records | Expected to occur at least Weekly | Moderate | 12 | LOW | 4 | 30-Jun-2020 | IGC review incidents to assess adequacy of current controls and determine further controls needed | There are still incidents of patient identifiable information being found within the Trust<br>Test the effectiveness of the policies and processes in place, and make amendments to ensure that staff adhere. |

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| 2537 | 1-Apr-2016 | 19/05/2016 | Incapacity to maintain & develop the ICT Infrastructure to support new/emerging technologies due to uncertain funding & resource | Corporate | Information Technology | Information & Communications technology | Core Services | ICT are not able to continually upgrade/maintain/secure the ICT infrastructure due to uncertain funding and technical resource, which is affecting the ability to support existing or essential new technologies. This includes the provision of new software or systems, upgrades to software and devices, server capacity and data storage. If this continues it could impact upon patient safety and this could affect our financial position and Trust reputation.□ | HIGH | Kiran Patel | Miss Jackie Weager | Mr Mark Powell | A revised digital strategy has been drafted and has been approved by Trust Board. □<br>□<br>Trust representatives are involved in developing the locality Digital Roadmap and an integrated Care Record is part of the digital work stream within the STP.□<br>□<br>□<br>□ | MOD | Availability of funding is outside the control of ICT.<br>Clinical and service developments needing unplanned ICT resources bypass assurance mechanisms.<br>Limited capital funding for major IT developments.<br>Challenge of recruitment and retention of scarce ICT resources. | Expected to occur at least Monthly | Major | 12 | MOD | 9 | 30-Apr-2020 | ICT Security and Compliance Group and Information Governance Committee.<br>Locality's Digital Transformation Board assures the development of the Local Digital Roadmap.<br>ICT projects and upgrades are managed using standard methods (e.g. Prince 2).<br>ICT is a Capital Budget Holder at EPRG. | None noted. |
| 2546 | 8-Apr-2016 | 06/06/2016 | Delayed discharge for fast track patients | Corporate | Operational | Integrated Discharge Team | Clinical Support Services | This risk is shared across the Trust. Fast Track patients are delayed in UHCW awaiting a POC or NH's, or become too unwell to leave the hospital due to the current process. The provision of Fast Track services is the responsibility of CHC who are commissioned by the CCG. | HIGH | Laura Crowne | Mr Martin Robinson | Mrs Kerrie Manning | Discussed within the community hub on a Mon - Fri basis with partner organisations. Patients who are not discharged within 48 hours are challenged. □<br>IDT complete a quarterly report for EOL committee, from Mat this is to be completed jointly with the CCG.□<br>□<br>Audit of May / Oct 2018 data identified Internal areas discussed at EOL; Actions:□<br>Fast Track information leaflet to be developed with the CCG in line with Trust guidance to manage patients / families expectations□<br>□<br>Fast track data now available on the palliative care dash board□<br>□<br>Daily hub call with Myton to discuss referrals and capacity.□<br>□<br>IDT can submit Fast track referrals with verbal consent waiting for formal signatures. UHCW have devised their own consent form currently with Information library.□<br>□<br>There has been an increase in the number of referrals this last quarter and the complexity of the patients has resulted in an increase in the number of DTOC's. The complexity has been discussed with the Strategy Team around the management of Trachy in the community.□<br>□<br>□ | MOD | Daily updates do not always result in an imminent discharge<br>Escalation at the twice weekly meeting does not always result in an imminent discharge<br>UHCW have no authority over the CHC SPA function and the process<br>There is nothing in the NH contracts to specify a time frame from referral to assessment to decision.<br>CCG offered 5 NH beds to trail fast track pathway, once these beds were filled no additional beds available<br>New paperwork leading to delays as CHC requesting additional information.<br>Training to take place<br>Unable to continue offering additional hours to staff to meet the fri demand for fast tracks | Expected to occur at least Weekly | Moderate | 12 | MOD | 8 | 29-May-2020 | Escalated to the CCG work stream in progress to explore the CHC SPA process<br>Escalated to the EOL committee meeting, letter sent from Mark Radford to CHC leads.<br>Completion of Fast track audit<br>CCG are bringing CHC back in house so will be able to manage the sourcing process directly<br>In house brokerage function for CHC being explored as part of a D2A model which will support fast tracks<br>New Chief nurse met with CCG Chief nurse to discuss possible solutions<br>New community Hub mapped out pathway and revised the pathway to trail from end of Jan2017 | No Authority to implement / influence a change in the CHC process as managed externally.<br>Unable to Bench Mark against other Trusts as the funding stream and managing organsiations vary<br>Fast tracks do not sit within D2A modelling |

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| 2646 | 8-Nov-2016 | 24/11/2016 | Cyber Security threats to the Trust | Corporate | Information Technology | Information & Communications technology | Core Services | The threat of Cyber Security incidents continues, with NHS Trusts continually being targeted. The outcome/affect of such attacks could seriously affect business critical systems which could ultimately result in patient care being affected. | HIGH | Kiran Patel | Mr Mark Powell | Mr David Baynton | A number of security systems have been put into place to help protect our IT infrastructure e.g. Anti-Virus, Perimeter Firewalls, data loss prevention tools and application control software. □<br>□<br>ICT monitor and act on all security alerts identified from NHS Digital, National Cyber Security Centre(NCSC) and other relevant intelligence sources. □<br>□ | MOD | Threats can never be fully mitigated, this was recently evidenced with a Cyber attack on our PFI partner ISS World who were victim to a ransomware attack on the 17th February.<br>Even with ICT's continuous efforts to monitor and mitigate threats, attacks can not be completely prevented.<br>Despite mandatory Data Security and Information Governance training, human factor remains the highest risk of an attack being sucessful.<br>Not all devices on our corporate network are managed by ICT, notably MEBS equipment.<br>The Trust has recently enforced a mobile device refresh scheme, however some outstanding work remains to be completed around unsupported mobile devices.<br>Essential patching cannot always be completed in the time frame given by NHS D, this is due to the necessity to test and the absence of a dedicated resource. | Expected to occur at least Monthly | Major | 12 | LOW | 6 | 30-Apr-2020 | Assurance is provided by the ICT Security sub-group, reporting through ICT Security and Compliance to the Trust's Information Governance Committee.<br>External assurance is led by NHS Digital and independent third party cyber security provider. | None noted |
| 2656 | 21-Dec-2016 | 21/12/2016 | Drug Security | Corporate | Safety - Clinical | | All Groups | If the security of medicines is compromised then this results in failure to comply with CQC standards and regulations. | HIGH | Kiran Patel | Mr Mark Easter | Mrs Janette Knight | Comprehensive medicines policy. Drug security breaches reported via Datix. Process for replacement of faulty locks and drug storage facilities. Medicines management training workshops for nursing & ODPs. Medicines security risk assessments completed and reviewed annually by ward and department managers. | MOD | Not all non-stock medicines are not stored in automated medicines cabinets<br>Training and education for medical and non clinical staff<br>Drug security relies on mannal lockdown systems i.e. non-automated areas and clinical rooms<br>Insufficient drug storage facilities where automated medicines cabinets are not in situ on a number of clinical areas resulting in medicines stored in unlockable cupboards and drawers to enable segregation of medicines.<br>No policy for the secure storage of PODs | Expected to occur at least Weekly | Moderate | 12 | MOD | 9 | 30-Apr-2020 | Drug security breaches discussed at ward or departmental QIPS<br>Annual Medicines Optimisation Report to Trust Board<br>Medicines storage risk assessments submitted and where appropriate approved by MMC<br>Pharmacy, Modern Matron and GTBR Audit programme presented at MMC<br>N&WQSM & PSC Risk assessments are monitored by the Trusts Riisk Committee<br>Groups - Quarterly Board Review, monitoring risk | Annual audit 2018/19 on hold during automated medicines cabinets install |

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| 2792 | 22-Jun-2017 | 22/06/2017 | Lack of effective system for management of medical equipment training | Corporate | Safety - Clinical | | All Groups | Staff in the Trust utilise a highly diverse range of items medical equipment (many hundreds of commonly used equipment models) and which are utilised within diverse designated clinical areas. Within such clinical areas there is also complexity of staff skills and responsibilities relating to use of medical equipment. □<br>□<br>This is currently no effective Trust wide system for managing the target and achieved levels of skills/competency against medical equipment as recommended, for example, by the MHRA (Managing Medical Devices: Guidance for healthcare and social services organisations, MHRA, April 2015).□<br>□<br>This implies that the Trust is inadequate in its management of medical equipment training by way of determining levels of compliance and managing improvements. This presents an immediate risk to patients and also of reputational risk from external auditing organisations such as the Care Quality Commission. □ | MOD | Nina Morgan | Mr John Knibb | Ms Elaine Clarke | Training in use of Resus equipment is currently managed within OLM.□<br>A limited set of training data of specific items of other medical equipment items is retained within OLM.□<br>Local training records may be retained in locally maintained spreadsheets or in paper records.□<br>Training undertaken by equipment manufacturers can be retained within their specific company formats and can be made available to specific clinical areas on request. See attached document for initial text.□<br>Update 3 Jan 20. The role of Lead Medical Devices Safety Officer has been revised to include responsibility for Medical Device Training and now incorporates the following elements:□<br>1.Chair and oversee the work of the Medical Devices Training Group.□<br>2.Provide the MEBS lead on Medical Equipment Training. □<br>3.Identify and manage the Trust's training needs for the use of medical equipment.□<br>4.Identify and develop lesson plans and competency checklists as appropriate in conjunction with the appropriate clinical trainers.□<br>5.Co-ordinate training undertaken by external trainers in conjunction with departmental clinical trainers and ensure such training is effectively delivered and captured.□<br>6.Ensure that the status of Trust trainers is maintained.□<br>7.Ensure production of appropriate training reports.□ | MOD | Trust wide data across all departments is not available and no competency matrix is available.<br>The MEBS administrator that enters medical equipment training records has been on long term sickness since November 19 with the result that records are not currently being entered by MEBS into OLM. | Expected to occur at least Weekly | Moderate | 12 | LOW | 6 | 1-Jun-2020 | Information on training compliance rates<br>With the retirement of the Lead MDSO the role of the post has been reviewed and revised to include the responsibility for being the MEBS lead on Equipment Training and to coordinate a training system across the Trust. It is planned to advertise this position in December 2019. | There is no Trust wide strategy for co-ordination of medical device training. Current reporting system not fit for purpose |

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| 3074 | 1-Apr-2018 | 10/05/2018 | Failure to effectively implement preventative measures resulting in hospital acquired pressure ulcers | Corporate | Safety - Clinical | | All Groups | If we are unable to consistently implement preventative actions to reduce the risk of a patient developing hospital acquired pressure ulcers/skin damage then the patient may come to avoidable harm.□<br>□<br>Key areas of concern are:□<br>Documentation not completed, esp. evidence of repositioning□<br>Skin assessment accuracy□<br>Nutritional management □<br>Medical device related pressure ulcers | MOD | Nina Morgan | Ms Elaine Clarke | Sr Amy Verdon | Current controls:□<br>Education programme by Tissue Viability Nurses;□<br>- Monthly Pressure Ulcer prevention study day (available to all staff)□<br>-Deliver Preceptorship study day incorporating pressure ulcer prevention and wound management□<br>- Deliver a monthly study session to HCSW on the effective care practice programme□<br>- 4 link worker study days per year□<br>-Facilitate and deliver annual tissue viability conference□<br>- Facilitate and deliver a 6 day wound management module annually which includes pressure ulcer prevention□<br>- Deliver adhoc training session to members of the MDT□<br>Accessible TVN team who have a high clinical presence and respond to requests for advice in a timely manner.□<br>The patient safety response team attend all category 3/4 and unstageable pressure ulcers.□<br>Monthly MDT pressure ulcer forum to discuss learning from category three, four and unstageable hospital acquired pressure ulcers. Learning disseminated via safety huddles and trust wide safety messages.<br>□<br>□<br>UHCWI methodologies used to improve performance on 2 clinical areas which has now rolled out to 7 clinical areas with further areas planned□<br>Weekly production board huddle between ADN and TVN's to review previous weeks activity and decide on areas of focus for following week.□ | MOD | Inconsistent recording of skin assessments and repositioning - may be contributed to by onerous documentation for nursing staff<br>Nutrition - bed scales difficult to access (currently being reviewed) , weighing of patients not conducted consistently, where nutritional problem identified, care not always implemented | Expected to occur at least Weekly | Moderate | 12 | MOD | 9 | 28-Aug-2020 | Pressure Ulcer Forum - review recent cases and oversee implementation of new controls<br>Performance metrics - trust scorecard (reviewed at QGC, PESC)<br>Pressure ulcer performance meetings with ward managers/ modern matrons<br>Production board weekly - review of previous weeks performance, trends and themes and focus for the week<br>Pressure ulcer numbers being monitored per 1000 bed days SPC charts | None identified |

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| 3285 | 26-Feb-2019 | 26/02/2019 | The impact that a no deal exit from the EU could have on UHCW to operate and function | Corporate | Emergency Planning | | All Groups | There are a number of work streams in place to mitigate against a no deal scenario. The current biggest threats to UHCW strategic objectives are;□<br>· National reliance on preparedness, and releasing prompt guidance from the Department of Health & Social Care, NHSI, & NHSE. □<br>· Regional reliance - Local Resilience Forum (LRF) preparedness and ability to respond to emergencies and recover from emergencies. □<br>· Local - UHCW preparedness and resilience. A no deal scenario would likely result in a financial impact upon UHCW, potentially compromising patient safety due to the availability or potential delay in delivering consumables / products including medication. This could also affect operational performance and the reputation of the Trust□ | MOD | Laura Crowne | Laura Crowne | Mr Luke Peachey | Gap analysis & risk assessments has been carried out to review the impact on UHCW covering;<br>□<br>· Financial□<br>· Supply of medical devices, clinical and non clinical consumables, goods and services□<br>· Supply of medicines and vaccines□<br>· Workforce reduction in the number of EU nationals at UHCW□<br>· Research and clinical trials funding schemes□<br>· Data sharing, processing and access from the EU/EEA to the UK & Data Protection□<br>□<br>Each subheading as identifed above has been captured in a supporting risk register to underpin this overarching risk. □<br>□<br>The above has been achieved through group level EU Exit impact meetings and information being shared with the EPM, and where required escalation to the COO directly. □<br>□<br>Daily Sit Reps are scheduled to recommence in mid october so there are real time updates on any local Trust issues as a direct result of EU Exit that central goverment can support as required in this response. | MOD | National gaps within plans as limited information has only been provided to Trusts<br>Regional gaps within plans; LRF plans only focused on responding to and recovering from emergencies and not sustaining/supporting critical businesss processes<br>Internal gaps within planning; competing performance priorities. | Expected to occur at least Monthly | Major | 12 | LOW | 4 | 31-Jan-2020 | UHCW aligning against national & regional guidance, feeding into regional committees to provide assurances;<br>Locally - Group meetings to discuss risks, gap analysis, and potential mitigation plans. Results feeding into Emergency Planning Steering Committee, Group Director of Operations weekly meetings, and Trust Delivery Group | National: Unknown specific response gap from DHSC, NHSI & NHSE |
| 3324 | 5-Apr-2019 | 05/04/2019 | Inadequate level of service from Roche under current Roche Managed Service contract | Corporate | Operational | | Clinical Diagnostic Services | Since Roche Diagnostics have put in a challenge against the Blood Sciences and Molecular Managed Service procurement process, the level of service from Roche against the current Managed Service Contract has further deteriorated. The level of service has been poor both responding to technical and IT faults and instrument failures, repairing faults on analysers, and in some cases, faults have been caused by Roche engineers working on equipment. This has already impacted significantly on the delivery of the Biochemistry and Serology services. This has caused failings in turnaround time KPIs, and also on occasions has led to the release of a number incorrect patient results which has had a direct impact on patient care. | MOD | Laura Crowne | Mr Malcolm Hunter | Ms Joanne Nicholson | 14/02/20 - Roche Regional Manager failed to communicate as agreed before Christmas, and we have subsequently been told that due to a large restructuring process within Roche, a number of key individuals that have previously supported CWPS have left the organisation with no communication to CWPS from Roche. Quarterly Review meeting due to be held in early February cancelled by Roche due to unavailability of Roche representative to attend. CWPS have requested that this meeting be rescheduled as soon as possible, but this now looks like March at the earliest. KPI report from Roche provided ahead of the cancelled meeting shows that a higher number of KPIs are red as compared to previous quarters, this is concerning. Contract with Roche requires extension due to the delay in the Siemens implementation following the Roche challenge, but progress is being made with Siemens to sign a contract at the end of March, and start implementation straight away to mitigate this risk. | MOD | No Gaps in controls. | Expected to occur at least Weekly | Moderate | 12 | LOW | 6 | 1-Apr-2020 | | No Gaps in assurance. |

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| 3366 | 21-Jun-2019 | 21/06/2019 | Operational impact of tax/pension legislation | Corporate | Workforce (HR) | | Core Services | As a direct consequence of membership of the NHS Pension Schemes, high earning employees are disproportionately affected by the tax charge and may find that their future pension benefits are affected. This is normally because they have either exceeded the Lifetime Allowance (LTA) threshold and/or are affected by tapering of the Annual Allowance. Such individuals are now reluctant to undertake additional work including WLI's which is impacting upon operational performance and potentially patient care. | MOD | Karen Martin | Mrs Karen Martin | Ms Wendy Bowes | All Groups have contingency plans in place.□<br>Potential solutions are being discussed at Rem Com and also nationally through NHS Employers.□<br>□<br>Sept 2019 - UHCW has launched its own Pensions Restructure scheme and is awaiting further national advice.<br>□<br>□<br>Nov 2019 - New national initiative launched to compensate tax earnings for 2019/2020 for those clinicans who undertake additional activity. Awaiting implementation plan from NHS England/Improvement. □<br>□<br>□<br>Dec 2019 - Senior clinicians have been made aware of the new national initiative. No further action required at this stage. | MOD | | Expected to occur at least Weekly | Moderate | 12 | LOW | 4 | 31-Mar-2020 | | |
| 2472 | 25-Jan-2016 | 25/01/2016 | LACK OF HYBRID OPERATING THEATRE | Corporate | Safety - Clinical | Theatres | Clinical Support Services | A hybrid operating theatre is an operating theatre which has a fixed image intensifier and equipment for performing vascular surgery. Modern vascular surgery requires good quality imaging and stock of equipment kept in theatre to perform modern surgical techniques. These cannot be carried out using the current facilities in both elective or acute settings. Hence patients are being offered 'older' techniques which have a higher morbidity and mortality rather than modern techniques.□<br>□<br>In addition, staff are being exposed to higher levels of radiation than would occur if we had a fixed system for imaging.□<br>A hybrid operating theatre is recommeded by the MHRA for the above reasons on safety grounds. | HIGH | Justine Richards | Mr Mark Easter | Dr Clare Ingram | No current controls in place. Access to interventional radiology on an adhoc basis. Working party for hybrid theatre.<br>□<br>□<br>11/03/16 Risk escalated to "corporate" at Theatre Management meeting. To be approved by D Moon.□<br>□<br>Discussed at risk committee in August - liklihood reduced by CEO and Chief Officers□<br>□<br>15/10/2019 - CI - Fortnightly meetings with Project Co preparing the outline business case - due to go to board in Jan 2020□<br>□<br>Trust recruiting to interventional radiology posts to staff a full 24/7 rota for fluroscopy.□<br>□<br>13/02/2020 -CI- OBC to go to Trust Board March 2020. | MOD | Use of interventional radiology is sub-optimal, with no immediate access to surgery. Interventional radiology is on a different floor to theatres | Expected to occur at least Annually | Catastrophic | 10 | LOW | 6 | 31-Jul-2020 | Monitored through incident reporting & Mortality review | None identified |

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| 1102 | 1-Apr-2018 | 01/03/2012 | Serious patient falls | Corporate | Safety - Clinical | | All Groups | There is a large proportion of patients in the Trust at risk of falling and a high number of falls reported.If a patient falls there is the possibility of the resulting fall would cause an injury with moderate harm or above which may also lead to financial and reputational loss for the Trust. | HIGH | Nina Morgan | Ms Elaine Clarke | Miss Diane Sheppard | Implementation of the new Falls Assessment August 2017□<br>Implementation of the new Falls Pathway August 2017□<br>Falls Alarms are available within the Trust.□<br>5 Sara Steady's are in use in wards areas which require this specialist handling equipment.□<br>New beds all have ultra low feature to reduce risk of harm from a fall from a bed.□<br>Quarterly reviews with wards/departments Q2 Q3 monitoring/supporting falls reduction effective□<br>Implementation of the Safe and Supportive Observation Tool□<br>Reviewing the 18.5% reduction in overall fall at end 2017/18 the risk rating has been reduced to reflect this change□ | MOD | A gap analysis of 2015 and 2017 RCP audit is underway | Expected to occur at least Monthly | Moderate | 9 | MOD | 9 | 30-Apr-2020 | Presentation of Falls Risk at Risk Committee by CNO<br>Benchmarking -<br>Monthly safety thermometer data on falls<br>Monthly Falls Forum minutes<br>Falls Trend analysis available in Insite<br>Report to NMC yearly and PSEC Bimonthly<br>National Falls Audit 2015 and 2017 by RCP<br>Falls Lead attends Network meeting with other regional hospitals | No gaps in assurances currently |
| 1864 | 1-Apr-2014 | 23/05/2013 | Unauthorised access of Trust systems - Mis use of access by Trust Staff | Corporate | Information Governance | | All Groups | If staff share passwords/access cards there is the risk of unauthorised access to systems and misuse of data. This could lead to breaches of the data protection act, the potential for financial penalty from the ICO and a negative finding from the CQC at inspection, with consequent damage to reputation. | MOD | Laura Crowne | Mr Geoff Stokes | Ms Harjit Matharu | 1. The ICT Security Policy explicitly states that staff must not share logins or passwords - this is the only policy that a staff member must sign to agree to the terms and conditions before access to the Trust network and systems is granted (after training). □<br>2. All Trust inductions specifically cover why staff must not share logins and passwords. | MOD | Not compliant with the security principle of the Data Protection Act 2018 - there are inappropriate organisational and technical controls.<br>Not compliant with the NDG's Data Security Standards (Caldicott 3)<br>There is anecdotal evidence that leads to these practices being tolerated as it is part of the Trust's culture / accepted behaviours. | Expected to occur at least Monthly | Moderate | 9 | LOW | 6 | 30-Jun-2020 | Incidents raised on Datix are reviewed at Information Governance Committee to identify patterns and evidence of compliance<br>Examples of disciplinary action being taken against staff known to have breached policy | The Trust is currently unable to undertake pro-active auditing which means that unauthorised access could be taking place and not come to light.<br>Increase in number of requests for retrospective auditing of system access which would suggest that unauthorised access is occurring. |
| 1898 | 1-Apr-2014 | 24/07/2013 | Limited (and cost of) Car parking for staff leads to recruitment and retention issues | Corporate | Health and Safety / Environment | Estates & Facilities | Core Services | Recruitment and retention issues due to lack of car parking for staff, which will prevent Prevent quality delivery of services.□<br>Impact on safety | MOD | Nina Morgan | Mr Lincoln Dawkin | Mrs Julie Rice | 14/02/2020 - Discussions continue between UHCW NHS Trust and Coventry City Council regarding the Planning Application for the 1600 space rear of site car park. The Trust's CEO and Director of Finance are attending a meeting with the Head of Coventry City Council week commencing 17th February 2020 to try and agree a way forward. | MOD | Project plan being developed and to be implemented -following planning permission<br>Submitted a variation enquiry into Project co to price.<br>Are developing a revised sustainable car parking plan with revised criterion for the issue of staff passes. | Expected to occur at least Monthly | Moderate | 9 | LOW | 6 | 29-May-2020 | 1. A revised staff permit system has been introduced<br>2. Plans for an additional 1500 space car park have been submitted for approval | None identified |
| 2255 | 1-Apr-2016 | 03/02/2015 | Quality of Duty of Candour | Corporate | Quality | Quality Department | Core Services | If the Trust is not fully compliant with the statutory Duty of Candour, then this may lead to contractual penalties from the CCG and regulatory action by the CQC. NHS Trusts have seen financial penalties for lack of compliance in 2019/20.□<br>□<br>In addition, the patient/family experience and evaluation of the process will be poor which may lead to further complaints and concerns. | MOD | Mo Hussain | Mrs Jenny Gardiner | Miss Chelsea Gilsenan | * Backlog reduced from 150+ historical cases dating back to 2017 to 30 in March2020 □<br>* Review of roles in current patient safety team to enhance family liaison requirement for 6 months as a pilot (band 4 post)□<br>*Internal Audit cycle completed with recommendations January 2020 □<br>*Paper for review of the current backlog due for presentation at PSEC March2020 □<br>* Daily management via patient safety team of current status of each case and compliance with DOC escalated via ADQ and DOQ | MOD | Need to provide further communications to staff<br>Need to provide support/training to staff to have DoC conversations | Expected to occur at least Monthly | Moderate | 9 | LOW | 4 | 31-May-2020 | Review of relevant incidents on Datix by the Quality Team<br>SIG review of RCA reports for evidence of DoC<br>Review of complaints relating to breach of DoC<br>DoC Audit established | Until the new process has been agreed & communicated there may be gaps in compliance<br>Need for more frequent (eg monthly) review of compliance as part of Trust performance dashboards |

# Corporate Risk Register

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| 2664 | 1-Sep-2016 | 05/01/2017 | Decommisioning of Rugby St Cross Theatres | Corporate | Strategy | Theatres | Clinical Support Services | Rugby St Cross theatres are nearing the end of their useful life: in terms of maintenance, upkeep, size and storage. They are currently revalidated on an annual basis. This means that following the next inspection, should they fail to achieve the minimum required standards in terms of airflow/air changes etc, they could be decommissioned or put out of action. This would result in loss of theatre capacity, increased waiting times by affecting RTT performance and cancer pathways also failure to retrieve income and detrimental impact on reputation and patient experience.□<br>□ | MOD | Justine Richards | Mr Mark Easter | Dr Clare Ingram | Regular assessment and support from trust estates with planned , preventative, reactive maintenance.Project group considering options and developing a business continuity plan in the event of a singular or multiple theatre failure. □<br>Initial plan to utilise additional Vanguards at Rugby deemed uneconomic and inefficient due to limitations on case mix suitability. Now looking at feasibility of modular theatres,external service providers NHS and private,utilising UHCW theatres for theatre capacity and developing a process to repatriate patients post op to St Cross. These are short term and long term options being considered.□<br>□<br>Yearly revalidation. Plans for building new Theatres Suite at Rugby St Cross underway.□<br>□<br>Formal start of process to write OBC commenced 20th July. □<br>□<br>Project to replace RSC Theatres formally put on hold by COG. OBC to install modular theatres to provide some resilience being compiled.□<br>□<br>30/8 Modular theatre project progressing to tender. Trust has approved £30k funding for investigations/plans than may be required. MR□<br>□<br>18/10/2019 - CI - Modular Theatre Meeting Today Investigation Plans to commence to allow Quotations for Trust Board to identify possible funding streams. 2nd team set up to look | MOD | PPM not completed in a timley fashion resulting in failures | Expected to occur at least Monthly | Moderate | 9 | VLOW | 3 | 1-Apr-2020 | Entered onto the Risk Register<br>Mobile theatre providers to be asked to assess Rugby site, with Estates, for suitabe position for mobile theatre<br>CD, MM and GM of theatres to look at ways of increasing staffing to run longer days should Rugby Theatres fail validation<br>Rugby Theatres Project Group has sent SOC to NHSI for approval<br>Theatres vaildated for one year<br>NHSI approval for FBC<br>Risks discussed with COS, plan to investigate modular theatres x 2<br>Risk discused at least monthly at RSC Theatre planning group<br>Business case for modular theatres to be put before TDG by end of March | Increasing working hours for theatre staff may involve management of change process which will take time<br>CDG delayed decision about modular theatres whilst awaiting further risk assessment.<br>failure to find replacement for vanguard theatre risks further disruption to RTT<br>potential for it not to be discussed |
| 2783 | 1-Apr-2018 | | Agency Expenditure | Corporate | Financial | Finance Department | Core Services | Failure to control and reduce agency staffing expenditure.□<br>Risk judged against the 19/20 internal agency target of £18m | MOD | Justine RichardsSusan Rollason | Ms Susan Rollason | Ms Susan Rollason | 1) Budgetary control processes.□<br>2) Monthly operational delivery meetings.□<br>3) WRP focus on agency controls.□<br>4) Group Targets for 2019/20□ | MOD | Medical booking process / links to medical rotas | Expected to occur at least Monthly | Moderate | 9 | LOW | 6 | 30-Mar-2020 | Intergrated Finance Report | None |
| 2784 | 1-Apr-2018 | | Delivery of Contracted Income & Activity levels | Corporate | Financial | Finance Department | Core Services | Failure to secure planned levels of activity and income from activities in 2019/20□<br>Potential of over performance against the Coventry & Rugby CCG contract (intelligent Risk Share Contract) | HIGH | Susan Rollason | Ms Susan Rollason | Ms Susan Rollason | Key contracts agreed (by specialty and POD) for 2019/20.□<br>- Agreed Operational delivery plans.□<br>- WRP focus on operational productivity.□<br>- Budgetary control processes.□<br>- Monthly operational accountability meetings.□<br>- Quarterly performance review meetings.□<br>Minimum income Guarantee with C&RCCG □ | MOD | Groups understanding of the new risk share agreement | Expected to occur at least Monthly | Moderate | 9 | LOW | 4 | 30-Mar-2020 | Intergrated Finance Report | None |

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| 2911 | 28-Nov-2017 | 28/11/2017 | Raising concerns | Corporate | Workforce (HR) | | All Groups | IF there are not sufficient opportunities for staff to raise concerns□<br>THEN patient safety or staff issues may not be identified□<br>RESULTING IN potential poor patient care or experience, or staff dissatisfaction or increased turnover | MOD | Andy Hardy | Mr Geoff Stokes | Mr Geoff Stokes | Raising Concerns policy□<br>Confidential contacts' network in place□<br>Permanent Freedom to Speak up Guardian in place□<br>Posters promoting policy under the value of 'openness'□<br>Regular contacts with chaplain, staff side and Head of Diversity□<br>FTSUG meets with Chairman, Lead NED and CWIO independently | MOD | Greater publicity for FTSUG and Raising Concerns<br>Raising Concerns policy to be reviewed and publicised<br>Not all cases are recorded and data captured | Expected to occur at least Monthly | Moderate | 9 | LOW | 6 | 30-Nov-2020 | Positive outcomes from national staff survey<br>6 monthly report to Board | |
| 3193 | 11-Sep-2018 | 03/10/2018 | Trainee Information System (TIS) | Corporate | Workforce (HR) | | All Groups | The Trainee Information System (TIS) which is the national Health Education England (Deanery)system replaces the Intrepid System early October 2018. Data previously stored on Intrepid will no longer be accessible to Trusts. □<br>There is concern that the national TIS system has functionality failures including being able to log on and access trainee details for forthcoming rotations in December 2018. These doctors are obliged to receive their work schedules 9 weeks in advance of commencement and their individual rota 6 weeks in advance. There is a risk that we will not be able to know which doctors will be attending the Trust in December and in addition, a risk that we cannot comply with the above requirements which is a part of the new national junior doctor contract. □<br>□<br>In addition, there are risks to service provision if we are not able to fill rota positions appropriately and in a timely way, and there is financial risk as we may be fined by the Guardian of Safe Working if non-compliant rotas are in use or if junior doctors receive their rota information outside of the required timescales. There is also a risk of a reduction in morale of junior doctors if | MOD | Karen Martin | Ms Wendy Bowes | Ms Wendy Bowes | We are in regular contact with Health Education England (West Midlands) to receive updates on the system.□<br>We are checking the system on a weekly basis. □<br>We have previously written to the Dean of HEWM to raise our concerns (dated 11.09.18)□<br>□<br>11.02.19 - The system issues continue. These concerns continue to be raised at the regional streamlining group, at which HEE representatives attend. Latest indication is that the system issues will continue until August 2019. A trial of the new reporting system is expected by the end of February 2019. Deanery data continues to be checked weekly by the centralised rota management team and Resourcing team. □<br>□<br>20.05.19 Work continues to address the technical issues with the system. Deanery data continues to be checked weekly by the centralised rota management team and Resourcing team. □<br>□<br>July 2019 Work continus to address the technical issues withe the system. The Deanery data continues to be checked manually by the centralised rota management team and Resourcing team.□<br>□<br>Sept 2019 Work continus to address the technical issues with the system. The Deanery data continues to be checked manually by the centralised rota management team and Resourcing team.□<br>□ | MOD | Weekly checks of the data being submitted are undertaken by the centralised rota team and Resourcing function | Expected to occur at least Monthly | Moderate | 9 | MOD | 9 | 28-Feb-2020 | Concerns and mitigation is escalated to the Rota Oversight Committee | Weekly checks of the data being submitted are undertaken by the centralised rota team and Resourcing function. |

