NHS
University Hospitals Coventry and Warwickshire
NHS Trust

PUBLIC TRUST BOARD
HELD AT 10:00 AM ON THURSDAY 1 DECEMBER 2022
CSB, ROOMS 10009/11

AGENDA

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

	Item	Lead	Format	Action	Duration
1.	Patient Story	M Hussain	Enclosure	N	10 mins
2.	2.1 Apologies for Absence 2.2 Confirmation of Quoracy 2.3 Declarations of Interest	Chair	Verbal/ Enclosure	As/Ap	5 mins
3	3.1 Minutes of previous meeting held on 06 October 2022 3.2 Action Matrix 3.3 Matters Arising				
4.	Chair's Report	Chair	Enclosure	As	10 mins
5.	Chief Executive Officer Update	A Hardy	Enclosure	As	15 mins
6.	Audit and Risk Assurance Committee 6.1 Approved Minutes 17 August 2022 6.2 Meeting Report 20 October 2022	A Ismail	Enclosure	As	5 mins
	People Committee 6.3 Meeting Report 27 October 2022	J Mawby-Groom			
	Quality and Safety Committee 6.4 Approved Minutes 29 September 2022 6.5 Meeting Report 24 November 2022	C Mills			
	Finance and Performance Committee 6.6 Approved Minutes 29 September 2022 6.7 Approved Minutes 27 October 2022 6.8 Meeting Report 24 November 2022	J Gould			
7.	Integrated Quality, Performance and Finance Report • Operations (Gaby Harris) • Quality (Mo Hussain) • Finance (Susan Rollason) • Workforce (Donna Griffiths)	Chief Officer's	Enclosure	R	15 mins
8.	Emergency Preparedness Resilience and Response (EPRR) Annual Report (Guest: Jo Lydon)	G Harris	Enclosure	N	5 mins
9.	Next Steps on Elective Care and Cancer Care Self Certification (Guest: Alex Monahan)	G Harris	Enclosure	Ap	10 mins
10.	Palliative and End of Life Care Annual Report 2021-2022	T Brigstock	Enclosure	N	5 mins
BREAK 11:25 – 11:35					

	Item	Lead	Format	Action	Duration
11.	Maternity Safety Improvement Plan (Guests: Gaynor Armstrong/Stephen Keay)	T Brigstock	Enclosure	As	10 mins
12.	Nursing and Midwifery Safe Staffing Report	T Brigstock	Enclosure	As	10 mins
13.	Mortality (SHMI and HSMR) Update	K Patel	Enclosure	As	10 mins
14.	Medical Education Report	K Patel	Enclosure	As	10 mins
15.	Patient Safety Learning Report	M Hussain	Enclosure	R	10 mins
16.	Corporate Risks Report	M Hussain	Enclosure	As	10 mins
17.	Board Assurance Framework	D Walsh	Enclosure	As	5 mins
The remaining agenda items will be taken as read, with no time allocated for discussion. Any questions from Board members should be raised in advance of the meeting.					
18.	Draft Board agenda	Chair	Enclosure	N	5 mins
19.	Meeting Reflections	Chair	Verbal	D	
20.	Questions from Members of the Public which relate to matters on the Agenda Please submit questions to the Director of Corporate Affairs (David.Walsh@uhcw.nhs.uk)	Chair	Verbal	D	5 mins

Next Meeting:
Thursday 02 February 2023 at 10.00am

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, rooted in our communities
Our Purpose:
Local Integrated Care
Centres of Excellence
Research, Innovation and Teaching
Sustainability
Valuing and Enabling Our People
Values:
Compassion
Openness
Improve
Respect
Partnership
Pride
Learn
UHCWi - Better Never Stops

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD 1 DECEMBER 2022

Subject Title	Patient Story Programme – Parents of Emily share their story of having a loved one in hospital who has additional care needs
Executive Sponsor	Mo Hussain, Chief Quality Officer
Author	Hayley Best, Associate Director of Quality – Patient Experience
Attachment(s)	Video - Sarah O'Toole, Patient Experience Administration Specialist Verbatim recording of the video
Recommendation(s)	The Board is asked to **NOTE** the Patient Story

EXECUTIVE SUMMARY

Emily – Ward 32

Patient Story:

This month's patient story is from Colin and Maggie the parents of Emily aged 24. Emily was born at 24 weeks and one day and was diagnosed at 18 months with Cerebral Palsy and Quadriplegia. Emily also has Epilepsy and is non-verbal with a sensory disorder.

In February 2022, Emily was admitted to University Hospital and has been an inpatient for most of the year. She has suffered with bowel issues for the past two years and has had an Ileostomy Surgery and a Suprapubic Catheter fitted.

Emily is a very unique patient, with many additional needs, which staff need to consider when caring for her. Colin and Maggie do praise the care Emily has received at UHCW, but there are themes that they raise that could be improved upon.

A video of the parents' experiences at University Hospitals Coventry and Warwickshire (UHCW) NHS Trust is provided with their consent, and the verbatim record of the interview is attached.

Response:

1. The Trust has tools and support in place to better understand the needs of patients like Emily. All patients who have additional needs like Emily should have a "Patient Passport" completed when they are admitted to our hospitals so that staff fully understand the individual needs of that patient i.e. for example Emily can wake easily so limiting noise at night is important and having her carers, who understand her complexities, close by to support her care provision and work alongside our staff is invaluable. The Patient Passport provides staff with the opportunity to tailor care for patients with additional needs to ensure they have the best hospital experience they can. A snap shot audit of Patient Passport compliance was undertaken at the beginning of October 2022 and the findings are currently being analysed/collated.

2. Patients like Emily and her family are supported by the Learning Disability Acute Liaison Team and their needs are discussed at the Learning Disability Huddle. A Dependency Rating Scale is also completed to understand the level of support an individual may need from their own carers.

3. A Steering Group is being established in partnership with the Associate Director of Nursing, Quality and Patient Safety, Emma Fish; Lead Professional for Safeguarding, Lisa Pratley and Associate Director of Quality- Patient Experience, Hayley Best. This Group aims to improve standards for patients with disabilities and their families, ensuring Patient Passports are used and implemented in all areas.

4. The Patient Experience Team have recently scoped the opportunity to introduce sensory equipment for adult patients at UHCW which Wards can use to support and stimulate patients like Emily. This proposal was approved at the Patient Experience ad Engagement Committee in September 2022 and the funding approved through Charity funds on 14 October 2022.

5. The iPM health record system used within UHCW has a section for staff to document patient need. This information can then be referred to when a patient is admitted or provide a prompt when staff undertake certain actions on iPM in order that the patients or carer's needs are met.

6. An internal audit was recently commissioned by the Chief Nursing Officer on: Learning Disability Improvement Standards – Access to Healthcare which has been reported through to the Audit and Assurance Committee.

7. Regarding the noise at night, the Modern Matron has advised that Emily was moved to a quieter side room as the side room that she was in was on the main corridor into the Ward which meant that there was a greater footfall of people outside the room to enter and exit the Ward.

8. It is not clear why the patient's tube was not managed at the weekend on this admission as indicated by her parents in the story however, this is a service that is provided 7 days a week. There are times when flatus tubes are unsafe to insert on the Ward and patients need to go to the Endoscopy Unit where the wait is indicated in the patients care.

9. The Ward have confirmed that they work with carers to ensure that they are supported appropriately when their relative is in hospital including ensuring that they are able to eat and drink.

10. The Trust continue to submit data to the NHS England and Improvement - Learning Disability Improvement Standards Collection. The data will be submitted in January 2023.

Please note that Emily is currently an inpatient at UHCW, the Ward continue to provide support to her carers throughout her admission.

This story has been shared with the Ward areas mentioned and made available for other future learning to highlight the importance to staff about treating every patient as an individual.

PREVIOUS DISCUSSIONS HELD

N/A

KEY IMPLICATIONS	
Financial	The cost of legal action from harm to patients and the waste that comes from processes not being streamlined.
Patients Safety or Quality	The patient story links to our strategic objective to deliver excellent patient care and experience.
Workforce	The effect upon staff providing care who have not been supported despite providing excellent initial care.
Operational	The impact on the patient experience given that the patients may need to be readmitted or face further issues.

University Hospitals Coventry and Warwickshire NHS Trust

MINUTES OF A PUBLIC MEETING OF THE TRUST BOARD OF UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST HELD ON 06 OCTOBER 2022 AT 10:00AM IN ROOM 10009/10011 CLINICAL SCIENCES BUILDING, UNIVERSITY HOSPITAL, CLIFFORD BRIDGE ROAD, COVENTRY

MINUTE REFERENCE	DISCUSSION	ACTION

HTB 22/83 **PRESENT**

Stella Manzie (SM), **CHAIR**
Tracey Brigstock (TB), Chief Nursing Officer
Donna Griffiths (DG), Chief People Officer
Andy Hardy (AH), Chief Executive Officer
Gaby Harris (GH), Chief Operating Officer
Douglas Howat (DH), Non-Executive Director
Mo Hussain (MH), Chief Quality Officer
Jerry Gould (JG), Non-Executive Director
Afzal Ismail (AI), Non-Executive Director
Jenny Mawby-Groom (JMG), Non-Executive Director
Carole Mills (CM), Non-Executive Director
Kiran Patel (KP), Chief Medical Officer
Gavin Perkins (GP), Non-Executive Director
Justine Richards (JR), Chief Strategy Officer
Susan Rollason (SR), Chief Finance Officer
Janet Williamson (JW), Non-Executive Director

HTB 22/84 **IN ATTENDANCE**

Lacey Bennett, Operational Head of Services, Perioperative and Critical Care Servies *(for item HTB 22/99)*
Lincoln Dawkin (LD), Director of Estates *(for item HTB 22/103)*
Lisa Dunn (LDu), Pathway to Excellence Facilitator Lead *(for item HTB 22/85)*
Michelle Hartanto (MHa), Resuscitation Practitioner *(for item HTB 22/85)*
Alex Johnson (AJ), Minutes
Sarah Rogers (SRo), Medical Directorate Business Manager (Observer)
Lynda Scott (LS), Director of Marketing and Communications
Anna Steward (AS), Cardiac Rehab Nurse *(for item HTB 22/85)*
David Walsh (DW), Director of Corporate Affairs

HTB 22/85 **STAFF STORY**

It had been agreed that this item on the agenda would be used to present a powerful staff experience which it was hoped would have a positive impact on patients. TB introduced the item. She explained that the Trust had been working towards the Pathway to Excellence accreditation and, after submission of a document of evidence earlier this year and a subsequent staff survey, for which an incredible 70% response rate was achieved, the Trust was awarded accreditation on 15 August 2022. This was a significant achievement for the Trust and

three members of staff were welcomed to the Board meeting to give their individual summaries of their experiences of Pathway to Excellence journey that they had been on over the past three years.

LDu explained that she, as Lead Facilitator, had overseen the implementation of the programme of work and the application submission. Infrastructure and a framework was set up to support the programme of work and this included the Pathway Document Writing Group, the Ambassador Network and a shared decision making model.

LDu noted that she had been on an incredible journey of both personal and professional development, with the programme having contributed to growth in her leadership skills, strategic thinking and ability to learn at pace. The work of the groups and their members culminated in a large document of evidence being submitted to the American Nurses Credentialing Center (ANCC) and LDu explained that the writing of this complex document had helped her develop additional professional skills.

Also, LDu had been afforded the opportunity to help support and empower others in the team to have a voice and therefore facilitate their own personal and professional growth. As part of the national cohort to achieve Pathway to Excellence designation, it was valuable to have the chance to work with organisations external to UHCW, where there was mentorship and a shared learning approach in place.

LDu concluded by saying that UHCW was her local hospital and that she was hugely proud and honoured to have been part of the Pathway to Excellence programme and its positive impact upon patient experience. Now that designation had been achieved, she looked forward to the next steps in sustaining the great work undertaken to date.

AS added that she had been part of the Document Writing Group and her participation had led to her learning so many new things and helped her gain an in-depth knowledge of Pathway to Excellence. AS was now able to share her learnings with other colleagues in the Trust.

MHa explained that she had been part of the Decision Making Council, a multidisciplinary group which had been focussed on creating educational resources based on best practice and quality of care. As Chair of the Council, MHa had had the opportunity to develop her leadership skills and work with external stakeholders. She expressed that she was very proud to work as a nurse at UHCW and was grateful that the Trust valued the shared decision making approach.

LDu, AS and MHa were thanked for their stories and asked to provide an example of what type of decisions the Decision Making Council had been required to make. MHa explained that some of the decisions had related to creation of content which had been identified by the Council members and/or external partners. For example, creation of educational models based on CQC recommendations which the council, through a shared decision making approach, would review, revise and approve as required.

JG congratulated the team on their achievements and noted that he hoped they would continue to develop as a result of what they had achieved. He added that the benefits to them as individuals and the wider organisation were considerable.

AH stated that the Trust had widely celebrated the wonderful achievement of the accreditation and that Chief Officers had separately discussed how to interrogate the success of the programme of work with a view to replicating it across the organisation, particularly that of the Decision Making Council.

TB thanked her colleagues for attending Trust Board today to share their stories. She noted the wider link to the Trust's development of the nursing and midwifery strategy and the UHCW improvement methodology. The accreditation cycle for Pathway to Excellence is 4 years so the Trust will now be focussed on maintaining momentum and planning ahead to demonstrate again in 4 years' time, all the work that it has done towards Pathway to Excellence.

The Trust Board **NOTED** the staff story and SM thanked attendees for their contribution. *LD, AS and MHa left the meeting.*

HTB 22/86 APOLOGIES FOR ABSENCE

There were no apologies.

HTB 22/87 CONFIRMATION OF QUORACY

The meeting was quorate.

HTB 22/88 DECLARATIONS OF INTEREST

DH – Coventry University
GP – The University of Warwick

HTB 22/89 MINUTES OF THE LAST PUBLIC TRUST BOARD MEETING HELD ON 4 AUGUST 2022

The minutes of the last meeting were **APPROVED**.

HTB 22/90 ACTION MATRIX

SM drew the Board's attention to the closed actions. DW confirmed that work was underway to identify a date for the Board to discuss the Rugby Strategy and the PFI.

The Trust Board **NOTED** the status of the actions.

HTB 22/91 CHAIR'S REPORT

SM referred to the written report on the agenda and drew attention to the visit by herself and AH to the British Organisation of People of Asian Origin, at which there was the opportunity to discuss with a number of senior influential figures within the community how the

Trust can engage with and become more visible to the variety of groups and communities which it serves within Coventry.