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| 2316 | 20-Apr-2015 | 20/04/2015 | Generic Business Continuity Risks | Corporate | Operational | | All Groups | Under the Civil Contingencies Act 2004 and NHS EPRR Guidance 2013 NHS organisations are required to plan for incidents that pose a threat to the operational capability of the Trust ensuring that all critical functions can continue as required. Service interruptions can occur for a variety of reasons including; adverse weather, industrial action, ICT disruptions, supplier failure, loss of acccess to buildings, fires and floods (though this list is not exhaustive). □<br>□<br>Each incident can pose multiple threats including but not limited to; loss of service delivery, and reputational damage. | MOD | Laura Crowne | Mr Luke Peachey | Mr Luke Peachey | The Trust has in a place a Strategic Level Business Continuity Plan that can be delivered along side the Major Incident Plan. □<br>□<br>The Trust has in place a Business Continuity Policy and Process that clearly identifies the roles and responsibilities of each group in developing business continuity plans. □<br>□<br>ICT and Information Governance require all ICT system owners to have in place a business continuity plan as part of the ICT System Standards to ensure that all systems within the Trust have a plan. □<br>□<br>Each ward area have in place red Contingency Boxes that contain the paper copies required to complete patient investigations, observations and TTOs. This box has recently been audited and guidance is being circulated to all clinical areas to ensure the documents stored meet their local needs. □<br>□<br>Trust BCP incorporates Business Impact Analysis (BIA) to determine criticality of functions, and have detailed arrangement covered in the MIP and Trust BCP. | MOD | None identified | Expected to occur at least Annually | Major | 8 | LOW | 6 | 31-Mar-2020 | April 2018: Majority of groups have completed their BIA. All groups have been provided with the second stage of their training to support writing their BCP. Further 1-1 support is avaialble to those who require.<br>SEPTEMBER 2017 update: All groups will shortly undergo training on how to complete BIA's and create group BCP's with deadlines to comply with. Previous BIA's and BCP's will then be re reviewed by all groups to ensure information is accurate and up to date. Data will then feed in local groups management meetings and approved at local groups QUIPS, before submitting to EPSC. This process will be updated through the Risk Committee as part of the EPSC TOR.<br>Dec 2017: All group managers have received training and groups are revaluating their BIAs. A update has been requested to all groups on 1st December on their progress.<br>Aug 2018: Steady progress continues to be made with BCP completion. Updates | None identified |

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| 3051 | 1-Apr-2018 | 30/04/2018 | Non standardisation of follow up processes resulting in a deterioration of RTT performance and harm to patient | Corporate | Safety - Clinical | Trust Out Patients | Clinical Support Services | Currently the Trust has a number of different processes to book follow up appointments. The differences occur Group to Group and also within Groups (i.e. PBFU/Non PBFU).□<br>□<br>Through validation of the outcome of future appointment required, outcomes being changed which could result in RTT clocks being reopened this could impact on the Trust's RTT position.□<br>□<br>In addition, patients who have suspended as their clinic appointment outcome, or require a follow up which has not been booked may have been lost to follow up and clinical harm caused.□<br>□<br>It should be noted that whilst the overarching risk score is currently 8; there have been incidents of moderate harm and above in the previous 12 months. | MOD | Laura Crowne | Mr Martin Robinson | Mr Kyle Wood | In place:□<br>□<br>Follow up project group established with 4 clear work streams:□<br>- Reporting□<br>- Ophthalmology□<br>- Validation□<br>- Future State□<br>□<br>The Project Group has also identified clear leadership and responsibilities for each area. The work streams are discussed at a weekly huddle and report into a monthly Project Group that also reports into the Elective Care Board on a monthly basis.□<br>□<br>Monitoring reports have been developed and are available on the intranet and are refreshed on a daily basis and can be used to track progress.□<br>□<br>The volume of suspended outcomes as at 21st March 2019 is has reduced to 3738.□<br>□<br>Black Status Patients - 7231□<br>Red Status Patients - 11987□<br>□<br>(No filters applied)□<br>□<br>Clinical Harm Review Group will be sited on any incidents that may have caused harm. Incidents are raised and will be escalated to the Significant Incident Group where necessary.□<br>□<br>All Groups (except Surgery) have submitted a recovery plan; however, it is acknowledged that work is on going to review surgical patients and a recovery plan is being developed.□ | MOD | There is no standard process hence no standard controls to mitigate risk. | Expected to occur at least Weekly | Minor | 8 | VLOW | 3 | 30-Apr-2020 | New AGM in place to meet with RTT Lead and report status and recovery plans back to ECB<br>Post-RPIW project team established to streamline follow-up process and reduce possible lost to follow up | AGM/RTT Lead meeting not yet held No update documented since 03-2019<br>Post-RPIW anticipated CRRS build delays, not scheduled until c02-2020 |
| 3155 | 3-Aug-2018 | 03/08/2018 | Capital Financing | Corporate | Financial | Finance Department | Core Services | IF there is insufficient capital financing □<br>THEN the Trust will not be able to invest in strategic and operational developments □<br>RESULTING IN reduction in the Trust's ability to achieve its strategic objectives.□ | MOD | Susan Rollason | AJ | Mr Antony Hobbs | 1) Capital Finance Update to TDG monthly.□<br>2) Additional controls/rigour in place in 19/20 pending loan approval.□<br>3) NHSI/E aware of capital constraints□<br>4) CPRG - on going review of capital priorities□<br>5) Long term solution being pursued with NHSI/E□<br>6) Funding now secured for 2019/20 (Nov 19) - but future years remain uncertain□ | MOD | No Gaps in controls. | Expected to occur at least Annually | Major | 8 | LOW | 4 | 31-Mar-2020 | Intergrated Finance Report | No gaps in assurance identified |
| 3518 | 1-Jan-2020 | 06/02/2020 | DPD blood testing pre 5fu chemotherapy | Corporate | Safety - Clinical | Radiotherapy / Oncology | Medicine | DPD deficiency testing is available now more routinely with recommended dose adaptation for 5fu chemotherapy dosing .□<br>this is a frequently used chemotherapy agent ,severe dpd deficiency□<br>can result in serious morbidity and even mortality (approx 1/1000 risk)NICE are reviewing and planning to issue guidance | MOD | Kiran Patel | Ms Natalie Bell | Dr Jo Hamilton | respond to risk after it has occurred with chemotherapy dose reduction , rather than pre-empt the risk and mitigate against it | MOD | | Expected to occur at least Annually | Major | 8 | MOD | 8 | 27-Apr-2020 | | |

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| 3020 | 28-Dec-2017 | 13/04/2018 | Medstrom MMO 5000 Bed brakes | Corporate | Safety - Clinical | Estates & Facilities | Core Services | The Medstrom MMO5000 bed has a newly introduced bed braking system that consists of rubberised brake pads that apply pressure directly onto the floor surface when the brakes are applied. □<br>It has been identified that on occasions the brake pads do not work effectively on the floor surface when the brake mechanism is applied. This potentially results in unexpected movement of the bed during staff or patient activity on or around the bed, whilst the brakes are applied. This has resulted in a significant number of near miss incidents for staff and patients and creates are real increased risk of harm/injury to patients and staff. | HIGH | Nina Morgan | DL2 | Dr William Peasgood | 1. A multidisciplinary working party has been established to review the fault identified in the incident reports and identify a potential solution.□<br>2. The fault and associated risks have been communicated to managers and staff to raise awareness of the risk and temporary risk reduction measures.□<br>3. An additional (temporary) cleaning procedure for cleaning of the brake pads has been developed and introduced to minimise contamination of the brake pads and improve surface friction.□<br>4. The supplier and manufacturer are currently working on an engineering solution to resolve the fault and eliminate the risk. □<br>4. The multidisciplinary group and technical representatives from the supplier have carried out a number of technical tests to identify the cause and identifying a permanent solution. □<br>5. Update 25.05.2018: The manufacturer and supplier are working with the trust to identify a permanent solution. A different design braking system has been fitted to 30 newly supplied beds and is currently being evaluated. Existing temporary risk reduction measures remain in place. DL□<br>6.Update 13/12/2018 A solution has been proposed by Medstrom which will replace the existing brake pads with a different design. This design has been on trial in the Trust for several months on a number of beds. There have been no datix incidents reported involving these modified beds. The process to modify all remaining | LOW | Provision of an effective braking system for the beds that will prevent unexpected movement when in use | Expected to occur at least Monthly | Minor | 6 | VLOW | 3 | 31-Mar-2020 | A multidisciplinary working party has been established to work with the supplier and manufacturer to review the fault identified in the incident reports and identify a potential solution.<br>The fault and associated risks have been communicated to managers and staff to raise awareness of the risk and temporary risk reduction measures.<br>An additional (temporary) cleaning procedure for cleaning of the brake pads has been developed and introduced to minimise contamination of the brake pads and improve surface friction.<br>The supplier and manufacturer are currently working on an engineering solution to resolve the fault and eliminate the risk.<br>The multidisciplinary group and technical representatives from the supplier have carried out a number of technical tests to identify the cause and identifying a permanent solution.<br>The manufacturer and supplier have provided a different | None identified |

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| 3030 | 16-Apr-2018 | 19/04/2018 | Violence and Aggression against staff | Corporate | Health and Safety / Environment | | All Groups | Staff are not well equipped to deal with violence and aggression when displayed by patients and visitors, meaning that either party or other patients could come to harm. | LOW | Nina Morgan | Sr Sarah Hartley | Mr Barry Newell | A working group to review this risk and formulate an action plan has been established and led by an ADN.□<br>□<br>A de-escalation policy is being written to support staff managing these situations.□<br>Staff can access conflict resolution training and further training is being sourced in relation to de-escalation.□<br>10/02/2020 meeting held with Barry Newell, David Powell, Lincoln dawkin, Sarah Watson, Donna Griffiths to discuss actions from task and finish group. Sarah and Donna believe the task and finish group actions are now outdated and we need to re-evaluate a current position before deciding on actions to take.□<br>20.06.19 - due to changes in structure, ownership of risk has been reallocated to Group Director of Nursing for Trauma and Neuro. Update given to Health and Safety Committee by GDN on 13.06.19, confirming that a Violence and Aggression policy has been approved.□<br>The Deputy Chief Nursing Officer and Group Director of Nursing and AHP's for Trauma and Neuro Services reviewed the policy and asked that the followong points were considered by the LSMS and this was discussed with the Chief Operating Officer and policy was to be updated accordingly. On review of the published draft further clarification around the follwong points have been asked to be considered and any agreed amendments made to the policy. This was therefore raised at the Health and Safety Committee | LOW | A lack of policy means staff will not be able to manage violence and aggression in the safest manner | Expected to occur at least Monthly | Minor | 6 | VLOW | 3 | 31-May-2020 | Regualr updates received | |

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| 3065 | 4-May-2018 | 04/05/2018 | Research and development | Corporate | Strategy | | Core Services | IF we fail to increase our output and participation in research and innovation and are unable to develop our students and trainees □<br>THEN it will have a negative impact on recruitment and quality of care for our patients □<br>RESULTING in reputational damage. | MOD | Kiran Patel | Mrs Ceri Jones | Mrs Ceri Jones | 1. KPIs used to track; resources (applications for resources , research income, research set-up and delivery times and grants submitted) and performance (number of patients recruited)□<br>2. Check and challenge of the wider research issues needed to support research (e.g. resource, space, culture etc.)□<br>3. Check and challenge of financial implications of research□<br>programme. □<br>4. All surveys have associated action plans.□<br>5. Assess the desirability, viability and feasibility of new product innovations; inclusive of intellectual property rights and new product innovation approval. | LOW | Implement robust process for manahing and developing new innovation ideas<br>Governanace structure for managing and exploiting innovations<br>Opportunities to free up staff time for research (e.g. 3 of 8 fellowships not taken up, 4 examples of failure to release staff for INCA)<br>Service gaps at junior doctor level<br>Ensure medical education strategy is line with Trust strategy | Expected to occur at least Annually | Moderate | 6 | LOW | 6 | 30-Sep-2020 | KPI's monitored at Board via Integrated Performance Report<br>Regular report to the board<br>Research and grant income reported twice yearly to Finance and Performance Committee<br>Reports to MERC, PSC and SWC and Trust Board<br>Reported to Director of Corporate Affairs & Subsequent boards (TDG or CDG) for approval<br>Receives Annual Report, Strategic Briefings and KPI and national comparative data<br>Receives reports on activities of Research Governance and Human Tissue Committee<br>Reports on progress against R&D Strategy<br>Monitors compliance with legislative requirements<br>Now Medical Education and Research Committee - reviews progress against planrategies<br>Reports on Income, Expenditure and opportunities | Medical Education Strategy reviewed 2019 |

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| ID | Date Identified | Date Risk logged on Datix | Title | Risk Type | Risk Subtype | Specialty | Specialty Group | Description | Risk level (initial) | Executive Lead | Person Accountable | Person Responsible | Current controls | Risk level (current) | Gaps in controls | Likelihood (current) | Consequence (current) | Rating (current) | Risk level (Target) | Rating (Target) | Next review date | Assurance | Gaps in assurance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3198 | 1-Jun-2018 | 08/10/2018 | Lack of Mental Capacity Assessments for key decisions towards End of Life | Corporate | Safeguarding | Safeguarding Team | Core Services | If the Trust do not ensure staff have sufficient knowledge and understanding of the MCA, how to apply it and the documentation required, specifically in relation to End of Life decisions and ReSPECT, then patients will be at risk of not being involved in their own end of life care package which could result in poor patient experience, breach of legal statute and Trust reputation. | HIGH | Nina Morgan | Nina Morgan | Mrs Lisa Pratley | The Safeguarding Team have updated the mental capacity assessment form utilising the UHCWi methodology with colleagues from wards 30&31 and ensured improved accessibility to this via TrustNav.□<br>□<br>A bespoke Mental Capacity Act training package was created in September 2018 and has been delivered by the safeguarding team to all speciality QiPS between October 18 and February 19. There is an agreed training plan that all clinical band 7's and above will receive training on the practical application of the Mental Capacity Act. □<br>□<br>Compliance as of 9.07.19 is 77%.□<br>□<br>Changes have been made to the Trust CRRS resuscitation tab in January 2019 to capture a reason as to why the patient is deemed to lack capacity if this option is chosen. Further work occurred in September 2019 to capture the full capacity assessment electronically□<br>□<br>A Trust Safety Message was dedicated to the recording of mental capacity assessments in February 19 and a Kaizen improvement event was subsequently hosted in March 19 to engage and empower staff to scope further improvements. There is a newspaper in place to monitor on-going improvements.□<br>□<br>The Safeguarding Team budget has been reviewed and altered to | LOW | If Staff are unable to attend training the workforce will not be adequatley equipped to assess mental capacity<br>If the revised paperwork is not utilised by staff then the standard for documentation may remain poor<br>If the audit compliance is not monitored then the Trust will not be sited on progress with mitigating the risk | Expected to occur at least Monthly | Minor | 6 | LOW | 6 | 30-Apr-2020 | Bi Monthly reporting to SAAC for assurance on performance and improvements<br>Audit results were seen to increase from 35% in January 19 to 100% in March 19 across 5 medical wards whom had been supported by the Safegaurding Team. Once improved audit compliance once maintained an additional 8 medical wards have been supported current compliance 73% (May 19) | Lack of check and challenge at Trust level committees may lead to a drop in performance against mitigations |

# Corporate Risk Register

| ID | Date Identified | Date Risk logged on Datix | Title | Risk Type | Risk Subtype | Specialty | Specialty Group | Description | Risk level (initial) | Executive Lead | Person Accountable | Person Responsible | Current controls | Risk level (current) | Gaps in controls | Likelihood (current) | Consequence (current) | Rating (current) | Risk level (Target) | Rating (Target) | Next review date | Assurance | Gaps in assurance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3133 | 6-Jul-2018 | 09/07/2018 | Telecommunications Failure | Corporate | Emergency Planning | | All Groups | Continuing to strengthen Trusts position on 'utilities' BC preparedness. Identified new risk whilst writing Telecommunications BCP in collaboration with ICT Telecommunications Manager. □<br>□<br>Every clincial footprint does not have a back up telephone in the event of the 'acute telephone switch' failure. This would result in whole clinical area not having a working telephone, therefore in the event of a emergency no help can be summoned. □<br>□<br>Risk discussed with Telecommunications Manager in ICT and reviewing options to install further/amend current telephone infrastructure to improve resilience in all clinical footprints. □<br>□<br>Also when the trust moved into the building in 2005/6 the backup telephones that were available on wards were identified by a red telephone in place. These have changed over the years for various reasons and replaced with a non red phone. The EPM is working in collaboration with Vinci and Estates Department to address this issues and replace handsets with red telephones and to label these accordingly. □ | LOW | Laura Crowne | Mr Luke Peachey | Mr Luke Peachey | Majority of clinical areas have back up phones, however these are not easily identified. in the event of the acute telephone switch failing trial and error' to find a working phone would be required to find a working phone. □<br>□<br>March 2019: Red phones are being installed across the site in every clinical area. estimate to complete by end of March 2019. □<br>□<br>May 2019: 68 Red phones have been successfully installed across UHCW site in clinical areas. Strengthening and reviewing resilience at st cross is under way□<br>□<br>June 2019: Red phones now installed across all clinical areas. Switchboard due for upgrade to VOIP in July/Aug. Tele Comms BCP being adjusted to reflect these chanages and will be published once work□<br>□<br>January 2020: BCP completed. | LOW | | Not expected to occur for Years | Major | 4 | VLOW | 2 | 2-Mar-2020 | Nov 2018: Follwoing the telephony failure om 12th October there is strong engagement with partners to explore all options to mitiagte risk. Working group has been established, update to follow after first meeting<br>Aug 2018: Vinci and ICT continue to work with EPSC to mitiagte risk, and develop robust BCP being supported by the Director of Estates & Facilities. Vinci currently purchasing replacement red telephones to replace fall back telephone on clinical areas. Requested at committee as likelihood is low, and mitigating actions in place, risk to be downgraded from corporate to local risk. To continue working with partners in addressing further mitigating actions.<br>March 2019: Full telephony audit completed across all clinical areas. Red phone instillation continues to make good progress. Works aim to be completed by end of April.<br>Jan 2019: Working group established. Audit being undertaken with ICT to establish how many | |
| 3499 | 18-Nov-2019 | 21/01/2020 | Change from Deprivation of Liberty Safeguards to Liberty Protection Safeguards | Corporate | Safeguarding | | Core Services | If the Trust is unable to comply with the Liberty Protection Safeguards replacing the Deprivation of Liberty Safeguards as detailed in the Mental Capacity Act Amendment Bill (May 2019) by not arranging relevant assessments, authorising, monitoring and reviewing detention / restriction, which may result in appeals to the Court of Protection (legal support required), there will be poor patient care and inability to safeguard patients under the care of UHCW. | VLOW | Nina Morgan | | Mrs Lisa Pratley | The risk is currently unknown as the national code of practice is awaited. However it is anticipated there will be a requirement for an increase in resource to meet the demands. Currently the Safeguarding Team have a Mental Capacity Act Co-Ordinator (0.64 wte) who co-ordinates the Deprivation of Liberty Safeguards (DoLS) and would support the new Liberty Protection Safeguards (LPS). There is currently a review of DoLS applications to try and forward plan the increase in workload following the introduction of LPS. | VLOW | | Expected to occur at least Annually | Negligible | 2 | VLOW | 1 | 1-Jul-2020 | | |

University Hospitals Coventry and Warwickshire NHS Trust

**REPORT TO PUBLIC TRUST BOARD**
**HELD ON *26* MARCH 2020**

| | |
|---|---|
| **Subject Title** | Serious Incident and Never Event Report |
| **Executive Sponsor** | Mo Hussain, Chief Quality Officer |
| **Author** | Chelsea Gilsenan, Associate Director Quality – Patient Safety and Risk<br>Kiran Paul, Head of Patient Safety and Risk |
| **Attachment(s)** | Serious Incident and Never Event Report |
| **Recommendation(s)** | The Trust Board is asked to **REVIEW** and **DISCUSS** the contents of the Report. |

## EXECUTIVE SUMMARY

**Summary of all SIs (February 2019 - January 2020)**

- From February 2019 to January 2020 UHCW NHS Trust has investigated a total of 132 SI's.
- Seven SI's were initially declared but further investigation revealed that the definition of a SI was not fulfilled and it was confirmed with the CCG that there were no acts or omissions in care which caused or contributed towards the outcome.
- This resulted in 125 SI's meeting the criteria for the National SI Framework.

**Actual Harm**

- Of the 125 SI's reported, 24 resulted in Death, 32 in Severe (permanent) harm and 65 caused Moderate harm
- 55% of all SI's reported caused the patient moderate, low or no harm but the organisation recognised an opportunity for learning in investigating these cases.

**SI Category**

- Of the 125 incidents reported, the highest reported category was slips, trips and falls, secondary to this was hospital acquired pressure ulcers and then treatment delay meeting the SI criteria.

**Trends and Themes**

<u>Falls</u>

- The number of falls up to the end of February 2020 is marginally less than data when compared to the previous year; the previous year's 23% reduction has been maintained and improved upon.

Emergency Department

- There have been twelve incidents reported as SI's, eight of which resulted in the Death of a patient.
- During the same data period, the Trust saw 140,351 attendances via our Emergency Department.

**Performance**

- There are currently 34 open SI under investigation by the Trust
- The SI governance group has reviewed the current threshold for SI investigation and the allocation of investigators to help to improve the efficiency of the process

**SI Action Plans**

The Number of overdue SI actions chart demonstrates an increased improvement in Perfomance of open overdue action.

| **PREVIOUS DISCUSSIONS HELD** |
|---|
| Nil |

| **KEY IMPLICATIONS** | |
|---|---|
| **Financial** | Nil |
| **Patients Safety or Quality** | To continue to embed learning from near misses and incidents to prevent avoidable harm and risk to patients. |
| **Human Resources** | Nil |
| **Operational** | Incidents may affect the operation of services; such as failed internal processes, people and systems, or from external events. If learning is not completed within agreed timescale then preventive measures will not be introduced, leading to further incidents resulting in patient harm |

# SERIOUS INCIDENT AND NEVER EVENT REPORT
# TO TRUST BOARD 26 MARCH 2020

**Chelsea Gilsenan, Associate Director Quality – Patient Safety and Risk**

**Kiran Paul, Head of Patient Safety and Risk**

## 1.0 Background

Serious Incidents (SI) are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations so significant, that they warrant a comprehensive response. The NHS SI Framework describes the response required and investigation procedures to be undertaken to ensure that lessons are learned. The national SI framework remains under review nationally and the Trust adheres to the most recent framework last updated in 2015.

At UHCW NHS Trust these incidents are reviewed and responded to in most cases by the Patient Safety Response team, to identify immediate learning, support staff and stop the line on any immediate safety issues. SI's are then monitored by the weekly multi-disciplinary Significant Incident Group (SIG), chaired by the Director of Quality.
SIG ensures that SI's are investigated to determine a root cause and that any lessons learned are identified and actions implemented to improve services and care to our patients. SIG also ensure that where required the SI's are externally reported to the Clinical Commissioning Group (CCG) and National Strategic Executive Information System (StEIS).

SIG reviews each investigation report and considers and approves the recommendations and associated action plan. The Quality Department maintains a database (Datix) of all ongoing and completed investigations and action plans and has a process for escalating actions that have not been completed within their agreed timescales.

SI's and the work of SIG are monitored monthly via the Patient Safety and Effectiveness Committee (PSEC) which reports to the Quality Governance Committee (QGC).

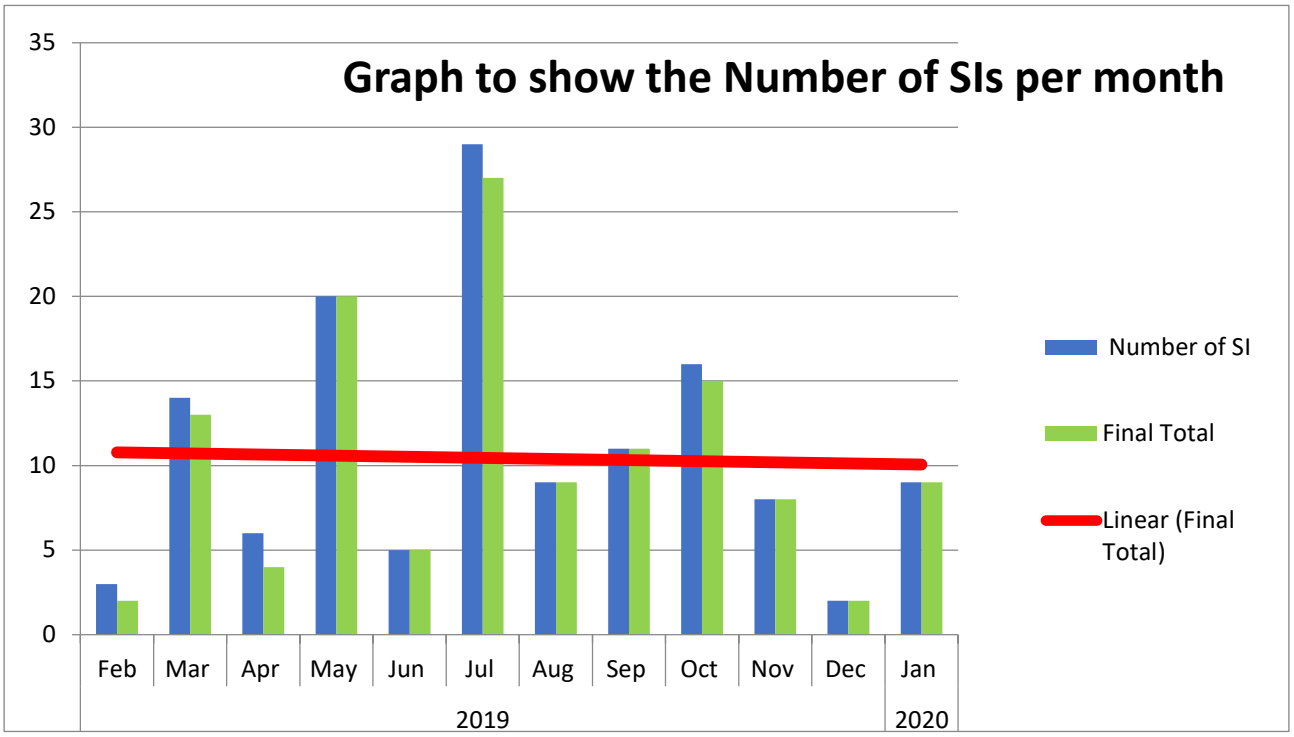
## 2.0 Summary of all SIs (February 2019 - January 2020)

This report summarises SI's that met the framework criteria for reporting and any trends for the last twelve calendar months (February 2019 – January 2020). To comply with the SI Framework each of the Trust's SI's must be investigated and a report submitted to the commissioners within 60 working days from the date of reporting. Clock-stops can be requested when additional time or relevant information is required to fully investigate an incident, for example; a case that has gone to HM Coroner or a case that Police are investigating.

The graph below shows the number of SI's registered by the Trust from February 2019 to January 2020, the graph shows the total number of incidents registered for investigation

and then the final total of SI's meeting the SI framework, the graph also shows the linear trend of the number of SI's over the last 12 months.

**Figure 1 Number of Serious Incidents reported by month**




From February 2019 to January 2020 UHCW NHS Trust reported 19,097 patient safety incidents, of these a total of 132 were registered as SI's. Where it was not clear whether or not an incident fulfilled the definition of a SI, UHCW NHS Trust and the CCG engaged in open and honest discussions to agree the appropriate and proportionate response, in the last twelve months, seven SI's were initially declared but further investigation revealed that the definition of a SI was not fulfilled and it was confirmed with the CCG that there were no acts or omissions in care which caused or contributed towards the outcome. This resulted in only 125 SI's meeting the criteria for the National SI Framework; this is 0.65% of all patient safety incidents reported.

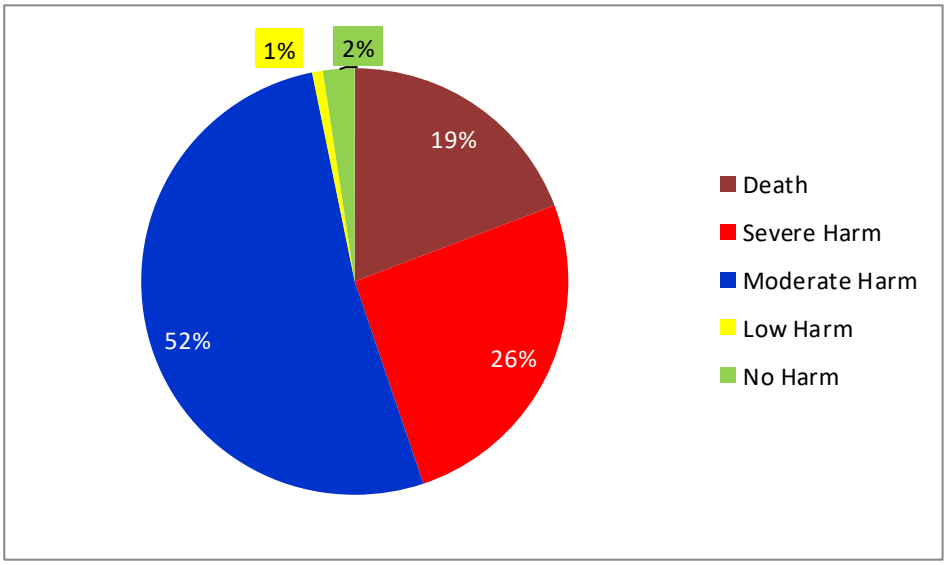
In the previous quarter, the Trust identified an increase in historical reporting impacting on the reporting rate for July 2019, since the last report, the Trust has implemented measures to increase the validation of all SI's and improve the timeliness of external reporting. This has seen an improvement since November 2019 reporting.

In the previous comparative year, February 2018 - January 2019, the Trust reported a total of 145 SI's which demonstrates a reduction of 20 reported SI's.

Actual Harm

Of the 125 SI's reported, 24 resulted in Death, 32 in Severe (permanent) harm and 65 caused Moderate harm (an increase in the patients' treatment such as an additional operation) to one or more patients or service users. The remaining SI's were reported as no or low harm. This is shown below in percentage of all SI's.

**Figure 2. Percentage of Actual Harm category SI's**




55% of all SI's reported caused the patient moderate, low or no harm but the organisation recognised an opportunity for learning in investigating these cases. The current National framework for reporting SI's describes the definition primarily as;

*Acts and/or omissions occurring as part of NHS-funded healthcare that result in:*

- *Unexpected or avoidable death of one or more people. This includes*
  - *suicide/self-inflicted death; and homicide by a person in receipt of mental health care within the recent past*
- *Unexpected or avoidable injury to one or more people that has resulted in serious harm*

See appendix one for the full criteria for reporting.

<u>SI Category</u>

Of the 125 incidents reported, the highest reported category was slips, trips and falls, secondary to this was hospital acquired pressure ulcers and then treatment delay meeting the SI criteria.

**Figure 3. Table to show the number of SI's per category, by month.**

| | 2019 | | | | | | | | | | | 2020 | Grand |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **SI Category** | **Feb** | **Mar** | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** | **Jan** | **Total** |
| Accident e.g. collision/scald (not slip/trip/fall) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| Confidential Information Leak / IG Breach | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 2 |
| Diagnostic Incident (incl delay, failure to act on test results) | 0 | 0 | 0 | 4 | 1 | 5 | 0 | 2 | 1 | 0 | 0 | 0 | 13 |
| HCAI / Infection Control incident | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Maternity - Mother & Baby (incl foetus, neonate & infant) | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| Maternity incident - Mother | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |

| | 2019 | | | | | | | | | | | 2020 | Grand |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **SI Category** | **Feb** | **Mar** | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** | **Jan** | **Total** |
| only | | | | | | | | | | | | | |
| Maternity Services - Unexpected admission to NICU | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 |
| Maternity incident - Baby only (incl foetus, neonate & infant) | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 3 |
| Medical equipment / devices / disposables Incident | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 2 |
| Medication incident | 0 | 0 | 1 | 2 | 1 | 0 | 5 | 1 | 2 | 0 | 0 | 0 | 12 |
| Other | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 2 |
| **Pressure Ulcer meeting SI criteria** | 0 | 4 | 1 | 6 | 1 | 7 | 0 | 1 | 0 | 0 | 0 | 3 | **23** |
| **Slips / Trips / Falls** | 1 | 2 | 0 | 2 | 0 | 6 | 3 | 2 | 7 | 3 | 2 | 4 | **32** |
| Sub-optimal care of the deteriorating patient | 0 | 2 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 4 |
| Surgical / Invasive procedure incident meeting SI criteria | 0 | 1 | 0 | 1 | 1 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 6 |
| **Treatment delay meeting SI criteria** | 0 | 4 | 0 | 3 | 0 | 6 | 0 | 1 | 3 | 2 | 0 | 1 | **20** |
| **Grand Total** | **2** | **13** | **3** | **20** | **5** | **28** | **9** | **11** | **15** | **8** | **2** | **9** | **125** |

## 3.0 Trends and Themes

The outcomes from the investigations are regularly collated for review to ascertain any common issues or causes from which the Trust can learn lessons and analysis is shared at Quality Governance Committee and with the local commissioners at the Clinical Quality Review Group.