SM also noted the sad death of Her Majesty the Queen. She thanked Chief Officers for their response in ensuring that the operational impact was managed accordingly.

The Board **RECEIVED ASSURANCE** from the Chair's Report.

HTB 22/92 CHIEF EXECUTIVE OFFICER REPORT

AH noted that it had been a great honour to welcome Gary Kaplan (Senior Vice President of CommonSpirit Health and former Chief Executive of the Virginia Mason Institute), creator of Virginia Mason Production System to the Trust on Friday 30 September. Lots of positive feedback had since been received and Gary held UHCW up as beacon site which was huge recognition for its UHCWi programme.

AH was honoured to be asked to talk at the EFMD (European Foundation for Management Development) Conference earlier that week. The audience included representatives from a collection of universities from Europe and further afield who provide excellent education. Attendees were keen to hear about UHCW's leadership development and AH noted that there were some opportunities to work with the National Fire Service and Warwick Business School on training.

AH drew the Board's attention to the three consultant appointments for ratification.

In response to a query from JG regarding the latest position on The Meriden Hospital, AH confirmed that the CQC had undertaken a further visit approximately 4 weeks ago and that the outcome of that visit was yet to be received.

The Board **RECEIVED ASSURANCE** from the report and **RATIFIED** the consultant appointments of Victoria Jane Bower (Consultant Anaesthetist), Joy Chang (Consultant Oncologist in Breast) and Jennifer Katherine Warren (Locum Consultant Intensivist).

HTB 22/93 ASSURANCE REPORTS

People Committee

JMG provided the key points from the People Committee report which included:

- The Committee had been alerted to the Royal College of Nursing ballot on industrial action which was now running;
- Development of the People Strategy continued and a decision had been made to delay bringing it to Trust Board until December 2022, as it was felt further work was required;
- A deep dive into medical and non-medical appraisal rates had taken place. Medical targets ere as now being met, however further focus was needed on the non-medical rates in order to reach the target. This will be monitored on an ongoing basis;

- A deep dive on agency utilisation had been completed and the People Committee had received a report in relation to that.

JMG added that the last couple of People Committee meetings had been somewhat lacking in discussions related to equality, diversity and inclusion, however the Committee will receive the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) reports in the coming weeks. DG noted that these reports were a key part of the People Strategy.

GP referred to the Trust's mandatory training performance and trajectory. He asked if any patient safety implications needed to be considered as a result of dipping performance, specifically in those areas where specialist/high level training may be required (as referred to in the minutes of the People Committee, held on 30 June 2022). DG provided assurance that there were key actions underway in relation to this matter. Mandatory training was covered in detail within the Integrated Quality and Performance Report (IQPR) and at the Quality and Safety Committee (QSC) earlier this year, a deep dive was undertaken on mandatory training and improvement actions were identified. This partly focussed on staff who may need to undertake bespoke specialist/high level training areas, dependent upon their role, such as resus or ALS (Advance Life Skills).

DG further explained that in some cases, there was a backlog in training, e.g. where staff had been recruited to UHCW from other NHS organisations where perhaps training had been stepped down during the pandemic. Actions were underway to address this backlog.

SM endorsed the positive focus on mandatory training and acknowledged that actions were underway to maintain focus and encourage staff to complete it. SM added that she was engaged in discussions with DW on training requirements for Non-Executive Directors.

The Trust Board **RECEIVED ASSURANCE** from the People Committee Meeting minutes of 30 June 2022 and the meeting report of 26 September 2022.

Quality and Safety Committee (QSC)

CM introduced the item and stated that the focus of the recent QSC meetings in July and September had been on patient safety, risk learnings and Ockenden action plans.

In relation to maternity services, CM noted that there had been a review from the regional and system Insight team, the outcome of which was positive for the service and it was great to see their work recognised.

The Committee received and were assured by the Hospital Transfusion Committee Annual Report and the Research and Development Annual Report. A detailed discussion took place at

QSC on the patient experience and engagement report and a presentation was given on nursing, midwifery and AHPs education.

AI referred to the QSC minutes of 28 July 2022 and drew the Board's attention to the reference to two sub-actions of the initial Ockenden action plan which were yet to be achieved. AI asked how the Board could be assured that actions put in place were working. TB responded and referred to one of the outstanding actions which was that of the identification of a bereavement room. She assured that work was underway to ensure that an appropriate location was found for the room and that a full business case was being developed, however there had been some challenges along the way related to the PFI build and capital funding issues.

In response to a further query from AI regarding the level of assurance that could be provided around the effectiveness of actions that had already been implemented, TB confirmed that there were a number of assurance routes in place, such as the weekly meeting with Women and Children's group triumvirate, chaired by KP/TB at which the focus was on quality assurance and monitoring the status of the actions from both Ockenden reports. Alongside this, there was a complete portfolio of evidence that had been collated and allowed benchmarking with other organisations. CM added that maternity and Ockenden were always a key topic of discussion at the QSC meetings and she had personally witnessed that the discussions were reflected upon production boards throughout the organisation. Therefore, she was fully assured that the focus was where it needed to be in this respect.

JG referred to the QSC minutes of 28 July and noted that under item QSC/22/079 – Mortality (SHMI and HSMR) Update, there was a reference to an agreed action regarding additional data being provided to FRPC. JG noted that there was no related escalation note in relation to this item and asked that a process was put in place for such cross-committee actions to ensure they were not missed.

ACTION: Confirm a process was in place for cross-committee actions to be captured in consideration of example highlighted on page 9 of QSC minutes of 28 July 2022. **DW**

The Trust Board **RECEIVED ASSURANCE** from the QSC minutes of 28 July 2022 and meeting report of 29 September 2022.

Finance, Resources and Performance Committee (FRPC)

SM noted the incorrect spelling of George Eliot Hospital (page 8) and asked for this to be corrected.

JG drew the Board's attention to the FRPC meeting report of 29 September and the salient points included the month 5 deficit position of £11.5m, which was largely driven by the challenges on high cost drugs and the waste reduction programme. JG noted that more waste reduction schemes were being identified all the time, however the challenge is the non-recurrent nature of the schemes, as well as the target timescales for delivery.

JG confirmed there was no clawback of the Elective Recovery Fund (ERF) for the first 6 months of the year and clarification of arrangements for ERF for the remainder of the year was yet to be received.

Other challenges included delivery of the 104% activity, capital and the impact of long length of stay patients upon performance.

In response to a query from SM, MH provided an update on the recent malware/cyber attack on the Urgent Treatment Centre (UTC). He informed the Board that the cyber attack was on Advance , the provider of Adastra software, utilised by UHCW at the UTC, NHS 111 and Care Notes. Adastra and the UTC were now fully operational, although there was a backlog due to reversion to paper during the attack. Care Notes was taking a little longer to resolve and was not yet up and running.

SM acknowledged the many financial issues highlighted and confirmed that the Board would discuss the challenges more fully in the Private Trust Board meeting.

The Trust Board **RECEIVED ASSURANCE** from the minutes of the FRPC meeting held on 25 August 2022 and the meeting report of 29 September 2022.

REVIEW OF THE BOARD COMMITTEE ANNUAL REPORTS 2021/22

AI introduced the item which was formed of the Board Committee Annual reports. AI confirmed that the reports had been presented to ARAC and had provided oversight around such matters as Board member attendance at the Committees, terms of reference, internal and external reports received, along with scrutiny of any actions required. AI confirmed that ARAC had received assurance from the reports and that they demonstrated good governance was in place.

SM welcomed the introduction of the People Committee this year and the increased focus on workforce it had provided to date.

The Trust Board **RECEIVED ASSURANCE** from the Board Committee Annual Reports.

HTB 22/94 BOARD ASSURANCE FRAMEWORK (BAF)

DW introduced the item and drew the Board's attention to the information contained within the executive summary of the report, specifically the snapshot information of the risk areas, the overall level of assurance and the cyber security risk which will be monitored by ARAC in future. AI assured that this was the case and that regular discussions were underway at ARAC in terms of managing the cyber security risk as effectively as possible.

SM noted that the BAF was now being used as a live document at individual Committees and she commended the improved format and the good governance that it demonstrated.

SM referred to the data presented for the People Committee. She specifically noted the gaps detailed under the Second Line of Assurance in relation to staff discrimination, as identified in the WRES (Workforce Race Equality Standard) and the WDES (Workforce Disability Equality Standard) and asked if the affected staff tended to be at more junior levels.

DG confirmed that the two gaps highlighted were reported in the WRES and WDES for the year 2020 and at that time, were areas where UHCW performed less well, however there was no connection to staff seniority. The People Committee was due to receive the latest (2021) WRES and WDES data/action plan in October. DG added that the National Staff Survey was underway and that this would form part of the WRES indicators.

The Trust Board**:**

1) **RECEIVED** the BAF entries for 'Financial Stability' and 'Operational Performance' following consideration by the Finance and Performance Committee on 29 September 2022

2) **RECEIVED** the BAF entries for 'Staff Wellbeing and Morale' and 'Workforce Supply' following consideration by the People Committee on 26 September

3) **RECEIVED** the BAF entries for 'Quality of Care and Patient Experience' and 'Service Stability' following consideration by the Quality and Risk Committee on 29 September

4) **CONSIDERED** any additional assurances received during the Board meeting in the context of the documents described above.

5) **NOTED** the update in relation to the development of a Cyber Security critical risk for BAF monitoring through the Audit and Risk Assurance Committee.

HTB 22/95 INTEGRATED QUALITY, PERFORMANCE AND FINANCE REPORT

KP summarised four key areas for the Board to note:

1) Meeting the emergency care 4 hour and 12-hour standards remained a challenge for UHCW and for most NHS Trusts;
2) UHCW was performing well in terms of elective care trajectory;
3) HSMR (Hospital Standardised Mortality Ratio) deep dive underway with a view to improving the position;
4) Mandatory training position has improved.

SM asked for an update on the work that was taking place within the Trust to address the challenges on the emergency care pathway and flow. GH confirmed that the flow value stream was well underway, led by Group Clinical Directors with Chief Officer support and utilising the UHCWi methodology. The first part of the value stream had comprised 5 Kaizen events covering a range of areas from admissions, through to discharge. The aim was to achieve small incremental improvements across a wide area which, it was anticipated, would lead to significant improvement overall. The work was underway until November 2022, with an ongoing PDSA (plan, do, study, act) approach in place which meant that results of any changes could be felt in real time and any

further steps could be implemented immediately. A wrap up session was scheduled early in December, at which next steps will be determined. GH confirmed that the full results of the work would be reported through FRPC.

SM asked what was happening at system level to address the challenges faced in relation to the emergency care pathway and flow. She asked whether the Trust should be lobbying for any specific system action to be taken. AH and JR both reflected that the situation was particularly difficult and was expected to worsen. The lack of community nursing home placements was having a significant impact and care homes were facing several challenges including increases in costs and a general lack of market management.

JR confirmed that UHCW was closely engaged with local authority colleagues on potential solutions to the challenges faced, which aimed to ensure equity and fairness of provision of enhanced care. Though the short-term solutions were few, JR felt that alignment of the Better Care Fund was one way forward. JR added that the Improving Lives programme of work was underway, however this was a long-term solution.

GH added that there were a number of national initiatives underway which were aimed at admission avoidance. These included paramedics managing patients in their own homes and a piece of work which CWPT was leading, focussed upon responses to category 3 ambulance calls within two hours. The benefits of these initiatives were yet to be felt but it was hoped there would be some positive impact imminently. JR added that there were also programmes of work underway which were focussed upon ageing well, anticipatory care and enhanced support and that UHCW was actively involved in this work.

SM acknowledged the pressure that staff at the front door were dealing with and asked what support was being provided to individual teams. DG confirmed that the Trust was working hard to ensure that staff were provided with the appropriate level of support. This included the roll out of psychological first aid training which would provide support to peers who found themselves in stressful situations. The training had already been launched with the Emergency Group.

GH and TB added that there were a number of other active campaigns underway which were aimed at supporting staff from a health and wellbeing perspective. Some of the focus of these campaigns was on ensuring effective use of processes and systems which should in turn lead to reduction in the burden felt by staff.

KP summarised that UHCW staff do bear the brunt of operational pressures and that these pressures were only likely to increase. However, he assured that UHCW was doing everything possible to alleviate the challenges felt by staff.

From an infection prevention and control perspective, TB reported to the Board that there had been an increase in the infection rate for CDiff and that this would be closely monitored. She added that although Covid infections had reduced in recent months, numbers had

increased again to approximately 90 and there was a "mini" peak expected, though these were incidental infections rather than hospital acquired. TB confirmed that testing was currently in place for symptomatic patients only.

The Board **REVIEWED** and **NOTED** the content of the report. The key areas of challenge around emergency pathways, flow, discharge and long length of stay patients were acknowledged and the Board **NOTED** the ongoing work underway to address those areas of concern.

Break

HTB 22/96 PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF)

DW introduced the item and summarised that PSIRF would replace the Serious Incident Framework (SIF) which had been in place since 2015. The Board was asked to approve the recommendation for MH, Chief Quality Officer to be appointed the lead executive to oversee the transition from SIF to PSIRF.

MH confirmed that all providers would be required to adopt PSIRF and the Trust was currently working through the implications of the change, which would be taken through QSC.

The Board **APPROVED** MH, Chief Quality Officer, as executive lead in relation to delivery of PSIRF.

HTB 22/97 OPERATIONAL ACTIVITY UPDATE

SM explained that this was the first update of this type to the Board and that it aimed to provide context around some of the operational challenges faced by the Trust in recent months. SM hoped that the Board felt that the report was a useful addition to the usual performance data provided.

GH summarised the events which had impacted the Trust's operational environment over the summer months. These included:

- The impact of the July heatwave upon both staff and patients;
- Visit of the JAG accreditation team;
- Emergency planning measures put in place for the Commonwealth Games;
- Implementation of the national elective recovery plan and the associated increased requirement to provide mutual aid;
- Death of Her Majesty the Queen and the period of national mourning which followed;
- Emergency incident declared due to hot water leak.

A discussion followed on the report and Board members gave their views on whether the content was useful and appropriate to be reported to Trust Board. It was generally felt that this type of information report provided a good oversight for Non-Executive Directors in particular. However it was suggested and **AGREED** that future such reports should form part of the CEO report, rather than being presented as a separate report.

JMG noted that the Trust seemed to be faced with emergencies on a regular basis and asked if the emergency planning team was resourced effectively to manage such scenarios. GH confirmed that this was being reviewed and an investment case being developed to increase the team.

HTB 22/98 WINTER PLAN 2022/2023

GH explained that the paper outlined the high-level winter plan for 2022/2023. The winter plan was linked to the Trust's operational delivery plan and detailed action plans formulated by the groups sit behind this winter plan.

GH referred to NHS England's 8 national priorities which the winter plan was also based upon and were listed under item 2.0 of the report and further detailed under item 3.0.

Item 4.0 of the report related to the external and internal assurances around the winter planning process and GH noted that one important element of the plan was in relation to working with the system to deliver A&E services, elective and cancer care. The Trust had completed a number of assurance templates and submitted a self-assessment to the system.

GH noted that the system had secured £9m to fund winter planning schemes. Bids had been submitted and funding confirmation was awaited.

From a governance perspective, GH confirmed that group action plans would be taken through the Operational Delivery Group and to Chief Officers Group. JG added that the Winter Plan had been taken to FRPC already.

In response to a query from JMG regarding formulation of winter action plans with the ICB, GH confirmed that there were a variety of routes for system colleagues to discuss winter plans, including the weekly system Chief Operating Officer call and the Urgent and Emergency Care Board.

SM asked if there had been any progress in the ongoing discussions regarding division of funding across the system. SR confirmed that discussions were still underway but it was her understanding that funding allocations would be directed to where the relative risk was expected to materialise.

The Board **RECEIVED ASSURANCE** and **APPROVED** the content of the report.

HTB 22/99 CRITICAL CARE OPERATIONAL DELIVERY PLAN (ODP)

LB joined the meeting and GH introduced the paper which outlined the critical care ODP in order to meet the requirement to achieve 104% activity levels for 2022/23.

LB provided the high-level detail of the ODP. She explained the proposed new bed model: 34 level 3 beds Friday Evening – Monday Evening, and 36 level 3 beds Tuesday Evening – Friday Evening. This model should sustain current demand, whilst ensuring that capacity was in place to deliver the additional activity levels (104% when compared to 2019/20). LB also drew the Board's attention to the proposals to close OIR beds and beds previously allocated to EPOC and explained that this should lead to an improvement in overall quality of care and patient experience.

LB referred to item 6 of the paper which outlined the staffing requirements for the new bed model and explained the financial costing for Trust Board approval which totalled £1.9m.

SR confirmed that the financial costing had been subject to a significant level of scrutiny due to the high value. She also warned that it was likely that Trusts would be required to deliver even higher levels of activity next year.

GP referred to the Trust's overall waste reduction agenda and queried whether there was any potential for additional critical care beds to be generated through better flow of patients. SR provided assurance that this had been taken into account already as part of the bed modelling work.

The Board **APPROVED** the recommended bed model and the financial request of £1.9M to resource the additional beds.

HTB 22/100 PATIENT EXPERIENCE AND ENGAGEMENT REPORT

MH summarised the content of the report, which covered a variety of themes and actions related to matters such as complaints, patient advice and liaison (PALS), national staff survey and Friends and Family test.

JG noted a common theme around staffing issues and vacancies in PALS, particularly related to more junior staff bands. MH explained that PALS was a patient facing team and therefore they receive a high number of patient queries. The PALS role can be challenging and high pressured with patients consistently searching for answers to their queries. This can take its toll on the PALS staff and MH assured the Board that actions were in place to support them in their roles. These included appointment of an additional manager and rotation of staff between the complaints and PALS teams.

SM referred to item 2.3 of the report (Complaints for further local resolution – FLR) and noted the importance of ensuring that the quality of responses to complaints was of a high level. She noted that additional staff training maybe required in order to ensure this was the case.

A Board discussion followed on the process for complaint letter response sign off. It was noted that a number of quality assurance checks were in place, which included checks by the appropriate group, the complaints team and finally by a Chief Officer or nominated deputy.

MH went on to explain that the overall complexity of complaints had increased in recent months and that the number of FLRs now received did not necessarily reflect upon the quality of the initial response the patient received. It was increasingly the case that a patient would receive the initial response which would then prompt further questions from them and this was leading to more FLRs.

SM acknowledged this point, however she reiterated that it was essential for complaint responses to be clear and that they provided assurance to the patient that they were being listened to.

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

HTB 22/101 RESEARCH AND DEVELOPMENT (R&D) ANNUAL REPORT 2021/22

KP provided the key highlights of the report, which included the following:

1) Restoration of formal meetings with Warwick Medical School had been productive and agreement had been reached to invest in clinical academics.
2) As part of ongoing service restoration, there was a requirement for the ICB to implement a Coventry and Warwickshire-wide R&D Committee. This was now in place and both AH and KP attend the meeting.
3) R&D features strongly in the latest UHCW Trust strategy.
4) The Trust was unsuccessful in securing funding for the NIHR (National Institute for Health Research) Clinical Research Facilities. CM queried why this was the case and KP explained that the process had been very competitive this year, with all organisations applying for funding. Unfortunately UHCW was one organisation which did not manage to secure funding, as it had expected to.

AH commended the production of the Trust's R&D strategy over the last 12 months and noted that it would be key to where UHCW goes from here.

In response to a query from SM regarding the Trust having the required number of clinicians with the appropriate level of research designation, KP assured that the figures were improving and reiterated that discussions were underway with Warwick Medical School on investment for clinical academics. GP added that this was subject to sign-off of The University of Warwick strategy bid, which was underway.

GP provided some feedback on the content of the report. Although it was positive to see so many successes being celebrated, within the national context of a challenging position for R&D, he noted that all organisations were likely to be underperforming in terms of R&D delivery to time and target of research. He suggested that it would be helpful for future reports to focus more on performance against the strategy, progress of the various institutes and overall progress, positive or otherwise so the Board was aware of things which had gone less well as well as the more positive acheivements.

The Trust Board **NOTED** the content of the report and confirmed ongoing support of the R&D strategy.

HTB 22/102 MEDICAL APPRAISAL AND REVALIDATION ANNUAL BOARD REPORT

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

HTB 22/103 ANNUAL HEALTH, SAFETY, FIRE AND SECURITY ANNUAL REPORT 2021/22

LD joined the meeting and TB introduced the item which was presented to the Trust Board for assurance.

LD summarised the work that had been undertaken over the last 12 months and he particularly noted the positive news that the Trust had now been awarded IS0 45001 accreditation – the internationally recognised standard for health and safety.

He added that there had been good engagement from the Health and Safety Committee over the past year and drew the Board's attention to the data contained within the report related to all incident trends, specifically sharps injuries and slips, trips and falls. LD also referred to the information presented under item 2.2 of the report related to RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013). He confirmed that a robust process was in place for reporting of RIDDOR incidents and noted the benchmarking exercise with other organisations that had been undertaken in this respect.

LD reported that although no contact has been necessary from the HSE with the Trust, there was ongoing contact with the fire authority due to long standing issues with fire dampers at the Trust. There was further work to do in this respect and LD confirmed that the Trust continued to work closely with the fire authority to ensure the appropriate controls were in place. There was also some further action required in relation to corridor storage which remained a stubborn issue.

LD noted that there was positive engagement from staff for fire training and the compliance rate varied on a monthly basis between 92% - 96%.

The Emergency Department had now introduced its own Violence and Aggression Review group and this was having a positive impact. The introduction of bodycams had been well received.

In summary, LD assured that there were robust systems in place for the management of health and safety at the Trust. There were some ongoing issues, outlined above, which were to be expected in a organisation of this size, however those issues were being managed in the appropriate way.

DG commended the introduction of post-incident debriefs for staff after any incidents of violence, aggression or abuse of staff. DG suggested

that the ISO14001 accreditation should be added to the BAF as a third line of assurance.

CM referred to item 2.13.3 which stated that the advanced support of the local policing team had been sporadic. LD explained that he believed the reason for this was related to a gap in police resource and that better engagement was hoped for in future.

In response to a query from SM, DG confirmed that the Trust's 'No Excuse of Abuse' campaign which was focussed on zero tolerance of aggression or violence towards staff, was still promoted throughout the Trust and there were ongoing discussions regarding the approach and what else could be done to support staff in this respect.

TB thanked the team for their work in producing the report and in particular she noted the great leadership demonstrated by David Millage, Health and Safety Manager in leading the health and safety agenda.

AI referred to the ongoing fire damper concerns. He noted that the issue was likely to take a number of years to resolve and the importance of ensuring that resolution was kept on track, even with any staff turnover that may occur. LD assured that the appropriate governance processes were in place to ensure this was the case.

In relation to falls, for which SM noted that there a reduction, TB confirmed that the team was always focussed on this issue and there was much to do around prevention. A new falls lead was now in place and there were some falls campaigns in development, along with training with sub-specialities to refresh the message around prevention.

DP drew attention to the data presented on instances of slips, trips and falls which stated there was a downward trend. It was confirmed this would be checked for completeness.

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

ACTION: Add ISO14001 to the BAF. **DW**

HTB 22/104 CARE QUALITY COMMISSION (CQC) REGISTRATION REPORT

The Trust Board **NOTED** and **APPROVED** the CQC registration report**.**

HTB 22/105 RECEIPT OF HUMAN TISSUE AUTHORITY (HTA) LICENCE

KP summarised the content of the report, which provided information on the four HTA licences held by the Trust and the new governance structure proposed due to the change of Human Application Licence Designated Individual at the Trust. KP thanked SRo for the work she had undertaken on the governance review.

The Trust Board **NOTED** the new governance structure.

HTB 22/106 TIMETABLE OF BOARD AND COMMITTEE MEETINGS 2023/24

DW summarised the content of the report and drew attention to the potential items (financial plan and PFI) to be covered at future Board development/Board Strategic Workshops. It was noted that JG will not be in attendance at the Board session planned for January 2023, therefore the item on the PFI would need to be rescheduled accordingly.

HTB 22/107 FUTURE BOARD AGENDAS

The Trust Board **NOTED** the content of the future Board agendas.

HTB 22/108 ANY OTHER BUSINESS

There was no other business.

HTB 22/109 QUESTIONS FROM MEMBERS OF THE PUBLIC WHICH RELATE TO MATTERS ON THE AGENDA

There were no questions raised.

HTB 22/110 DATE AND TIME OF NEXT MEETING

The next meeting will take place on Thursday 1 December 2022 at 10:00am.

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

1

PUBLIC TRUST BOARD MASTER ACTION MATRIX 2022

The Board is asked to **NOTE** progress and **APPROVE** the closure of the completed actions.

Meeting Date	Item	Minute Reference	Action	Lead Officer	Deadline	Update
06/10/2022	Strategic Delivery Board Update	HTB 22/69	Schedule Rugby Development/Strategy for a future Board Strategy Workshop	DW	01-Dec-22	Difficulty placing due to availability of key Board members at BSW in January, and use of March date for Board Development session on Insights. Now tentatively scheduled for May 2023 but subject to Board acceptance.
06/10/2022	Approval of Committee minutes	HTB 22/93	Confirm a process was in place for cross-committee actions to be captured in consideration of example highlighted on page 9 of QSC minutes of 28 July 2022.	DW	01-Dec-22	The mechanism in place for these to be captured would ordinarily enable committee-to-committee actions. There is an ongoing effort to improve the speed after meetings with which actions are circulated, but recognition that there is capacity for improvement.
	Health, Safety, Fire and Security Annual Report	HTB 22/103	Add ISO14001 to the BAF as a third line of assurance.	DW	01-Dec-22	Complete

Deadline Key:	
	Not started
	In Progress
	Overdue
	Completed

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 1 DECEMBER 2022

Subject Title	Chair's Report
Executive Sponsor	Dame Stella Manzie, Chair
Author	Dame Stella Manzie, Chair
Attachments	None
Recommendation	The Board is asked to **RECEIVE ASSURANCE** from the Chair's Report

EXECUTIVE SUMMARY

This report covers the period since the last Board meeting which took place on 6 October 2022.

First, I would like to reflect on the two wonderful evenings of celebration we had when the Trust recognised the hard work and commitment of our staff members at the Outstanding Service and Care Awards (OSCA) Ceremony in October and more recently the Long Service Awards which acknowledges those members of staff who have dedicated many years of their working career within the NHS. Andy Hardy and I along with various colleagues also attended celebrations to mark Coventry Hospital Radio's 50th Anniversary – our Hospital radio has a fantastic history – it is run entirely by volunteers and has contributed an enormous amount to the Trust and the well-being of patients.

On a more sombre note the annual service of Remembrance of the Fallen took place in the Faith Centre and was streamed within both this Trust and Coventry and Warwickshire Partnership Trust. The Trust has good links with the military including our Veterans Charter and a number of our staff participate in various ways. Commemorating those who have been lost defending their country remains very important even if increasingly we want to focus on reconciliation rather than conflict.

A number of Non-Executive Directors have been involved in consultant recruitment processes – in my case for the Nephrology specialism. A further recruitment process which is currently underway is that of a further Associate Non-Executive Director with a view to broadening further the experience of the Non-Executive cohort on the Board. This has meant that I have been speaking informally to a number of candidates expressing an interest. Applications have now been received and interviews are taking place on 15th December.

As usual, Andy Hardy has continued to keep myself and my fellow Non-Executive Directors fully up to date on all the operational issues facing the Trust, and I or fellow NED Jerry Gould have continued to join the regular regional health leaders update calls with Dale Bywater (NSHE/I Regional Director for the Midlands). I have also received my regular briefings from individual Chief Officers. I have chaired the Coventry and Warwickshire Pathology Services Stakeholder Board and covered the chairing of the People Committee for colleague Jenny Mawby–Groom. Along with new Non-Executive Director Janet Williamson I met with Janine Beddow at Rugby St Cross and we visited various parts of the Hospital of St Cross. Janet and I also visited the newly opened Minor Injuries Unit.

I have also undertaken some elements of my mandatory training (fire safety and information governance) to ensure my compliance has remained at 100%. As part of fulfilling my role as NED lead on Staff Health and Well–being I had the pleasure of undertaking (virtually) the Enhanced Psychological First Aid session which is being rolled out to a number of staff groups, in order to enhance my understanding of what it involved. I found this very interesting and informative. I was also part of the welcome to the Director of Strategy and Impact from NHS Charities who came to the Trust to hear about our work on Health and Well- being and help launch the well-being walk round the University Hospital site, supported by the UHCW Charity.

Other meetings I have attended externally have included Chairs' meetings relating to the ICS; the Coventry and Warwickshire Integrated Health and Well-being Forum and the Integrated Care Partnership meeting where the key issue was discussing the Coventry and Warwickshire ICS Strategy due to be submitted in December; I have also met one to one with Danielle Oum (Independent Chair of the Coventry and Warwickshire ICS) discussing strategic issues facing the ICS.