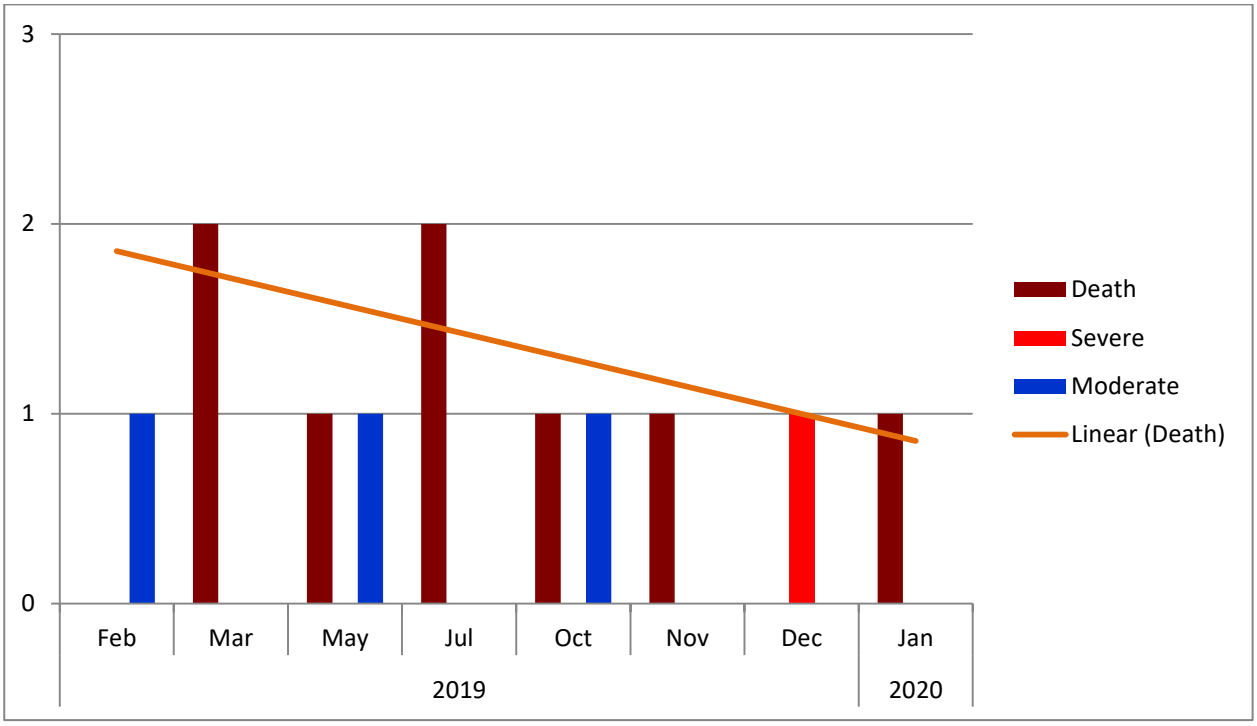
Falls

The overall number of falls up to the end of February 2020 is marginally less than data when compared to the previous year (hence the previous year 23% reduction has been maintained and improved upon). This will be further analysed at financial year end when the Trust will calculate the final figure, based on per 1000 bed days which will take into consideration the additional beds that have been open throughout the year.

Emergency Department

Following media coverage of a SI occurrence in the Emergency Medicine department in December 2019, this report has reviewed all of the SI's reported for the Emergency Medicine department in the last twelve months.

**Figure 4. Graph to show the number of SI in the Emergency Department**




There have been twelve incidents reported as SI's, eight of which resulted in the Death of a patient. During the same data period, the Trust saw 140,351 attendances via our Emergency Department; this is 0.008% of all attendances resulting in a SI.

In the previous comparative year February 2018 – January 2019 there were 135,036 attendances and 17 reported SIs for the Emergency Department, demonstrating a reduction of five reported SIs in this data period and a 0.012%.

Each SI reported is externally reviewed by the CCG following investigation for trends and themes. In addition internally within the Trust, the department participate in an immediate Patient safety Response visit for all moderate harm and above incidents, to ensure immediate learning is implemented where required. The department have implemented all SI incident actions from investigations to date.

## 4.0 Performance

There are currently 34 open SI under investigation by the Trust; the patient safety team continue to work closely with SI investigators who take on the investigation role in addition to their existing workload. The current model of investigation has been evaluated by the SI Governance group following difficulties in confirming SI investigators.

The SI governance group has reviewed the current threshold for SI investigation and the allocation of investigators to help to improve the efficiency of the process. An options paper is to be drafted to explore the options of how the current group of lead

investigators could be expanded and the time required to complete the investigations may be supported by the trust.

**5.0 Never Events (NEs)**

The last Never Event reported by the Trust was in December 2017; this was a wrong route administration of medication. There have been no NEs reported by UHCW in either 2018/19 or in the year to date.

There are no outstanding open actions from NEs reported by UHCW.

**6.0 SI Action Plans**

All SI investigation report generate actions for implementation to improve the service and reduce the likelihood of reoccurrence of any incident. All actions arising from SI Investigations are monitored by the Patient Safety Team. There are currently 31 individual SIG actions overdue the date for completion, originally set by the SI investigation.

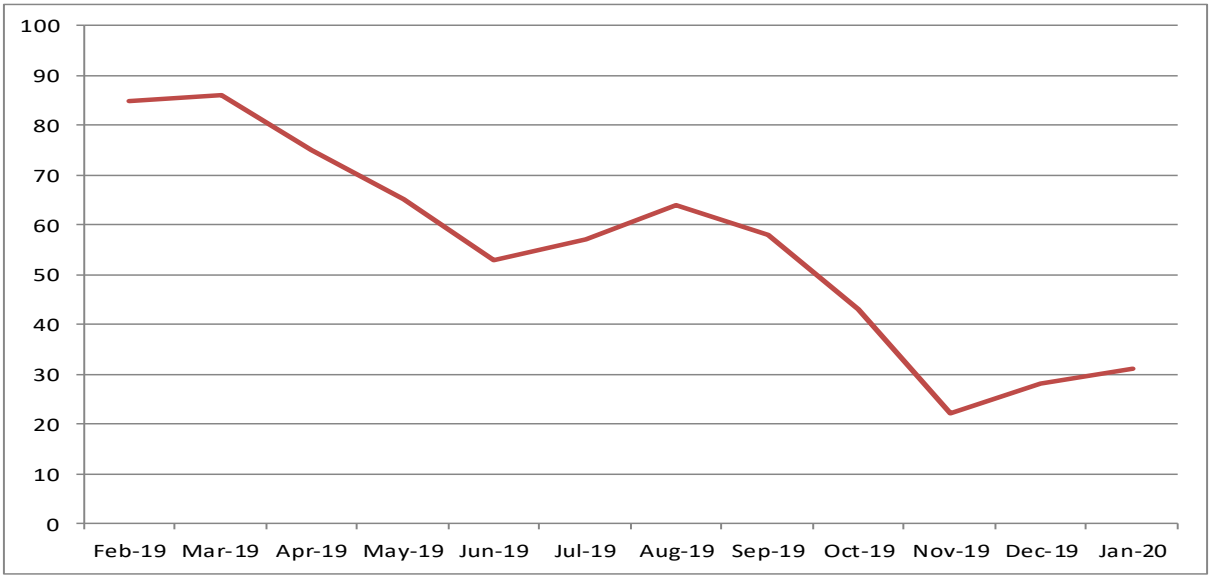
There has been an improvement on past performance and this reflects the additional steps that have been introduced but the patient safety team have introduced additional measures to further reduce the number of actions not completed within the allocated timeframe.

The progress on each overdue action is reported bi-monthly to Patient Safety and Clinical Effectiveness Committee chaired by the Chief Medical Officer. In addition, further assurance on the Trusts progress with overdue actions was sought by the Quality Governance Committee and a confident level of assurance of the Trusts processes was obtained.

Furthermore, the Quality Department have introduced the role of a Quality Partner into every Clinical Group in 2019 to support the governance agenda and promote performance on quality metrics. Any overdue SI actions are monitored by the Quality Partner, in addition to the performance and accountability meetings oversight each quarter.

The following chart demonstrates performance over the last twelve months.

**Figure 5. Number of overdue SI actions and number of month's oldest action is overdue**




## 7.0 Other updates

## The Healthcare Safety Investigation Branch (HSIB)

The National HSIB provides expert and impartial insight into systematic safety risks, through professional safety investigations they aim to make evidence based recommendations to enable change for safety improvement and learning.

To date the Trust has not had any cases referred to National HSIB for inclusion in national investigations.

In February 2019 the Trust went live with the National HSIB programme for reviewing Maternity Serious Incidents. To date the Trust has referred four maternity cases to HSIB for review and of those, three have been accepted as meeting the full criteria and therefore they have commenced an investigation. All National HSIB updates and reports will be subject to the Trust's usual governance process and managed via SIG. There has been one final report submitted by National HSIB, this has been reviewed by SIG and the report was accepted with no suggested amendments. The maternity team have raised concerns regarding the extended length of time taken for National HSIB to complete the investigation has been escalated to the CCG for escalation in the regional and national arena. This is captured on the Trusts risk register.

## 8.0 Conclusion

The SI process continues to perform well under the current guidance to ensure learning is identified from any SI's as demonstrated by:

- SI Governance review of current investigation process for continues improvement
- The senior level attendance at SIG with scrutiny and oversight of all SIs
- The nationally recognised Patient Safety Response team review and identification of immediate learning for all serious incidents.
- Sharing of safety lessons via Grand Round and Trust Wide Safety Messages.

## Appendix 1.0

## Serious Incident Framework (2015) Extract of Definition of a Serious Incident

Serious Incidents in the NHS include:

**Acts and/or omissions** occurring as part of NHS-funded healthcare (including in the community) that result in:

- Unexpected or avoidable death of one or more people. This includes
  - suicide/self-inflicted death; and homicide by a person in receipt of mental health care within the recent past
- Unexpected or avoidable injury to one or more people that has resulted in serious harm
- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:—
  - the death of the service user; or serious harm;
- Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:
  - healthcare did not take appropriate action/intervention to safeguard against such abuse occurring
  - where abuse occurred during the provision of NHS-funded care.

- A Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death. See Never Events Policy and Framework for the national definition and further information;

An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:

- Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues
- Property damage;
- Security breach/concern;
- Incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population;
- Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS);
- Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services[14]);
- Activation of Major Incident Plan (by provider, commissioner or relevant agency)
- Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation.

University Hospitals Coventry and Warwickshire NHS Trust

# REPORT TO PUBLIC TRUST BOARD
# HELD ON 26 MARCH 2020

| | |
|---|---|
| **Subject Title** | Gender Pay Gap Report |
| **Executive Sponsor** | Karen Martin, Chief Workforce & Information Officer |
| **Author** | Satpal Gill, Head of Employment Services |
| **Attachments** | - |
| **Recommendation(s)** | Trust Board is asked to **NOTE** the report |

## EXECUTIVE SUMMARY

**1. Purpose**

This report details the results from the gender pay review analysis (31st March 2019) for University Hospitals Coventry and Warwickshire NHS Trust undertaken as part of the Equality Act 2010 specific duties.

**2. Background and Context**

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 requires employers to report their gender pay gaps for any year where they have a headcount of 250 or more employees with effect from 31 March 2017.

Employers must publish the results on their Trust website and the government website within 12 months. On that basis, results from 31st March 2019 must be published by 30th March 2020.

**3. Findings**

The analysis of data shows that there has an slight improvement in the gender pay gap year on year.

- Medium Average Pay Gap – women's pay is 24.15% lower than men (compared to 25.90% in 2018)
- Median Bonus Pay – women's bonus pay is 54.92% lower than men (compared to 55.75% in 2018)

An action plan has been developed to further support the reduction in the gender pay gap.

## KEY IMPLICATIONS

| | |
|---|---|
| **Financial** | N/A |
| **Patient Safety or Quality** | N/A |
| **Human Resources** | Potential reputational risk as an Equal Opportunity Employer. Action plan in place to mitigate risks |
| **Operational** | N/A |

# GENDER PAY GAP – 2019/20 REPORTING YEAR

## SUMMARY POSITION

This report details the results from the gender pay review analysis (31st March 2019) for University Hospitals Coventry and Warwickshire NHS Trust undertaken as part of the Equality Act 2010 specific duties.

## 1. Background and Context

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 requires employers to report their gender pay gaps for any year where they have a headcount of 250 or more employees with effect from 31 March 2017.

Employers must publish the results on their Trust website and the government website within 12 months. On that basis, results from 31st March 2019 must be published by 30th March 2020.

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

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

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

- A higher proportion of women choose occupations that offer less financial reward (e.g. administration). Many high paying sectors are disproportionately made up of male workers

  (e.g. information and communications technology).
- A much higher proportion of women work part-time and part-time workers earn less than their full-time counterparts on average.
- Women are still less likely to progress up the career ladder into high paying senior roles.

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

## 2. Results

All Trust staff are included in the gender pay analysis. ISS staff have not been included as nationally ISS will be completing their own analysis for submission.

The calculations are based on all staff and on their net pay. The bonus gender pay gap for UHCW NHS Trust is based on the Consultant Clinical Excellence Awards (CEAs). NHS Employers guidance details that it is appropriate to include CEAs in the bonus pay calculations.

Data for this report has been collated using the national ESR reporting module which has been developed in line with NHS requirements.

The report includes data for 2017, 2018 and 2019 to allow direct comparison between data year on year.

The ESR module has been used to produce the data for the six mandatory calculations for the Gender Pay Analysis for 31st March 2019, as detailed below:

**Calculation 1: Average gender pay gap as a mean average**

| Group | Average Mean Hourly Rate of Pay (31st March 2017) | Average Mean Hourly Rate of Pay (31st March 2018) | Average Mean Hourly Rate of Pay (31st March 2019) | Comparison |
|---|---|---|---|---|
| Male | £23.98 | £23.87 | £24.20 | Positive **decrease of 1.77%** variation between female and male hourly mean pay **between 2018 and 2019** |
| Female | £15.46 | £15.60 | £16.24 | |
| Difference | £8.52 | £8.27 | £7.96 | |
| **Percentage Variance** | **35.53%** | **34.65%** | **32.88%** | |

The mean hourly rate is calculated for each employee based on 'ordinary pay' which includes basic pay, allowances and shift premium pay.

The percentage variance for the average hourly rate of pay is 32.88% for 2019. This calculation is based on the average hourly rate of a total of 6,757 Female staff compared to 1,826 Male staff; because the average is calculated over different numbers of staff (there are approximately 3.7 times more female than male staff), some variance is to be expected.

When reviewing the Gender Pay analysis data it is important to note that the overall Trust gender split is 79% (Female) and 21% (Male). The largest number of female staff are employed in lowest quartile (lowest paid) compared to largest number of men being employed in the highest quartile (highest paid).

The 2019 data illustrates that there has been a slight increase in both male and female staff mean hourly rates of pay which was expected in line with the National NHS pay award made payable to staff in 2018/2019.

Overall, the mean pay gap between female and male staff has decreased from £8.52 (2017) to £7.96 (2019) which is a decrease of 2.65%.

**Calculation 2: Average gender pay gap as a median average**

| Group | Median Hourly Rate of Pay (31st March 2017) | Median Hourly Rate of Pay (31st March 2018) | Median Hourly Rate of Pay (31st March 2019) | Comparison |
|---|---|---|---|---|
| Male | £19.53 | £19.16 | £19.19 | Positive **decrease of 1.75%** variation between female and male hourly median pay **between 2018 and 2019** |
| Female | £14.15 | £14.20 | £14.55 | |
| Difference | £5.38 | £4.96 | £4.63 | |
| **Percentage Variance** | **27.53%** | **25.90%** | **24.15%** | |

The median rate is calculated by selecting the average hourly rate at the mid-point for each gender group. The percentage variance between the female and male median hourly rate of pay is 24.15%.

As detailed within calculation table 6 (page 5) the largest proportion of male staff (40.21%) are employed within the upper pay quartile of posts and lowest proportion of male staff within the lower pay quartile (13.40%). This is the opposite for female staff with the highest proportion within the lowest pay quartile (86.60%) and lowest proportion of female staff within the highest pay quartile (59.79%).

**Calculation 3: Average bonus gender pay gap as a mean average**

| Group | Average Bonus Payments (31st March 2017) | Average Bonus Payments (31st March 2018) | Average Bonus Payments (31st March 2019) | Comparison |
|---|---|---|---|---|
| Male | £15,876.27 | £15,653.58 | £15,756.79 | **Increase of 4.82%** variation between female and male average mean bonus payments between **2018 and 2019** |
| Female | £7,990.79 | £8,425.10 | £7,720.30 | |
| Difference | £7,885.48 | £7,228.47 | £8,036.48 | |
| Pay Gap % | 49.67% | 46.18% | 51.00% | |

**Calculation 4: Average bonus gender pay gap as a median average**

| Group | Median Bonus Payments (31st March 2017) | Median Bonus Payments (31st March 2018) | Median Bonus Payments (31st March 2019) | Comparison |
|---|---|---|---|---|
| Male | £11,934.30 | £12,053.96 | £12,063.96 | Positive **decrease of 0.83%** variation between female and male average median bonus payments between **2018 and 2019** |
| Female | £4,952.95 | £5,333.90 | £5,438.88 | |
| Difference | £6,981.35 | £6,720.07 | £6,625.08 | |
| Pay Gap % | 58.50% | 55.75% | 54.92% | |

**Calculation 5: Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment**

| Group | Female | | | Male | | | |
|---|---|---|---|---|---|---|---|
| **Reporting Year** | **2017** | **2018** | **2019** | **2017** | **2018** | **2019** | Decrease in total number of bonus payments made. Positive increase (0.03%) in females receiving bonus payments |
| **Number of Staff Receiving Bonus Pay** | 44 | 44 | 47 | 119 | 115 | 109 | |
| **Total Employees** | 7,425 | 8,170 | 8,190 | 1,971 | 2,201 | 2,195 | |
| **% Variation** | 0.59% | 0.54% | 0.57% | 6.04% | 5.22% | 4.96% | |

In relation to the three tables above, it is important to note that the only bonus we apply is the Clinical Excellence Awards scheme, which is the same scheme that all other NHS Trusts apply. A Clinical Excellence Award is available to consultants who have at least one years' service with the opportunity to apply annually for the awards scheme. Consultants can apply every year until they reach the maximum CEA threshold. To gain the award consultants need to be able to demonstrate that they have made a difference above and beyond their role to research, innovative ways of working or developing the service.

In 2018/19 reporting year there has been a slight increase in the proportion of females receiving payment despite the proportion of female staff within the Medical & Dental staff group decreasing slightly by 1.35%. Therefore, this is a small but, positive shift for female staff receiving bonus payments

**Calculation 6: Proportion of Males and Females when divided into four groups ordered from lowest to highest pay.**

| Quartile | Female | | | | | | Male | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2017 | | 2018 | | 2019 | | 2017 | | 2018 | | 2019 | |
| Reporting Year | Total | % | Total | % | Total | % | Total | % | Total | % | Total | % |
| 1 – Lower (lowest paid) | 1702 | 86.88 | 1758 | 86.35 | 1855 | 86.60 | 257 | 13.12 | 278 | 13.65 | 287 | 13.40 |
| 2 - Lower Middle | 1682 | 84.95 | 1747 | 85.76 | 1808 | 84.17 | 298 | 15.05 | 290 | 14.24 | 340 | 15.83 |
| 3 - Upper Middle | 1704 | 86.28 | 1715 | 84.23 | 1811 | 84.35 | 271 | 13.72 | 321 | 15.77 | 336 | 15.65 |
| 4 - Upper (highest pay) | 1193 | 60.47 | 1225 | 60.14 | 1283 | 59.79 | 780 | 39.53 | 812 | 39.86 | 863 | 40.21 |

- In order to create the quartile information all staff are sorted by their hourly rate of pay, this list is then split into 4 equal parts (where possible).
- When reviewing the quartile information it is important to take into account the types of roles available within the organisation and the different gender splits that occur within specific roles.
- The highest variances for the quartiles when compared to the overall Trust value are in the lower and upper quartiles.
- There is a higher proportion of female staff in the lower quartile; included in this quartile are Administrative and Clerical

  & Additional Clinical (HCA's) staff groups that have a higher proportion of female staff which is reflected in the calculation.
- The upper quartile has the highest proportion of Male staff.

Overall, in each quartile there are a significantly higher proportion of female staff employed compared to male staff which brings down the average rate of pay for female staff. The higher concentration of female staff in the lowest quartiles particularly brings down the average rate of pay.

The largest proportion of staff appointed in 2018/19 were female with the largest proportion of these staff (158wte) appointed within the two lower pay quartiles which will have an impact on the average rate of pay.

There continues to be a positive increase in the number of female staff employed in the upper quartile with this increasing by 58 staff compared with 51 male staff.

## 3. Results & Context

There have been positive decreases in the difference in average rates of pay between females and males year on year and it is expected that this decrease will continue.

It is recognised that traditionally there has been a higher proportion of males within Medical and Dental and managerial roles. Whilst there have not been significant increases across all these groups there has been some positive increase in Executive roles and a slight decrease in M&D roles as detailed below:

- Executive Team – 71% female staff in 2019 (increase from 60% in 2018)
- Agenda for Change (Band 8 above) – 65% female staff in 2019 (remained the same as 2018)
- Medical & Dental - 39.65% female staff in 2019 (slight decrease from 41% in 2018)

It is expected as females within these staff groups progress and given the rise in the number of females being appointed in the upper pay quartile this will have a positive impact on the gender pay gap over the coming years.

Whilst, the above appointments will have had a positive impact it is important to note the following:

- Additional 158 females were employed within the 2 lower pay quartiles within 2019 compared to 59 males based on vacancies. These roles will include Nursing and Healthcare Assistant roles which have traditionally been undertaken by women, with many newly qualified staff commencing at the bottom of the band.
- Overall, 126 females have retired in 2018/2019 compared with 17 males. These staff are most likely to have been at the top of their pay band.

The impact of a high proportion of female staff commencing in post at the bottom of pay band and female staff retiring at the top of the pay band will have an impact on the difference between average pay for female and male staff. However, this cannot been viewed in isolation as it is recognised that there are other contributing factors which impact females in attracting higher levels of pay as previously outlined.

## 4. Next Steps

In line with NHS employer's guidance, a review of the gender pay data and existing activity has been undertaken against the self-assessment checklist to identify actions.

On this basis, an action plan has been developed to focus efforts to support work to reduce the gender pay gap as outlined on page 7.

## Action Plan – 2020/21

| | Actions | Leads | Timescales | Outcome/Impact |
|---|---|---|---|---|
| **Communication & Marketing** | Promote staff stories from women in and developing into senior roles.<br><br>Positive statement regarding commitment to reducing gender pay gap | Communication & Marketing Group<br><br>Communication & Marketing Group | June 2020<br><br>April 2020 | Provide transparency regarding UHCW positive approach to development of women in the workplace. |
| **Recruitment Practices** | Annual review of proportion of women who are successful at different points within the recruitment process e.g. shortlisting, interview for senior posts.<br><br>Review existing training to ensure continued focus on unconscious bias. | Head of Employment Services<br><br>Head of Employment Services &<br>Head of Equality and Diversity | June 2020<br><br>June 2020 | Allow understanding of where women are disproportionally represented within the different recruitment stages and allow actions to be developed to improve position.<br><br>Increase manager's awareness and understanding of bias to support fair and transparent recruitment processes. |
| **Wellbeing & Retention** | Build on existing staff roadshows to promote<br>- Flexible working<br>- Retire & Return<br>- Parental leave<br>- Wellbeing support and interventions<br><br>Expand NHSI retention plans across Trust<br><br>National NHS Staff Survey – deep dive into staff experience based on gender | Retention Group<br><br>Health & Wellbeing Group<br><br>Retention Group<br><br>OD Committee | Ongoing<br><br>Ongoing<br><br>April 2020 | Increase awareness to all staff and particularly men regarding how they can access work life balance and share parental/ carer responsibilities.<br><br>Increase in flexible working<br><br>Measure staff satisfaction based on gender and ensure appropriate actions |
| **Supporting Women in the Workplace** | Targeted promotion/analysis for women on the following<br><br>- Clinical Excellence Awards (CEAs)<br><br>- Coaching & Mentoring<br>1.1<br><br>- Talent Management Mapping<br><br>Build on events/activities targeted at women e.g. International Women's Day | Director of Workforce and Deputy Chief Medical Officer<br><br>OD Committee<br><br>OD Committee<br><br>Head of Equality and Diversity | March 2021<br><br>March 2021<br><br>October 2020<br><br>March 2021 | Increase in women CEA applications/awards<br><br>Identified coaches focusing on women's development in and into senior roles<br><br>Understanding the ratio of women who are rated in the top talent category & develop actions to address any underrepresentation.<br><br>Increased opportunities for women to share their views and contribute to any actions/learning. |
| **Data** | Review how data can be broken down further to support above actions | Head of Employment Services | June 2020 | Allow greater understanding regarding hotspot areas where women underrepresented in leadership roles |

University Hospitals Coventry and Warwickshire NHS Trust

**REPORT TO PUBLIC TRUST BOARD**
**HELD ON 26 MARCH 2020**

| | |
|---|---|
| **Subject Title** | Medicines Optimisation Strategy Report |
| **Executive Sponsor** | Kiran Patel, Chief Medical Officer |
| **Author** | Mark Easter, Group Clinical Director of Clinical Support Services, Chief Pharmacist and Controlled Drugs Accountable Officer<br><br>Janette Knight, Trust Medicines Assurance Lead and Pharmacy Governance Manager |
| **Attachments:** | None |
| **Recommendations:** | The Trust Board is invited to **NOTE** the Trust's Medicines Optimisation Strategy report |

## EXECUTIVE SUMMARY


This paper is complimentary to the annual Controlled Drugs Board Report and provides the Board with information of the medicines management activities over the last financial year to support the Trust's medicines optimisation strategy.

The objectives of this report are to assure the Board that delivery of Trust's medicines optimisation strategy is undertaken and managed effectively, outlines the risks and mitigation associated with the delivery of the medicines optimisation strategy whilst continuing to improve the safe use of medicines within the organisation to deliver patient care.

This second medicines optimisation strategy report builds on the first report that was submitted to the Board in January 2019 to provide details of the Trust's medicines budgets and productivity metric's benchmarked against our peers and national NHS Trusts that are monitored by NHS Improvement.

- The 2019 Use of resources inspection highlighted pharmacy as an area of high performance within the high performing CSS group, and recognised the use of embedded NHSe pharmacists to manage high cost medicines as outstanding practice.
- The 2019 QCQ inspection highlighted the Trustwide Omnicell medicines cabinets as an area of outstanding practice
- Four core services, and 6 services overall, were inspected as part of the 2019 CQC inspection. In each of these areas the CQC found that "they managed medicines well" and "the services used systems and processes to safely prescribe, administer, record and store medicines."


## PREVIOUS DISCUSSIONS HELD

January 2019 – The first Medicines Optimisation Strategy Board Report was presented to the Board to provide a background and information on the key priorities and risks associated with the delivery of the Trust's medicines optimisation strategy.

## KEY IMPLICATIONS:

| | |
|---|---|
| **Financial** | NHSI Carter Productivity Metrics – Trust's Pharmacy staff costs are considerably lower than peer medians. |
| **Patients Safety or Quality** | Medicines Reconciliation – Risk identified associated with resource to meet the national standards for completing medicines reconciliation for all adult patients within 24 hours of admission. |
| **Human Resources** | Workforce recruitment and retention – National workforce shortage of qualified pharmacy technicians continue to impact on the recruitment to vacant pharmacy staff positions. |
| **Operational** | EU exit – maintaining supplies of medicines and vaccines |

# UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST
# REPORT TO TRUST BOARD

## Medicines Optimisation Strategy Report

## 1. INTRODUCTION

1.1 The purpose of the Medicines Optimisation report is to provide an account of medicines management and optimisation activities undertaken during the 12 months for 2019/20. This medicines optimisation report is intended to update to the Board on the Trusts medicines optimisation arrangements, outlining progress with the objectives in the Medicines Optimisation Strategy that underpins the Trust's Quality strategies made in the year, the key areas of concern, plans for the next 12 months and provide assurance to the Board that medicines are appropriately and effectively used throughout the Trust. Medicines optimisation is a patient centred approach to delivering safe and effective medicines use.

## 2. CONTENT

2.1 Background

.Medicines optimisation is a patient focused approach that seeks to maximise the beneficial outcomes for patients from their medicines with an emphasis on four overriding principles that support national guidance and good practice guidance:

- Understanding the patient experience
- Evidence based choice of medicines
- Ensuring medicines use is as safe as possible
- Making sure medicines optimisation is a part of routine practice

To support focus on these objective the UHCW NHS pharmacy department recently reviewed its vision through discussion with the team to "delivering patient focused excellence in medicines use."

2.2 The Trust medicines spend per annum is £55m of which £15m is on internal (tariff) spend and £40m (73%) is pass through (the cost is claimed back from the commissioners) on high cost medicines.

2.3 The Carter report published in February 2016 set out the unwarranted variations in the operational productivity and performance in NHS Acute Hospitals in England. The report highlights that the NHS spends £6.7bn on medicines in hospitals, managed by just 7000 pharmacists, supported by pharmacy technicians and other staff. The principles of the report are that these limited pharmacy resources should work collaboratively with all healthcare professionals to ensure the Trust delivers a safe and effective medicines optimisation strategy.

2.4 In response to The Carter report, NHS Improvement developed a digital information service known as the 'Model Hospital' that supports NHS Trust providers to explore their comparative productivity, quality and responsiveness against self-selected peers to provide a

clearer view for improvement opportunities. Key performance metrics are categorised into themed compartments that include an area for pharmacy and medicines.

2.5 The NHSI Carter Productivity Metrics, Model Hospital data to October 2019 reported that:

- UHCW's medicines cost per Weighted Activity Unit (WAU) of £336 for 2019/20 compares favourably with the national median of £369 and peer median £548
- Pharmacy Staff and Medicines Weighted Activity Unit (WAU) of £367 compares favourably with the national median £409 and peer median £716.
- The Trust's Weighted Activity Unit (WAU) for high cost medicines of £252 compares favourably with the national median of £267 and peer median of £442.
- The Trust's Weighted Activity Unit (WAU) for non-high cost drugs of £85 compares favourably with the national median £92 and peer median of £135.

The Trust's Pharmacy staff costs of £5.11 million are significantly lower than the peer median of £7.82 million. Indeed, the spend on pharmacy staffing is £3.5m lower than the next peer pharmacy department.

The Carter Productivity Metrics demonstrate that UHCW NHS Trust has effective governance systems to support delivery of the medicines optimisation strategy and deliver value for money through cost effective management. This was reinforced in the 2019 CQC Use of Resources review that considered Pharmacy to be "an area of high performance." This inspection also highlighted the embedded NHSe pharmacists as outstanding practice

These metrics confirm that the Trust has significant lower pharmacy staff than our peers which impacts on:

- Staff turnover, morale and wellbeing
- Medicines reconciliation and a timely review of sick patients
- Counselling and discharge of patients to support patient flow

Mitigation to reduce the impact of significantly lower pharmacy staffing levels compared to our peers includes:

- Medicines reconciliation priority tools used to identify high risk patients
- Ward based service tool that provides an oversight view of pharmacy staffing levels each day by monitoring annual leave and sickness.
- When the ward based service staffing levels are identified as 'red' patients reviews and medicines reconciliation are aimed to be completed within 72 hours.

2.6 Medicines Governance - Overarching Governance

An overarching Medicines Optimisation Committee (MOC) to which the Drug & Therapeutics Committee, Medicines Safety Committee and Medicines Management Committee report. This structure assures that all healthcare professionals work collaboratively to ensure that the right patient receives the right medicine at the right time. This governance structure delivers:

- a single, unified Medicines Optimisation report to Patient Safety and Clinical Effectiveness Committee

- clear sign off of medicines related policies by senior pharmacy, nursing, medical and quality representatives
- that appropriate assurances regarding medicines practice, policies, action plans and risks are monitored.

2.7 Drug &Therapeutics Committee (D&T)

Ensures the Trust's focus is on the:

- evidence based choice of medicines in its decisions when reviewing new medicinal products for the inclusion in the Trusts Drug Formulary
- review prescribing compliance with the Formulary
- approve NICE Technology Approvals
- monitor the use of unlicensed products and their risks

2.8 Medicines Management Committee (MMC)
Its purpose is to ensure all Trust medicines management practice, policies, clinical guidelines and clinical operating procedures relating to medicines practice comply with legislative and regulatory requirement, NICE guidelines and professional standards best practice recommendations where applicable.

2.9 Medicines Safety Committee (MSC)
Ensures medicines use is:

- safe by analysing and reviewing trends in Datix reports of incidents involving medicines
- To consider actions and learning points from incidents.