By the time of this Board meeting I will have attended the thought Leadership Event being hosted by Andy Hardy on 30th November and the launch event for the 2023 British Transplant Games which will be taking place in Coventry July 27th to 30th 2023, having been delayed due to the Covid 19 pandemic. The Trust plays an important role in transplant services and the Games are an important way of demonstrating the capabilities of those who have received transplants and the importance of exercise and activity.

Operational activity in the Trust remains challenging and these issues will be covered in the Board papers on this agenda. Thank you to all those staff responding to the challenges which winter months bring, in addition to those with which they are already dealing.

Dame Stella Manzie

PREVIOUS DISCUSSIONS HELD

Not applicable

KEY IMPLICATIONS

Financial	Not relevant to this report
Patient Safety or Quality	Face to face engagement by Non-Executive Directors is a part of the quality and assurance processes in the Trust
Workforce	Health and wellbeing of our staff remains an important theme.
Operational	A number of operational issues are discussed in meetings attended by the Chair either locally or system wide.

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 1 DECEMBER 2022

Subject Title	Chief Executive Officer Update
Executive Sponsor	Andrew Hardy, Chief Executive Officer
Author	Andrew Hardy, Chief Executive Officer
Attachment	None
Recommendations	The Board is asked to **RECEIVE ASSURANCE** from the report and to **RATIFY** the consultant appointments listed on page 3.

EXECUTIVE SUMMARY:

This paper provides an update to the Board in relation to the work undertaken by the Chief Executive Officer (CEO) 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 October and November 2022.

Professor Andrew Hardy – Chief Executive Officer

Firstly, myself and other members of the Board had the honour and pleasure of attending the Outstanding Service and Care Awards (OSCAs) ceremony in early October. This is one of the highlights of our year where we have the opportunity to celebrate and acknowledge the outstanding individuals and teams who go the extra mile to care for our patients, epitomising UHCW's Trust values. I would like to reiterate my congratulations to all the winners, finalists and nominees who helped to make the evening such a memorable occasion.

I was also delighted to attend the Long Service Awards ceremony to recognise the dedication and commitment of some of our longer serving employees. This year marks the 50th anniversary of our trailblazing Coventry Hospital Radio. I attended the celebrations with presenters and contributors old and new and the station held a commemorative 50-hour radio programme.

I'm proud to say the brilliant work we have been leading as a Trust has been recognised once again externally. At the coveted HSJ Awards 2022 we won the award in the Reducing Health Inequalities category. The Trust has developed a unique tool to consider clinical prioritisation of elective care, which takes into account factors driving health inequality and uses them to help prioritise access to healthcare. We were also shortlisted for Acute Trust of the year for a second year running.

Another noteworthy event I was proud to host recently was our latest UHCW 'Thought Leadership' held event at the end of November. This included a range of well-respected expert speakers speaking to leaders in our organisation and region on the subject of people and wellbeing. The event was a big success and was very well received.

As usual, my internal commitments have included Board briefings (including those with our Chair and Non-Executive Directors); regular monthly 'catch up' sessions with the Chief Officers, the monthly local VMI Trust Guiding Teams meetings and the wider VMI Transformation Guiding Board meeting; I joined the monthly Chief Officer Forum briefing sessions, was briefed during my weekly discussion/update meeting in relation to Referral to Treatment Time (RTT) and Emergency Department (ED). Other internal meetings I have attended include the elective recovery meetings; the Electronic Patient Record (EPR) Programme Board along with the regular update meetings; Star Chamber meetings with all Groups, and I have carried out some Rounding sessions with UHCWi; joined a QIPS session and met members of the Plastic Surgery Team and the Trust hosted a visit from NHS Charities.

I have undertaken my regular staff Q&A sessions at both University Hospital and Rugby St Cross and sat on the Interview Panel that recruited Gaby Harris to the role of Chief Operating Officer. I joined Kiran Patel when he met with the GCDs and Clinical Leads at their regular meeting, and enjoyed an informal evening dinner with Kiran and the Group Clinical Directors (GCDs). I also virtually met with Taiwo Owatemi (MP for Coventry North West).

I received my regular Innovation Update briefing, joined fellow Chief Officers for a COG Residential event which included a session with Alison Wynne which focussed around the 'Time to Think' methodology. Myself, and other members of the Board, attended the annual Remembrance Service in the Faith Centre to remember our loved ones and fallen heroes. I joined the Coventry and Warwickshire Pathology Services (CWPS) Stakeholder Board and attended the UHCWi's Coventry Improvement System follow up meeting.

I have been involved in wide range of other miscellaneous engagements which have included the Warwick Business School Advisory Board meeting and evening Dinner; a breakfast meeting with Stuart Croft (the Vice-Chancellor and President of University of Warwick); I attended the CWLEP AGM and Board meeting; joined the launch event for the 2023 British Transplant Games; attended a meeting with Mark Britnell and Sir Bruce Keogh; joined colleagues from Maggies, Myton Hospice, Healthwatch and Wasps at their Elite Performance and Innovation Centre and a meeting with Peter Saunders and Matt Custance from Grant Thornton.

I also attended the BME Leadership Network meeting and 'Race, Science and the NHS' event with Dr Adam Rutherford in London; I also joined the NHS National Leadership event for Integrated Care Board (ICB) and Trust CEOs. I joined the Development session for the Coventry and Warwickshire Integrated Care Board; the UKHSA /NHS Providers Member Engagement Roundtable event and the PMM Live: Public Value through Local Public Audit session at the House of Lords.

In terms of partnership working, I have had my regular 'catch up' / briefing sessions with Phi Johns; Glen Burley; the collective NHS Chief Executive sessions with Phil, Glen and Mel Coombes; I have attended the monthly ICS Executive Group meetings; virtually joined the Coventry and Warwickshire Integrated Care Board; virtually attended the Global Impact Committee which brings together colleagues from numerous healthcare settings from around the world; Chaired the University Hospital Association (UHA) CEO meeting in London; met with Matthew Hopkins (CEO at Worcester Acute Hospitals NHS Trust), met with Tim Kelsey (Chief Executive Officer) from Beamtree and joined Tim and others for a Dinner in London. I also met with Andy Street (Mayor of the West Midlands) in relation to the University of Warwick and UHCW partnership working.

My commitments in relation to NHSE/I have included the usual NHS Midlands Leaders Update calls with Dale Bywater (NHS England and NHS Improvement Midlands Regional Director).

I undertook a number of speaker commitments including 'Leading change in Healthcare' at the MSc Healthcare Operational Management event; the GB/HPBA Robotic HPB meeting; the opening

speech at the Centre for Care Excellence event; and finally a speaker slot at the NHS Providers Annual Conference in Liverpool on the subject of tackling elective backlogs.

My external commitments have included attending a number of commitments in relation to Extracare. As a Trustee for the Board, I joined their Audit and Assurance Committee, their Annual General Meeting (AGM) and the Board of Trustees meeting.

Professor Andrew Hardy

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 Candidates	
Styliani Maria Kolokotroni	Consultant Thoracic Surgery
Surabhi Talwar (awaiting confirmation of acceptance) Gemma Banham (awaiting confirmation of acceptance)	Consultant Nephrologist
Karim Kassam	Locum Consultant Oral & MaxFax Surgeon - Microvascular Reconstruction

KEY IMPLICATIONS:

Financial	None arising from this report
Patients Safety or Quality	None arising from this report
Workforce	None arising from this report
Operational	None arising from this report

MINUTES OF THE AUDIT AND RISK ASSURANCE COMMITTEE MEETING

HELD ON WEDNESDAY 17 AUGUST 2022 AT 9.10AM

VIA MICROSOFT TEAMS

ITEM	DISCUSSION	ACTION
ARAC/22/68	**PRESENT**	
	Afzal Ismail (AI), Non-Executive Director **– Chair** Jerry Gould (JG), Non-Executive Director	
ARAC/22/69	**IN ATTENDANCE**	
	Rob Andrews (RA), KPMG [*for ARAC/22/85]* Amar Bhagwan (AB), Director of Procurement [*for ARAC/22/88]* Paul Capener (PC), Consortium Director, Coventry & Warwickshire Audit Services (CWAS) Lisa Cummins (LC), Director of Quality [*for ARAC/22/90]* Lisa O'Brien (LOB), Audit Manager, CWAS Michael Dove (MD), Chief Financial Accountant Cathy Hughes (CH), Local Counter Fraud Specialist, CWAS [*for ARAC/22/81]* Jules Martin (JMA), EPR Programme Director *[for ARAC/22/91]* James Matthews (JM), Director of ICT and Digital Services *[for ARAC/22/89]* Kiran Patel (KP), Chief Medical Officer *[for ARAC/22/78]* Susan Rollason (SR), Chief Finance Officer Sarah Swan (SS), CWAS Malcolm Taylor (MT), Associate Counter Fraud Specialist (CFS), CWAS David Walsh (DW), Director of Corporate Affairs	
ARAC/22/70	**APOLOGIES FOR ABSENCE**	
	Christopher Dean, KPMG Mo Hussain, Chief Quality Officer	
ARAC/22/71	**CONFIRMATION OF QUORACY**	
	The meeting was declared quorate	
ARAC/22/72	**DECLARATIONS OF INTEREST**	
	No declarations were made	
ARAC/22/73	**MINUTES OF THE PREVIOUS MEETING**	
	The minutes of the previous meeting held on 21 April 2022 were **APPROVED** as a true and correct record.	

ITEM	DISCUSSION	ACTION
ARAC/22/74	**ACTION MATRIX**	
	ARAC/22/51 Risk Management Report – it was agreed that the action be left open as there remained aspects of the original question which had not been fully responded to. It was agreed that actions ARAC/22/52 and ARAC/22/61 to remain open, and for responses to ARAC/22/51 and ARAC/22/61 to be pursued outside of the meeting given the delay in responses.	**DW**
	The Committee **RECEIVED** the updated matrix and **APPROVED** the closure of all actions except ARAC/22/51, ARAC/22/52 and ARAC/22/61.	
ARAC/22/75	**MATTERS ARISING FROM THE MINUTES**	
	There were no matters arising other than presented in other discussions.	
ARAC/22/76	**INTERNAL AUDIT RECOMMENDATIONS UPDATE**	
	LOB presented the report noting the following; As at 31 July 2022, there were no overdue recommendations. However, there were eight recommendations where revision to the original/revised intended implementation date has occurred (i.e. deferral). The Chair expressed concern over the extended period some of the recommendations were outstanding. These would be added to the Action Matrix. The Chair stated that the committee required a solid and robust response to the concerns. The cyber risk was highlighted, with the Chair questioning what the risks were to the actions remaining incomplete. It was requested that this assurance in relation to the cyber risk in particularly be reported to the committee.	**MH**
	The Committee **NOTED** and **APPROVED** the report subject to the caveat above.	
ARAC/22/77	**INTERNAL AUDIT PROGRESS REPORT**	
	LOB presented the plan. It was highlighted that there had been updates and changes to the Internal Audit Plan following discussions at the previous meeting. This included follow-up reviews on Sustainability: Pathway to Net Zero, a follow-up review on the Faster Diagnosis Standard Data Quality and an audit on Maternity Services based on the Ockenden report findings. These replaced reviews on medical appraisals, EPR Governance and support time around deprivation of liberty safeguards. Completed work and finalised reports in respect of the project PathLAKE Plus expenditure claim (5th review) the project PathLAKE claim (4th review) had been undertaken,	

along with. Follow up reviews of the WMSTC and E-Procurement (21/22 review) had been completed as well as reviews of Complaints and the final DSP Toolkit. An advisory review of CT/MRI scan capacity was completed towards the end 2021/22 with approval being received in May 2022.

Terms of reference had been produced and issued for the reviews of Financial Systems, Financial Sustainability and Discharge Planning - TTO prescribing. The terms of reference supporting the Payroll review had been approved.

The Committee **NOTED** and **RECEIVED ASSURANCE** of the report.

ARAC/22/78 INTERNAL AUDIT REPORTS

8.1 IA REPORT

LOB reported that following the previous review in January 2021, the Procurement team had worked to update local procurement guidance, strengthen checks performed on new supplier set-ups and remind staff of the correct processes to follow when placing orders using supplier frameworks and the use of call off orders. SFI waivers continued to be used and the auditors had provided some comparative information across 2020/21 and 2021/22.

A review of sampled waiver forms confirmed that these were being used appropriately in line with the Trust's SFIs. Of the 10 recommendations from the January report, seven had been fully implemented and the remaining three had been partially implemented.

Following questions by JG, SR stated that she did not believe EPR would remove the need for ongoing work on Integra, but that any work that was being undertaken was being cross-referenced to EPR to ensure compatibility. SR stated there was a development plan around Integra but there were challenges around capacity to deliver this.

The Committee **NOTED** the report

8.2 CT/MRI SCAN CAPACITY

LOB stated that the results of the review were positive. Observations noted that appointment schedules were normally being maximised with flexible arrangements in place such as bringing patients forward or delaying based on priority or to accommodate delays, to help ensure optimal use of scanners.

It was noted that there were some periods of unforeseen downtime mainly as a result of inpatient arrival delays into the department/scanning area due to a lack of patient

preparation or incomplete/incorrect documentation completed on wards, as well as non-attendances. In these instances it was observed proactive work by Radiographers and support teams to fill these gaps was undertaken.

The Committee **NOTED** the report.

8.3 & 4 PathLAKE IAR 5 & 4

It was noted that there was a minor reservation regarding the inclusion of VAT for some items of non-pay expenditure claimed in line with the grant conditions. However, the auditors were advised by the Trust following assurances received from Innovate UK that VAT could be claimed in instances where this is classed by the Trust as non-recoverable. This reservation stood for both reports concerning VAT recoverable.

The Committee **NOTED** and **RECEIVED ASSURANCES** on both reports.

8.5 DSPT FINAL ASSESSMENT

SS presented the report, The report summarised the findings from the final review of the DSP Toolkit and provided a status update at the point when the work was undertaken in May 2022. At that time, the Trust had not fully completed all of the work necessary for final submission.

The Trust took a very proactive approach to Data Security and Information Governance and had again asked for the whole toolkit to be reviewed rather than the mandated 13 assertions for audit. Against this background the outcome of the review was excellent for the Trust. SS stated that the work of the team and the proactive approach should be congratulated. The review assessed the Trust's compliance across each of the 10 National Data Guardian Standards in the DSP Toolkit. The standards comprise 38 assertions of which 33 were mandatory and are included in this review. The 33 mandatory assertions were supported by 110 evidence text items.