The MSC facilitates:

- the implementation of changes in working practices from the shared learning
- reviews medicines' related patient safety alerts
- ensure appropriate actions are taken
- and maintains the risk register associated with high risk medicines.

2.10 Key Achievements - Medicines Optimisation Strategy
The Medicines Optimisation Strategy was developed as part of the Trust's response to the Carter Report and continues to drive the Trust's approach to Medicines Optimisation. The action plan is monitored by the Medicines Optimisation Committee.

Approval of new and reviewed Trust Corporate Business Records for:

- Self-Administration of Medicines by Inpatients Policy
- Policy for Managing Medication Errors

Corporate Business Records currently under development and anticipated to be approved this year:

- Midwives Exemption Policy

Significant risk assessments approved for:

- Sepsis Trolleys in the Emergency Department and Paediatric Emergency Department
- Epidural Trolley in Labour Ward

2.11 Audit

The Medicines Optimisation Committee approved the MMC & MSC audit plan in April 2019. The programme includes 24 local audits with 54% of these audits completed at month 6 (October) for 2019/20. The results of these audits are discussed at the relevant committee and presented to MOC. Overall there is evidence of improvement in areas of clinical practice against the standards.

2.12 Safe and Secure Handling of Medicines

The Trust has successfully completed the installation of 56 automated medicines cabinets' (the largest installation programme within the UK). The instalment of these automated medicines cabinets has enabled the Trust to increase capacity for the secure storage of medicines, provide efficiencies and cost savings in: stocks, nursing and pharmacy staff time, provide audit data, and support the patient safety strategy in reducing the number of omitted doses.

In October 2019 the Trust was inspected by the CQC and the use of these cabinets was highlighted as outstanding practice. The CQC described the system as a "highly accurate, novel and innovative system for managing medicines across the organisation with many benefits including reducing medicines waste."

The annual medicines management audit that was scheduled to take place in the last quarter of 2018/19 following the installation of the automated medicines cabinets was postponed to enable practice to embed and consider how these new automated medicines cabinets can support monitoring standards for auditing purposes. This is still under development and is one of the audit priorities for the Medicines Optimisation Committee in 2020/21.

A deep dive medicines management walk-round assessment by a multi-professional team, that includes a patient representative, is undertaken in a clinical area each quarter. The findings are reported to the Medicines Management Committee and shared with the clinical specialty medical, nursing and pharmacy leads. These assessments provide opportunities to share common themes and improve practice. Common themes identified for improvements include:

- Controlled Drug Register amendments
- Storage - medicines retained in original packaging
- Storage of cold chain medicines (medicines that are required to be stored within a fridge)
- Labelling of insulin pens

On-going work to drive improvements in this area of practice includes the development of a clinical guideline for completing Controlled Drug Registers and plans for the utilisation of the automated medicines cabinets to support cold chain medicines storage and temperature monitoring.

2.13 Self-Administration of Medicines by Inpatients

The Trust's original self-administration policy was designed to support rehabilitation patients and was never intended for other in-patient use. The policy was completely re-written to enable the roll out across all adult in-patient areas in response to patient survey results.

A task and finish group has been set up to pilot the implementation of this new practice, develop the clinical operating procedures to support the training of staff in these new procedures to ensure that regulatory standards for medicines safety is not compromised and that self-administration of medicines is practised safely within the Trust. It is expected to be rolled out by the end of 2020/21.

2.14 Antimicrobial Stewardship

The term 'antimicrobial stewardship' is defined as 'an organisational or healthcare system wide' approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness'. The Trust's Antibiotic policy is reviewed and updated in accordance with Public Health England guidance and is consistent with local CCG (or regional) guidance. Antimicrobial prescribing and pharmacy interventions are monitored on an on-going basis by ward pharmacists and reported as a standing agenda item at the Infection Control Group by the Antibiotic Pharmacist and any deviations from the Trust's prescribing guidance are reported back to relevant consultants.

The quarterly antibiotic point prevalence audit is undertaken to monitor that prescribing standards are in line with the Trust's antibiotic policy. Results are shared through Specialty Quality Improvement and Patient Safety meetings and the Medicines Safety Committee. Table 1 below provides the 2019/20 results.

Table 1: Antibiotic Point Prevalence Audit Results

| Standard | Results | |
|---|---|---|
| | April 2019 | July 2019 |
| Patients with allergy status documented | 95% | 89% |
| Patients with an allergy type of reaction documented | 54% | 42% |
| Indication stated | 83% | 82% |
| Antibiotics prescribed appropriately when indication stated on medicines chart | 91% | 93% |
| Course length or review stated | 78% | 67% |

The Trust Medicines Policy has been updated to provide clear guidance for all registered healthcare professionals to ensure who can record and what information is required to document the allergy status on medicines charts.

In 2019 Antimicrobial Stewardship committee Terms of reference and reporting arrangements were reviewed. It is chaired by the Consultant Microbiologist and Antimicrobial Steward, with members including infectious disease specialists, senior nurses, and the antimicrobial pharmacist.

2.15 Medicines Safety

The Trust's Medicines Safety Officer (MSO) supports the Trusts Quality strategy around medication safety through clinical leadership.

The Trust is committed to the safe use of medicines and actively encourages the reporting of medicine incidents to enable learning and prevent patient harm. The Trust's Quality Strategy (2016-21) clearly defines the Trust's commitment to improve the management of medicines by:

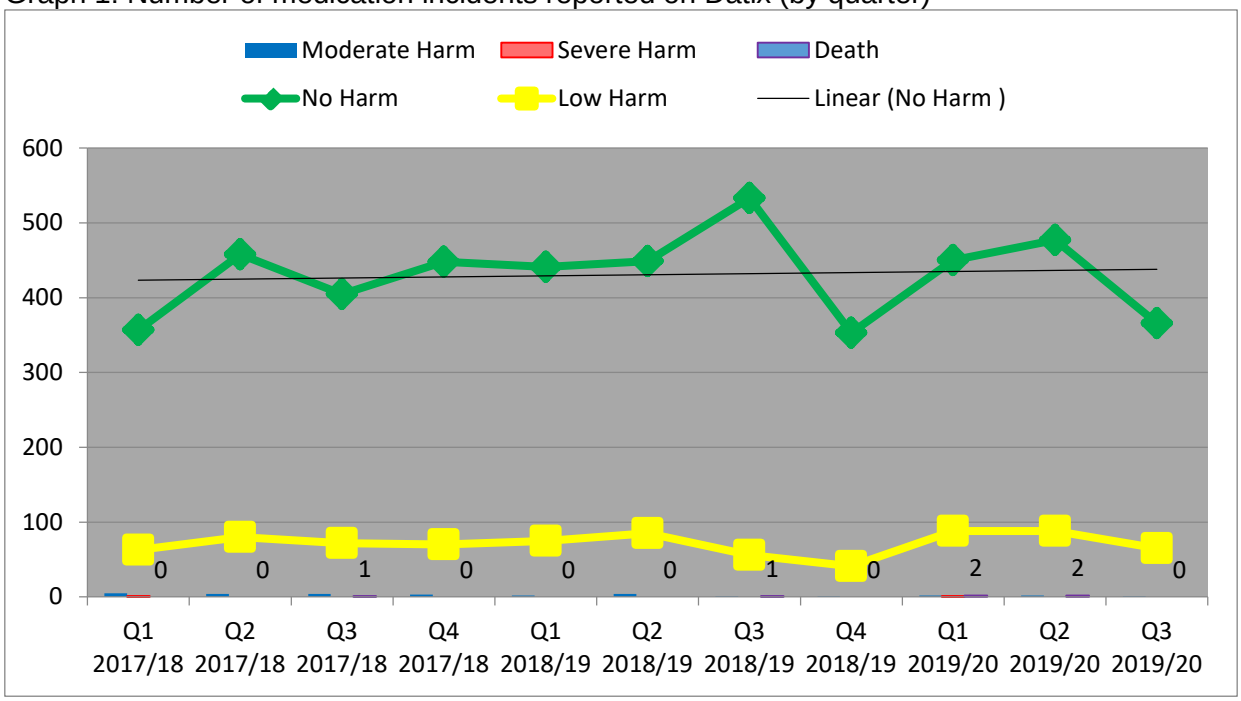
- Increasing medication incident reporting by 20% increase (using incident data) by 2021 (baseline 1626 (2015/16))

The NHS Improvement state in its National Reporting and Learning System (NRLS) National Patient Safety Incident Reports: commentary, March 2019, 'that increases in the number of incidents reported reflects improved reporting culture, and should not be interpreted as a decrease in the safety of the NHS. Equally, a decrease cannot be interpreted as an increase in the safety of the NHS.'

The medication incident data taken from the Trust's Datix system shows the trend in graph 1 where there has been an increase in the number of medication 'no and low harm' incidents reported since April 2019.

Graph 1 below demonstrates the number of medication incidents reported for each quarter by harm with linear line for 'no harm' incidents. The Trust's award winning Patient Safety Response Team attends all serious harm incidents which are investigated and managed through the Trust Serious Incident Group (SIG) process.

Graph 1: Number of medication incidents reported on Datix (by quarter)




Medicines use is inspected under the "Safe" domain during CQC inspections. In 2019 the CQC inspected Critical Care, Medical Care, Urgent and Emergency Services, Outpatients at St Cross, Maternity, and Neurosurgery.

In all of these areas the CQC found:

- They managed medicines well

- The service used systems and processes to safely prescribe, administer, record and store medicines.

There were no “must do” actions relating to medicines, and a single should do action. This was related to the Critical care inspection and states that the trust should “review the trust policy for writing separate prescriptions that can be given by different routes.”

An action plan is being developed by pharmacy, Critical care and the Quality team that will be approved via the medicines governance structures.

2.16 Moderate or Severe harm or Death Medication Incidents

There were a total of 4 Deaths and 5 Moderate harm incidents reported in the Q1 and Q2 periods.

All serious incidents (moderate harm and above) are considered on a case by case basis, and subject to an immediate incident review (IRR) and assessment by the Patient Safety Response (PSR) team

Serious incidents are defined as events where the potential for learning is so great, or the consequences to patients, families and carers, staff and organisations is so significant to warrant a comprehensive response. Serious incidents can extend beyond serious incidents which affect patients directly and include incidents which may indirectly impact on patient safety or an organisations ability to deliver ongoing care (NHSE SI Framework, 2015)

These incidents are referred to the Serious Incident Group (SIG) who are responsible for supporting the Trust Board in assuring that serious incidents (e.g. serious incidents, never events) are investigated, reviewed and acted upon appropriately and that lessons are learned, implemented and monitored.

The reported incidents are related to medication omissions, prescribing and administration errors and adverse drug reactions. All the above reported incidents underwent incident analysis and a robust investigation process and key recommendations were identified and an action plan was developed to reduce the risk of reoccurrence of the incident

2.17 Learning lessons and Action Plan themes

Insulins: Prescribing and administration omissions of insulins accounted for half of the reported moderate harm incidents. Gaps in insulin awareness amongst the medical and nursing workforce were noted in the investigation findings and educational and training sessions are being delivered to all health care professionals to raise awareness on safe use of insulin. Chief Medical Officer Safety messages were shared Trust wide to highlight key learning points from the incidents. The incident report, key recommendations and risk reduction action plans have also been shared and discussed at Specialty Quality Improvement & Patient Safety (QIPS) meetings.

A Trust wide Insulin Safety week campaign was run successfully in May 2019 and over 350 staff benefitted from educational visits to wards and 189 staff completed the e-learning training module on the safe use of insulin.

Prescribing and Administration errors resulting in adverse drug reactions: These have been noted to be errors of commission due to knowledge gaps and lack of adherence to Trust policies. Incidents reported have been thoroughly investigated and key learning points have

been discussed and reinforced at specialty QIPS and Trust wide via Chief Medical Officer Safety messages. Individuals involved in the error were appropriately supported with their learning and reflection by their clinical and educational supervisors.

2.18 Critical Medicines

Medicines identified as 'critical medicines' can cause harm when delayed or omitted. In 2010 the National Patient Safety Agency issued an alert 'Reducing harm from omitted and delayed medicines in hospital' following the number of medication incidents reported to National Reporting & Learning System (NRLS).

The Trust's most frequently reported medication incident is in line with the NRLS data that is omitted medicines. The Trust's commitment to improve medicines safety to reduce the number of omitted medicines is set out in the Quality Strategy (2016-21) to:

- Reduction to zero omissions of critical medicines (Anticoagulants, Opiates, Insulin, Anti-infective and Parkinson's treatments) by 2018 (baseline 11%). The Medicines Safety Committee and clinical teams are working hard to achieve this and early indications that the new automated medicines cabinets are supporting this work to achieve this target. The on-going work to support and deliver the Quality Strategy during 2019/20 includes:

Automated Medicines Cabinets – Following the completion of the installation of all 56 automated medicines cabinets in January 2019, work continues to embed this new practice and train new staff in the use to access critical medicines across both University Hospital and the Hospital of St. Cross. The automated medicines cabinets enable nursing staff to locate medicines anywhere within the Trust to support the efficient and timely access to critical medicines to prevent omissions.

The Trust continues to audit and monitor the number of omitted medicines and the results of the Q2 2019/20 No Omitted Dose audit confirmed that 16 wards achieved a 100% no omission rate for critical medicines.

The Medicines Safety Committee have conducted a deep dive audit working with nursing teams to enable an understanding of the root causes for critical medicines omissions. This project has provided valuable data that will support the development of a new action plan for the Trust to drive a reduction in critical medicines omissions in 2019/20.

Anticoagulants - The prioritisation for the safe use of these high risk medicines in 2019/20 includes:

- The anticoagulant pharmacist has completed their Non-Medical Prescriber training and practices in the thrombosis and multidisciplinary team clinics.
- The development of the new Cancer Associated Thrombosis Policy/Guideline
- Provide safety alert cards and books for all patients receiving anticoagulation medicines on discharge
- Anticoagulant medicines training for healthcare professionals

Opiates – Following the national supply shortages with diamorphine that are anticipated to continue throughout 2020 the pharmacy department are working closely with clinicians to maintain there are sufficient supplies available within the Trust. A project is currently being

undertaken by the Theatres Pharmacist to establish if the conservation of existing diamorphine stocks can be supported by the in house aseptic manufacture of pre-filled syringes for use in the Labour/Obstetric Theatres. The in-house manufactured products provided by the aseptic laboratory supports the best value procurement of medicines and to respond to national shortages of medicines.

Insulin - In May 2019 the Trust participated in National Insulin Safety Week, to raise the profile of insulin as a high risk medicine, to promote the 'Six Steps to Insulin Safety' and provide training & education to Trust staff on wards and departments using a roaming training board. The weeks leading up to and during the National Insulin Safety Week were shared and posted on the Pharmacy and Trust's Twitter feeds. The Trust was approached by the Quality in Care (QiC) Diabetes team and shortlisted for the 2019 Insulin Safety Week Excellence Award. The Trust received a commendation award that was presented to the Medicines Safety Technician at the Awards Ceremony in October.

Home Parental Nutrition – Long-term PN patients are supplied via homecare companies. The pharmacy approach has been to spread the risk and we used 2 companies for this work. In 2019 one of these companies had their license withdrawn by the MHRA. UHCW was able to manage this situation because of this managed risk approach and with in-house manufacturing supported by blood bikers supporting deliver of these medicines to patients homes.

2.19 Medicines Reconciliation

Medicines reconciliation is the process by which a patient's previous, and most current, medication history is corroborated using multiple sources including the Summary Care Record (SCR), contacting patient's GP The Patient's Own Drugs (PODs) are checked against the medicines prescribed upon admission which has been recorded and clearly documented in the patients records, to prevent patient harm.

The National Institute for Health & Clinical Excellence (NICE), Medicines Optimisation NICE guideline and the National Patient Safety Agency (NPSA) considers that medicines reconciliation is essential and should take place at the earliest opportunity following a patient's admission to hospital. This is to prevent medication errors on transfer between care settings.

Primarily medicines reconciliation is undertaken by Pharmacists but can be undertaken by the admitting doctor or nurse. It has been recognised there is a national shortage of qualified skilled pharmacy; nursing and medical staff. This national shortage of highly skilled staff has led UHCW NHS Trust to experience difficulty in recruiting staff to existing vacant positions and provide the resource to meet the national standards for completing medicines reconciliation for all adult patients within 24 hours of admission.

The risk of not meeting the national standards for medicines reconciliation has been added to the Medicines Optimisation Committee's risk register. Mitigation controls include the use of an electronic computer program known as Pharmacy On Wards (POW+) that was developed by pharmacy and ICT to interface with the Trust's CRRS system that identifies and enables the ward pharmacist to prioritise medicines reconciliation for 'high risk' patients.

This risk continues to be monitored by the Medicines Management Committee but it continues to remain a 'high risk' whilst there is difficulty in recruiting skilled staff to existing vacancies and without considerable investment in pharmacy staffing to match the establishment model of our peers (as identified in section 2.5 NHSI Carter Productivity Metrics, Model Hospital

data) and IT systems to support the resource needed to meet the national standards for medicines reconciliation.

2.20 Pharmacy Clinical Activity

Clinical pharmacy services are embedded across inpatient wards, outpatient clinics, clinical trials (research and development), Arden Cancer Centre and Quality & Patient Safety. New models of working are being tried and tested to optimize efficiency and focus on key outcomes aligned to the Trust priorities, including improving patient flow, patient safety and reduced wastage.

2.21 Discharge Planning – UHCW Improvement Programme (UHCWi)

Simple Discharge - There has been multi-disciplinary involvement in an on-going nurse-led project on Simple Discharge, focusing on key areas to improve patient flow through the Trust. Objectives of the project include improvement in early ward discharge before 12 midday as well as improving communication around discharges and discharge planning. The project is being run on specific wards both at the UCHW site and at Rugby St Cross.

Electronic Transfer of Discharge Prescriptions - Pharmacy are currently working with ICT to produce a process for electronic transfer of prescriptions between prescribers and pharmacy, using the hospitals existing Clinical Results Reporting System (CRRS). The electronic transfer of prescriptions between prescriber and pharmacy will reduce waste identified in the currently process. Once a prescription is written by a prescriber, it will immediately become available for clinical screening by pharmacy and then electronically transferred to the inpatient pharmacy for dispensing. This should, in most cases, eliminate the need for printing the prescription at ward level; reduce waste associated with transportation and make for a leaner process. At present when a discharge prescription is completed, the paperwork is scanned into CRRS to be made available as part of the patient's medical record, so that the patient's GP can view the discharge prescription when the patient is discharged. The proposed new system will enable prescriptions to be electronically uploaded onto CRRS on completion, aiding clarity, reducing the risk of pages being scanned incorrectly and improve patient experience by reducing waste and improving flow.

2.22 Theatres

Theatres have an annual drug budget spend in excess of £2m. Following the successful recruitment of the Theatres Pharmacist and Pharmacy Technician in September 2018 the work to improve and support the theatres medicines optimisation delivery plan has continued in 2019/20 resulting in significant cost savings, delivery of the cost improvement target of £100k but also increasing quality and safety. The success of this work was showcased at national and local events, demonstrating the efficiencies and savings, training of theatre staff and developing close working relationships between multi-professionals teams. This work was shortlisted for the Association of Pharmacy Technicians UK (APTUK) award in September 2019.

2.23 Medicines Optimisation in Care Homes Project

NHS Coventry and Rugby and NHS Warwickshire North CCG choose to collaborate with UHCW NHS Trust on this joint project. Following the successful recruitment of a Care Homes Pharmacist in September 2019 the project will develop and improve:

- The interface between primary and secondary care
- Keep care home patients within the care home and prevent unnecessary admissions to hospital

- How we identify care home patients through CRRS
- Provide training for teams in both primary and secondary care
- Improve discharge counselling and follow-up for care home patients

2.24 Controlled Drugs Governance

The Trust's Controlled Drug Policy is linked to the Trust's Medicines Policy and supporting clinical operating procedures that provide in detail the requirements for the storage, prescribing, administration and management of controlled drugs across the Trust.

Following a review by the Medicines Optimisation Committee of the Gosport War Memorial Hospital, The Report of the Gosport Independent Panel, additional governance arrangements put in place during 2019/20 include:

- The Medicines Optimisation Committee has incorporated the reporting of 'fitness to practice' concerns to the Accountable Officer as a standing agenda item. This standing agenda items ensures that the Trust's Accountable Officer is notified of suspected medicines misuse or misappropriation. Working is in progress with the Trust Associate Director of AHPs, the Lead Clinical Scientist and the Chief pharmacists to ensure fitness to practice covers all professional groups involved in medicines use

- A multi-professional group (Controlled Drug Incident Review Group) attended by representatives from Palliative Care, Pain Management, Pharmacy, Practice Facilitators, Nursing Quality & Improvement and the Local Security Management Specialist has been set up to review all Accountable Officer Incidents for patterns, trends and learning opportunities. This group meets monthly and reports quarterly to the Medicines Management Committee.

2.25 Medicines Management Training

The medicines management training workshops are delivered by the Practice Facilitator and Pharmacy Governance Team and are included in the preceptorship nursing programme. The workshops include information on drug storage, drug security, time critical medicines and preventing omissions. The workshops continue to receive positive feedback, from nursing and operating department practitioners, who find the workshops both informative and fun.

| Number of Training Sessions provided at Q3 2019/20 | Number of attendees |
|---|---|
| Preceptorship x 2 | 235 |
| Medicines Management Training | 65 |

2.26 Nursing Associates

A new medicines management training workshop has been developed and delivered to the first cohort of the newly qualified Nursing Associates. These workshops provide information on the Trust's governance arrangements for the safe use and administration of medicines, the new automated medicines cabinets, time critical medicines and preventing omissions.

2.27 Medicines & Healthcare products Regulatory Authority (MHRA) Licenses

UHCW NHS Trust pharmacy department hold the following licenses to enable the sale and supply of medicines as part of the Trust's Service Level Agreements

- Wholesalers Dealers License
- Home Office Controlled Drugs License
- MHRA Pharmacy Aseptic Laboratory License

Inspections are undertaken by the MHRA and Home Office every 3 years to ensure that the Pharmacy Department are operating under the conditions of legislation and the license.

## 3. IMPLICATIONS

3.1 Medicines Procurement, National Supplies Problems

The Trust continues to experience difficulty in maintaining supplies of medicines where there are national supply chain problems. The pharmacy department works closely with national and regional procurement teams to maintain sufficient stocks are available for patient use, by following national guidance to conserve stocks or source alternative licensed/unlicensed supplies where appropriate.

NHS England, the Department of Health & Social Care and the Medicines Healthcare and products Regulatory Agency (MHRA) anticipate that there will be an increase in medicines supply problems following the United Kingdom's exit from the European Union in 2020 and are currently developing a business continuity plan to ensure availability of medicines within the national supply chain remains stable. Chief Pharmacists have been advised by the Department of Health & Social Care that they are responsible for ensuring their organisation does not stockpile medicines unnecessarily.

3.2 Falsified Medicines Directorate

The EU Falsified Medicines Directive (2011/62/EU) (FMD) was adopted in 2011 and introduced new harmonised measures to ensure that medicines in the European Union (EU) is safe and that trade in medicines is properly controlled. The purpose of the directive is to protect supply chains, falsified medicines are considered a major threat to public health with seizures by regulators increasing annually across the globe. The directive affects the whole medication supply chain. From 9th February 2019, the regulation obliges those supplying medicines to the public to verify authenticity of the product via:

- the placement of a unique identifier (UI) i.e. serial number on each pack, in the form of a 2D matrix barcode, to allow verification of medicines throughout the supply chain and
- the addition of an anti-tamper evidence device (ATD).

The directive will impact on 6,000 medication interactions, within the Trust on average each day. The Trust have identified and procured JAC which is already aligned to the pharmacy dispensing and procurement system and are awaiting installation.

3.3 G5 – Carter Report

A key recommendation from Lord Carter's report "Operational productivity and performance in English NHS acute hospitals: Unwarranted variations" 2016 is to shift the balance of activity in the pharmacy workforce from essential pharmacy infrastructure services to clinically facing roles. Each non-specialist acute trust in England then produced a Hospital Pharmacy Transformation Plan by April 2017. Many of these contained plans to consolidate services across a wider footprint

The five Chief Pharmacists of the five Acute Trusts in the West Midlands South Region form a group thereby referred to as the G5. This group consists of the Chief Pharmacists from the following Trusts:

- Wye Valley (WVT)
- George Eliot (GEH)
- South Warwickshire (SWFT)

- Worcestershire Acute (WHAT)
- University Hospital Coventry and Warwick (UHCW)

The G5 have been meeting for the last 24 months and have agreed a broad plan of areas to collaborate on to streamline pharmacy services and deliver the recommendations of Lord Carters report locally.

The six themed areas worth investment of collaborative time and effort to develop improvements in productivity and efficiency across the West Midlands South Area include:

- Aseptic Production
- Homecare
- Medicines Information - achieved
- Formulary
- IT
- Quality Assurance

The Medicines Information collaboration work has been achieved and the Trust's Medicines Information service is provided in partnership with South Warwickshire Foundation Trust. Further to the G5 there is a sub group of aseptic production lead pharmacists who have also been meeting regularly to review aseptic services with a report due at the Provider Alliance in the spring 2020.

3.4 Workforce Planning

The NHS continues to experience a national shortage of skilled healthcare professionals to deliver NHS services. In response to the recruitment difficulties in Medical, Nursing and Allied Healthcare Professionals the Trust workforce team continue to support the development of roles including Non-Medical Prescribers (NMPs), Nursing Associates, Physicians Associates and Allied Healthcare Professionals. Pharmacy is working closely with the Trust's Lead for NMPs and aims to provide a clear position regarding the Trust's non-medical prescribing workforce this year.

3.5 Nursing Associates

This is a new generic role in the nursing team which has been introduced to help build the capacity and capability of the nursing workforce. The aim is to supplement not replace the work of Registered Nurses. Nursing Associates will contribute towards the delivery of high quality care by supporting Registered Nurses and the wider multidisciplinary team, enabling them to focus on more complex clinical duties (NHS Employers 2019).

Whilst Nursing Associates will contribute to most aspects of care, including delivery and monitoring, Registered Nurses will take the lead on assessment, planning and evaluation. Registered Nurses will also continue to lead on managing and coordinating care with full contribution from the Nursing Associate within the integrated care team (NMC 2019).

The Trust's first cohort of six registered Nursing Associates commenced in post in July with the next cohort scheduled to qualify in April 2020.

3.6 Allied Healthcare Professionals (AHPs)

The Trust has successfully recruited an Associate Director of Allied Health Professionals to support trust wide leadership for this large group of staff. Many AHPs are now able to

prescribe medicines and how this role interfaces with the trust medicines Governance Structures is being explored.

The national shortage of qualified skilled pharmacy staff is particularly relevant where registered Pharmacy Technicians are concerned who support the delivery of the clinical pharmacy service. The pharmacy department has reviewed its workforce and remodeled the establishment to recruit dispensers and support workers to deliver the pharmacy clinical service. The implementation of the new Step 4 to 5 training program for pharmacy technicians is anticipated to provide an attractive career package and support the retention of staff.

## 4. OPTIONS - PARTNERSHIP WORKING

4.1 Outpatient, Shared Care and High Cost Medicines

Lloyds Pharmacy have been running the outpatient pharmacy contracted to deliver the outpatient service of the Trust since 2013, with most of the Trust outpatient prescriptions being handled by the sites at University Hospitals (UH) and Rugby St Cross (approx. 10, 000 items per month). Lloyds as a provider also offers the opportunity for partnership working on several innovative projects:

- Immunosuppressant dispensing pathways, bringing collection closer to the patient's home
- A bespoke arrangement for compliance aid (blister pack) dispensing and delivery
- Timely supply and counselling for pre procedure contrast media
- Supply of larvae therapy for wound healing
- Cancer 2 week wait in bowel screening

At UH the outpatient pharmacy is to being relocated to the main entrance. The opening of the new premises is scheduled for April 2020, offering our patients enhanced benefits; a 'better life' product selection, with an approved stock range of enablement product supported by our Trust Therapists, also a small selection of essential pharmacy stock items available for sale to the general public. In the new premises Lloyds will also look to take over the screening of outpatient oral chemotherapy, currently this is done by the Pharmacy Oncology Team in the Arden Cancer Centre. The Pharmacy Oncology Team is currently engaged with Lloyds to design a bespoke training package to support them to take over this service. The benefits for our patients will include shorter waiting times and an enhanced level of medication counselling at point of dispensing.

4.2 Shared Care Prescribing

It is long established practice that some conditions and associated medications when stable, care is then shared between the Specialist Consultant and General Practitioner (GP). This arrangement is known as shared care, normally instigated by the Consultant and the paperwork and governance is underpinned by agreement at the local Area Prescribing Committee (APC), which has multidisciplinary attendance across all local healthcare settings. There have been some issues with this approach recently with GPs withdrawing from the scheme.

A clinically lead task and finish group formed in 2018/19 to resolve two main issues:

- GPs having blood results visible which cause refusal
- Appropriate remuneration in records for extra work

The revised share process goes live in April 2020 and is expected to enable patients care to be managed at the most appropriate location by the most appropriate clinician.

4.3 High Cost Drugs

The Trust's High Cost Drugs Pharmacy Team ensures implementation of any Cost Improvement Projects (CIP) relating to high cost drug usage at UHCW; ensuring cost effective prescribing for local and national commissioners. The team ensure there is consistency across the healthcare economy, prescribing protocols are in place and monitoring of the high cost drug budgets. The team support the Trust in ensuring timely access to evidence based medicines for our patients; approval of NICE Technology Approvals (TA's) through the Drug & Therapeutics Committee, NHSE Medicines Optimisation CQUINs, Individual Funding Requests (IFR). The results of this work are demonstrated in the NHSI Carter Productivity Metrics, Model Hospital data provided in Section 2.5 of this report where the Trust compares favorably with the national and peer median metrics.

This approach was recognized as an outstanding practice in the 2019 CQC Use of Resources inspection.

4.4 Electronic Prescribing Records (EPR)

The Trust is committed to EPR solutions. Pharmacy and clinicians are fully engaged in the procurement process and the pharmacy team have a close involvement with the EPR team. It is envisaged that pharmacy input and resource will increase as the Trust prepares and then goes live with an EPR system that will fully incorporate the Trust's drug formulary, improve efficiencies and prescribing processes in 2022.

## 5. CONCLUSIONS

5.1 The medicines management governance structure provides assurance through the committees that the use of medicines within the Trust is safe, cost effective and meets regulatory requirements to support the delivery of the Trust's Medicines Optimisation and Quality Strategies. However the impact of having lower pharmacy staff costs compared against a peer medium has lead to significant risks in the delivery of the medicines optimisation strategy. The top 5 medicines risks that impact on the Trust Medicines Optimisation and Quality Strategies are:

- **Medicines Reconciliation** – Review of the pharmacy staffing establishment benchmark verses peers to determine resource required to meet national standards
- **Accurate and Timely Medicines Reconciliation** - EPR project – pharmacy staff are working with the EPR project team to consider programmes that can be built in to allow pharmacists to identify patients needing Medicines Reconciliation.
- **Omission of Time Critical Medicines** – There are early indications that the automated medicines cabinets are supporting the on-going work to reduce the number of time critical medicines omissions.
- **Pharmacy Staff Recruitment & Retention** – Career development step training programs have been developed for both Pharmacists and Pharmacy Technicians to attract and retain pharmacy staff.
- **Self-Administration Policy - Practice Implementation** – A pilot project has commenced to support the training and practice implementation of the new self-

administration policy. This project is essential to ensure that the new policy and practice of self-administration of medicines is carried out safely to protect patients and does not compromise safe custody requirements for medicines within the Trust.

## 6. RECOMMENDATIONS

6.1 The Trust Board is asked to accept this Annual Medicines Optimisation report as part of the regulatory and governance assurance for the delivery of the Trust Medicines Optimisation Strategy.

Author Name: Mark Easter
Author Role: Group Clinical Director of Clinical Support Services, Chief Pharmacist and Controlled Drugs Accountable Officer

Author Name: Janette Knight
Author Role: Trust Medicines Assurance Lead and Pharmacy Governance Manager

Date report written:

University Hospitals Coventry and Warwickshire NHS Trust

**REPORT TO PUBLIC TRUST BOARD**
**HELD ON 26 March 2020**

| | |
|---|---|
| **Subject Title** | Mortality (SHMI and HSMR) Performance Update (Q3 February 2020) |
| **Executive Sponsor** | Kiran Patel, Chief Medical Officer |
| **Author** | Mumtaz Goolam, Head of Clinical Effectiveness |
| **Attachment(s)** | Quarterly Mortality Performance Report Q3 – February 2020 |
| **Recommendation(s)** | The Board is invited to **NOTE** the Trust's mortality performance for the given time period. |

## EXECUTIVE SUMMARY

### 1. Purpose

The purpose of this report is to provide a quarterly overview of Trust-level mortality data for the time period Q3: October 2019- December 2019, and performance for the time period November 2018 to October 2019 (latest available Dr Foster Intelligence data), providing assurance that any highlighted concerns are investigated thoroughly and appropriate action is taken.

### 2. Background and Links to Previous Papers

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

### 3. Narrative

Mortality Review

- The completion rate for primary mortality reviews during Q3 October 2019- December 2019 is 64%.
- During Q3: October 2019- December 2019 there has been 5 NCEPOD E graded deaths.

89.81% of completed primary reviews between Q3 October 2019- December 2019 received an NCEPOD grade A highlighting good standards of patient care.

All primary reviews graded B-E have a further secondary mortality review; these are discussed at specialty mortality and patient safety meetings to share the learning and improve patient care. There have been 49 identified opportunities graded B-E for learning from deaths between October 2019- December 2019.

During Q3 October 2019- December 2019 there has been 1 death of a patient with Learning Disabilities and 3 deaths of patients with identified Mental Illness during the primary review process.

Mortality indicators: HSMR

- The Trust HSMR value for the latest available 12 months of data (November 2018- October 2019) is 110.7. This is 'higher than expected' statistical ranges compared to acute non-specialist trusts in England. The months January 2019, April 2019, May 2019, June 2019 and September 2019 indicated more deaths than expected. This is being investigated by the Mortality Review Committee.

The Hospital Standardised Mortality Ratio (HSMR) compares all inpatient deaths to expected deaths. HSMR above 100 indicates more deaths than expected, and a HSMR below 100 indicates fewer deaths than expected. The Mortality Review Committee (MRC) continues to proactively undertake investigations into diagnosis groups with a higher than expected number of deaths to identify potential improvements in care. Ongoing actions to reduce HSMR include the review of diagnosis groups with higher observed deaths than expected.

Mortality Alerts – Dr Foster Intelligence

- Between November 2018- October 2019 the Trust received 34 mortality alerts, 35% of which were positive alerts.

- One external mortality outlier notification, in the Septicaemia (except labor) diagnosis group has been received from Imperial College, for the data period: August 2018- July 2019. Analysis has been completed and a response submitted to Imperial College, following discussion at MRC.

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

Mortality Indicators: SHMI

- The SHMI value (August 2018 – July 2019) is 1.0871 indicating a 'within expected' position.

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

An action plan to focus on the key diagnosis groups of Septicaemia and Intracranial Injury with a view to reduce SHMI has been completed alongside further work to progress collaborative working with the Clinical Commissioning Groups, Partnership Trust, GP's, other local Secondary Care Provides and Public Health to understand patient pathways including advanced care planning on discharge from hospital and explore ways of learning from deaths 30 days after discharge.

The group is initially focussing on reviewing the current SHMI position of local providers within the local area and working with community services to understand the factors that may be influencing patient care and experience including admission and discharge methods.

A scoping exercise has commenced with the UHCW@Home team to determine number of deaths outside hospital and to establish a process for the review of these deaths.

Learning from Deaths

Learning themes and areas for improvement identified from the mortality review process include recognition and escalation of the deteriorating patient, timely reconciliation of medications and management of fluid balance. Admission to hospital of patients who are recognised as being at the end of life and a need for appropriate advanced care planning are also learning themes identified from the learning from deaths process and have been discussed as part of the regional mortality oversight group when looking at system wide themes and out of hospital mortality.
During October 2019- December 2019, the weekly safety message highlighted learning identified

from patient deaths relating to the management of patients post fall. The message highlighted the immediate action that must be taken as per the Post Falls Protocol. The learning was also shared widely across the Trust in safety huddles and QIPS meetings.

**4. Areas of Risk**

There are two risks relating to learning from deaths on the risk register.

- ED mortality data. ED deaths are managed separately from the inpatient primary review process and requires the manual entry of data that is not linked to the Trust central electronic system CRRS. There is a risk to data quality and integrity with a process that manages ED deaths separately to the Trust wide mortality process. Input from ICT is required to support the amalgamation of the ED mortality form into the Trust's existing electronic form on CRRS

- Completion of mortality reviews in a 30 day timeframe. If mortality reviews are not completed in a timely manner, then delays in the identification of problems in care can occur, resulting in a delay in the identification of improvements in patient care.

**5. Governance**

Mortality assurance and reporting is monitored by the Mortality Review Committee chaired by the Deputy Chief Medical Officer (DCMO) and attended by the Chief Medical Officer. The Committee's actions are monitored through Patient Safety and Clinical Effectiveness Committee, which provides assurance to Quality Governance Committee. Trust Board receives a report on mortality performance every 3 months to meet national expectations.

**6. Responsibility**

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

| **PREVIOUS DISCUSSIONS HELD** |
|---|
| Mortality Review Committee<br>Patient Safety and Clinical Effectiveness Committee 5 March 2020 |

| **KEY IMPLICATIONS** | |
|---|---|
| **Financial** | NA |
| **Patients Safety or Quality** | If the trust did not review learning from deaths and outcome data when comparing with other providers, opportunities for improving patient care will not be identified clearly. |
| **Human Resources** | There are implications in terms of the time available for clinicians to review all deaths in the organisation in a timely manner |
| **Operational** | Operational implications for reviewing mortality in a timely manner |

**UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST**

**REPORT TO PUBLIC TRUST BOARD 26 MARCH 2020**

# Quarterly Mortality Performance Report Q3 – February 2020

## 1.0 Background to Report

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

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

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

In addition to this, the Trust has an in-depth structured mortality review process where each death of an inpatient aged 18 and above has an initial review of their care and graded according to the standard of care they received. Deaths in patients under 18 years old are reviewed using a separate mortality review process. This incorporates external processes for example, Child Death Overview Panel (CDOP). Further reviews are conducted by an appropriate consultant or team if potential problems in care have been identified. This is to encourage learning from patient outcomes.

The Trust mortality review process works to achieve the Trust objective to deliver safe and effective patient care and excellent patient experience through:

- Sharing and identifying learning from mortality reviews and analysis of mortality indicators.

- Actively participating in system wide working within Coventry and Warwickshire to ensure effective population health through collaborative working with the Clinical Commissioning Groups and support of the LeDeR programme for Learning Disability deaths.

All mortality processes are overseen by the Trust's Mortality Review Committee, chaired by a Deputy Chief Medical Officer and attended by the Chief Medical Officer. The Mortality Review Committee reports into the Trust's Patient Safety and Clinical Effectiveness Committee each month.

This report provides information to the Trust Board on the performance of UHCW NHS Trust during Q3 October 2019- December 2019, meeting national recommendations.

## 2.0 Trust-wide Mortality Review: October 2019- December 2019 Performance

Each inpatient aged 18 or above has a structured primary mortality review undertaken by the specialty involved in their care at the time of their death. Aspects of their care are graded by a

Consultant, using the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) Classification of Care grading A-E.

**2.1** During the time period 1st October 2019 to 31st December 2019 there have been 554 deaths (including ED and aged under 18) with 554 requested primary mortality reviews for inpatients (and those who died within the Emergency Department), 66% of which have been completed (368/554).

| | Completed | Incomplete | Grand Total |
|---|---|---|---|
| **2018/2019** | **1791** | **78** | **1870** |
| **2019/2020** | **658** | **395** | **1053** |
| Quarter 1 | 388 | 78 | 466 |
| Quarter 2 | 243 | 172 | 415 |
| Quarter 3 | 314 | 176 | 490 |

Primary review completion of Inpatient deaths as at 10/02/2020 (excluding ED deaths)

The Trust aims to conduct primary mortality reviews within a 30 day timeframe. Steps taken to support the timely completion of mortality reviews include:

- Automated weekly emails to mortality leads for each specialty identifying the outstanding mortality reviews
- Inclusion of Mortality review completion rate on the Trusts group scorecards for reporting at performance and governance meetings
- Regular attendance of specialties to Mortality Review Committee to discuss completion of mortality reviews

**2.2** To meet national recommendations, the Trust has moved to a peer review model for assessing primary and secondary reviews. Clinicians continue to be supported by the Clinical Effectiveness Team to promote the Trust Wide mortality review process with specialty focused training and frequent updates on the status of any outstanding primary mortality reviews.

The figure below shows the NCEPOD grade of all completed primary reviews between October 2019- December 2019. It highlights that 89.81% (314/490) of inpatient reviews were graded NCEPOD A for ‘good care’.

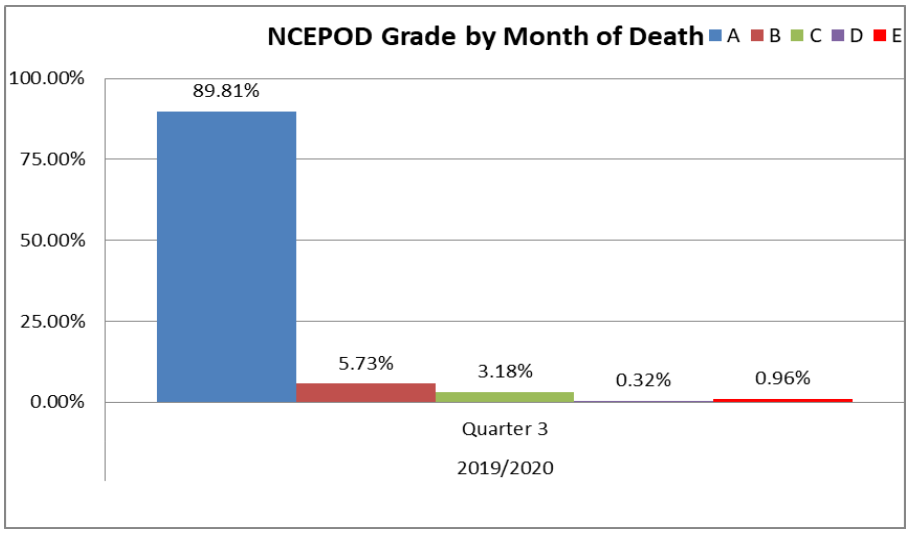


**Figure 1: NCEPOD Classification Rate (All data extracted 10/02/2020)**

**2.3** All patients who are graded NCEPOD B-D during primary review, have a further secondary review completed as the grade highlights that there were aspects of care which could have been improved. The purpose of the secondary review is to identify areas for learning and actions to help improve patient care and avoid similar problems occurring. This is a multi-disciplinary approach and these cases are discussed in specialty meetings to ensure that learning is shared. Theme analyses are conducted from secondary reviews and shared at the Mortality Review Committee. All deaths categorised as NCEPOD E are presented to the MRC and the learning disseminated in an aggregated NCEPOD E report. This is then shared Trustwide to promote improvements in patient care, through Safety Huddles, Quality Improvement Patient Safety (QIPS) meetings and Mortality and Morbidity (M&M) meetings.

For all deaths between October 2019- December 2019 which have had a completed primary mortality review, there were 44 requested secondary reviews (cases graded NCEPOD B-D), suggesting further opportunities for learning. Currently 59% of these secondary reviews have been completed (26). Of the incomplete secondary mortality reviews (18), 77% are still within the 2 month allocation for completion (as at 10/02/2020). Of the completed secondary reviews 6 reviews have been re-graded to NCEPOD A (good care) following discussions with their specialty's team members. The Trust is committed to identifying areas for improvement in an open and transparent manner.

**2.4** Deaths which are graded NCEPOD E (less than satisfactory care) have an investigation into their death reviewing all aspects of care. This is completed by the Mortality Lead for the specialty involved and reported to the Mortality Review Committee. The Committee then discusses the case and agrees appropriate action including investigation via the serious incident group. Trend analyses for NCEPOD E deaths are also conducted in the Trust to enable identification for improvement areas and to disseminate learning.

For all deaths between October 2019- December 2019 there have been 5 cases graded NCEPOD E at primary or secondary review. All deaths graded E are investigated via the Serious Incident Framework.
The total number of deaths investigated via the Serious Incident Framework for Q3 October 2019- December 2019 is 5.

**2.5** The deaths of patients with a Learning Disability are monitored within the Trust in line with national recommendations and reviewed as part of the Trust wide mortality review process. Patients with a Learning Disability are identified by the Learning Disability team using an alert on Clinical Results Reporting System (CRRS). Data on the number of patients with a learning disability who have died is received by the Clinical Effectiveness Facilitator and Head of Clinical Effectiveness from the Performance and Informatics Office.

The number of inpatient deaths of patients with a learning disability between October 2019- December 2019 is 1. During the last financial year April 2018- March 2019 there were 7 deaths with reported learning disabilities. This information along with the learning identified from the mortality review process is reported through the Trust Mortality Review Committee.

The national Learning Disabilities Mortality Review Programme LeDeR has launched in the West Midlands. The Trust is committed to supporting the review programme as part of the current mortality review process. All patients with learning disabilities who have died at UHCW during Q3 have been referred to the LeDeR programme. The Trust is represented at the regional LeDeR steering group where learning from the LeDeR process is shared.

**2.6** In hospital deaths of patients with severe mental illness are monitored as part of the Trust's current mortality process for all in hospital deaths over the age of 18. During October 2019-

December 2019 there were 3 in-patients that died with an identified mental illness on the Primary Mortality Review form.

## 3.0 Learning from Deaths

The mortality review process allows specialties to identify areas of learning and improve care for patients.

Learning themes identified from the Trust Wide mortality review process are transformed into local actions by specialties to improve patient care and fed back through the mortality review committee. Learning is also shared across the wider organisation with weekly safety messages, daily safety huddles and Grand Round presentations.

**3.1** Learning themes and areas for improvement identified from the mortality review process include recognition and escalation of the deteriorating patient, timely reconciliation of medications and management of fluid balance. Admission to hospital of patients who are recognised as being at the end of life and a need for appropriate advanced care planning are also learning themes identified from the learning from deaths process and are themes discussed as part of the regional mortality oversight group when looking at system wide themes and out of hospital mortality.

**3.2** Septicaemia is a diagnosis group that is continuously monitored by the mortality review committee. Learning from mortality reviews has enabled a continued focus on improving the recognition and management of sepsis and has resulted in improvements and the development of specific Sepsis screening tools for the Emergency Department, Maternity, Oncology and Paediatric areas. The Acute Kidney Injury team are currently conducting a trustwide audit to measure compliance with the accurate completion of fluid balance charts.

**3.3** During October 2019- December 2019, the weekly safety message highlighted learning identified from patient deaths relating to the management of patients post fall. The message highlighted the immediate action that must be taken after a fall, as outlined in the Trust's Post Falls Protocol. The learning was also shared widely across the Trust in safety huddles and at Quality Improvement Patient Safety (QIPs) meetings.

## 4.0 Mortality Indicators: Hospital Standardised Mortality Ratio (HSMR)

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

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

**Equation 1: HSMR and Relative Risk Calculation**

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

**4.2** HSMR data is received by the Trust 3 months in arrears. The most recent release of data includes mortality for all deaths for the year to October 2019. The HSMR for the most recent 12 months of data (November 2018- October 2019) is 110.7. This position is 'higher than expected' statistical ranges. The HSMR value for October 2019 is 89.6 which is within the 'expected' ranges.

4.3 The chart below shows the HSMR trend for UHCW for each month from November 2018- October 2019. During the latest rolling 12 months, there have been 5 months with a reported higher than expected mortality. January 2019, April 2019, May 2019, June 2019 and September 2019 indicated more deaths than expected. These areas of higher HSMR are currently being discussed and investigated through the Mortality Review Committee, including a review of elective admissions, clinical coding and diagnosis groups with more observed deaths than expected.

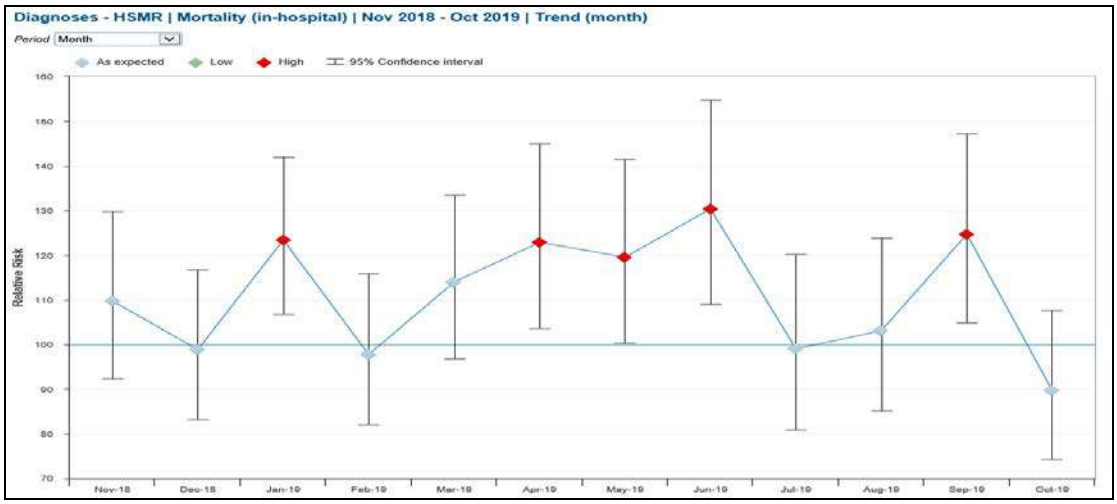



**Figure 2: HSMR Trend by Month (November 2018- October 2019)**

## 5.0 Mortality Alerts

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

5.2 During the rolling 12 month period November 2018- October 2019 (latest available Dr Foster Intelligence data), the Trust has identified 34 diagnosis or procedure groups as negative mortality alerts. All negative mortality alerts have been reviewed by the Mortality Review Committee and appropriate actions assigned and monitored for completion. Ongoing actions to reduce HSMR include the investigation of the diagnosis groups with the highest difference between observed and expected deaths.

## 6.0 Mortality Indicators: Summary Hospital-level Mortality Indicator

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

6.2 The most recent publication for the SHMI is for August 2018 – July 2019 (published by NHS Digital, in December 2019). The majority of Acute Trusts in this publication were within the 'expected' mortality range (82.17%; 106 Trusts). In this publication, UHCW is within the expected position with a SHMI value of 1.0871. During this time period there were 2,840 deaths recorded compared to 2,610 'expected' deaths. The majority of deaths were inpatient deaths (67%), and 33% of deaths were within 30 days of discharge. The Trust monitors SHMI through the mortality review committee and has identified areas of focus via a system wide Mortality Oversight Group in response to the data.

**6.3** An action plan to focus on the key diagnosis groups of Septicaemia and Intracranial Injury with a view to reduce SHMI has been completed alongside further work to progress collaborative working with the Clinical Commissioning Groups, Partnership Trust, GP's, other local Secondary Care Providers and Public Health to understand patient pathways including advanced care planning on discharge from hospital and explore ways of learning from deaths 30 days after discharge.

The group is initially focussing on reviewing the current SHMI position of local providers within the local area and working with community services to understand the factors that may be influencing patient care and experience including admission and discharge methods.

## 7.0 Mortality Outlier Alerts

**7.1** The Care Quality Commission (CQC) monitors mortality outlier alerts using statistical data. Outlier alerts are generated when there have been a significantly higher number of deaths than calculated. Other external or national bodies such as Royal Colleges will also contact the Trust regarding mortality outlier Alerts. During October 2019- December 2019 the Trust has responded to:

- The mortality outlier alerts for Septicaemia and Acute Myocardial Infarction, which are being followed up by the CQC local inspection team.

- Imperial College contacted the Trust with a mortality outlier notification, in the Septicaemia (except in labour) diagnosis group for the data period: August 2018- July 2019. Analysis has been completed and a response submitted.

## 8.0 Additional Developments

**8.1** Mortality Oversight Group
Collaborative working across the STP footprint between UHCW, surrounding providers, Clinical Commissioning Groups, GP's and Public Health has provided the opportunity to explore learning from deaths of patients in hospital and after discharge. The oversight group meets quarterly to review the key diagnosis groups identified in SHMI data and discuss the pathways of patients to identify improvement in primary and secondary care.

**8.2** UHCW@Home Deaths
A scoping exercise has commenced with the UHCW@Home team to determine number of deaths outside hospital and to establish a process for the review of these deaths.

**8.3** Structured Judgement Reviews and the Medical Examiner Role
UHCW is currently exploring the move to align our mortality review process with the national structured judgement review process, alongside the introduction of the medical examiner role. UHCW progress includes:

- The Trust is currently piloting the medical examiner service as part of the Trust's Learning from Deaths programme to support accurate death certification.

- Recruitment of medical examiners is currently in progress, with one medical examiner appointed, who has been in post since the beginning of February 2020.
- The medical examiner will screen all deaths and identify deaths where review, investigation, reporting to Her Majesty's Coroner (HMC) or as incidents very soon after death is needed. They will complete and support medical staff in the completion of cremation documentation
- The medical examiners will also support and engage relatives and carers to further identify cases for review and learning.
- The implementation of the national Royal College of Surgeons structured judgemental review method is currently being appraised against the UHCW primary and secondary mortality review method, to support implementation.

Author: Mumtaz Goolam, Head of Clinical Effectiveness and Assurance
Date of Report: 09 March 2020

University Hospitals Coventry and Warwickshire NHS Trust

**REPORT TO TRUST BOARD**
**HELD ON 26 MARCH 2020**

| | |
|---|---|
| **Subject Title** | Medical Education Report |
| **Executive Sponsor** | Prof Kiran Patel, Chief Medical Officer |
| **Author** | Prof Sailesh Sankar, Associate Medical Director for Education, Training and Professional Development |
| **Attachments:** | None |
| **Recommendations:** | The Trust Board is asked to **NOTE** the contents of the report |
| | |

## EXECUTIVE SUMMARY


Plans to implement the Faculty model and all other activities within the Medical Education directorate will be moderated to accommodate the current Covid-19 pandemic and the impact this is having on the Trust and its activity.

The Directorate has drawn up a plan and put measures in place to offer training and education to support non-medical staff and others so that they have the clinical skills needed to help with the changed and increased workload the pandemic is likely to generate.

Over the last 3 months the feedback from the WMS students on their clinical placements at UHCW has continued to be generally very positive. Details of the current and planned improvements to Child Health in years 3 and 4 (which was the one area lagging for UHCW) are included in this report. These show that all areas of teaching are now highly evaluated by students.

The Clinical Tutor is now in post and has an immediate set of objectives which he is embarking upon.

All areas of the Directorate are now fully staffed. Services and courses have continued to run and have been highly evaluated.

All the departments are working on their strategic plans and all have made significant progress and improvements in their services.

The STC is back to full staffing and is currently making plans to support the Trust's contingency plans linked to Covid-19, these plans will inevitably impact on the teaching provided by this department but they are able to provide a valuable additional resource for the Trust.


## PREVIOUS DISCUSSIONS HELD

This report is a follow up to the report made to the Trust Board in November 2019

## KEY IMPLICATIONS:

| | |
|---|---|
| **Financial** | The delay and cancellation of teaching programmes and courses will impact on the income generated by Course income. It is hoped that HEEWM will continue to release the training tariff even if training is postponed but this has yet to be |

| | |
|---|---|
| | confirmed. Other potential sources of income e.g. MTI project will be put on hold for the next month or so. |
| **Patients Safety or Quality** | The Medical Education directorate is regearing it's activity to support the Trust's plans with regard to ensuring patient safety. |
| **Human Resources** | The Medical Education directorate has skilled staff groups, e.g. clinical teaching fellows and senior nursing staff who can provide the Trust with additional support. In addition the administration staff will be able to support the process of ensuring that staff have access to relevant clinical skills training. |
| **Operational** | - |

# UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

## REPORT TO PUBLIC TRUST BOARD HELD ON 26 MARCH 2020

## Medical Education Report - March 2020

### 1. INTRODUCTION

This report covers the activities of the Medical Directorate

1.1 This report covers the progress, challenges and new developments that have occurred over the last three months in Medical Education.

1.2 The three departments under the directorship of Dr Sailesh Sankar are Medical Education and Simulation, Resuscitation, Surgical Training and Clinical skills Centre.

1.3 Medical Education has a Service Level Agreement with WMS and a Learning Development Agreement with HEEWM. These give us a clear framework for facilities, delivery, and in particular quality, of teaching and training, and of 'working conditions' for our learners. We are subject to frequent inspection, particularly of the training we provide for trainee doctors (postgraduate - PG) Training.

### 2. CONTENT

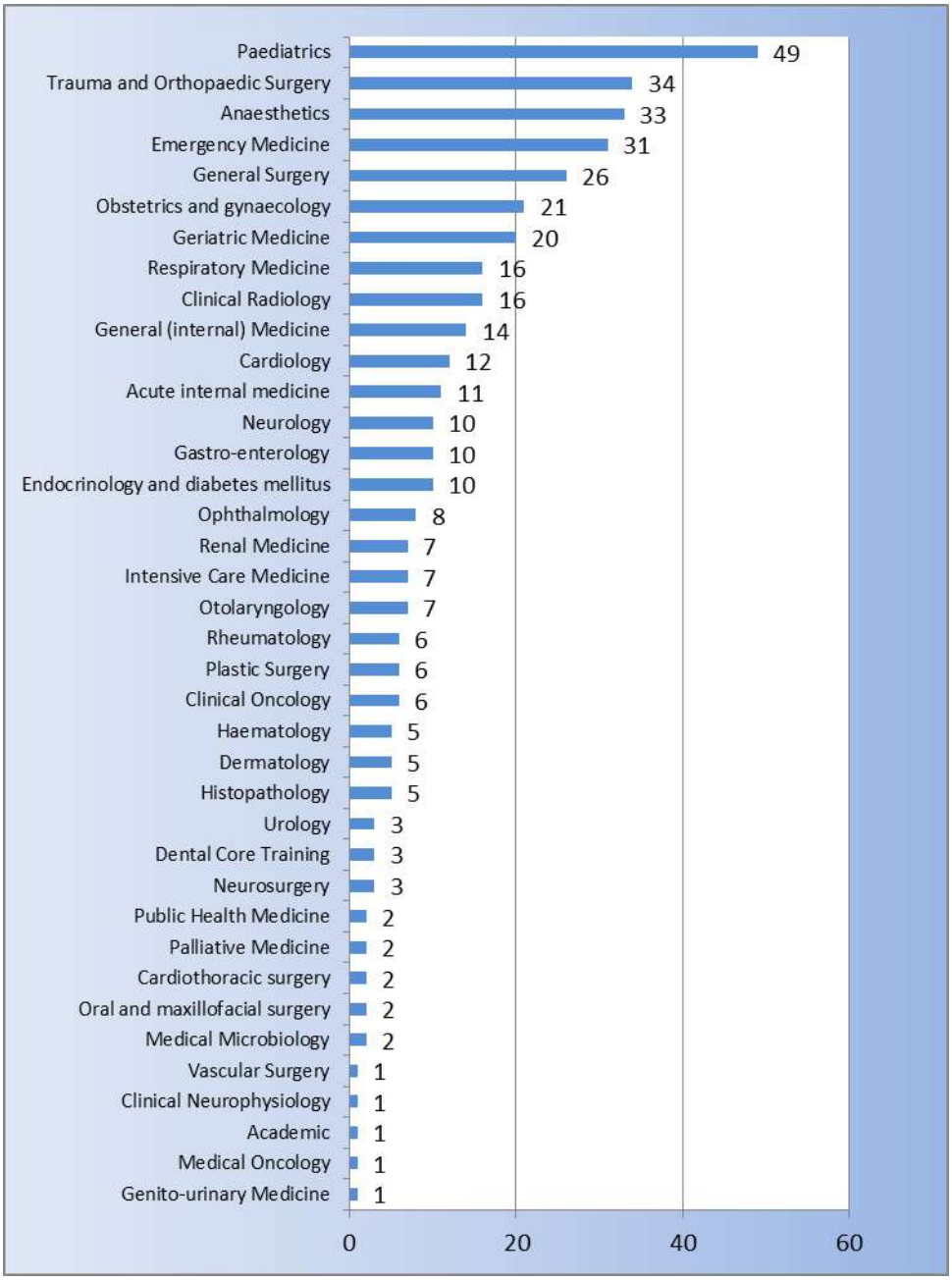
2.1 The Chinese doctor project was highly evaluated by the participants and although some supervisors found that there were some spoken language difficulties with a few of the participants the plan is to continue this project once the current pandemic and associated disruption has passed. Other international projects have also been postponed until later in the year.

2.2 In line with the Trust's response to the Covid-19 pandemic the Surgical training centre and it's staff are working with the Trust's operational planning team to ensure that the facilities and staff skills can be used to support contingency planning.

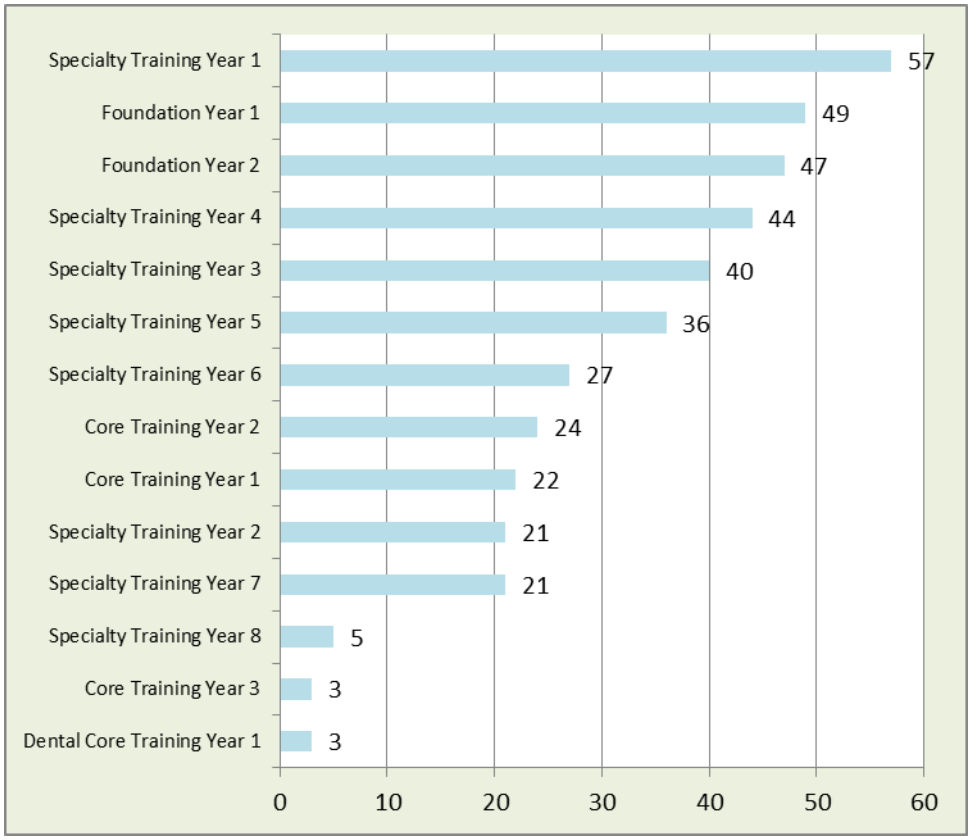
2.3 The new Clinical Tutor, Mr Shabin Joshin has taken up his post and will begin working with the Educational Leads in each specialty to ensure that all trainees have a good induction, regular access to JDFs, adequate supervision and training that matches their specialty requirements. In addition he will survey the training provision for our Trust grade and SAS doctors and will put together a package of proposals and a plan for ensuring that all doctors within the Trust receive the training and career support they require including LTFT and those returning to training.

2.4 The following two tables give an indication of how many trainees there are in the Trust. The exact number of trainees in the Trust is subject to constant fluctuations due to the rotation patterns. This data was pulled on the 20th January 2020. The first table shows which specialty the trainees are working in and the second table shows the level of training.