DW advised that the two main areas where there was a shortfall had now been completed in that more than 95% of staff had completed their annual Data Security Awareness training and also that the data security incident response had been tested, although the outcome report was awaited.

The Committee **NOTED** the report.

8.7 COMPLAINTS

SS advised that testing of sampled complaint cases was in the main positive. Overall investigations were dealt with in a timely manner. The auditors did however identify the need

for some clarity to be provided within the Trust's Complaints policy around at what point the clock should start for the 25 day turnaround of complaints which may in turn lead to the need to consider the challenging timescale set.

Chair asked that the Committee's thanks be recorded to the complaints team for their work in this matter.

The Committee **NOTED** the report.

8.6 WEST MIDLANDS SURGICAL TRAINING CENTRE

KP joined the meeting to contribute to the discussion.

SS advised there was evidence to show that excellent progress has been made by the Centre in completing the majority of actions raised as part of the initial review. There was an extensive amount of work for the centre to do to improve governance so they should be congratulated on the progress to date. Declaring interests by WMSTC Committee members and attendees has been strengthened, an Annual Report has been produced for the Centre for 2021, and work has been undertaken to improve publication of the Centre's services through one centrally hosted platform on the Trust's website.

Evidence of financial information for the Centre being presented in the form of a formal report to the WMSTC Committee in May 2022 and documentation held for the transfer of plastinates to Warwick Medical School had been reviewed for appropriateness.

Following assessment by the Royal College of Surgeons, the Centre had achieved accreditation for a period of 3 years from June 2022. This was excellent news for the Trust and was a reflection of the work undertaken by the Centre's staff and management over the last 12 months.

The Committee **NOTED** the report.

KP departed the meeting.

ARAC/22/79 ANNUAL SATISFACTION SURVEY REPORT 2021/22

PC presented the report giving highlights of some of the figures. It was reported that each year a customer survey was conducted among the executive management team and those non-executive directors and lay members on Audit Committees. The survey gauged satisfaction with services. The presentation of the annual customer satisfaction survey report for 2021/22 showed that from a 64% response rate:

- 98% rated their overall satisfaction as 7 or above (with 10 = excellent), equivalent to the last survey

- 98% would recommend the service to others, equivalent to the last survey
- 97% rated added value as 7 or above, compared to 94% previously. It was added that 55% rated the service 9 or 10 out of 10.

One thematic area for change/improvement was a desire from some clients to see our on-site presence increase once again. A measured approach was needed to achieve this, on a case-by-case basis depending upon client circumstances.

The Committee **NOTED** the report.

ARAC/22/80 COUNTER FRAUD ANNUAL REPORT 2021/22

MT presented the report, the purpose of which report was to:

- Summarise the proactive work undertaken against national counter fraud standards during the year 2021/22;
- Provide outline details of any investigations undertaken.

The work undertaken during 2021/22 had been aligned to the NHS Counter Fraud Authority Government functional standards. Standard 3 was rated red and standards 5,6,10 and 11 rated as amber. The rationale for these ratings were explained at section 7 of the report submitted alongside the associated papers to the Committee.

No fraud referrals were carried forward from 2020/21, but it was reported that 13 referrals were received during the year, 10 of which had since been closed off.

MT/CH

JG asked for expansion of comments where amber or red were shown on the report. It was agreed that this would feature in future reports.

The Committee **APPROVED** the report.

ARAC/22/81 COUNTER FRAUD PLAN 2022/23

MT presented the report, commenting that mandate fraud was now a priority. Cathy Hughes (CH) was the Trust's nominated operational support officer with MT in support of her and was introduced to the Committee.

The report detailed the Trust's risk assessment and work plan for 2022-23 which proposed the work programme for counter-fraud activity.

The Committee was advised that CW Counter Fraud Specialists had liaised with Trust officers and updated the

ITEM	DISCUSSION	ACTION

risk assessment for existing and emerging risks and outlined their tasks in order to meet each of the standards.

The Committee **APPROVED** the report.

ARAC/22/82 COUNTER FRAUD PROGRESS REPORT

MT presented the report which covered the first quarter of the year. Any items in the interim would feature in the subsequent report.

There had been two new potential incidents of fraud which were being investigated, bringing the total ongoing incidents to five.

The Committee **NOTED** the report.

ARAC/22/83 NATIONAL FRAUD INITIATIVE SUMMARY REPORT

MT presented the report noting that the National Fraud Initiative (NFI) exercise was virtually complete with only a couple of minor issues outstanding for the past year and this did not commence progress being made on the current year audit.

The process on uploading the 2022/23 data had already commenced.

The Committee **RECEIVED ASSURANCE** on the report.

ARAC/22/84 CWAS THE CASE FOR MERGER

PC presented the report giving context to the paper, noting that 360 Assurance were a much larger internal audit organisation with greater resource particularly in the cyber realm.

The committee was advised that 360 Assurance and CW Audit had been working together in a number of ways, with 360 Assurance providing some specialist resource with some clients and bids to support to CW Audit.

Both organisations were NHS consortia with aligned business objectives. Both parties recognised that there was a real opportunity to work together more and significant potential benefits to making the relationship more formal. The respective Management Boards had agreed in principle to move forward towards merger. This would make the new body the second largest supporting the NHS.

JG raised concerns on the conflict between consultancy and audit, reducing competition. PC responded that the skills were sometimes difficult to attract and that the merger would provide an opportunity to develop a pool of skilled staff to support the organisations more widely.

ITEM	DISCUSSION	ACTION
	DW commented on 360 with other Trusts. He questioned the governance changes that might happen, and whether the merger would impact on UHCW's relationship with CW Audit as a member of its consortium board, in the context of the governance arrangements that 360 Audit had with the Trusts it supported. PC agreed there was a difference in terms of membership due to the scale of 360 Audit.	
	The Chair requested that officers consider the impact on UHCW, with consideration to whether it would affect how the Trust would commission its audit services in the future.	**DW** **SR**
	The Committee **NOTED** the report.	
ARAC/22/85	**ANNUAL EXTERNAL AUDIT LETTER**	
	RA joined the meeting to present this item. He noted that the annual audit was now complete and that KPMG were now looking at the new Financial controls and reporting, as well as the new auditing standard which would be discussed with the Trust over the coming months.	
	The Committee **NOTED** the report.	
ARAC/22/86	**LOSSES AND SPECIAL PAYMENTS DEBT WRITE OFFS**	
	SR presented the reports, noting that the Trust was now using Docusign to help reduce losses and improve processes. The losses from the period March 2022 to June 2022 comprised: • one special payment for an employment tribunal settlement of £12,100; • four ex-gratia payments for lost or damaged personal items totalling £738; • reimbursements from NHS Resolution of £38,431; • theatre and pharmacy stock losses for the period of 1st April to 30th June 2022 totalling £54,376.	
	The special payment related to an Employment Tribunal decision and had been already declared in the Trust's Annual Accounts.	
	The debt write offs were for a total of £243,548.35 of which there were 74 cases of Overseas Patients totalling £241,651.39. The Trust had attempted to contact the Overseas Patients in every case and had all been placed with debt collection agencies except where there is insufficient information available to conduct a trace.	
	The Committee **NOTED AND APPROVED** the reports.	
ARAC/22/87	**ACCOUNTING POLICIES AND TECHNICAL ACCOUNTING UPDATES**	

SR presented the paper noting that the detail of the report had been discussed at previous meetings. The Trust was still awaiting guidance on the implementation of IFRS 16. This meant that the values reported in the accounts were audited on the basis of being a disclosure of the likely impact rather than the actual impact on the accounts.

JG requested information on the potential worst case scenario of this implementation and should this be placed on the Risk Register. SR responded that this was still an unknown and therefore too early for that action. As soon as further information is supplied then a decision on whether this item can be placed on the Risk Register can be made.

The Committee **NOTED** the report.

ARAC/22/88 WAIVERS of SO/SFIs/SoRD

AB joined the meeting to present the report.

AB gave further information concerning the full implementation of Contracts Catalogues and all were now held within the DHSC ATAMIS procurement system meaning that the Trust was now 100% compliant.

AB then gave highlights from the report and noted some of the changes that would happen in the future. There was an active action to reduce Waivers and later in the year doing a review of the Waiver policy. It was further noted that the average number of Waiver requests approved had dropped over the three month period compared to the previous three months.

JG requested that an additional column be added to the report to show in the large requests to show negotiations and variances in price. AB noted that changes to Docusign would be able to produce this information requested and information would be sent to suppliers to guide the completion of the forms.

This, however would take time to bed in and for the department to be able to extract the necessary information.

AB was thanked for his responses and the Committee **NOTED** the report.

AB departed the meeting.

ARAC/22/89 CYBER SECURITY UPDATE

JM joined the meeting at this point to present the report.

He stated that threats were increasing to the Trust and the wider NHS and in particular noted the Adastra attack which

was still ongoing and affecting the Trust through the degradation of the 111 and Coventry Urgent Treatment Centre provision. This resulted in the Trust activating the business continuity process and having to revert to using paper in some cases for nearly two weeks. He further reported that CWPT would be using a paper system for up to four weeks, to mitigate the effects of the cyber-attack.

JG noted that staffing levels were very low and questioned whether this was due to competition or budget. JM confirmed that staffing levels had not increased despite the increase in physical devices and increasing numbers of remote users within the Trust. The figures used to support this comment were that the Trust had increased the number of devices by over 3000 and the number of remote workers had increased from 200 to more that 2500.

Correspondingly this increased the management required for these devices and also the support provision for remote workers.

JG stated that this needed escalating to the Board due to the high risk to the Trust. The Chair agreed and gave further background to strengthen the case. Chair asked DW to frame the ARAC response to the Board noting that the Risk is rated as a 20 with a target of six. SR stated that there was a piece of work being undertaken to make the case for increased resource for the team. Chair asked for a timeline for progression of this item. **DW** **JM**

JM continued the report by stating that capital funding was available from NHS Digital but no revenue funding which reflected the discussion within this minute. Key successes were in patching devices, removing Office 2010, and third-party suppliers. 200-300 devices needed updating and approximately 2000 Office 2010 required an update. The Chair thanked JM for the progress made so far.

Chair stated that he had not been made aware of the issues with the Coventry Urgent Treatment Centre.

The Committee **NOTED** the report.

ARAC/22/90 CORPORATE RISKS REPORT

LC joined the meeting to present the report. It was noted that there were still four open risks under the ARAC portfolio these being;

- Risk ID 2416: Breaches of Confidentiality
- Risk ID 1864: Unauthorised access of Trust systems - Misuse of access by Trust Staff
- Risk 2911: Raising concerns

- Risk ID 2646: Cyber Security threats and vulnerabilities to the Trust

As previously discussed, Risk ID 2646 was rated as High. The Registers were being revised to be submitted to the Board for ratification.

JG noted that staff resourcing in Cyber Security was not properly highlighted. Chair agreed and stated that this information concerning the 20 point rating would strengthen the case to the Board in the business case for the IT team.

The Committee **RECEIVED ASSURANCE** of the report.

ARAC/22/91 CHANNEL 3 ASSURANCE REPORT

JMA was welcomed to the meeting to present the report.

She noted that Channel 3 were external partners brought in to provide additional support and assurance. The potential "Go live" date was under discussion but was expected to be May 2022. There were some concerns raised by Channel 3 so the rating was Amber.

RAG ratings of red were noted as the need for the appointment of a new Programme Manager persisted and the Transformation Strategy had not been signed off. An action plan has been produced and circulated. JMA noted the content of the action plan highlighting the completed actions and where work continues to progress towards the delivery date.

The role of the NED required alignment and definition with the programme and needed terms of reference together with roles and functions to be reviewed and documented to enable clearer decision making processes. The programme needed to link better to ICS for the future. The action plan was written for a future context to embed with business as usual.

The Chair asked who was to monitor the programme and then to ensure that the ARAC received timely information and changes to the risks were clearly and appropriately flagged. The process was designed for the Project Board to assure ARAC in terms of the programme.

The Committee **RECEIVED ASSURANCE** of the report.

ARAC/22/92 POLICIES, PROCEDURES, AND STRATEGIES UPDATE

LC presented the paper. There were a total of 176 Policies, Procedures and Strategies (PPSs) open on E-library of which 68.2**%** (56) were within the review date.

ITEM	DISCUSSION	ACTION
	The paper submitted with the minutes provided an overview of the status of all 56 expired PPSs as of the 3rd August 2022, these all being with the PPS author for review.	**MH**
	JG requested that the pie chart showed movement indicating whether there had been an improvement or otherwise, to more clearly define risk.	
	The Committee **NOTED** the report.	
ARAC/22/93	**REVIEW OF CLINICAL AUDIT EFFECTIVENESS**	
	LC presented the report which provided a final update on the end of year performance for the Trust-wide Clinical Audit Programme 2021-2022 and introduced the programme for 2022-2023. The highlights of the end of year performance were as follows: • The Trust participated in 97% of mandated national clinical audits during 2021-22. Two national audits where data deadlines were not met are Emergency Medicine QIPs: RCEM Pain in Children and National Diabetes Foot care Audit (NDFA). • Since 1st April 2021,1 clinical audit action plan has been fully implemented; a further 94 are currently in progress. • There are currently 11 overdue actions which will be followed up with the relevant action leads.	
	For the current year the programme had been finalised and approved and a total of 129 new clinical audits had been identified and registered of which 81 were external and 48 internal must-do clinical audits.	
	JG asked whether this was the correct Committee to be considering the amber and red RAG rated audits. He was advised that it was PSEC who monitored this.	
	The Committee **NOTED** the report.	
ARAC/22/94	**BOARD ASSURANCE FRAMEWORK**	
	DW presented the report, highlighting that the role of the Committee was to gain assurance on the BAF as a control mechanism rather than consider the detail. Nonetheless, the detail was included in the appendices for context.	
	DW stated the cyber security consideration was a critical risk, which had been a recurring theme during the meeting, and noted that it was the one critical risk identified by the Board which was not fully reflected in the BAF. Although	

ITEM	DISCUSSION	ACTION
	ICT matters would ordinarily come before the Finance and Performance Committee, DW highlighted that this committee was already dealing with two BAF risk areas, and suggested that cyber security would better be brought back to this committee. This was agreed by JG and the Chair, and an action agreed to develop a BAF risk for presentation and monitoring before the Committee.	**DW**
	The Committee **RECEIVED** and **NOTED** the report.	
ARAC/22/95	**REVIEW OF BOARD COMMITTEE ANNUAL REPORTS 2021/22**	
	DW presented the report detailing all the standing committee reports for the past year, their terms of reference, how many meetings they held in a year and the matters considered by each Committee, the report also detailed the quoracy changes in the terms of reference.	
	It was confirmed that the annual reports of all four committees would proceed to Board in October.	
	The Committee **NOTED** the report and **ENDORSED** the submission of all four Board committee annual reports to Trust Board.	
ARAC/22/96	**DRAFT AGENDA FOR NEXT MEETING**	
	DW noted the presence of both Committee Officers and commented on changes particularly to pre-meetings moving forward. Time allocations and paper leads could be improved for future meetings. Both Committee Officers were welcomed to the meeting and the Chair expressed the wish to establish a working relationship with both Officers.	
	The Committee **RECEIVED** the draft agenda for the next meeting.	
ARAC/22/97	**ANY OTHER BUSINESS**	
	No other business was brought before the Committee.	
ARAC/22/98	**MEETING REFLECTIONS**	
	The Chair appreciated the high quality of the papers which helped the meeting flow well. The Chair also asked for further comments to be made to assist future meetings.	
ARAC/22/99	**DATE AND TIME OF NEXT MEETING**	
	The next meeting would take place on Thursday 20 October 2022 at 9.30-12noon.	