Trainees in UHCW on 20th January 2020 – showing numbers of trainees in each specialty




| **Total Trainees** | **399** |
|---|---|
| In Post | 377 |
| Parental leave | 13 |
| In Post Extension | 7 |
| OOPT | 2 |




| SITE | Number of Trainees |
|---|---|
| Hospital Of St Cross (RKB03) | 11 |
| University Hospital (Coventry) (RKB01) | 388 |
| **Grand Total** | **399** |

2.5 The Resuscitation manager has been working hard to rebuild her team and now has a fully staffed department. They are working on driving up the training compliance figures for the Trust. Previously they had relied upon staff attending sessions but now they are moving toward clinical training from 1st April, aiming to target non-compliant areas and staff groups. They are also working with the ESR team to ensure that the compliance data for staff is correct and therefore that the ESR reports reflect the Trusts actual needs.

| | Compliant | Non-Compliant | Target | % Compliance JANUARY | TREND from previous month |
|---|---|---|---|---|---|
| Advanced Life Support Update (Ref 20) | 248 | 43 | 291 | 85.22% | ↓ 0.69% |
| Advanced Life Support - 4 Yearly | 101 | 28 | 129 | 78.29% | ↓ 1.86% |
| European Paediatric Advanced Life Support (EPALS / APLS) Annual Update | 152 | 20 | 172 | 88.37% | ↑ 1.93% |
| European Paediatric Advanced Life Support (EPALS / APLS) - 4 Yearly | 76 | 17 | 93 | 81.72% | ↓ 3.39% |
| In-Hospital Resuscitation including AED - Annual | 3206 | 320 | 3526 | 90.92% | ↓ 0.42% |
| Immediate Life Support (ILS) - Annual | 59 | 25 | 84 | 70.24% | ↓ 1.19% |
| Neonatal Life Support (NLS) Update - Annual | 305 | 27 | 332 | 91.87% | ↑ 1.48% |
| Neonatal Life Support (NLS) - 4 Yearly | 85 | 14 | 99 | 85.86% | ↑ 0.57% |
| Paediatric Basic Life Support - Annual | 141 | 9 | 150 | 94.00% | ↑ 5.24% |
| Paediatric Immediate Life Support Course / Update (1 Yearly) | 104 | 13 | 117 | 88.89% | ↓ 1.38% |

Appendix 1 - Mandatory training report for January
Total attendance figures for period 01/01/2020 - 01/03/2020

The department has a busy course schedule:-

| Course | Female | Male | Grand Total |
|---|---|---|---|
| 218 Advanced Life Support (ALS) Update: Cardiac Arrest Team Leaders/Members Only | 32 | 37 | **69** |
| 218 European Paediatric Advanced Life Support (EPALS / APLS) - Annual Update | 15 | 17 | **32** |
| 218 Immediate Life Support (ILS) | 26 | 9 | **35** |
| 218 In-Hospital Resuscitation (IHR) Referral Training | 49 | 4 | **53** |
| 218 In-Hospital Resuscitation (IHR)Assessment Training Bands 1-4 & all Therapies | 269 | 47 | **316** |
| 218 In-Hospital Resuscitation (inc AED) | 516 | 93 | **609** |
| 218 Neonatal Life Support (NLS) Update | 102 | 4 | **106** |
| 218 Paediatric Basic Life Support and Airway Management | 85 | 11 | **96** |
| 218 Paediatric Immediate Life Support (PILS) | 14 | 2 | **16** |
| 218 Paediatric Immediate Life Support Course (PILS) / PLS - Annual Update | 9 | | **9** |

2.6 The team are working more closely with the clinical teams e.g. attending medical handovers daily to ensure the cardiac arrest team allocation runs smoothly, working with patient safety and quality to investigate SUI's as appropriate, and working with the Trust to plan our response to Covid-19.

2.7 The team are continuing their work with ReSPECT and other audit and research projects and generally they are making excellent progress against their 5 year strategic plan targets.

2.8 The Clinical Skills team and the Simulation team have also been working on filling vacancies to help them meet the challenging training targets set by changes in the WMS curriculum and the increased simulation training requirements for Foundation doctors. The team are still working to resolve the problem with the Simulation AV equipment which is out of warranty and is not supported by the upgraded server. This puts the simulation sessions for both undergraduate and postgraduate medical education at risk. The Trust has managed to attract some funding from HEEWM to pay for an upgrade and the equipment is on the capital spending list but delays in procurement are putting the purchase at risk that it will not be addressed this year. The medical education senior team are working with IT to try to resolve the hold ups but events may overtake this initiative.

2.9 The satisfaction feedback from the WMS students continues to be positive.

**UHCW CHILD HEALTH FOR SCP 1 – STUDENT FEEDBACK (FEBRUARY 2020)**

| Topic being evaluated (on a scale of 1 – 5 – Poor to Excellent) | UHCW | GEH |
|---|---|---|
| 1. Staff have made the subject interesting. | 4.42 | 4.00 |
| 2. Feedback on my work has been timely. | 3.08 | 3.64 |
| 3. I have received useful comments on my work | 3.83 | 3.36 |
| 4. I have been able to contact staff when needed. | 4.08 | 3.73 |
| 5. The timetable works efficiently for me. | 4.00 | 3.82 |
| 6. Any changes in teaching arrangements have been communicated effectively. | 4.42 | 4.00 |
| 7. This placement is well organised and is running smoothly. | 4.08 | 3.73 |
| 8. I received sufficient preparatory information prior to my placement. | 3.58 | 4.09 |
| 9. I received appropriate supervision during my placement. | 4.00 | 3.73 |
| 10. I have been given opportunities to meet my required learning outcomes / competences. | 4.00 | 3.91 |
| 11. My supervisor(s) understood how my placement related to the broader requirements of the course. | 4.42 | 3.73 |
| 12. I have had the right opportunities to provide feedback on my placements. | 4.42 | 4.00 |
| 13. Staff value students' views and opinions about placements. | 3.92 | 3.55 |
| 14. It is clear how students' feedback about my placements have been acted on. | 3.50 | 3.18 |
| 15. Overall, I am satisfied with the quality of this placement. | 4.25 | 4.00 |

2.10 The table above shows the areas that need improving within the Child Health module of the 3rd and 4th year medical students rotations. This is the data for the last block which finished in February 2020. The module was performing poorly last year and has been making steady improvements. As can be seen by the figures the block although the weakest of the subjects run at UHCW is still performing pretty well and above the minimum required and in line with the sister Trusts (there are no red flags). Most of the improvements that still need to be made focus on how the block is organised rather than on how it is delivered. The subject lead has worked hard on improving the content of the block and the recent appointment of

additional administration support dedicated to supporting the block will no doubt have a significant impact. The senior management team under Dr Jacky Woodman's leadership as Trust lead for undergraduate medical education will continue to monitor progress. The Trust is seeking scores of 4.00 as a minimum for all questions and an overall average score of 4.5.

## 3. IMPLICATIONS

3.1 Overall there have been a number of positive outcomes for the Trust in the area of medical education but financially things are more challenging and therefore the Directorate is keen to explore all opportunities to maximise it's efficiency and effectiveness. The Trust has been very supportive of this work.

## 4. OPTIONS

4.1 No option appraisal required for this report

## 5. CONCLUSIONS

5.1 Medical Education is making progress in all areas and this is in line with it's previous plans and reports. We are working in a challenging environment which continues to demand more service for less funding and therefore in order to succeed we need to do more and think and act in innovative ways. The medical team has been strengthened in preparation for this challenge. The Medical Education Directorate has resources and skill sets which are being redirected to support the Trust's overall strategy in response to the Covid-19 pandemic.

## 6. RECOMMENDATIONS

THE TRUST BOARD IS ASKED TO NOTE AND APPROVE THE CONTENTS

| | |
|---|---|
| Author Name: | Dr Sailesh Sankar |
| Author Role: | Associate Medical Director for Education, Training and Professional Development |
| Date report written: | 13th March 2020 |

University Hospitals Coventry and Warwickshire NHS Trust

# REPORT TO PUBLIC TRUST BOARD
# HELD ON 26 MARCH 2020

| | |
|---|---|
| **Subject Title** | Guardian of Safe Working Hours 2019 Annual and Trimester Report October 2019 to January 2020 |
| **Executive Sponsor** | Professor Kiran Patel – Chief Medical Officer<br>Karen Martin – Chief Workforce and Information Officer & Deputy CEO |
| **Author** | Dr Andreas Ruhnke, Guardian of Safe Working Hours |
| **Attachments** | Guardian of Safe Working Hours 2019 Annual and Trimester Report October 2019 to January 2020 |
| **Recommendation(s)** | The Board is invited to **NOTE** the content of the report and **RECEIVE ASSURANCE** |

## 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
- Rota Redesign
- Work schedule review
- 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** | - |

University Hospitals Coventry and Warwickshire NHS Trust

# UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

# REPORT TO PUBLIC TRUST BOARD 26 MARCH 2020

## Guardian of Safe Working Hours Trimester Report October 2019 to January 2020 and Annual Report from 01 January to 31 December 2019

## 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 Trimester Report covers the period from 01 October 2019 to 31 January 2020 and the Annual Report section covers the year 2019.

UHCW NHS Trust currently employs 396 JDTs working under the new 2016 TCS.

Additionally there are 178 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 01Oct2019 and 31Jan2020 by specialty:**

| Specialty | ERs carried over from last report | ERs raised | ERs closed | ERs outstanding |
|---|---|---|---|---|
| General Surgery | 14 | 48 | 24 | 38 |
| General Medicine | 12 | 19 | 22 | 9 |
| Ophthalmology | 6 | 12 | 13 | 5 |
| RespMed | 4 | 6 | 1 | 9 |
| Gastro | 2 | 0 | 0 | 2 |
| Gerontology | 1 | 0 | 0 | 1 |
| EmergMed | 0 | 1 | 1 | 0 |
| Psychiatry | 5 | 0 | 0 | 5 |
| Anaesthetics | 0 | 6 | 3 | 3 |
| ITU | 0 | 4 | 2 | 2 |
| Urology | 0 | 4 | 2 | 2 |
| Endocrinology | 0 | 3 | 2 | 1 |
| Neurosciences | 0 | 3 | 0 | 3 |
| Renal | 0 | 3 | 1 | 2 |
| MaxFax | 0 | 1 | 0 | 1 |
| ENT | 0 | 9 | 6 | 3 |
| Total | 44 | 119 | 77 | 86 |

ERs by grade:

| Grade | ERs carried over from last report | ERs raised | ERs closed | ERs outstanding |
|---|---|---|---|---|
| F1 | 22 | 71 | 45 | 48 |
| F2/CT/ST1-2 | 17 | 39 | 23 | 33 |
| ST3+ | 5 | 9 | 9 | 5 |
| Total | 44 | 119 | 77 | 86 |

ERs response time:

| Response time | <48h | <7d | >7d | Still outstanding |
|---|---|---|---|---|
| F1 | 13 | 5 | 27 | 48 |
| F2/CT/ST1-2 | 4 | 7 | 12 | 33 |
| ST3+ | 2 | 0 | 7 | 5 |
| Total | 19 | 12 | 46 | 86 |

This Trimester Trust Board Report covers a 4-month-period from Oct 2019 to Jan 2020 during which 119 ERs have been reported which is a nearly 300% increase compared to the last trimester. This seems to have coincided with the introduction of the new amended T&Cs as up to August there were only 10 or fewer reports per month. Again, the main reasons for staying late were: increased workload, unable to handover and unfamiliarity due to ward change (medical outliers). The contractual obligation to review exception reports within 7 days has been breached in almost 75% of ERs covered by this report. However this is still a vast improvement compared to the previous trimester. The overall review rate of exception reports has significantly improved to slightly more than 60%. I would like to highlight the positive efforts in General Medicine and Ophthalmology where all new ERs had been reviewed.
Only 5 ERs outstanding from the previous report had been completed so that 39 historical outstanding ERs had to be added to the 47 un-reviewed ERs from this report which explains the high number of outstanding ERs despite of the overall improvement.

By far, the highest number of ERs raised was in General Surgery this time (48 ERs). 45 ERs were due to additional hours worked; about 10 alone due to the late finishing of the weekend 3rd on-call shift (late urology ward rounds). 3 ERs were submitted due to educational reasons.
The response times have also improved: **31** ERs (26%) were reviewed within the 7 day target period. The delayed review times are claimed to be caused by an unfamiliarity with the electronic reporting system and failure to find a meeting date within 7 days due to leave. Again, 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 significant improvement there is still a lack of engagement from some educational supervisors with the reviewing process.

From 01 December 2019 the GSW was given the authority to close ERs which have not been reviewed within the contractual 7-day-period. I have closed 2 un-reviewed ERs dating back from December 2019 leading to the awards of overtime payment. A process where these awards will be paid un-bureaucratically has been agreed with Finance and Payroll so that further actions on un-reviewed ERs can follow soon if necessary.

**Annual Summary of Exception Reports submitted between 01 January and 31 December 2019**

There were 165 ERs in total of which 92 were completed and 4 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. 64 ERs still show as ‘pending’ on Allocate. Some of these ‘pending’ cases have been reviewed by the educational supervisors and the trainees but have not been logged properly in the Allocate Software but some of those ‘pending’ ERs have never been reviewed despite having been prompted by reminder emails from me. Unfortunately a few educational supervisors still do not seem to engage with the exception reporting process.
5 ERs were logged as ‘request for more information’ and had to be resubmitted.

Most ERs were submitted by F2 and CT Doctors in various specialties (79 ERs) closely followed by F1 Doctors in General Surgery and General Medicine (72 ERs). Only 14 were submitted by Specialty Trainees. This mirrors what happens in other Trusts that Specialty Trainees do not seem to engage with the exception reporting process.

The vast majority of ERs were due to overtime working (142 ERs).
ERs submitted as change in ‘service support’ were mostly due to staff shortages (9 ERs).
The same number were due to 'educational' issues and only 5 due to change in 'pattern'.

## Annual summary per specialty by category

| Specialty | Hours | Pattern | Service Support | Educational | Total |
|---|---|---|---|---|---|
| AcuteMed JNR | 2 | 0 | 0 | 0 | 2 |
| Anaesthetics JNR | 0 | 0 | 2 | 1 | 3 |
| Anaesthetics SNR | 0 | 1 | 1 | 0 | 2 |
| Endocrinology JNR | 7 | 0 | 0 | 2 | 9 |
| ENT/Plas/MF JNR | 5 | 2 | 3 | 0 | 10 |
| Gastro JNR | 2 | 0 | 0 | 0 | 2 |
| GenMed F1 | 13 | 0 | 0 | 1 | 14 |
| GenSurg F1 | 49 | 0 | 1 | 3 | 53 |
| Gerontology JNR | 1 | 0 | 0 | 0 | 1 |
| ITU JNR | 0 | 0 | 3 | 0 | 3 |
| MaxFax SNR | 1 | 0 | 0 | 0 | 1 |
| Neonatology | 1 | 0 | 0 | 0 | 1 |
| Neurosciences | 3 | 0 | 0 | 0 | 3 |
| Ophthalmology JNR | 24 | 0 | 0 | 0 | 24 |
| Ophthalmology SNR | 7 | 1 | 0 | 0 | 8 |
| Psychiatry F1 | 5 | 0 | 0 | 0 | 5 |
| RenDermRheu JNR | 1 | 0 | 0 | 0 | 1 |
| Resp JNR | 21 | 1 | 0 | 1 | 23 |
| **Total** | **142** | **5** | **10** | **8** | **165** |

## Annual summary per specialty by review status

| Specialty | Complete | Unresolved | Request for more information | Pending | Total |
|---|---|---|---|---|---|
| AcuteMed JNR | 2 | 0 | 0 | 0 | 2 |
| Anaesthetics JNR | 0 | 0 | 3 | 0 | 3 |
| Anaesthetics SNR | 2 | 0 | 0 | 0 | 2 |
| Endocrinology JNR | 8 | 0 | 0 | 1 | 9 |
| ENT/Plas/MF JNR | 7 | 0 | 0 | 3 | 10 |
| Gastro JNR | 0 | 0 | 0 | 2 | 2 |
| GenMed F1 | 12 | 2 | 0 | 0 | 14 |
| GenSurg F1 | 21 | 0 | 0 | 32 | 53 |
| Gerontology JNR | 1 | 0 | 0 | 0 | 1 |
| ITU JNR | 1 | 0 | 2 | 0 | 3 |
| MaxFax SNR | 0 | 0 | 0 | 1 | 1 |
| Neonatology | 1 | 0 | 0 | 0 | 1 |
| Neurosciences | 0 | 0 | 0 | 3 | 3 |
| Ophthalmology JNR | 20 | 0 | 0 | 4 | 24 |
| Ophthalmology SNR | 8 | 0 | 0 | 0 | 8 |
| Psychiatry F1 | 0 | 0 | 0 | 5 | 5 |
| RenDermRheu JNR | 1 | 0 | 0 | 0 | 1 |
| Resp JNR | 9 | 1 | 0 | 13 | 23 |
| **Total** | **93** | **3** | **5** | **64** | **165** |

## 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

Due to the vast number of ERs originating from the 3rd on-call weekend rota in General Surgery (urology) the shift will be extended by 2 hours to 16:00h from April onwards.

Unfortunately no solution could be found yet for the understaffed F2/CTs ITU rota as there are not enough recruits nor any agency locums available to fill the vacant slots.

## 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.

Monitoring of Additional Duties
There is currently no comprehensive system in place to monitor the additional hours undertaken by trainees when undertaking additional duties correctly. **Such system will have to be in place by 2021 under the new contract (2018 contract review)** and the approval has been given to introduce Allocate Software to support on-line booking and payment of locum shifts across the Trust.

Therefore it remains important that Junior Doctors are reminded of their ongoing obligations around the controls on their working time, which is highlighted at induction, through discussions when exceptions are raised and in their contracts of employment issued to them.

Opting-out of WTR:
As previously reported there is still no central data base for opting-out of WTR.

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.
Due to the absence of an e-roster software at UHCW which would allow to update Junior Doctors' actual working hours in real-time it has not been possible to monitor their working times for possible breaches of their working hours.

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

Vacancy information was requested but not received and therefore an accurate assessment of role vacancies has not been undertaken.

The vacancy rates in the previous Trust Board reports were between 8-10% and it is likely to be currently within this range.

There is no guarantee future recruitment rounds will attract enough doctors to fill all HEE hospital training posts, however the Trust has taken steps to direct recruitment to potential gaps across general medicine and general surgery.

## 8. Fines

There was a fine for 'breach of the minimum 5 hours continuous rest between 22:00 and 07:00 during a non-resident on-call shift' in ophthalmology. The total fine to be paid into the Guardian's penalty account is £93.16.

## 9. Qualitative Information

All 58 JDT rotas are currently WTR-compliant on paper.

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

## 10. Issues arising

Again, 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.

Without an appropriate electronic system in place to monitor the total working hours (normal rota hours plus additional locum work) of the Junior Doctors in Training covered by the TCS2016 the Trust might fail on its obligation to monitor safe working hours. E-rostering must be in place by 2021 under the terms of the new framework (2018 contract review).

## 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. An integrated software solution is urgently needed to monitor the JDTs' contracted and additional working hours with regards to opt-out status and individual average working hour week. This integrated software solution should also provide the data for accurate staff vacancy rates. This system must be in place by 31 Dec 2020.

3. 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.

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

5. Dedicated admin support for Allocate Software is needed.

6. The next GSW report will be the Trimester Report on 30 July 2020.

## 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 Karen Martin

## 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**:** 10/03/2020

University Hospitals Coventry and Warwickshire NHS Trust

# REPORT TO PUBLIC TRUST BOARD
# HELD ON 26 MARCH 2020

| | |
|---|---|
| **Subject Title** | Caldicott Guardian Annual Report 2019/20 |
| **Executive Sponsor** | Kiran Patel, Chief Medical Officer |
| **Author** | Jenny Gardiner, Director of Quality |
| **Attachment(s)** | Caldicott Guardian's Annual Report |
| **Recommendation(s)** | Trust Board is asked to **NOTE** the work undertaken to date |

## EXECUTIVE SUMMARY

1. The Trust has a comprehensive IG Framework in place and responsibilities for the CG continues to be shared jointly by the Chief Medical Officer and the Director of Quality. The Senior Information Risk Officer is the Chief Operating Officer.
2. The GDPR came into effect on 25 May 2018 and has been incorporated into the Data Protection Act (2018).
3. UHCW NHS submitted a final assessment for the Data Security and Protection Toolkit. The final score was 'Standards Met'.
4. Discussions are underway to make changes to the Caldicott Guardian which will be taken through Information Governance Committee and reported to the Board

Following self-assessment against the CG Checklist, a number of actions have been completed during 2019/20 to improve compliance.

## PREVIOUS DISCUSSIONS HELD

-

| KEY IMPLICATIONS | |
|---|---|
| **Financial** | Failure to comply with Caldicott principles and guidance could result in regulatory and reputation damage, fines and claims. |
| **Patients Safety or Quality** | Failure to comply with Caldicott principles and guidance could result in Information Governance patient safety incidents |
| **Human Resources** | Failure to comply with Caldicott principles and guidance could result in Information Governance incidents affecting staff |
| **Operational** | - |

# CALDICOTT GUARDIAN ANNUAL REPORT 2019-20

## 1. Purpose

This is a routine annual report to advise the Board of work undertaken by the Caldicott Guardians during 2019/20. Trust Board is asked to note the work undertaken to date and the plans for 2020/21.

There is no statutory requirement for this report.

## 2. Background and Links to Previous Papers

Dame Fiona Caldicott was appointed as the National Data Guardian (NGD) in November 2014. The NDG's role is to help make sure the public can trust their confidential information is securely safeguarded and to ensure that it is used to support citizens' care and to achieve better outcomes from health and care services. In July 2016 the NDG together with the CQC published 'Review of data security, consent and opt-outs'. Dame Fiona's report discusses that the public should be engaged about how their information is used and safeguarded, and the benefits of data sharing beyond direct clinical care, with a wide-ranging consultation on her proposals as a first step.

The Manual for the Caldicott Guardians published in 2017 states that the NHS Information Governance Framework mandates the appointment of two senior roles, typically at Board or Governing Body level within each NHS organisation. These roles are the Caldicott Guardian (CG) and the Senior Information Risk Officer (SIRO).

## 3. Executive Summary

3.1 National Developments

3.1.1 The Data Security and Protection Toolkit (DSPT) is an online assessment tool that all organisations must complete annually if they have access to NHS patient data and systems. It allows organisations to measure their performance against the National Data Guardian's 10 data security standards. Organisations and their current DSPT status can be searched for, via https://www.dsptoolkit.nhs.uk/organisationsearch. (NHS Digital, 2 December 2019).

3.1.2 The UK Caldicott Guardian Council has recently published 'Considerations to support information sharing between police and health and care'. It has been developed with the National Crime Agency to provide guidance on police information requests to NHS organisations, GPs and other healthcare providers in respect of potential homicide investigations, proof of life enquiries and to trace missing persons.

3.2 Information Governance Framework

The Trust has a comprehensive IG Framework in place and responsibilities for the CG continues to be shared jointly by the Chief Medical Officer and the Director of Quality. The Senior Information Risk Officer is the Chief Quality Officer.

The Director of Corporate Affairs is responsible for Subject Access Requests and Freedom of Information requests and also chairs the Information Governance (IG) Committee.

The Head of IG leads a team of IG specialists and liaises directly with NHS Digital and the Information Commissioner's Office in relation to IG breaches.

3.3 Review of actions and achievements 2019/20:

3.3.1 Outward Patient Information Flow
A formal log of CG requests is maintained within the Trust which captures and demonstrates the approval and non-approval of the different categories of outward flow of patient information to ensure such information is adequately protected. A total of 30 applications were submitted in 2019/20 to date. Of these, 23 have been approved, two are in progress and five were redirected as they did not require UHCW CG approval. This log was an improvement action from the previous year.

They were recorded as follows:

User Registration Authorisations - 10
Data Sharing Authorisations - 15
Other - 3
Data Protection - 2

In comparison to 2018/19 21 applications had been submitted which shows a slight increase in applications. There is no discernable reason for this increase.

3.3.2 Data Security and Protection Toolkit (DSPT)
UHCW NHS sent a final assessment for the DSPT at the end of March 2019. The final score was ‘Standards Met’ (the alternative being ‘Standards not met’).

The Trust is on target to achieve a ‘Standards Met’ on the DSPT for the 2019-20 submission.

The Trust does not foresee any risk to maintaining compliance for 2020/21 as there is a programme of work in place for the DSPT that show year on year improvements, and the evidence for the DSPT is independently assessed by auditors before the final submission.

3.3.3 Biannual Caldicott Guardian Meetings – Due to changes in roles meetings are to be rescheduled for 2020/21.

3.3.4 Assessment against CG checklist

Following assessment against the CG Checklist, the following were intentions and outcomes for 2019/20:

- Initiate a discussion for further assurance that CG related issues from internal audit are reported to the Caldicott Guardians, and to consider any CG related audits required. **No CG related audits were identified as being required. No CG related issues have arisen from internal audits.**
- Review how Caldicott decisions are recorded – the checklist suggests a decision log as a way of monitoring and evidencing the impact of the CG's role. **This is the formal log of requests as detailed in 3.3.1 above.**
- Review access to the generic Caldicott Guardian email address (caldicott.gs@uhcw.nhs.uk) and ensure it is easily accessible for patients and staff. **This address has been listed on the Contact Us page of the Trust internet website.**
- Change membership of the Information Governance Committee to reflect that the Quality Department representative is the Caldicott Guardian, or a representative. **Terms of reference were changed to add Quality Department representative as a representative of Caldicott Guardian.**

3.5 Plans for 2020/21

Plans for 2020/21 will be discussed at rescheduled Biannual Caldicott Guardian meeting. This meeting has been deferred given the current priorities and will be arranged in the next few months.

## 4. Areas of Risk

Risk 2974 'If the Trust does not follow Caldicott Guardian principles and recommendations there could be patient identifiable data breaches and subsequent regulatory or reputation damage' was closed on Datix due to the following controls being in place:

- Annual assessment for The Data Security and Protection Toolkit 'Standards met'
- Quarterly schedule of switchboard testing in place
- Bi-annual CG meetings scheduled
- Caldicott Guardian roles in place (CMO and DoQ)
- Caldicott data sharing request log in place
- Contact details available via internet, switchboard
- Caldicott Guardian training carried out for both CGs

- Caldicott Guardian email inbox in place

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

N/A

## 6. Governance

Progress against the Caldicott Guardian actions have been monitored via the Quality Department through production of this report and completion of Risk 2974 and via presentation of the annual CG report at the Information Governance Committee. The 2018/19 Annual Caldicott Guardians report was presented in full to the Information Governance (IG) Committee in March 2019 and this 2019/20 report is to be presented at Information Governance Committee in May 2020.

## 7. Responsibilities

The Caldicott Guardian is responsible for compliance with the Caldicott Principles. The Chief Medical Officer and the Director of Quality share the responsibility of the Caldicott Guardianship for UHCW and are therefore responsible for implementing the actions described in this paper.

## 8. Recommendations

Trust Board is asked to note the work undertaken to date and the plans for 2020/21.

Name and Title of Author: Jenny Gardiner, Director of Quality
Date**:** March 2020

## 9. References

NHS Digital. *Data Security and Protection Toolkit.* [ONLINE] Available at https://www.dsptoolkit.nhs.uk/News/69 [Accessed 26 February 2020].

NHS Digital. *Data Security and Protection Toolkit*. [ONLINE] Available at https://www.dsptoolkit.nhs.uk/News/34 [Accessed 26 February 2020].

Gov.co.uk. *UK Caldicott Guardian Council.* [ONLINE] Available at https://www.gov.uk/government/groups/uk-caldicott-guardian-council [Accessed 25 February 2020]

## 10. UHCW Associated Records

Confidentiality and Data Protection Policy. GOV-POL-003-08. Version 7.

University Hospitals Coventry and Warwickshire NHS Trust

**REPORT TO PUBLIC TRUST BOARD**
**HELD ON 26 MARCH 2020**

| | |
|---|---|
| **Subject Title** | Patient Led Assessments of the Care Environment (PLACE) Annual Report 2019-20 |
| **Executive Sponsor** | Nina Morgan, Chief Nursing Officer |
| **Author** | David Powel, Soft Services Performance Manager |
| **Attachment(s)** | Appendix 1: Guide to Enhancing Your Environment |
| **Recommendation(s)** | The Board is asked to:<br>- **NOTE** progress and **RECEIVE ASSURANCE** |

## EXECUTIVE SUMMARY

PLACE assessments are an annual appraisal of the non-clinical aspects of the patient environment, how it supports patients' privacy and dignity and its suitability for patients with specific needs, eg: disability or dementia. All assessment teams must include a minimum of two patient assessors, making up 50 per cent of the team. PLACE assessments provide a framework for assessing quality against common guidelines and standards in order to quantify the environment's cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or with a disability.

The PLACE assessments were carried out in line with the National Audit Assessment Forms in October 2019. At University Hospital the assessment groups were made up of representatives from Infection Prevention & Control, Estates and Facilities, Senior Nurses and Patient Partners. At the Hospital of St Cross the assessment group comprised of the Site Manager, Matron, Patient Partners and members of the Estates and Facilities Team.

The audit covered a number of areas, reported under the following eight headings:

- **Cleanliness** – covers all items commonly found in the healthcare premises including patient equipment (examples are baths, toilets, showers, furniture, floors, fixtures and fittings).
- **Food and Hydration** – includes food choice, 24 hour availability, meal times, access to menus.
- **Organisational Food** - includes food choice, 24 hour availability, meal times, access to menus.
- **Ward Food** – includes an assessment of food at ward level, including the taste, texture, and appropriateness of serving temperature. The food was tasted by the assessment team at the end of the meal service.
- **Privacy, Dignity and Wellbeing** – includes infrastructure and organisational aspects such as the provision of outdoor and recreational areas, changing and waiting facilities and access to television, radio, internet and telephones, the practicality of male and female services (sleeping and bathroom/toilet facilities, bedside curtains sufficient in size to create a private space

around beds and ensuring patients are appropriately dressed to protect their dignity and that patient information is not on display.

- **Condition, Appearance and Maintenance** – General environment including décor, condition of fixtures and fittings, tidiness, signage, lighting (including access to general light), linen, access to car parking, waste management and the external appearance of the building and maintenance of the grounds.

- **Dementia** – flooring, décor and signage, availability of handrails, appropriate seating and food.

- **Disability** – issues of access including wheelchair, mobility (eg: handrails), signage, hearing loops, and aspects of food and food service.

**Results Table:**

| | 2019 % | National Average % | Above or Below National Average % |
|---|---|---|---|
| **University Hospital** | | | |
| **Cleanliness** | **99.38** | **98.6** | **0.78** |
| **Food & Hydration** | **93.91** | **92.2** | **1.71** |
| **Food Organisation** | **97.78** | **91.9** | **5.88** |
| **Food Ward** | **93.14** | **92.6** | **0.54** |
| **Privacy, Dignity and Wellbeing** | **80.51** | **86.1** | **5.59** |
| **Condition Appearance and Maintenance** | **99.32** | **96.4** | **2.92** |
| **Dementia** | **63.72** | **80.7** | **16.98** |
| **Disability** | **72.54** | **82.5** | **9.96** |
| | | | |
| **St Cross** | | | |
| **Cleanliness** | **98.57** | **98.6** | **0.03** |
| **Food & Hydration** | **88.54** | **92.2** | **3.66** |
| **Food Organisation** | **93.33** | **91.9** | **1.43** |
| **Food Ward** | **84.31** | **92.6** | **8.29** |
| **Privacy, Dignity and Wellbeing** | **71.01** | **86.1** | **15.09** |
| **Condition Appearance and Maintenance** | **95.02** | **96.4** | **1.38** |
| **Dementia** | **71.63** | **80.7** | **9.07** |
| **Disability** | **76.67** | **82.5** | **5.83** |

The 2019 results are not comparable with those in previous collections, due to the large scale national review, question set changes and scoring matrix.

**Summary of Findings and Action Plan:**

**Cleanliness:**

This year saw a slight decrease against the National Average cleanliness across both sites with only minor issues being found at the time of the PLACE audits. Regular audits will continue throughout the year to ensure that standards remain high but a decision needs to be made on which department

will lead the audits given they are patient focused.

**Food and Hydration - Organisational Food and Ward Food:**
The Hospital of St Cross saw an decrease against the National Average whilst there was a slight increase on the University Hospital site for the Food and Hydration, Food Organisation and Ward Food elements. During the coming year these aspects will be reviewed and agreed with Dieticians following which the appropriate menu changes made to drive improvements over the next 12 months.

**Privacy, Dignity and Wellbeing:**
This year's audit has seen a decrease against the National Average across both sites. Nursing leads will need to be vigilant and ensure patient information is not on display after it was observed that on occasions patients notes were left in easily accessible areas. Good practice was seen on Wards 24/25 where they have installed doors on patient boards so that the information cannot be seen by patients and visitors. Progress will be monitored over the coming months to ensure improvements are made within all elements. The clinical teams will need to drive the improvements within this domain.

**Condition and Appearance and Maintenance:**
**University Hospital –** There was an improvement against the national average and work will continue with the Estates Performance Team and the two painters at our disposal to ensure clinical and non-clinical areas are painted on a "Forth Bridge" approach.
**Hospital of St Cross –** There was an improvement against the national average following improvements made in 2019. The Rugby Lifecycle Group continue to undertake ward refurbishments and life-cycling.

**Dementia:**
It is disappointing to see that both sites fall well below the national average. Examples of common failures were the lack of large faced clocks showing the date and date, hot and cold taps not being clearly colour coded and wet-look flooring. Hospedia entertainment units are being installed in side rooms of Hoskyn Ward at St Cross. The Guide to Enhancing Your Environment has been prepared and is awaiting approval – a draft of this document is included at Appendix 1). This contains templates for colour and finishes and will be used when undertaking lifecycle and maintenance work. The recent Hoskyn Ward refurbishment has been undertaken in line with the Guide.

**Disability:**
Both sites fall below the national average. A DDA Assessment is to be undertaken on both sites. Once complete an action plan will be developed and any investment requirement assessed.