ITEM	DISCUSSION	ACTION
	There being no further business the meeting closed at 11.45am	

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 1 DECEMBER 2022

Report of the Audit and Risk Assurance Committee following its meeting held on 20 October 2022

Committee Chair:	Afzal Ismail
Quoracy:	The meeting was quorate
Purpose:	This report is to provide assurance that the Audit and Risk Assurance Committee has formally constituted its duties in accordance with the terms of reference and to advise of the business transacted.
Recommendations:	The Board is asked to: 1. Confirm assurance received from the business discussed at the meeting; 2. Raise any questions in relation to the same.

Key highlights of discussions held during the meeting

ISSUE	**DETAILS**
6. Internal Audit Recommendations	The Committee received an update on progress against delivery of recommendations arising from previous internal audits. It was reported that there were no overdue recommendations at that time, although there were nine recommendations where the original date had been extended or deferred. The majority of these related to the Cyber Security Arrangements audit (so item below) or the Learning from Deaths audit. *Post-meeting note – further to the above consideration the Learning from Deaths audit action plan has been presented to QSC – see separate meeting report for 24 November 2022 for that committee*.
15. Risk Management Report 16. BAF – Cyber Threats	These reports were considered in the context of the above item and previous consideration by the committee, as reported to Board, to develop a BAF entry specifically focused on Cyber Threats. The committee was concerned about this issue, noting the Corporate Risk that existed and was scored as 20 (high) around cyber security threats and vulnerabilities to the Trust. The committee separately received an update on progressing the development of the Cyber Threat BAF entry and it was agreed that this would be provided to members of the committee in advance of the January meeting.

ITEMS FOR ESCALATION, WHY AND TO WHERE		
Item or issue	Purpose for escalation	Escalated to
Cyber Threats Issue	For the reasons as described above.	Board for information.

OTHER ITEMS CONSIDERED
• Items 7 and 8 - Internal Audit Progress Report and Internal Audit Reports • Item 9 - Counter Fraud Progress Report • Item 10 – Annual External Audit Progress Report • Item 11 – Losses and Special Payments • Item 12 – Debt Write-offs • Item 13 – Waivers of SO/SFIs/SoRD • Item 14 - Accounting for PFI Equipment and Proposed Changes

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

TERMS OF REFERENCE: Did the meeting agenda achieve the delegated duties?	
Item from terms of reference	State which agenda item achieved this
Advise the Trust Board on the strategic aims and objectives of the Trust	
Receive assurance on the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and recommend modifications	
Receive reports from the Chief Officers relating to organisational performance and quality within the remit of the Committee	
Receive assurance on the delivery of strategic objective and annual goals within the remit of the Committee	
Review the annual audit letter from the external auditor	
Review the Head of Internal Audit opinion	
Review any breaches of standing orders	13 - Waivers of SO/SFIs/SoRD
Review write-off of losses or the making of special payments	11 - Losses and Special Payments 12 - Debt Write-Offs
Review the Trust's annual report, accounts and quality account and recommend approval to the Trust Board	
Review the effectiveness of financial reporting	
Receive assurance about the effectiveness of arrangements for; • Governance • Risk management • Internal audit • Internal control • External audit • Counter fraud • Clinical audit • Information governance	6 - Internal Audit Recommendations Update 7 - Internal Audit Reports 9 - Counter Fraud Progress Report 10 – Annual External Audit Progress Report
Review the Standing Orders, Scheme of Reservation and	

TERMS OF REFERENCE: Did the meeting agenda achieve the delegated duties?	
Item from terms of reference	State which agenda item achieved this
Delegation and Standing Financial Instructions	
Review the Trust's policies and procedures for the management of risk	15 Risk Management Report 16 Board Assurance Framework – Cyber Threats
Review the arrangements for declaring interests, gifts and hospitality	
Other	

ATTENDANCE LOG						
		Apr	**Jun**	**Aug**	**Oct**	**Jan**
Was the meeting quorate?		Yes	Yes	Yes	Yes	
Non-Executive Director (Afzal Ismail)	Chair	✓	✓	✓	✓	
Non-Executive Director (Jerry Gould)	Member	✓	✓	✓	✓	
Non-Executive Director (Sudhesh Kumar)	Member	✓	✓			
Non-Executive Director (Gavin Perkins)	Member				✓	
Assoc. Non-Executive Director (Douglas Howat)	Member				✓	

Alert, Advise, Assure Report to the Trust Board

Reporting Committee: **People Committee**

Committee Chair: **Jenny Mawby-Groom – in whose absence Stella Manzie acted as Committee Chair for the meeting**

Date of meeting: **27 October 2022**

ALERT (Include here areas of concern, lack of assurance, risks of non-compliance or matters requiring urgent attention)

Report	Assurances received	Gaps in assurance identified	Actions agreed	Deadline for actions
None				

ADVISE (Include here areas of ongoing monitoring for information or for communication)

Report	Assurances received	Gaps in assurance identified	Actions agreed	Deadline for actions
WRES/WDES	The committee received the WRES/WDES and approved its publication in line with the previously agreed decision of the Board. The committee was advised of the action plans that were in place to address shortcomings in each.	There was concern that the documents did not fully capture the extent of the work that had been undertaken, which non-executive attendees had been sighted on separately. While committee members had been otherwise assured of these actions, there was a concern that the documents would not	The WRES/WDES was approved subject to changes which were communicated outside of the meeting.	Complete

		fully demonstrate this to those who had not benefitted from being sighted separately.		

ASSURE (Include here areas of generally positive assurance)

Report	Assurances received	Gaps in assurance identified	Actions agreed	Deadline for actions
None				

University Hospitals Coventry and Warwickshire NHS Trust

MINUTES OF THE MEETING OF THE QUALITY AND SAFETY COMMITTEE HELD AT 09:30 ON THURSDAY 29 SEPTEMBER 2022 IN ROOM 00051, CSB, UHCW

MINUTE REFERENCE	DISCUSSION	ACTION

QSC/22/094 **PRESENT**

Carole Mills (CM) – Non-Executive Director (Chair)
Janet Williamson (JW) – Non-Executive Director
Mo Hussain (MH) – Chief Quality Officer
Kiran Patel (KP) - Deputy CEO & Chief Medical Officer

QSC/22/095 **IN ATTENDANCE**

David Walsh (DW) – Director of Corporate Affairs
Lisa Cummins (LC) – Director of Quality
Falguni Choksey (FC) – Consultant Anaesthetist [For Item **QSC/22/106**]
Vicky Williams (VW)
Suzanne Wilson (SW) – Deputy Director of Midwifery [For Item **QSC/22/104**]

QSC/22/096 **APOLOGIES FOR ABSENCE**

Apologies were received from Douglas Howat – Associate Non-Executive Director and Tracey Brigstock – Chief Nursing Officer

QSC/22/097 **CONFIRMATION OF QUORACY**

The meeting was confirmed quorate.

QSC/22/098 **DECLARATIONS OF INTEREST**

No declarations of interest were made.

QSC/22/099 **MINUTES OF THE PREVIOUS MEETING**

The minutes of the previous meeting held on 28 July 2022 were confirmed as an accurate record.

QSC/22/100 **ACTION MATRIX**

Chair asked for updates on actions due to be reported to this Committee. DW stated that some of the actions were being presented later in the agenda.

The committee **NOTED** the actions and agreed that the completed actions should be closed.

QSC/22/101 **MATTERS ARISING**

MINUTE REFERENCE	DISCUSSION	ACTION
QSC/22/102	**CHIEF OFFICERS' EXCEPTIONS/UPDATE**	
	KP reported that the final dermatology report had been received and that, due to some very sensitive issues, it would be presented to the Private Trust Board scheduled for 6 October and CQC will be advised. The report's recommendations include a need for Non-Executive Director oversight. In the light of some concerning patient outcomes, the Chair asked if the Trust had contacted the patients involved since the review had taken place. KP stated that it was not for this Trust to contact them as this was a South Warwickshire issue. SWFT is also required to take action and we will be working in partnership with them on this matter. UHCW need to be reassured that all necessary actions are being taken by both Trusts but cannot be held accountable for another Board's actions or inactions. There were a whole range of consequences and these needed to be thought through. JW asked whether there was any oversight required through the Integrated Care Board (ICB). It was stated that this issue needed to be dealt with as quickly as possible, KP reported that there were some legal issues with this and on a statutory basis the Trusts had to work together as there was a legal challenge to the report. The legal challenge being made against SWFT, but this Trust could be held accountable.	
	MH reported on the Patient Safety Instant Response Framework, which is replacing the Serious Incident Framework. The previous report had dealt with cases of serious harm and had not focussed on moderate harms. Work had been undertaken across different organisations as to how learning was taking place. There are significant changes which will need significant resources to be applied. There is national recognition that many organisations are not adequately resourced for this so there will be a 12 month delay until implementation. MH recommended that a report be brought back at a later date, which was agreed. The new framework is good but will require some cultural change for some organisations, particularly how they relate across their areas. There is a requirement for a named NED for Patient Safety. An interim or full report would be brought to the next QSC, dependent on timings. MH had met, via Teams, with the surgical team and there were no surprises. A detailed report had been provided, the DMA is monitored by the CQC who will not be worried either and will not inspect the Trust over this issue. This concern can now be removed from the BAF.	**MH**
	The Chief Officers were thanked for their reports.	
QSC/22/103	**INTEGRATED QUALITY, PERFORMANCE AND FINANCE REPORT**	
	KP presented the report. The latest reported HSMR figure is 122.81 for May 2022 and is outside Dr Foster's calculated relative risk range, some of this was due to coding issues. Due to the flow of patients it was noted that on some occasions patients were placed in the wrong type of ward for their condition or need, (for example surgical patients being placed on cardiac wards and vice versa), which increased consultants' time having to go to different wards to see patients. KP	

potentially impacted on their care. The Chair asked how many times this was happening, KP replied that there were 70-80 patients involved at any one time, the equivalent of three wards full. This is a national issue and social care scarcity issues are adding to delays with patient discharge. Nighttime moves of patients between wards is a further issue which can lead to some people having falls if they become disoriented. There have been two serious issues following patients moves during the night. The ideal being that no patients are moved at night. KP stated that generating capacity in wards would solve the problem. There needs to be a debate on moving patients.

There has been an increase in the number of RTT 52 week wait patients, as a result of service changes required in response to Covid-19. There were 4,811 for July, up by 586 since June. This compares to a national average of 2,147. RTT 78 week waits are reducing with 127 reported for July, down 19 since June. The average number of long length of stay patients for August was 199, up 17 since July. This could also be linked with the inability to discharge medically fit patients into social care due to lack of capacity in that sector. A discussion on reasons and actions took place.

Reason to reside data collection compliance for eligible areas is 82%. Urgent clinical letters sent in 7 calendar days is 79.3%. A Category 4 pressure ulcer had been reported for June. The Trust reported four 12-hour trolley waits within the Emergency Department. Comparative activity levels with that of 2019 (pre-pandemic) were disclosed and show how Day Cases contribute to the Referral To Treatment Open Pathways. Some national submissions have been suspended due to the pandemic. Where possible the KPI is reported within scorecards.

The Committee expressed concern about the situation and acknowledged the pressures within the wider system due to high demand and capacity issues and noted the actions that were underway and planned.

The Committee **REVIEWED** and **NOTED** the report.

QSC/22/104 **MATERNITY SERVICES: FINDINGS OF REGIONAL AND SYSTEM INSIGHT VISIT**

SW joined the meeting. KP provided some context. Overall it was a positive report although he disagreed with some aspects, particularly NED visibility within the unit when the Trust was preventing birth partners access to the unit due to the Covid restrictions. The Chair said that she agreed with KP and would not attend a unit under such circumstances. She shared an example based on an experience elsewhere which had been given by one of the reviewers.

SW presented her report outlining the Insight visit on 11 August led by the NHSE Regional Chief Midwife alongside members of the Local Maternity and Neonatal System (LMNS). The purpose was to provide assurance against the seven Immediate and Essential actions (IEAs) from the initial Ockenden report of December 2020. Evidence was submitted in advance to demonstrate compliance. There had been focus groups with all levels of staff including the CEO and the board

midwives and obstetricians and included a full walk round of all clinical areas. Both initial feedback on the day and the formal feedback (attached) received/concluded that the team were really impressed with what they had seen. Points highlighted as follows:

- Ockenden themes were well embedded and implemented across the Trust.
- Cohesive and collaborative leadership across all levels of the organisation.
- Quality improvement embraced at all levels.
- Improvements in practice following incidents observed.
- Good engagement with the Maternity Voices Partnership (MVP) and equality work for BME service users.
- Excellent international recruitment programme.
- Informative maternity safety production boards and governance boards.

Points of consideration for the Service:

- Links between the MVP and the Maternity Safety Champion to be strengthened.
- Increase evidence of co-production with service users.
- Review process for choice for women with vulnerabilities and complex pregnancies.
- Progress with the Bereavement Suite.
- Improve transitional care pathways.
- Potential risk with the new EPR system as replacing a fully functioning maternity system.