**On-going Monitoring:**
A program of mini PLACE inspections will take place in 2020 and these will report into PEEC together with any actions identified.

| **PREVIOUS DISCUSSIONS HELD** |
|---|
| None |

| **KEY IMPLICATIONS** | |
|---|---|
| **Financial** | To be assessed once action plans have been developed. |
| **Patients Safety or Quality** | The maintenance of a high standard of patient environment is linked closely to minimizing hospital acquired Infections (HAI) at the organisation – any reduction in standards would potentially lead to an increase in HAIs. |

| | |
|---|---|
| | Patient Experience – Any reduction in the patient environment will have a direct impact on the patient experience.<br><br>The annual PLACE score feeds into the CQC, a reduction in current standards would have a detrimental effect on the outcome of CQC assessments undertaken at the Trust. |
| **Human Resources** | None |
| **Operational** | None |

University Hospitals Coventry and Warwickshire NHS Trust

# Enhancing your Environment

## Staff Toolkit

## Introduction

With information published by the Department of Health into creating dementia friendly health and social care environments, UHCW NHS Trust is encouraging any improvements to its spaces now reflects upon the principal of this guide as a standard going forward and supports a concise principal when making improvements.

The following guide offers support to enhancing patient environments at University Hospital, Coventry and the Hospital of St Cross in Rugby. If you are looking to improve your ward or department through redecoration then please read this guide carefully.

***Please note: some images have be sourced via the web to offer a visual reference, due to copyright this document is for internal use only.***

*Supporting people who are living with dementia is one of the biggest challenges that our health and social care system will face in the 21st-century. There is rightly much emphasis placed upon how we deliver care, but the environment within which we deliver care, can also make an enormous difference to the quality of people's lives. There is clear evidence to show that if you get the environment right, this has benefits not only for people who use care services, but also for their families, friends and staff.*

*Professor Martin Green OBE*
*Chief Executive, Care England DH:*
*Independent Sector Dementia Champion*

The DoH guide can be viewed here:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/416780/HBN_08-02.pdf

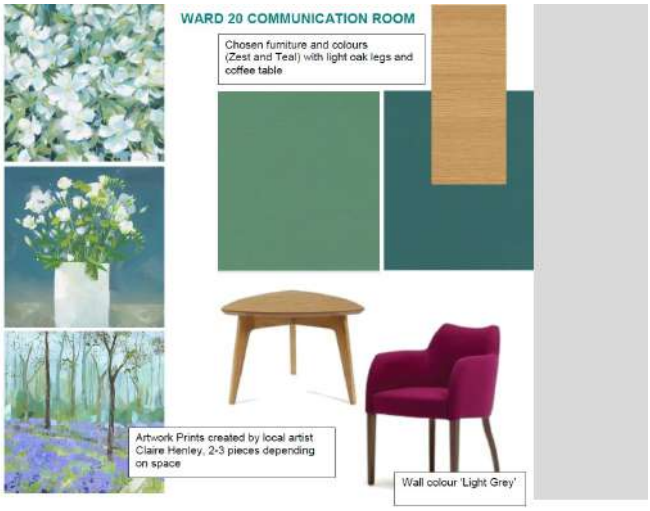
We Care. We Achieve. We Innovate.

# Where to Start

We strongly advise you gather together a small project steering group to lead on decisions and be a point of contact for UHCW Charity and Estates and Facilities.

## Funding

For any project there needs to be a budget available, in most cases funding is sought by charitable means, either by accessing your own ward/department charitable fund or applying for a general purposes grant. In all cases please contact UHCW Charity for advice before moving forward.




*Example mood board*

## Small Works

**works up to a value of £75k**

As we are a PFI Trust, all works need to be done via the PFI provider (Vinci Facilities). A small works process has been put together to capture works up to a value of approximately £75k. Small works are centrally funded and go through a review process. Works carried out on behalf of UHCW Charity follow the same process but funding will be secured differently.

A small works request form will need to be completed and authorised appropriately. Please contact Estates for advice and assistance if required. Once received by Estates they will review and if the works are suitable then a small works request will be raised with Vinci. Vinci will quote for the works and the quote will be issued to Estates for review.

Once approved by Estates the quote will be issued to the requester who will complete the UHCW Charity funding form, which the quote will need to be attached to. Once approved by UHCW Charity then a date for the works to be carried out can be secured by Estates with Vinci.

# General Redecoration

Avoid excessive use of patterns and ensure consistent choice of decoration themes across spaces.

## Colour

The Trust has a standard colour scheme in use and requests the use of the hospital's own mix of white is used wherever possible
Formerly known as DULUX 'Jasmine White'

We understand colour is often required to define a space and so we have compiled a small colour palette,
**defining 5 alternative DULUX colours:**

TBC (HOSKYN)

NEPTUNES JEWEL
70GG 39/303

MYSTIC MAUVE
69BB 17/324

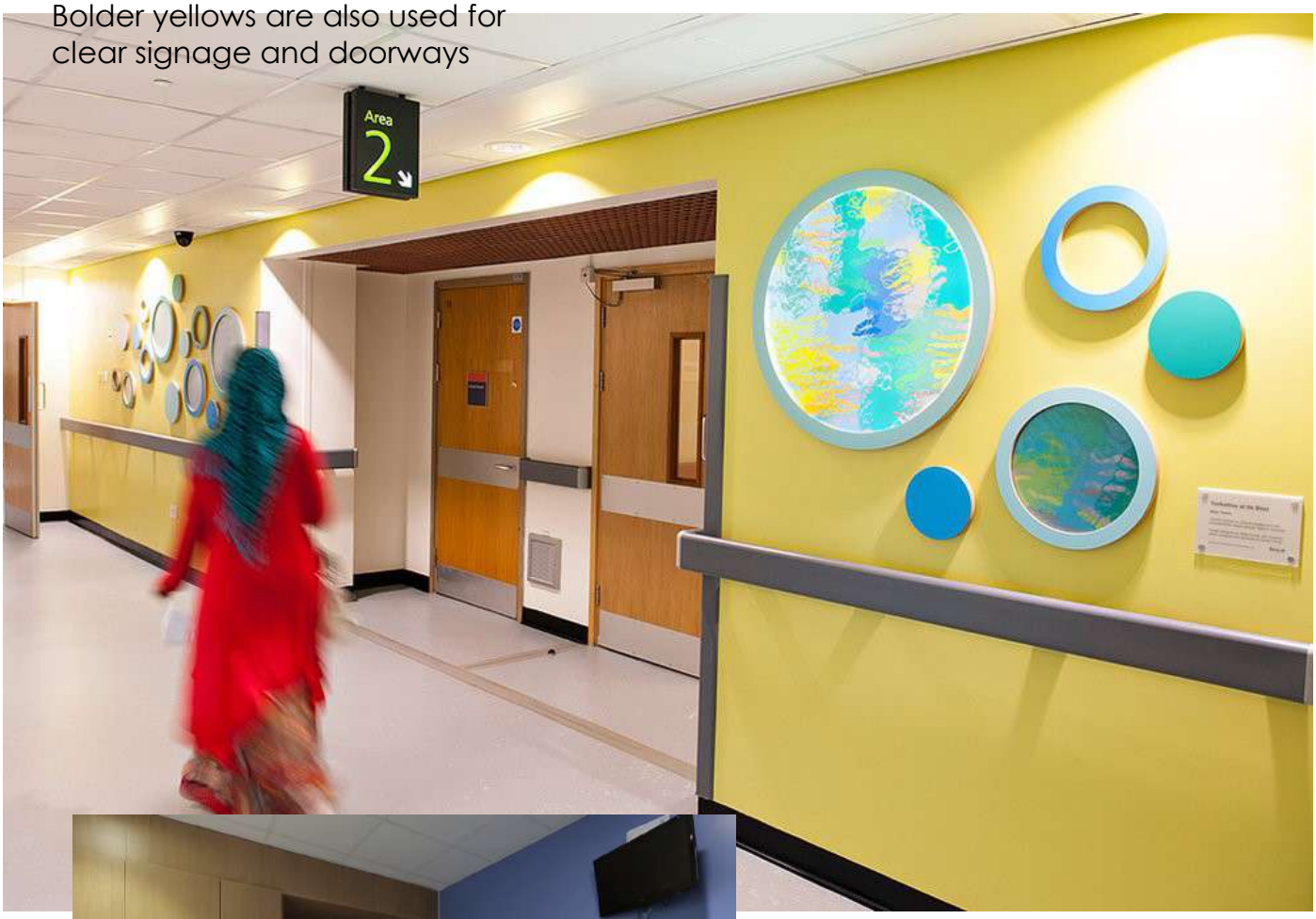
TBC

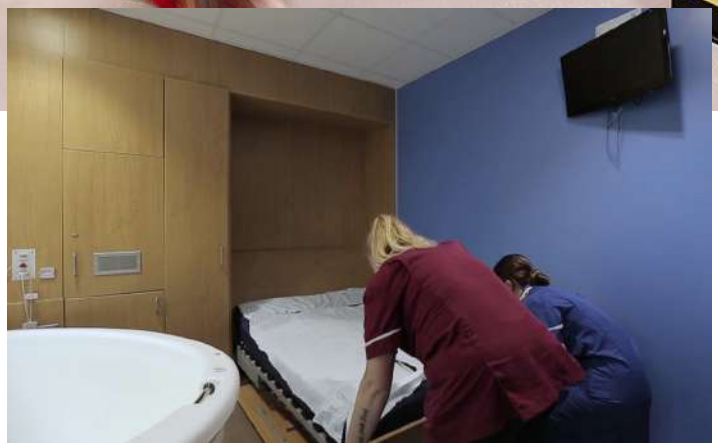
AZURE FUSION
70BG 31/332

## YELLOW

Helps stimulate the senses and improves brain activity therefore works well in dayroom/activity rooms . Also along corridors that have no natural light.

Bolder yellows are also used for clear signage and doorways



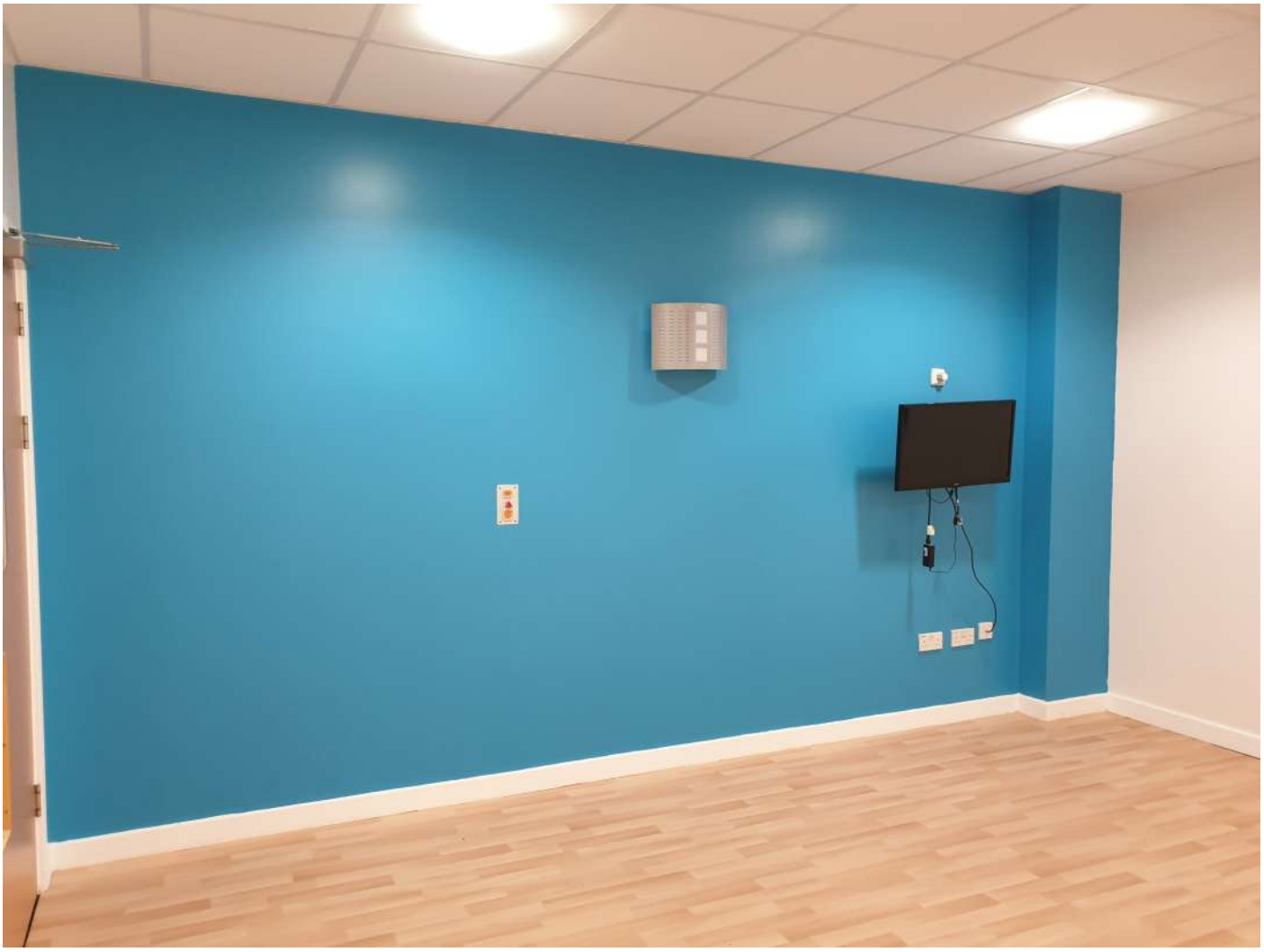



## MAUVE (DARK PURPLE)

A colours already used widely across UHCW, a bold contrasting choice to help create a focal point a such as the reception desk, or information hub.

## BLUES AND GREENS

Green's Teals and Blues create a calming and restful environment, therefore are suited to patient bays and waiting's areas.

## MAGENTA

The bold impact of reds create good contrast, however can be overwhelming if used incorrectly. Therefore we often find variations of magenta are used in dementia settings, further to piloting this in a 4 bedded bay on Hoskyn it not only creates a distinctive space but also compliments the existing NHS blue curtains and bedside armchairs

IMAGE OF HOSKYN TO FOLLOW

## How to use colour

Ageing eyes see colour in lower saturation therefore pastel shades become difficult to distinguish. Bright saturated colours, if used correctly can provide the perfect environment.

- Painted as solid blocks on an otherwise white canvas will define a space more effectively (refer to the orange wall indicating a section of corridor as a seating area) and allow for the easy colour matching when touching up walls (as the white areas are those more likely to be damaged by knocks)
- Using solid colour above the beds only, keeping the rest white… will draw the eye in more and define the bed-space.
- With white walls we can be bold with our choice of door colours for example toilets. Brighter the better!
- Lounge spaces and quiet rooms should remain restful, therefore injecting colour through soft furnishings, using bold choices of furniture colour

## Doors

As standard all doors at University Hospital are finished in a light oak wood finish to detract from an institutional feeling.

To support patients with dementia stronger colours and uniformity should be used to clearly identify toilet doors, ensuring a colour contrast between the door and its handle for visual impairment.

Areas where staff do not wish patients to access, such as linen cupboards or ward exits should be masked, using wall protection materials to blend the door into the surrounding wall, however still offering easy calcification for general use.

## Glazing

Decorative window films can help to enhance privacy and reduce glare if other solutions are not available. Suitable scenic images can be used on the corridor windows (observation glaze art) to improve privacy, but 'line of sight' should be always maintained for nursing staff, carers and visitors, to reduce distress and anxiety and to ensure safety and observation.

Vinyl images can be applied to window interiors to provide points of interest. These can also be used to reduce glare and sun downing, and enhance privacy. Natural and historic themes can result in a calmer, non-institutional environment and can act as reminiscent aids

## Lighting

lighting is a key aspect of the hospital environment and must be LED where possible including a control regime and form part of a detailed lighting design based on the principles detailed in the guidance.

Lighting design should consider:

- The use of the room
- Viewing angles of the users in the room to minimise glare
- Uniformity of light to ensure a consistent light level throughout the room minimising shadows and darker areas. Hot spots on walls are to be avoided.
- Ensure that the light levels are sufficient
- Ensure intelligent control is used to allow staff to dim light levels or increase them to improve the clinical environment.
- The use of light panels that can imitate windows and clouds or views of the countryside could be used in areas without natural light.

Beware the full guidance should be considered in the design of lighting. Lighting design will consider the points above and many more based on the use and users of the room. The design must consider the surfaces and coatings to ensure reflection and glare are minimised.

Lighting design should also be adaptable in control of intensity, colour and individual lamp control.

## Flooring

Guidance in relation to flooring specifications is currently under review by the Department of Health & Social Care Dementia and Disabilities Team.

In the interim we should refer to Health Building Note 08.02
Dementia Friendly Health & Social Care Environments has advised as follows:
Flooring should be:

- Matt (non-patterned) and seamless (consistent and avoiding steps)
- Material finishes and colours should differentiate room and space function.
- Non-institutional flooring solutions in non-functional rooms.

## Fixtures/Fittings

Colour contrasting fixtures and fittings can support recognition and orientation. Where possible and appropriate the use of traditional and familiar shapes and patterns should be used to facilitate recognition and identification as people living with particular types of dementia may not be able to rely on colour alone.

Fixtures and fittings should be colour contrasting, easily identifiable and within a clutter-free environment.

## Furniture

Use furniture that enables people to accomplish daily activities safely and independently.

Consider patient need and ease of getting in and out of chairs. Arrange furniture in small non-institutional clusters and provide a choice of fittings.

Upholstered furniture needs to comply with Infection Control and is recommended to be a deeper colour if used heavily, to prevent discolouration from clothing.

Furniture is sourced through Knightsbridge

www.knightsbridge-furniture.co.uk

For Information and brochures contact Estates and Facilities

## Signage

All signage must comply to Trust standard (as pictured) using consistent signage and visual cues across site.

To improve our signage we are introducing the use of pictograms to help identify locations for people who cannot read English or are unable to read or decipher words.

Use clear, visible and legible signage, avoiding information overload.

Locate signage in such a way that people can independently identify where to go to fulfil basic needs.


# Artwork

Art can define environments, help de-institutionalise and Individualise spaces and support wayfinding.

## Theme

We advise all artwork is selected for the purpose of its location, therefore do not wish to set 'standard theme', however our primary aim for creating a healing environment is to bring the outdoors in. In most cases areas in need of a facelift will have no access to outside space, nor will they have a view, and so we can offer this through the use of colour and artwork. Ideas include: nature, wildflowers, insects and wildlife, natural forms, organic materials etc.

For any project it is imperative you contact the arts coordinator who will advise you on themes and materials, ensuring considerations have been made for the service user inclusive of physical impairments or cultural heritage.

### Older patient groups

For older patients use photorealistic (non abstract) scenes of natural landscapes or local heritage and elements of interest. 'Off the shelf' dementia friendly art is also available and listed under 'extras' on page 13.

### Young patient groups

If you are looking to enhance a paediatric area we would suggest keeping colours bright and themes consistent. A lovely example of a newly refurbished paediatric space is the new Children's ED.

For any artwork installation please avoid clutter and consider line of sight for service users.

*wall vinyl*

*framed artwork*

*hand painted motifs*

# Artwork

## Cost

If you would like to add artwork to your area there are options to suit different budgets.

**Small room refurbishments, such as a dayroom**
**£250-£1,000** will fund a number of framed works for display
**£1,000-£4,000** will fund a larger commission such as a mural or vinyl installation .

**Larger Spaces**
If you are looking to enhance a number of treatment rooms or a large waiting area it is advised a budget of at least **£5,000** is set aside for a bespoke commission of works, the increase in cost would allow for materials, installation and any small works required.
***Please note: additional costs for installation will need to be included into your small works budget.***

## Practicalities/Room Closures

All framed artworks are secured to the wall with mirror-plates, these are very easy to install and take just a few minutes to hang. There will be minor noise disruption from the drill.

All other works that require more advanced installation (or a mural) will require a room closure for a period of time. If more than one area is being enhanced the Arts Coordinator will liaise with the ward to plan a sequence of room closures.

# Extras

## Clocks and calendars

Clocks and calendars in bedrooms and bedded areas can help with time orientation for people who are in bed. They are also useful within day spaces (i.e. dining rooms and activity spaces) and circulation areas. Clocks need to be large and clear to enable people living with dementia to read time

## Reminiscence hardware

- MiLife Software
- Digital Photoframes
- Digital Aquariums

To provide an element of interest and promote physical and meaningful activities

## Memory Boxes

Can be located in different areas and spaces to prompt memories and encourage engagement
https://www.new-vision.co.uk/health/products/memory-boxes

## No Window?

Why not add a false window
https://www.new-vision.co.uk/health/products/false-windows

## Privacy

The use of retractable a **Kwikscreen**, also doubles up as a great way to bring colour and interest into a clinical space www.kwickscreen.com

# What next?

## Enhancing your environment

To Do List

| | Complete (Tick) | Date | Comments |
|---|---|---|---|
| Identify patient need | | | |
| Create a small steering group with colleagues | | | |
| Review budget with Charity | | | |
| Arrange to meet with Estates and Facilties to discuss<br>-Small Works<br>Furniture<br>-Artwork | | | |
| Obtain quotes for works | | | |
| Apply for funding | | | |
| Agree work plan with Estates once funding is received | | | |

What is/is not considered a 'Small Works'

| | Small Works Request | Other | Notes |
|---|---|---|---|
| Painting Walls | ✓ | | |
| Changing the colour of a door | ✓ | | |
| Changing the floor | ✓ | | |
| Changing/adding signage | ✓ | | |
| Buying furniture | | ✓ | Purchase through Estates and Facilties |
| Artwork | Installation Only | ✓ | Purchase with support from Arts Coordinator |
| Reminiscence aids | Installation Only | ✓ | These items can be purchased through supplies |

Cost Checklist

| Item | Received | Quote Date | Included in Funding Application |
|---|---|---|---|
| Small works estimate | | | |
| Furniture quotes | | | |
| Artwork quotes | | | |
| Reminiscence aids quote | | | |

Charity Award Number Granted

| |
|---|
| A_ _ _ _ _ _ _ _ _ _ |

University Hospitals Coventry and Warwickshire NHS Trust

**REPORT TO PUBLIC TRUST BOARD**
**HELD ON THURSDAY 26 MARCH 2020**

| |
|---|
| **Finance and Performance Committee Report** following the meeting held on **20 FEBRUARY 2020** |
| **Chair of the Committee:** Ian Buckley |
| **Was this meeting quorate:** Yes |
| **Purpose:** This report is to **provide assurance** that **Finance 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 |
| 2018/19 National Cost Collection Outputs | The concerns regarding deterioration were noted but more detail is needed to understand the implications and recovery plans |
| Annual plan challenge | The Committee noted the difficulties of arriving at a system position alongside the Trust position. |

| **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 |
| Monitoring monthly income and expenditure variance to provide assurance to the Board and escalate any emerging issues of concern | Integrated Finance Report (Month 10) 2019/20<br>Trust-wide WRP Reviews – Service Line Reporting |
| Monitoring delivery of key access targets and operational delivery plans to provide assurance to the Board and escalate any emerging issues of concern. | Referral to Treatment (RTT) Update<br>Emergency Care Update |
| Providing a forum for scrutiny of any of the Trust's performance indicators at the request of the Board, referring any potential impact on quality to the Quality Governance Committee. | Integrated Finance Report (Month 10) 2019/20<br>Workforce Information Report |
| Reviewing the performance management arrangements for each Group, scrutinising the arrangements in place to meet financial and operational targets. | 2018/19 National Cost Collection Outputs |
| Reviewing the performance of Service Providers within the PFI contract. | |
| Providing effective oversight of all major capital and development projects including associated risks with the projects. | Capital Planning 2020/21 – 2024/25 |
| Ensuring adequacy of the Trust's Strategic Financial Planning | Annual Plan Update |
| Other | |

**TERMS OF REFERENCE**: Did the meeting agenda achieve the delegated duties?

**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.

**ATTENDANCE LOG**

| | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Was the meeting quorate? | | Yes | No | Yes | Yes | Meeting cancelled | Yes | No | Yes | Yes | Yes | Yes | |
| Non-Executive Director (Ian Buckley) | Chair | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | |
| Non-Executive Director (Jerry Gould) | Member | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | |
| Non-Executive Director (Brenda Shiels) | Member | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | |
| Chief Operating Officer | Member | × | × | × | ✓ | | ✓ | × | ✓ | × | ✓ | ✓ | |
| Chief Workforce and Information Officer | Member | ✓ | × | ✓ | ✓ | | ✓ | × | ✓ | ✓ | ✓ | ✓ | |
| Chief Finance Officer | Member | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | |
| Associate Non-Executive Director (Jenny Mawby-Groom) | Attendee | ✓ | ✓ | ✓ | ✓ | | × | ✓ | ✓ | ✓ | ✓ | × | |

University Hospitals Coventry and Warwickshire NHS Trust

# REPORT TO PUBLIC TRUST BOARD
# HELD ON THURSDAY 26 MARCH 2020

| |
|---|
| **Quality Governance Committee Report** following the meeting held on **20 February 2020** |
| **Chair of the Committee:** Sudhesh Kumar |
| **Quorate:** Yes |
| **Purpose:** This report is to provide assurance that Quality Governance 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** |
|---|---|
| CQC Update | The Committee congratulated staff on the recent CQC rating of 'good' and heard of the plans to address the issues in the report. These plans will also identify and track actions that the Trust needs to do to move towards an 'outstanding' rating |
| Quality Account Priorities 2020-21 | The process for identifying priorities for the Quality Account was explained and the emerging themes were being discussed. This will be approved at Board in March. |
| Complaints Detailed Report | The Committee were pleased to hear the improved performance of the complaints process with a performance of 100% against the 25 day standard being noted. The paper also address the 'deep dive' requested by the Board into one of the major causes of complaints, communication. |
| Quality Account Indicators – External Audit Concerns | Following issues raised by the KPMG as part of last year's audit of the quality account, a report was provided to give assurance about the robustness of the indicators used. There is still ambiguity in relation to the VTE indicator so a formal Trust position will be established which will be shared with external auditors, in the event of a further audit this year. |
| Any Other Business | An update on the Trust's response to the coronavirus (COVID 19) situation was given and the Committee heard about the guidance being given by NHS England and NHS Improvement and the Trust's response. |

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

| **Terms of reference** | **Agenda item** |
|---|---|
| Providing a forum for scrutiny of any of the Trust's quality indicators or priorities at the request of the Board. | Integrated Quality, Performance and Finance report<br>Quality Account Priorities 2020-21<br>SHMI Update (Neurology/Trauma)<br>Quality Account Indicators – External Audit Concerns |
| Providing assurance to the Board that arrangements are in place for identifying, prioritising and managing risk and that risks are escalated to the Board as appropriate. | Risk Management Committee Report<br>Complaints – Detailed Report<br>Patient Story Discussion Paper<br>Strategic Workforce Committee Report |
| Promoting safety, quality and excellence in patient care | Patient Experience and Engagement Committee Report<br>Ward Accreditation Framework |

| **Terms of reference** | **Agenda item** |
|---|---|
| | CQC Update<br>Quality Standards Committee |
| Ensuring the effective and efficient use of resources through evidence-based clinical practice | |
| Protecting the safety of employees and all others to whom the Trust owes a duty of care | |
| Ensuring that effective systems and processes are in place to support high quality care through an effectual training and education and ICT infrastructure | Information Governance Committee update |
| Ensuring that the Health and Safety Committee has an overarching view of health and safety and provide assurance that non-clinical risks are effectively managed on behalf of the organisation. | |
| Other | |

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

| **Attendance** | | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **Mar** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Was the meeting quorate? | | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes | Yes | |
| Non-Executive Director Ed Macalister-Smith | Chair | ✓ | ✓ | × | ✓ | ✓ | ✓ | ✓ | × | ✓ | ✓ | × | |
| Non-Executive Director (Barbara Beal to April 19) | Member | × | | | | | | | | | | | |
| Non-Executive Director (Brenda Shiels) | Member | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | |
| Non-Executive Director (Guy Daly from Oct 19) | Member | | | | | | | ✓ | ✓ | ✓ | ✓ | × | |
| Non-Executive Director (Sudhesh Kumar) | Member | ✓ | × | ✓ | X | ✓ | ✓ | ✓ | ✓ | × | ✓ | ✓ | |
| Chief Medical Officer | Member | × | ✓ | × | × | ✓ | ✓ | × | ✓ | ✓ | ✓ | ✓ | |
| Chief Nursing Officer | Member | ✓ | ✓ | ✓ | ✓ | × | × | ✓ | ✓ | ✓ | ✓ | × | |
| Chef Operating Officer | Member | ✓ | × | × | ✓ | × | × | × | ✓ | × | ✓ | ✓ | |
| Chief Workforce and Information Officer | Member | × | × | ✓ | ✓ | ✓ | ✓ | × | ✓ | ✓ | ✓ | ✓ | |

University Hospitals Coventry and Warwickshire NHS Trust

**REPORT TO PUBLIC TRUST BOARD**
**HELD ON 26 MARCH 2020**

| | |
|---|---|
| **Subject Title** | Patient Experience (We Care) Quarterly Report |
| **Executive Sponsor** | Mo Hussain, Chief Quality Officer |
| **Author** | Paula Lloyd Knight , Associate Director Quality |
| **Attachment(s)** | We Care Quarter 3 (2019/2020) Report |
| **Recommendation(s)** | Trust Board is asked to **NOTE** the Patient Experience Quarterly Report for Q3 (19/20). |

## EXECUTIVE SUMMARY


This quarterly Patient Experience Report (covering Q3 19/20) brings together information on compliments, complaints, PALS, patient feedback, patient involvement, board walk rounds and information from the Involvement Hub.

The Complaints Service has benefited from the changes that have taken place over the last 12 months. Performance has improved month on month. Performance against the Trust's 25 Working Day Response Standard in Quarter 3 finished at 90% (123 out of 137) an improvement on Q2 (51%). Quarter 3 highlights the vast improved level of performance, complaints received in November finished at (92%) and complaints received in December were fully met with a 100% response rate. This level of improvement demonstrates the new processes put in place across the service are now having the impact anticipated.

The subjects most complained about during Q3 include:

- Clinical treatment (Accident and Emergency) is the top subject most complained about (18/137).
- The second highest complaint area was Clinical Treatment (Surgical Group), with 17/137 this did not appear in Q1 and was third in Q2.
- Appointments with (16), was the third most complained about subject this did not appear in Q1 or Q2.
- Communications moves from first to fourth most complained about subject with (14), this was 2nd in Q1.
- Clinical Treatment (General Medicine Group) was the fifth most complained about subject with (13/137), this has not previously appeared in Q1 or Q2.

The Trust had 3 complaints decided by the Parliamentary Ombudsmen in quarter three.

The PALS received 1142 enquires in Q3 compared to 949 in Q2 (an increase of 193).The response rate for the 5 working day response standard for quarter three is 98% against the standard of 90% this is an increase on quarter two 93%.

The top five issues remain largely unchanged;

- Appointments remain the top PALS enquiry in Q3 with 340/1142 compared to 222 Q2.
- Communications remain second with 157 compared to 144 Q2
- Admissions discharge and transfers remains third with 153/1142 compared to 136 in Q2.
- Access to Treatment or Drugs moves to fourth with 108 and has not previously appeared in Q1 or Q2.
- Facilities moves to fifth from fourth last quarter with 68 / 1142 this is a reduction from 77 last quarter. (The reduction is largely due to a new process put in place where patients are now going directly to parking via security).

The Trust wide roll out of the values survey which was placed on hold due to NHS England's changes to the FFT question will now be rolled out on the 1st April to coincide with the release of the new FFT question.

Changes made following the FFT feedback include improvements around parking, food and drink and discharge process (see page 19 of the report).

509 responses were received from the Involvement Hub this quarter. The Hub continues to be utilised by staff and health awareness campaigns. There were a total of 40 bookings of the hub in Q3 which is an increase from Q2 (26).

Board Walk Rounds continue to take place on a monthly basis with departments sharing their ideas for positive change with senior colleagues. Five areas were visited on the Board Walks this quarter (update action reports have been received for all five areas with another four from Q1 and Q2). Each area has reported the action that has or is being taken to deliver improvements in the areas of concern. Actions/areas of progress based on the feedback are included within the report (pp24-32).