Next steps:

- Director of Midwifery to link the Maternity Safety Champion and the MVP chair and Engagement Lead to strengthen co-production and links with service users.
- Complex care team, consultant midwife and high-risk midwifery community team to review process for choice and personalisation for women with vulnerabilities and complex pregnancies.
- Task and finish group progressing the Bereavement Suite, site confirmed, service user representative identified to co-produce. This requires a full business case and capital investment.
- Task and finish group formed to progress transitional care pathways – inaugural meeting planned.
- Risks of Cerner as a maternity system escalated to the EPR team for assessment, evaluation and recommended way forward.

The Chair asked that the bereavement suite issue be prioritised and thanked SW and asked that good wishes be sent to the team in achieving such positive feedback from the review.

MH asked a question about EPR implementation and said that there was already a digital solution in place which questioned the need for Cerner as some Trusts used BadgerNet some trusts used K2. Walsall Trust was used as an example and was on SystemOne. There were questions as to how the system is accessible and representatives of Cerner were to attend the EPR Board meeting in

MINUTE REFERENCE	DISCUSSION	ACTION
	October. MH said it was great that there were EPR champions in the Maternity Unit. JW asked about vacancies and the delivery of the Ockendon report recommendations. SW said that there had been international recruitment of midwives, the Trust had been very fortunate in recapturing staff who had gone on longer term leave and had been able to retain a large number of the midwife trainees as they had completed their course. Although a large number of bank staff had been used the Trust had not had to stand down home births. The Chair recognised that there were very high pressures on the service due to vacancies and then noted the comments made re the Action Plan which was to be brought back to the Committee in January 2023. JW asked whether this resulted in an increased risk score. The Chair also expressed concern and noted the several actions underway, understanding that this was an ongoing national problem. SW said that the CQC was being briefed and were aware and satisfied with the current situation. MH stated that there had been a number of reports on safe staffing.	SW
	MH asked about continuity of care. SW said that there were no national targets for this and minimal impact on the Trust. JW asked about the CQC reviews and whether anyone had responded to them. SW stated that there had been a response. The Committee **RECEIVED** the NHSEi Regional Insight Report (11 August 2022) detailing compliance and progress with the 7 IEAs detailed in the Ockenden (first) Report (December 2020) and were **ASSURED.** The Committee **NOTED** the work in progress and the next steps identified. The Committee **NOTED** that all Trusts providing maternity services are expecting a further review by the CQC in the next 6-12 months. SW was thanked for her attendance and left the meeting.	
QSC/22/105	**CORPORATE RISKS REPORT** LC presentation highlights from the report. There are 17 open corporate risks (one graded as low; ten as moderate and six graded as high). A summarised version of the 11 risks graded as moderate or below were included in the papers. The following risk had been added to the QSC portfolio since the last meeting: • **Risk ID 4097: Emergency Medicine overcrowding and patient flow.** This is graded as moderate and so summarised details were included in the table in the main report. **Risk Overview:** There are currently no risks rated between 20 and 25. The six highest rated risks (15-16) are: • **Risk ID 2540: Potential Risk of Major Fire incident.** • **Risk ID 3810: Inability to meet the demand for breast imaging / screening services within the capacity**	

MINUTE REFERENCE	DISCUSSION	ACTION

- **Risk ID 3975: Inability to deliver a sustainable Dermatology service.**
- **Risk ID 2646: Cyber Security threats and vulnerabilities to the Trust**
- **Risk ID 2658: Auto Reported Examinations**

VW noted that there had been an overcrowding risk identified within ED. LC said that this had been mitigated, so no longer showed on the register. The Chair questioned Risk 3816 which KP responded to. The cyber risk was discussed which was being looked at by other committees, MH stated that there had been a direct attack on the NHS through a company called Advance which impacted our 111 services. CWPT had lost their systems and had reverted to paper records. Outsourcing was allowed but Trusts did not lose their accountability over any issues faced. MH and KP talked about the Trust's contingency plans in the event of losing digital services and systems.

The Committee **RECEIVED ASSURANCE** from the report.

QSC/22/106 HOSPITAL TRANSFUSION COMMITTEE ANNUAL REPORT

FC joined the meeting. KP stated that she was an expert in her field. FC outlined developments in the Transfusion Service and from whom the Blood Bank service is provided as both the Trust and the Coventry & Warwickshire Pathology Service (CWPS) provide different aspects of the service. FC further noted the involvement of the service within the wider region.

Blood component transfusion supports the care of adult and paediatric patients across a wide spectrum of clinical disciplines such as trauma, surgery, cancer, renal, gastroenterology, haemo-globinopathy and intensive care. It is essential to define clear policies and processes for the multiple healthcare teams involved, to support safe and appropriate use of blood for effective patient care. Over recent years there has been considerable improvement in transfusion practice supported by evidence from clinical trials, implementation of guidelines and process improvements that have resulted in an overall reduction in blood use and significant cost savings for the NHS. However, there is evidence of ongoing variability in transfusion practice within and between hospitals that may impact on patient outcomes needing further action.

The HTC at UHCW actively seek to promote safe, appropriate and cost effective transfusion practice through a number of mechanisms including:

- Use of local policies and protocols based on national recommendations and guidelines
- Multi-professional audit of the use of blood within UHCW, focusing on specialties where demand is high, including medical as well as surgical specialties.
- Review and take appropriate action regarding data on blood stock management, wastage and blood use provided by the

- Educational strategies for all clinical, laboratory and support staff involved in blood transfusion
- Modify and improve blood transfusion protocols and clinical practice based on new guidance and evidence
- Contribute to the development of clinical governance
- Proactively implement Patient Blood Management strategies.

UHCW HTC also explore opportunities for innovation in processes, technology and blood components in collaboration with NHSBT that will improve the clinical and laboratory transfusion service and benefit patients.

The Trust had now returned to pre-Covid practice in terms of screening and identifying patients and the Trust was very close to achieving treatment targets in terms of both national and local performance targets. The major challenge being faced at the moment is the acute shortage of staff in labs across the whole region meaning that clinical staff are having to undertake non-clinical duties and projects identified and discussed are not being progressed or have very little progress to show. O negative use is higher than national average and comparable major trauma centres. This is causing issues with stock management. It appears that there is an issue with the EPR system, and this means that some records are being handwritten. Clinician engagement is difficult, but this is a national issue. Pre-medication supply to the ambulance service is an issue due to wastage and the suggestion is to split the supplies up to prevent this. Some communication from this Committee was requested to help speed up the process of dividing the boxes into two. An action was approved to write to the Diagnostics Group to encourage this to happen. Also for the EPR Group to be made aware of the handwritten notes issue. KP stated that the issue over O negative blood was simple to solve when full access to the EPR system was available in the ED. Communication was needed and detail would be added to the medical bulletins from both KP and TB to assist in making the problem more of a priority. The Chair asked a question relating to the speed blood testing and screening could be done. FC said that it took five minutes to find blood type and a full screening took 45 minutes, but samples from a different Trust can take considerably longer. Sample rejection is creeping up to around 6% against a national average of 5%. Using NHS numbers would reduce the issue compared to identify patients via the Trust requestor.

The Committee discussed and **NOTED** the report.

FC was thanked for her report and left the meeting.

QSC/22/107 RESEARCH AND DEVELOPMENT ANNUAL REPORT

KP presented the report noting that the majority of the elements of had been presented to the Committee in previous meetings. He noted that there had been a review of the strategy and the Arden Tissue Bank which had exposed a weakness in the HTA licensing

MINUTE REFERENCE	DISCUSSION	ACTION

Support for the formal application of a HTA licence needed to be included in the Chair's Report to Trust Board and would reduce the amount of paperwork created than an action from the Committee.

The Committee discussed and **NOTED** the report.

QSC/22/108 QUALITY STRATEGY UPDATE

MH presented the update and reminded the meeting of what the strategy was to cover and how it had been developed to date. LC noted that this report was merely an update of progress made and to bring the committee up to date with the timeline. At the end of September the Group was conducting the consultation with a view to then consolidating all responses within a three month period. The strategy would be finalised by the end of January 2023. The consultation and discussion taking place had included:

- Group triumvirates
- Key professional stakeholder groups e.g. medical, nursing, therapists, leadership forums
- Patient and user representative
- Our partners e.g. Healthwatch, system partners.

The strategy would cover five key areas:

- **Safe: w**e will deliver services in a way that protects people from avoidable harm, neglect and abuse and should mistakes occur; lessons are learned
- **Effective:** to improve health outcomes for our patients, our services will be informed by evidence-based practise and will be delivered (through consistent high-quality training) in a way that enables continuous improvements.
- Provides a positive experience **(Caring and Responsive)**: Services will be shaped by people who deliver, use and access them
- **Well-Led: o**ur services will be delivered by teams who are accountable and have effective governance arrangements; delivered in a culture of compassion, inclusivity and continuous learning and improvement in quality.
- **Sustainably-resourced**: based around sustainable use of resources (with optimum outcomes within financial envelopes) and minimisation of waste.

The Chair asked when something substantive would be presented to the Committee. LC responded that a three month report could be produced for the end of 2022. This was agreed. JW commented that the strategy goals were excellent.

The Committee **NOTED** and received **ASSURANCE** from the report.

QSC/22/109 PATIENT EXPERIENCE AND ENGAGEMENT REPORT

LC presented the report as follows:

Complaints: The Trust received 110 complaints in Quarter 1 (Q1)

MINUTE REFERENCE	DISCUSSION	ACTION

The performance indicator is 90% responded to within 25 working days. In Q1 the Trust received 22 requests for further resolution of complaints (FLR) (25 received in Q4 2021/22).

Primary themes: of complaints received in Q1, communication with patients and relatives/carers was the most complained about subject. Clinical Treatment - General Medicine Group, was the second most complained about subject in Q1. Patient care including nutrition / hydration, was the third most complained about theme in Q1.

Patient Advice and Liaison: The Patient Advice and Liaison Service (PALS) processed 768 enquiries in Q1 managing 78% of enquiries within five working days. The performance indicator is 90%

within five working days. A new PALS Coordinator commenced in post in Q4 2021-22 and the team have recruited five new starters. The PALS team performance is expected to see continued

improvement in Q2 2022/23.

Primary themes: appointments were the primary theme in Q1. Communication is the second theme (specifically communication with relatives/carers. Values and behaviour of medical and nursing

staff remains PALS third highest subject. 286 compliments and thanks were received in respect of Trust services in Q1.

Patient information leaflets: During Q1, 230 leaflets were updated including five new leaflets uploaded. The Trust achieved 92.9% compliance for all Patient Information leaflets. 455 queries were received and responded to during Q1.

National Survey Programme:

Maternity Survey 2021 - the action plan in response to the Maternity 2021 findings lists the areas the Trust scored in the bottom 25% of the Trust's Picker surveyed. They are split by sections in line with the format of the survey:

Antenatal and Labour /Postnatal/Feeding. The following are examples of actions taken by the Maternity Service:

- Consultant midwife reviewing Birth Options Leaflet to include Personalised Care Support Plans
- Ongoing monthly audit for Ockenden Report assurance
- Specialist midwife to offer virtual antenatal sessions around infant feeding on a regular basis

Patient partners: during Q1 Patient Partners supported a Patient Visitor Survey and presented their findings to the Patient Experience and Engagement Committee. The aim was to measure if the new visiting hours introduced on both sites meet the needs of loved ones and carers and to invite comments and concerns from visitors regarding the length of visiting times available.

Friends and Family Tests (FFT): The Patient Insight and Involvement Team have put in place several measures during Q1 to improve FFT response and recommender rates which include:

- Further streamlining and developing reports for each of the groups.

MINUTE REFERENCE	DISCUSSION	ACTION

- Plans in place to introduce FFT in all areas, where we previously have not asked the survey before.
- The team has introduced #FFTFriday on the patient experience Twitter account which shares compliments the Trust has received via FFT.
- The FFT QR code and website link will now be included on all Trust patient information leaflets.
- Supporting the implementation of the Post COVID-19 FFT survey, a national requirement.
- The team have invested and implemented a three-month trial to increase the messaging of patients across all seven touch points. The impact of this investment will be monitored during

Q2 2022/23:
The Chair thanked LC for her summary following the highly detailed report. JW asked a question re the gynaecology speciality and the numbers of compliments received as this represented c25% of all compliments received. KP stated that two out of the three consultants working within the department were national experts in their field.MH talked about the demographics of feedback and that a new national resolution process was being implemented. A general discussion ensued on ethnicity and deprivation issues and improvements to the reporting system for this aspect. LC was asked to take this issue from the meeting and report back concerning more complete capture of data. JW commented on the stable number of complaints received after looking at the SPC figures. LC stated that we were comparable to other similar sized Trusts. The PALS service was significantly helping with complaints and handling them properly by ward leaders before they escalated. **LC**

The Committee **NOTED** the report.

QSC/22/110 QUALITY ACCOUNT PRIORITIES PROGRESS UPDATE

LC presented the report noting that the Trust Board had approved the three priorities for the Quality Account. Against each priority LC stated the progress update made to date;

Priority One – Patient Safety
In line with the patient safety strategy the Trust will roll out patient safety training level one and two, this will be monitored by the ESR and compliance shared. This had been presented to the Mandatory Training Committee and was awaiting approval for update to the ESR. All staff had completed patient safety level 1 training. PSIRF will support the trust in further developing and embedding the Human Factors Accident classification system to identify common themes and trends. The Trust is adopting the standards and guidance of the PSIRF in the patient liaison role.

Priority Two – Clinical Effectiveness
Following a national directive the GIRFT Central Team are currently focussing on supporting specialities to increase elective activity to the maximum possible levels through a programme called High Volume Low Complexity. Currently the HVLC programme is focussing on six specialities: Ophthalmology, General Surgery, Trauma and

MINUTE REFERENCE	DISCUSSION	ACTION

Orthopaedics, Gynaecology, ENT and Urology. Five out of six reviews had taken place. In the assessment and measuring the effectiveness of new and novel procedures a group had been formed and would be holding monthly meetings from September onwards.

Priority Three – Patient experience
The Patient Portal workstream is being developed as part of the EPR programme and the detailed benefit plan has been reviewed to improve visibility of patients health information giving them online access to their own health records. The secure messaging is improving the communication channels giving patients the ability to book and change appointments themselves.

MH asked about the progression for level 1 training. LC said that PSIRF had changed some of the needs so work being done. New starters were on the new training. The Trust seemed to be ahead of others. The total plan should be ready in 2023 and is being worked towards that. The Chair asked whether EPR will join up with GPs' records in particular allergy records. MH stated that records are due to go live very soon across the Trust area.

The Committee **NOTED** and received **ASSURANCE** from the report.