The "mystery shoppers" programme has now commenced with the first shoppers arriving at the Coventry site on the 24.02.2020. An update of their experience has been presented as this month's patient story.

| **PREVIOUS DISCUSSIONS HELD** |
|---|
| Approved at Patient Engagement and Experience Committee November 2019 |

| **KEY IMPLICATIONS** | |
|---|---|
| **Financial** | Deliver value for money and other regulatory compliance |
| **Patients Safety or Quality** | NHSI and other regulatory compliance |
| **Human Resources** | To be an employer of choice |
| **Operational** | Operational performance and regulatory compliance |

Public TB 26-03-2020
Item 24: Patient Experience (We Care) Q3 Report

University Hospitals Coventry and Warwickshire NHS Trust

# We Care
# Patient Experience Report Quarter 3 (2020)

26th March 2020

# Contents



*Compliment of the Quarter*

*"Thank you so much for all your care, I'll be here a while, but I think it is important to let you know how much I appreciate all you do and have done for me thank you"*

# **Objective one**:

## Improve the way we listen, respond and use patient feedback to support improvements

To support the delivery of this objective data for quarter three is being shared on:

**Complaints**

- Performance
- Themes
- Learning

**PALS**

- Performance
- Themes
- Learning

# Complaints & PALS Activity

## COMPLAINTS:

- 90% of complaints responded to within 25WD (improved from 51.35% Q2)
- 137 Total number of complaints received in Q3
- 32 Total number returned for further local resolution (FLR)*
- 237 WD The age of oldest complaints case at end of quarter
- 42 out of 196 cases upheld
- 39 out of 42 upheld action plans completed
- 3 Parliamentary and Health Service Ombudsman cases received in Quarter 3

## PALS:

- 11 42 PALS enquiries received
- 26WD The age of oldest PALS case at end of quarter
- 1121 (98%) 5 working day performance
- 432 Compliments and Thanks reported about numerous services across the Trust

# Complaints Activity & Performance

| | Quarter 4 2018-19 | Quarter 1 2019-20 | Quarter 2 2019-20 | October 2019 | November 2019 | December 2019 |
|---|---|---|---|---|---|---|
| Total number of formal complaints received | 191 | 166 | 148 | 57 | 39 | 41 |
| | | | | **137** | | |
| % of complaints acknowledged within 3 days | 137 (72%) | 113 (68%) | 133 (90%) | 53 (93%) | 34 (87%) | 40(95%) |
| | | | | **127** (93%) | | |
| % of complaints responded to in 25 working days | 123 (69%) | 71 (43%) | 76 (51%) | 46( 81%) | 36 (92%) | 41 (100%) |
| | | | | **123 (90 %)** | | |
| % of complaints over 25 working days | 68 (36%) | 95 (57% ) | 72(49% ) | 11( 19%) | 3 (8%) | 0 (0%) |
| | | | | **14 (10%)** | | |
| No. of cases closed by quarter | 149 | 144 | 167 | 81 | 63 | 52 |
| | | | | **196** | | |
| Oldest open complaint at end of month | 137WD | 195WD | 179WD | 190WD | 214WD | 237WD |
| Total number returned for further local resolution (FLR)* | 20 | 6 | 0 | 13 | 6 | 13 |
| | | | | **32** (this is due to the large number of cases closed) | | |
| Total number of new PHSO cases | 0 | 0 | 0 | 1 | 2 | 0 |
| | | | | **3** | | |

** This is the number of complaints returned for Further Local Resolution. These do not necessarily relate to the complaints received that month as complaints can be returned for further local resolution up to a year after the complaint was responded to.*

# PALS Activity & Performance

| | Quarter 4 2018-19 | Quarter 1 2019-20 | Quarter 2 2019-20 | October 2019 | November 2019 | December 2019 | Quarter 3 Total |
|---|---|---|---|---|---|---|---|
| PALS Enquires | **871** | **775** | **949** | **459** | **386** | **297** | **1142** |
| | | | | | | | |
| Signposting | 41 | 54 | 33 | 6 | 7 | 7 | 20 |
| Immediate Response | 183 | 224 | 225 | 100 | 64 | 31 | 195 |
| Liaise and Respond | 359 | 171 | 121 | 18 | 16 | 8 | 42 |
| Refer to Specialty | 267 | 319 | 567 | 333 | 298 | 250 | 881 |
| On-going support | 21 | 27 | 3 | 2 | 1 | 1 | 4 |
| % of PALS enquires resolved or referred in 5 working days | 756(87%) | 700 (90%) | 886 (93%) | 447 (97%) | 380(98%) | 294 (99%) | 1121 (98%) |

# Learning from Complaints and PALS

| Datix ID | Main Issues of Complaint | Outcome | Actions Taken |
|---|---|---|---|
| | | COMPLAINTS | |
| 29946 | • Patient was receiving chemotherapy and required a PICC line to have treatment administered.<br>• Patient was unaware of how to care for their dressings and PICC lines appropriately. | • Chemotherapy Suite Team apologised for any miscommunication regarding correct maintenance of dressing.<br>• Patient was informed of the correct maintenance procedure<br>• Patient was provided with new bandages and scheduled time with the nurse. | • Following complaint, Chemotherapy suite have reviewed the patient leaflets to ensure patients are given a leaflet on how to care for dressings and PICC lines when the lines are inserted. |
| | | PALS | |
| 30634 | • Family presented to PALS regarding the release of their son's body that had been within UHCW for 3 months due to ongoing investigations involving Patient Safety. | • With the support of PALS the family met with the lead investigator and Patient Safety.<br>• Family were supported by PALS during the visit to see their son in the mortuary.<br>• PALS were able to help and support the family with the arrangements for their son to be transferred to the funeral parlour. | • PALS have improved the triangulation with complaints and patient safety.<br>• PALS have also improved their knowledge of the mortuary process and now are familiarised with the location. |

# Top 5 Complaint Subjects

| Top 5 Primary Subjects out of 138 Complaint Cases received in quarter 3 | | Top 3 themes for quarter 3 | Position of subjects in previous quarters Q1 | Q2 |
|---|---|---|---|---|
| **Clinical Treatment - Accident & Emergency** | **18** | **Lack of clinical assessment** | Did not appear | 2nd |
| | | **Patient not listened to** | | |
| | | **Delay in treatment** | | |
| **Clinical Treatment - Surgical Group** | **17** | **Patient not listened to** | Did not appear | 3rd |
| | | **Delay or failure in treatment or procedure** | | |
| | | **Delay in treatment** | | |
| **Appointments** | **16** | **Appointment delay (inc length of wait)** | Did not appear | Did not appear |
| | | **Appointment - failure to provide follow-up** | | |
| | | **Appointment Cancellations** | | |
| **Communications** | **14** | **Communication with relatives/carers** | 2nd | 1st |
| | | **Patient not listened to** | | |
| | | **Communication with patient** | | |
| **Clinical Treatment - General Medicine Group** | **13** | **Communication with relatives/carers** | Did not appear | Did not appear |
| | | **Patient not listened to** | | |
| | | **Missed or incorrect diagnosis** | | |

# Top 5 PALS Subjects

| Top 5 Primary Subjects out of 1142 PALS Enquiry received in quarter 3 | | Top 3 Themes identified in quarter 3 | Position of subjects in previous quarters | |
|---|---|---|---|---|
| | | | Q1 | Q 2 |
| **Appointments** | **340** | **Appointment delay (inc length of wait)** | 1st | 1st |
| | | **Appointment Cancellations** | | |
| | | **Other - Appointments incl delays / cancellations** | | |
| **Communications** | **157** | **Communication with patient** | 2nd | 2nd |
| | | **Communication with relatives/carers** | | |
| | | **Other - Communications** | | |
| **Admissions, Discharges & Transfers (excl. delayed discharge due to absence of care package - see Integrated care)** | **153** | **Other - Admissions, Discharges & Transfers** | 4th | 3rd |
| | | **Discharge Arrangements (inc lack of or poor planning)** | | |
| | | **Admission Arrangements** | | |
| **Access to Treatment or Drugs** | **108** | **Delay in Treatment** | Did not appear | Did not appear |
| | | **Other - Access to treatment or Drugs** | | |
| | | **Cancellation of operation / procedure** | | |
| **Facilities** | **68** | **Car parking - management (including fines/clamping etc.)** | 3rd | 4th |
| | | **Car parking - cost** | | |
| | | **Smoking issues** | | |

# **Objective two** :

Improve the way we develop and manage patient information leaflets

To support the delivery of this objective  Trust wide performance data for patient Information is provided, along with plans to improve access to patient information on the Trust website

# Patient Information

Quarter 3 data for Patient Information shows that we are 98.4% compliant for all Patient Information Leaflets. Work is taking place to provide access to Trust patient information leaflets through the Trust website by the 1st April 2020

*Below information is from Insite and eLibrary*

| | Leaflets available | For review | Expired leaflets | % In date |
|---|---|---|---|---|
| **October** | 1595 | 143 | 24 | **98.5%** |
| **November** | 1593 | 200 | 14 | **99.1%** |
| **December** | 1609 | 186 | 26 | **98.4%** |

| Total Number of Leaflets updated | Number of New Leaflets uploaded | Total Number of queries received and responded to |
|---|---|---|
| **110** | **15** | **211** |

# **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 staff are living the Trust values

# National Patient Survey Programme

The National Patient Survey Programme, running since 2002, is a mandatory programme which all Trusts have to take part in. The Programme is overseen by the CQC. It currently consists of the Annual Inpatient Survey and Maternity Services Survey with the A&E Survey and the Children and Young People's Survey being carried out every 2 years. The Trust commissions Quality Health Ltd to carry out the surveys on its behalf. The CQC provides the Trust with a benchmark report which compares the Trust nationally.

**2018 Inpatient Survey :**
The CQC's Benchmark report was received on 20th June 2019. The Trust has improved its position in 5 areas from 2017:

- While you were in the A&E Department, how much information about your condition or treatment was given to you?
- Was your admission date changed by the hospital?
- From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?
- Were you ever bothered by noise at night from other patients?
- Were you ever bothered by noise at night from hospital staff?

The Trust scored worse than expected in 2 areas (compared to 6 questions in 2017).

- If you brought your own medication with you to hospital, were you able to take it when you needed to?
- Do you think the hospital staff did everything they could to help control your pain?

A comprehensive programme is underway on the two areas requiring improvement . The pain management work is being led by nursing and work has taken place across Rugby St Cross where the data identified variation between the two sites. Work on self medication administration which is now at pilot stage is being monitored through the Medicines Management Committee.

**2018 Urgent and Emergency Care Surveys 2018: two surveys – Emergency Department & Urgent Care Centre Position:**
The CQC's Benchmark Reports were received on 23rd October 2019. The Trust has scored 'about the same' compared to as most other Trusts across both surveys. Work is taking place on improvements. An update will be reported at the April Patient Experience and Engagement Committee

**2018 Children and Young People's Patient Experience Survey :**
The CQC's benchmark report, was published on the 19th November 2019 .An action plan has been developed and work is underway . Progress on the action plan was provided at the February Patient Experience and Engagement Committee.

**2019 Maternity Survey :**
The CQC's benchmark report, report published on the 28th January 2020. An action plan has been developed and work is being progressed

# **Objective four** :

Ensure that patient voice is at the centre of care improvements

To support the delivery of this objective an update is provided on the following areas:

- Involvement activity
- Friends and Family Test (FFT) performance
- Responding to FFT comments

# Patient Involvement Activity

**Patient Partners have played a curial role in providing a patient perspective in the following improvement activities.**

- ❑Mini Patient Led Audit of the Clinical Environment (PLACE) at University Hospital
- ❑Medicine Audit Walk round
- ❑Radiology Walk round
- ❑Daisy Award staff recognition initiative
- ❑Co – Development of the Quality Account 20/21

The Trust is committed to working in partnership with patients to improve the way we deliver care, to support this Patient Partners are members of a number of Trust committees and groups

- ❑End of Life Committee
- ❑Paediatric QIPS
- ❑Patient Experience Delivery Group
- ❑Patient Experience & Engagement Committee
- ❑Patient Partners' Forum
- ❑Patient Insight & Safety Learning Group
- ❑Patient Information Governance Advisory Group
- ❑Rugby Quality Committee
- ❑Independent Advisory Group
- ❑Accessible Information Standards Working Group
- ❑Healing Arts Committee
- ❑Infection Control
- ❑Medicines Safety Committee
- ❑Daisy Nomination Panel

46 Patient Partners have been recruited to date with 24 Patient Partners currently active. A review and recruitment drive is planned for Q4.

# Involvement Hub Activity

**A highlight of events that took place this quarter**

- Hand Hygiene – 8 days
- HBP Cancer Awareness – 2 days
- Safeguarding – 1 day
- Crohn's Disease Awareness – 2 days
- Cancer Services – 1 day
- Pharmacy – Antibiotic Awareness – 3 days
- Lung Awareness – 1 day
- Mouth Cancer Awareness – 3 days
- Recruitment – 1 day
- HPB Cancer Awareness – 1 day
- World Radiology Day – 1 day
- National Pathology Day – 4 days
- Neuro Oncology Service Awareness – 1 day
- Malnutrition Awareness Week – 3 days
- National Pharmacy Technician Day – 1 day
- Stroke Recruitment Event – 1 day
- Respiratory Recruitment Event – 1 day
- Healthy Life Styles – 9 days

# Feedback from Involvement Hub Kiosks

Since January 2019, the Involvement Hub Kiosks have asked members of the public the Friends and Family Test question, along with the follow up question.

**Q3 2019/2020**

| | Number of Responses | Number that Recommend Service | Percentage that Recommend Service |
|---|---|---|---|
| Inpatients & Day Case Combined | 140 | 95 | **68%** |
| A&E (all areas) | 73 | 42 | **58%** |
| Outpatients all departments | 170 | 127 | **75%** |
| Antenatal (before 36 weeks) Experience | 22 | 14 | **64%** |
| Antenatal (after 36 weeks) Experience | 14 | 5 | **36%** |
| Birth/Labour Experience | 49 | 29 | **59%** |
| Postnatal (hospital) Experience | 41 | 25 | **61%** |
| **Overall Total** | **509** (505 Q2) | **337** (329 Q2) | **66%** (66% Q2) |

# Friends and Family Test - Activity and Performance – Response Rates

**Code**:

- Red = outside of the Trust target,
- Amber = within 5% of the Trust target
- Green = met trust target or above
- Arrow = the change from the previous quarter

| | | | 2019 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | Q2 | | | Q3 | | | |
| | FFT Setting | Target | Jul | Aug | Sep | Oct | Nov | Dec | Change |
| Response rate | Inpatients & Day Case Combined | 26% | **22.7%** (3085/13563) | **23.7%** (2963/12482) | **23.5%** (2906/12377) | **20.70%** (2773/13371) | **18.80%** (2389/12700) | **21.70%** (2572/11847) | ▼ |
| | A&E (all areas) | 15% | **14.6%** (2404/16504) | **15.6%** (2465/15795) | **14.4%** (2305/16057) | **15.10%** (2492/16545) | **12.20%** (2002/16435) | **14.00%** (2266/16216) | ▼ |
| | Outpatients (all departments) | 8% | **4.09%** (2187/53478) | **5.79%** (2641/45636) | **6.29%** (3050/48469) | **8.62%** (4521/52433) | **7.01%** (3463/49390) | **8.53%** (3793/44483) | ▲ |
| | Antenatal (after 36 weeks) Experience | 15% | **16.70%** (87/521) | **15.98%** (81/507) | **22.61%** (109/482) | **14.65%** (69/471) | **8.02%** (36/449) | **13.70%** (60/438) | ▼ |
| | Birth/Labour Experience | 15% | **19.77%** (103/521) | **17.36%** (88/507) | **15.77%** (76/482) | **12.31%** (58/471) | **12.50%** (56/449) | **15.07%** (66/438) | ▼ |
| | Postnatal (hospital) Experience | 15% | **23.22%** (121/521) | **23.87%** (121/507) | **32.37%** (156/482) | **27.60%** (130/471) | **29.84%** (134/449) | **23.29%** (102/438) | ▲ |
| | Postnatal (community) Experience | 15% | **16.77%** (81/483) | **19.87%** (94/473) | **23.49%** (105/447) | **27.71%** (120/443) | **24.58%** (103/419) | **18.23%** (76/417) | ▲ |
| | Trust | - | **9.43%** (8068/85591) | **11.14%** (8453/75907) | **11.05%** (8707/78796) | **11.47%** (9663/84205) | **10.20%** (8147/79872) | **12.03%** (8935/74277) | ▲ |

# Friends and Family Test - Activity and Performance - Recommender Rates

**Code**:

- Red = outside of the Trust target,
- Amber = within 5% of the Trust target
- Green = met trust target or above
- Arrow = the change from the previous quarter

| | | | 2019 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | Q2 | | | Q3 | | | |
| | FFT Setting | Target | Jul | Aug | Sep | Oct | Nov | Dec | Change |
| Recommender rate | Inpatients & Day Case Combined | 95% | **90.11%** (2780/3085) | **91.23%** (2703/2963) | **91.29%** (2653/2906) | **90.95%** (2522/2773) | **90.21%** (2155/2389) | **91.29%** (2348/2572) | ▼ |
| | A&E (all areas) | 87% | **80.3%** (1924/2404) | **79.11%** (1950/2465) | **76.66%** (1767/2305) | **77.25%** (1925/2492) | **73.73%** (1476/2002) | **79.30%** (1797/2266) | ▼ |
| | Outpatients (all departments) | 95% | **93.14%** (2037/2187) | **91.75%** (2423/2641) | **91.51%** (2791/3050) | **91.29%** (4127/4521) | **90.67%** (3140/3463) | **91.51%** (3471/3793) | ▼ |
| | Antenatal (after 36 weeks) Experience | 97% | **90.80%** (79/87) | **93.83%** (76/81) | **91.74%** (100/109) | **92.75%** (64/69) | **83.33%** (30/36) | **95.00%** (57/60) | ▼ |
| | Birth/Labour Experience | 97% | **88.35%** (91/103) | **81.82%** (72/88) | **93.42%** (71/76) | **87.93%** (51/58) | **89.29%** (50/56) | **87.88%** (58/66) | ▼ |
| | Postnatal (hospital) Experience | 97% | **90.08%** (109/121) | **90.08%** (109/121) | **89.10%** (139/156) | **95.38%** (124/130) | **92.54%** (124/134) | **87.26%** (89/102) | ▲ |
| | Postnatal (community) Experience | 97% | **98.77%** (80/81) | **98.94%** (93/94) | **94.29%** (99/105) | **99.17%** (119/120) | **99.03%** (102/103) | **96.05%** (73/76) | ▲ |
| | Trust | 95% | **88.00%** (7100/8068) | **87.85%** (7426/8453) | **87.52%** (7620/8707) | **87.88%** (8932/10163) | **86.48%** (7077/8183) | **88.34%** (7893/8935) | ▲ |

# FFT Improvements

The action log supports the Trust to monitor and respond to patient feedback by directly asking the areas where the feedback came from to identify the actions they are taking to ensure the service can learn and make improvements based on the feedback. All services feedback on the actions they will take within the 14 days of the feedback being received.

| Number of improvement actions Q3 2019/2020 | Group with highest number of actions for Q3 2019/2020 | Number of closed actions for Q3 2019/2020 | Number of open actions for Q3 2019/2020 |
|---|---|---|---|
| **39** ↑ Q2: 37 | **Emergency Medicine** | **15** | **24** |

- 664 negative comments were received for long waiting times in the Emergency Department compared to 384 in quarter 2
- 999 comments were received mentioning car parking in quarter 3 compared to 591 for quarter 2. Common themes were lack of car parking spaces and the cost to park.

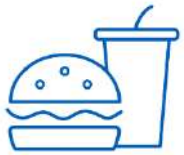
# Patient Insight

## Results from Friends and Family Test (FFT)

Bottom 3 service areas for quarter 3 2019-20 & associated actions

**Car Parking – (University Hospital)**

- Regular communications through the hospital website and social media to inform patients and visitors of the use of ANPR.
- Better flow of traffic around the site with the removal of barriers.
- The Trust and ISS have undertaken a review of car park signage in view of feedback and modifications are due to be made as a result.



**Food and drink**

- ISS have been rolling out an electronic ordering system for patient menus. The rollout at Hospital of St. Cross is complete and as it is anticipated that the system will be fully rolled out at University Hospital in due course.
- Monthly food tasting sessions are held with ward teams which gives an opportunity for the patient meals to be tested by the clinical teams so they can best advise patients on choice.
- As part of The MINI place audit review the quality of the food is monitored on a bi-monthly basis.

**Discharge Process**

- The Integrated Discharge Team (IDT) are working on a new policy 'Supporting Patients Choices to avoid long hospital stays' which will be ready for approval in quarter 4. This is about providing patients with the relevant information relating to their discharge plans to keep them and their families informed of their choices. IDT are also, in conjunction with the CCG and the Local Authority, continuing to work with Health Watch following their review of the discharge pathways on the information that is provided both in hospital and post discharge.
- The Trust's Flow Improvement Lead is also undertaking work on simple discharges.

# **Objective five** :
# Improve the patient care environment

To support the delivery of this objective an update is provided on:

- Board walk round activity and actions taken to support improvements

# Board Walk Round

## Clinical Support Services

**<u>Arden Cancer Centre</u> (Thursday 11th April 2019)**

**Visiting Team:**

- Jenny Mawby-Groom, Associate Non-Executive Director
- Lisa Kelly, Chief Operating Officer

**The Visit Noted that:**

- That the entrance and OP waiting area felt very calm.
- The Modern Matron was praised for being positive, passionate, having loads of energy and pride for her service.

**Areas of Concern:**

- Toilet capacity and Chemo Capacity

**Action Taken**

- The department were unable to make any changes to current environment until the opening of the new Rugby St Cross Oncology & Haematology Day Unit in September 2020.

# Clinical Support Services

**<u>Main Outpatients</u> (Thursday 20th June 2019)**

**Visiting Team:**

- Jenny Mawby-Groom, Associate Non-Executive Director
- Debby McBride, Lead Nurse N&M and AHP Workforce

**The Visit Noted that:**

- It noted that the Leader board / Operation Board and Morning Huddle all worked well.
- Mandatory training was managed well.

**Areas of Concern:**

Clinical cancelations (there were 17 on 20th June 2019)

- The area failed on the 10 point checklist due to uniform trousers.

**Action Taken:**

The utilisation group are hoping to hand over the process to speciality groups within the next 6-12 weeks. The 6 week clinic request deadline is already in place at booking centre accompanied by SOP.

- The uniforms are addressed in daily huddles; uniform checks are completed weekly and audits are undertaken monthly and fed back to the Matron.

# Clinical Support Services

**<u>Ground Floor Theatres</u> (Thursday 24th October 2019)**

**Visiting Team:**

- Jerry Gould, Non-Executive Director
- Tracey Brigstock, Deputy Chief Nursing Officer

**The Visit Noted that:**

- Good quality care within the department, supporting a range of specialties and services – responsive to new technologies
- Good visual Production Board – with 'walk the wall' concept whereby those attending discuss the information displayed and agree daily action

**Areas of Concern:**

- Need to move the decontamination equipment and staff, from main theatre to ground floor theatre – to improve efficiency and responsiveness. This is in discussion with the Decontamination Lead.
- Managers do not receive the outcome of Datix Investigations – this would ensure that matters raised are followed through to completion and maximise learning

**Action Taken:**

The need to move the decontamination equipment was now completed.

- All Band 7 and above had Datix training , now added as investigators for incidents and feedback received and shared at huddles

# Medicine

**<u>Mulberry Ward</u> (Thursday 20th June 2019)**

**Visiting Team:**

- Jerry Gould, Non-Executive Director

**The Visit Noted that:**

- The was standard of care was praised, as all of the team were seen be “going the extra mile” for patients and their relatives.
- The teamwork seen was of an excellent standard.

**Areas of Concern:**

- Effective assessment of new patients before arrival.
- Open trolley holding patient consumables

**Action Taken:**

- The department had altered the referral pathway for patients coming from UH to Rugby. They were now evaluating this and will make further changes if required.
- The trolley used for linen and consumables is in the process of being changed, however, it has been a challenge to identify a suitable closed trolley which suits the department needs. Staff are more mindful about keeping the trolley more tidy while we are still using the open trolley at the present time.

# Medicine

**Ward 1 - Dermatology/Diabetes & Endocrinology/ Rheumatology (Thursday 11th July 2019)**

**Visiting Team:**

- Jerry Gould, Non-Executive Director

**The Visit Noted that:**

- Good cross-speciality / great teamwork (incl. consultants)
- Consultants “listen” and attend regularly including weekend cover
- Willingness of team to do extra hours through bank (essential due to vacancy levels)

**Areas of Concern:**

- Level of trained nurse vacancies was at 40%
- Comparatively young Bariatric patient with mental health issues unable to go home and no suitable social services solution

**Action Taken:**

- The nursing vacancy levels remain unchanged. However an excellent robust recruitment drive is currently in place, with 3 newly qualified, and nursing associates being arranged to start from February. Competencies are being designed for new starters on the ward. Attending recruitment events to boast interest for the speciality.
- The bariatric patient was discharged, with all needs met.

# Medicine

**<u>Ward 34</u> - Haematology (Thursday 17th October 2019)**

**Visiting Team:**

- Ed Macalister-Smith, Non-Executive Director
- Geoff Stokes, Director of Corporate Affairs

**The Visit Noted that:**

- Good teamwork reported, both doctors and nurses. Nurses fully recruited
- Safety huddle and board rounds programmes so they are co-ordinated and allow for information flows
- Good, rapid liaison with referrers from GPs, GE and SWFT
- Excellent patient feedback, zero complaints

**Areas of Concern:**

- Tablets to take out (TTOs) – turnaround to facilitate quicker discharge
- Keeping hold of trained staff and encouraging development of existing staff without posts to promote into

**Action Taken:**

- The department confirmed that the focus on next day discharge preparation has improved this
- Staff have been internally promoted and supported in secondments and learning opportunities. This is all within existing roles.

# Medicine

**Ward 24 – Antenatal (Thursday 24th October 2019)**

**Visiting Team:**

- Jenny Mawby-Groom, Associate Non-Executive Director
- Lynda Scott, Director of Communications

**The Visit Noted that:**

- A patient experience midwife role was created and this has helped increase the amount of feedback but also the ways in which it is received – through cards and iPads, with a "You Said, We Did" patient feedback display by the day room – this includes negative feedback and what the ward is doing to improve
- Staffing within two weeks maternity will be fully staffed for the first time – although there has been quite a change in leadership over the last 18 months, the culture and approach to change and improvement has really improved. The ward also has a Change Maker to help support improvements.

**Areas of Concern:**

- Day Room for patients – this is an active project the team are trying to drive through. The current facilities are a room with chairs and information leaflets and posters. As mums to be can be waiting for some time, the plan is to have a range of ways for sitting (e.g. birthing balls) but also TV, books and activities so that for those who need distraction whilst waiting, its an improved experience.
- Signage and flow through ward – requests have been made to improve clarity of signage between Ward 24 and 25. There is also a degree of people "cutting through wards" between ISS offices to go to Ward 25 etc. which is not ideal but it was agreed that improved signage may help.

**Action Taken:**

- Day room for patients – The Deputy Ward Manager has taken this on as a project and is liaising with the Charities Department as to how to how the best way of going forward is.
- Signage – The Communications Team ordered new signage for the doors to Ward 24 and going through to Ward 25

# Women and Childrens

**<u>Children's Outpatient Department</u> (Thursday 21st November 2019)**

**Visiting Team:**

- Sudhesh Kumar, Non-Executive Director
- Kiran Patel, Chief Medical Officer

**The Visit Noted that:**

- Nice environment
- Teamwork and staffing was great and all staff had good morale

**Areas of Concern:**

- Access to virtual and evening clinics
- Having flexible appointments

**Action Taken:**

- Virtual clinics are already set up for Paediatric Oncology, Epilepsy and Diabetes with other specialities under development
- COPD already offers Choose and book, Rugby St Cross Paediatric Clinics some weekend clinics

# Medicine

**<u>Centre for Reproductive Medicine</u> (Thursday 21st November 2019)**

**Visiting Team:**

- Jerry Gould, Non-Executive Director
- Su Rollason, Chief Finance Officer

**The Visit Noted that:**

- The department should be proud of their great work
- High success rate of the centre
- The centre had an open culture

**Areas of Concern:**

- Overseas visitors not adhering to letter and presenting at clinics without pre-checks for eligibility for free treatment

**Action Taken:**

- The department have now secured input for 3 days a week from the overseas team who will be based in CRM to deal directly with patients. So this should solve many of the problems around understanding of the rules regarding funding.

# Performance Update

An update is provided on the 5 objectives and 15 key performance indicators for

Q1-3

# KPI Progress Update Q3

| Objective | KPI | 2019/20 Trajectory where appropriate | Q1 | Q2 | Q3 | Delivery Lead | Status at the end of each quarter |
|---|---|---|---|---|---|---|---|
| To improve the way we listen, respond and use patient and carer feedback to support improvements | ≥90% of PALS contacts have their enquiry locally resolved of referred in 5 working days | By Q4 2020 | GREEN | GREEN | GREEN | Rob Finnie | Achieving target Q3 |
| | To be in the top 20% of Trusts for the National inpatient survey responses around listening and responding to patients. | By Q4 2020 | AMBER | AMBER | AMBER | Groups | Partially achieving target<br>Q. When you had important questions to ask did you get an answer you could understand? 8.1/10 2018 8.1/10 2017 ( The trust is currently within the expected range) |
| | To have 95% of patients recommend us in the Friends and Family Test (or NHSi Test) | By Q4 2020 | AMBER | AMBER | AMBER | Groups | Partially achieving target InPat 91.29% A&E 76.66% Anten 91.74% Birth 93.42% P hosp 89.10% P comm 94.29% |
| To improve the way we we will manage the provision of patient health information | All core Trust patient information leaflets to be available in easy read and large print formats at the Trust and on the Trust website | By Q4 2020 | AMBER | AMBER | AMBER | Imrana Ghamra | Partially achieving target<br>All core trust information available in easy read leaflets through ward based information stands , work has taken place on the website, with an expected live date on schedule for before March 2020 |
| | 90% of all patient facing information leaflets to be within its review date | By Q4 2020 | GREEN | GREEN | GREEN | Imrana Ghamra | Q3 Oct 98.5 % Nov 99.1% Dec 98.4 |
| | 100% of adult inpatient ward patient information carousels to be audited annually | By Q4 2020 | GREEN | GREEN | GREEN | Imrana Ghamra | Achieving target All ward carousels are now audited quarterly and a schedule has been developed for the year for both sites |
| To ensure that staff place Trust values at the centre of delivering patient care | Use patient co-developed values based questions across all adult inpatient and outpatient services | By Q4 2020 | AMBER | AMBER | AMBER | Sarah Brennan | Partially achieving target values based questions have been rolled out across outpatient areas and will be rolled out across inpatients as part of the new all codes for new inpatient areas have been completed set for the 1st April 2020 FFT process |
| | 100% of adult inpatient wards to display the results of their values based surveys and actions taken to improve care | By Q4 2020 | GREEN | GREEN | GREEN | Groups / Sarah Brennan | Achieving target |
| | To be in the top 20% of Trusts for the National inpatient survey responses around delivering values based care | By Q4 2020 | AMBER | AMBER | AMBER | Groups / Sarah Brennan | PARTIALLY ACHIEVED reported to PEEC<br>Q overall did you feel you were treated with respect and dignity? 9/10 (2018) 8.9/10 (2017)<br>The trust is currently within the expected range |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| To ensure that staff place Trust values at the centre of delivering patient care | Use patient co-developed values based questions across all adult inpatient and outpatient services | By Q4 2020 | AMBER | AMBER | AMBER | Sarah Brennan | Partially achieving target values based questions have been rolled out across outpatient areas and will be rolled out across inpatients as part of the new all codes for new inpatient areas have been completed set for the 1st April 2020 FFT process |
| | 100% of adult inpatient wards to display the results of their values based surveys and actions taken to improve care | By Q4 2020 | GREEN | GREEN | GREEN | Groups / Sarah Brennan | Achieving target |
| | To be in the top 20% of Trusts for the National inpatient survey responses around delivering values based care | By Q4 2020 | AMBER | AMBER | AMBER | Groups / Sarah Brennan | PARTIALLY ACHIEVED reported to PEEC<br>Q overall did you feel you were treated with respect and dignity? 9/10 (2018) 8.9/10 (2017)<br>The trust is currently within the expected range |
| To ensure that patient voice is at the centre of care improvements | The Trust has a co-developed patient partners programme, which supports people to be involved in a range of service improvement activities across the Trust | By Q4 2020 | GREEN | GREEN | GREEN | Manni Bassra | ACHIEVED |
| | A patient mystery shopper programme is in place to support improvements in the patients experience of care | By Q4 2020 | AMBER | AMBER | AMBER | Manni Bassra | PARTIALLY ACHIEVED, progress has been made to develop a process for Mystery shopper areas. Adverts have been posted across social media and through a |
| | The Trust Patient Partner Forum's annual report provides positives observations and examples of patient voice being at the centre delivering patient care and service improvement | By Q1 2021 | | | | Manni Bassra | First report due in March 2020 |
| To improve the patient environment | To achieve a 5% increase in positive comments from FFT verbatim comments on the environment | By Q2 2021 | AMBER | AMBER | AMBER | Groups / Sarah Brennan | PARTIALLY ACHIEVED, positive comments have been received regarding the internal environment; however the trust has received a number of comments which relate specifically to parking. |
| | To be in the top 20% of trust across all PLACE domains in the annual PLACE assessment | By Q4 2020 | | | | Lincoln Dawkin | Results not yet available for 2019 annual PLACE assessment (results expt. by end of of April 2020 |
| | Achieve ≥90% on the Matron's ICNA audits | By Q4 2020 | GREEN | GREEN | AMBER | Lincoln Dawkin | partially achieved<br>Oct 90.14 %<br>Nov 90.49%<br>Dec 88.38 % |

PATIENT EXPERIENCE TEAM
QUALITY DEPARTMENT
3RD FLOOR CENTRAL
EXT 25166

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