QSC/22/111 NMAHP EDUCATION UPDATE

VW presented the report giving an overview of the key activities undertaken and the assurance evidence in relation to non-medical education covering the three groups at the Trust, as follows:

Pre-Registration
Ensuring the programmes are compliant with the HCPC, HEE and HEI Practice education agreements. There were c900 nursing placements per year, which include a Masters programme, apprenticeships for nursing associates are offered and also healthcare support workers which is a new in house programme. There is a focus on midwifery which has seen an 66% increase in capacity. AHPs are offered a 34 programme placement training.

Preceptorship
For nursing, the programme has been nominated for programme of the year again. There were 37 midwife preceptees and 65 AHPs had already completed the newly developed programme

Continuing Professional Development
The investment plan for funded training submitted to HEE which includes workforce development and CPD. 28 NMAHP staff were undertaking a funded MSc in advanced clinical practice and there would be a further 14 commencing next year. A newly launched Nurse Development Programme with 102 staff was due to complete in December 2022. The programme had been shortlisted for a Workforce Nursing Times Award. 21 professional nurse advocates had gained the qualification; UHCW is part of a national evaluation research study. A new innovative programme to implement the in house maternity support worker training was in place. New offerings of CPD were in place to upskill and support leadership in AHP. DW asked about programme approval and compliance. This is provided both by the University and the Trust checking against national

MINUTE REFERENCE	DISCUSSION	ACTION
	standards. The Chair asked about benchmarking against CQC standards to strengthen the assurance the Committee receives around numbers of students and their achievements. VW reported that there is a gap analysis against national targets and would provide additional information where this exists. The Chair asked whether VW had any concerns against what was being achieved. VW stated that there were a number of migratory students who were leaving the Trust after training and the Trust was not gaining as many newly qualified staff. Outliers in quality are being closely looked at so there were no concerns there. Further discussion continued on staff accommodation the lack of which meant that staff appeared to be selecting against UHCW. This issue was under investigation. It was agreed that future reports would present UHCW data compared with relevant benchmarks, targets and other comparisons. The Committee **NOTED** the contents and received **ASSURANCE** from the report.	**VW**
QSC/22/112	**BOARD ASSURANCE FRAMEWORK** DW presented the Board Assurance Framework and stated that the BAF circulated for this meeting was correct as of 2pm yesterday. It had been updated in the light of discussions and information at the meeting, but nothing had changed the overall level of assurance. Items added to the first line of assurance from this meeting could all be rated as green. IQPFR had received further comment and transfers at night, also the Bristol model changes were added. In the second line of assurance column there had only been minor amendments made to reflect detail given at this meeting. In the third line a report had been received concerning the JAG inspection which would alter the rating. There were a number of other updates, actions would be amended around EPR, CERNER and the bereavement suite. HTA inspection would also change the ratings. The Chair asked about the stated dates in the BAF around the CQC surgery visit. DW reassured the Chair. LC gave further detail together with MH about the confusion from the initial and subsequent calls and visits. MH said there were no outstanding actions and no surprises arising from the visit. It was reported that the Trust would not receive written confirmation of this and members of the Trust would just have a meeting at the end. JW confirmed the Committee's understanding of the situation. The Committee received **ASSURANCE** from the report.	
QSC/22/113	**DRAFT AGENDA FOR NEXT MEETING** CM outlined the current draft agenda of the next meeting, which was agreed. MH advised that the Patient Engagement and Experience	

MINUTE REFERENCE	DISCUSSION	ACTION
	Report would not come to the next meeting. LC stated that the gap analysis would be ready for the next meeting so the NMAHP item could be amended to reflect this. MH asked whether the cyber security issues faced by the Trust would affect patient safety, it was resolved that a short report on the issue be brought to the Committee for discussion.	DW
QSC/22/114	**ANY OTHER BUSINESS**	
	None.	
QSC/22/115	**CHAIR'S REPORT TO TRUST BOARD**	
	CM proposed to include the maternity services review findings, the blood transfusion annual report and the research and development annual report along with feedback on the patient experience and engagement strategy and NMAHP education items. This was agreed.	
QSC/22/116	**MEETING REFLECTIONS**	
	The conduct and content of the meeting was agreed as satisfactory and appropriate.	
	Given that the meeting room had no heating this time, CM asked that an alternative be sourced or the heating fixed.	
	Guests and substitutes to the meeting were well received and thanks were extended to them.	
	MEETING END TIME 11.35	

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 1 DECEMEBER 2022

Report of the Quality and Safety Committee following its meeting held on 24 November 2022

Committee Chair:	Carole Mills
Quoracy:	The meeting was quorate.
Purpose:	This report provides assurance that the Quality and Safety Committee (QSC) has formally constituted its duties in accordance with the terms of reference and to advise of the business transacted.
Recommendations:	The Board is asked to: 1. Confirm assurance received from the business discussed at the meeting. 2. Raise any questions in relation to that. 3. Consider any matters highlighted for escalation.

Key highlights of discussions held during the meeting

ISSUE	DETAILS
7. Patient Experience and Engagement Report	This provided an update on various work programmes as at Quarter 2 (Q2). There had been 300 compliments and 116 complaints of which 97% were sent a response within the 25 working day target. The top three primary complaint themes were communication with patients, relatives and carers; clinical treatment – obstetrics and gynaecology; and clinical treatment – surgical group. There were 791 PALS enquiries, up from 768 in Q1. 82% were processed within the target of five working days - an improvement of four percentage points since last quarter. The top three themes were communication, appointments and values and behaviour of medical and nursing staff. A number of survey outcomes have been received although some are embargoed and others due to be received in the coming months. An action plan has been devised for the seven most declined areas in the maternity survey 2022. For the cancer survey we are within the expected range for many of the questions, with a considerable number at the higher end.
8. Patient Safety and Risk learning Report	There were two KPIs showing reduced performance – the number of overdue serious incidents and percentage of duty of candour conversations held within ten days. For the former issue, review shows that there have been delays in appointing lead investigators, delays in obtaining medical records and issues with lead investigator capacity. We discussed the practical issues associated with such investigations and how we might optimise capacity. There were eight serious incidents in September.
9. Maternity Safety Improvement Plan	We received an update on progress in Q2 against the standards around the CNST Maternity Incentive Scheme, national recommendations and PRMT/ATAIN action plans. All of these were showing as on track. We also received an update on midwifery vacancies showing a current rate of 28wte, with a further 15.5wte due to start in the next two months. The report also included a summary of remaining actions and a gap analysis relating to the Ockenden Report Insight visit and the East Kent report.

16. Mortality Review Committee report (including update on the Learning from Deaths internal audit action plan)	We looked in detail at this, focusing specifically on the concerning Hospital Standardised Mortality Ratio (HSMR) data which places UHCW second highest in the country. There was a lot of discussion particularly about the cause and actions required to address this. We heard about a weekly meeting to monitor this as efforts continue to bring the rate down, with a particular focus on the likely impact of clinical coding issues. Given the extent to which UHCW is an outlier, we moved our assurance rating from 'green' to 'red' and asked to receive a full update at the next meeting, by which point it is expected some of the actions will have started to deliver some demonstrable improvement. Separately, we received a copy of the action plan in relation to the Learning from Deaths internal audit. It showed sufficient progress that we moved our assurance rating from red to amber, with a view to moving to green upon receipt of an update (and complete) action plan in six months.
17. Royal College Review of Dermatology	An update was provided on progress against this action plan, following consideration at the October Board meeting. As there remained some gaps in relation to some of the actions, we agreed to receive a more detailed update against the action plan at our meeting in January 2023.

Item or issue for escalation	**Purpose for escalation**	**Escalated to**
HSMR issue as described above	Board is asked to note the issue and the attention QSC is giving to this. An update will be provided in future reports from the committee.	Trust Board
Other items considered		
Item 10 Corporate Risks Report Item 11 IPC Update Item 12 Nursing and Midwifery Safe Staffing Report Item 13 NMAHP Education Report Item 14 Medical Education Report Item 15 IPQFR Item 18 Quality Schedule Item 19 BAF		

Terms of reference	**Agenda item**
Advise the Trust Board on the strategic aims and objectives of the Trust	
Review risks to the delivery of the Trust's strategy as delegated by the Trust Board	Item 10 Corporate Risks Item 19 Board Assurance Framework
Approval of the quality strategy	
Review the Quality Account	
Receive assurance on the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and recommend modifications	Item 12 Nursing and Midwifery Safe Staffing Report Item 14 Medical Education Report Item 16 NMAHP Education
Receive reports from the Chief Officers relating to organisational performance and quality within the remit of the Committee	Item 15 IPQFR

Terms of reference	Agenda item
Receive assurance on the delivery of strategic objective and annual goals within the remit of the Committee	Item 18 Quality Schedule
Review performance against quality indicators and seek assurance about the effectiveness of remedial actions and identify good practice.	Item 15 Integrated Quality, Performance and Finance Report Item 18 Quality Schedule
Receive assurance about the effectiveness of arrangements for; • infection prevention and control • patient safety • patient experience • clinical effectiveness • managing patients with mental health issues • health and safety	Item 7 Patient Experience and Engagement Item 8 Patient Safety and Risk Learning Report Item 9 Maternity Safety Improvement Plan
Review the terms of reference for the Committee and recommend approval to the Trust Board	
Other	

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

Attendance			**May**	**July**	**Sep**	**Nov**	**Jan**	**Mar**
Was the meeting quorate?			Yes	Yes	Yes	Yes		
Non-Executive Directors	Carole Mills	Chair	✓	✓	✓	✓		
	Jerry Gould	Member	✓	×				
	Jenny Mawby-Groom	Member		✓				
	Sudhesh Kumar	Member	✓					
	Doug Howat	Member			×	✓		
	Gavin Perkins	Member			×	×		
	Janet Williamson	Member			✓	✓		
Chief Medical Officer		Member	×	×	✓	✓		
Chief Nursing Officer		Member	✓	✓	✓	×		
Chef Quality Officer		Member	✓	✓	✓	✓		

University Hospitals Coventry and Warwickshire NHS Trust

MINUTES OF THE MEETING OF THE
FINANCE AND PERFORMANCE COMMITTEE
HELD AT 13.30 ON THURSDAY THE 29 SEPTEMBER 2022
IN ROOM 00051, CSB, UHCW, COVENTRY

ITEM	DISCUSSION	ACTION
FPC/22/139	**PRESENT**	
	Jerry Gould (JG), Non-Executive Director – Chair Jenny Mawby-Groom (JMG), Non-Executive Director Janet Williamson (JW), Non-Executive Director	
FPC/22/140	**IN ATTENDANCE** Lisa Cummins (LC), Director of Quality for item **FPC/22/152** Gaby Harris (GH), Chief Operating Officer Antony Hobbs (AH), Director of Operational Finance Jo Lydon (JL), Deputy Chief Operating Officer Su Rollason (SR), Chief Finance Officer David Walsh (DW), Director of Corporate Affairs	
FPC/22/141	**APOLOGIES FOR ABSENCE** There were no apologies received.	
FPC/22/142	**CONFIRMATION OF QUORACY** The Chair confirmed the quoracy of the meeting and declared the meeting open in accordance with Standing Orders.	
FPC/22/143	**DECLARATIONS OF INTEREST** There were no declarations of interest made.	
FPC/22/144	**MINUTES OF THE MEETING 25 AUGUST 2022** The minutes of the Finance and Performance Committee held on 25 August 2022 were **APPROVED** as a true and accurate record.	
FPC/22/145	**ACTION MATRIX** It was agreed that actions 21/156, 22/125 and 22/131 could now be removed as complete. In relation to action 22/128, SR confirmed internal audit plans had commenced for 2022/23 so the date would need to be amended to reflect inclusion for 2023/24.	
FPC/22/146	**MATTERS ARISING** There were no matters arising.	

ITEM	DISCUSSION	ACTION
FPC/22/147	**INTEGRATED FINANCE REPORT** SR introduced the report and highlighted that the Trust submitted a revised financial plan on 20 June 2022 showing a £14.8m deficit. The Month 5 year-to-date position showed a £11.5m deficit compared to the NHSE deficit plan of £5.4m. The forecast position showed a £20.4m deficit compared to the NHSE deficit plan of £14.8m deficit. Waste Reduction Plan (WRP) performance was £5.6m year-to-date against a target of £10.5m, an improvement of £0.7m from month 4 with a forecast delivery of £38.8m. Capital expenditure was £10.1m at Month 5 compared to a £10.7m plan, while agency expenditure was £10.1m, which was £1.4m above the year-to-date agency ceiling of £8.7m. Forecast expenditure was £21.6m at Month 5, which was £0.8m above the agency ceiling of £20.8m. It was reported that NHSE had indicated there would be no financial adjustments related to under-delivery against the 104% target in H1. The way Elective Recovery Fund (ERF) was to work in the second half of 2022/23 was under review by NHSE, with an announcement expected. In relation to income, the forecast was based on delivering on-plan for the rest of the year for emergencies and critical care. The forecast for elective was based on 104% delivery from October. For August and September, the following forecasts had been used: • Women's and Children's Services – 103% • Surgical Services - 102% • Emergency Medicine - 102% • Medicine - 102% • Trauma and Neuro Services - 98% • Others - 104% SR stated that the focus of the Trust was turning more from the identification of WRP schemes to their delivery. The internal assessment was also that the Trust was more prudent than the NHSE assessment. The HFMA assurance work had been undertaken which would go through to Board and Audit and Risk Assurance Committee as well as Finance and Performance Committee to produce action plans if the Trust was not achieving a score of at least four out of five. JW asked when the winter allocations would be made, and was advised that a prioritisation process was being undertaken so no timeline was available but due within next two months. GH noted that winter had now started so monies would flow from that.	

ITEM	DISCUSSION	ACTION
	JG asked whether NHSEI saw the finance report and were able to see the deficit. This was confirmed. JG questioned the waterfall diagram for “other” costs and asked if there were any significantly large items. SR outlined some of the costs and confirmed that no large amounts were contained. JMG questioned why SWFT payments were slow to come in. It was reported that SWFT had stated they had not had time to look at items to either pay or dispute due to capacity. GH gave further information concerning services provided to other Trusts and the payment situation. In response SR stated that Andy Hardy had expressed a desire to be involved in the conversations with SWFT’s Finance Director. SR said that the ICB was also informed about the situation. The Committee **RECEIVED ASSURANCE** from the report.	
FPC/22/148	**INTEGRATED QUALITY, PERFORMANCE AND FINANCE REPORT** GH presented the report giving the following highlights relating to operational KPIs for August. The Trust delivered performance of 64.4% for August for the four hour standard, below the national standard of 95%. Performance deteriorated by 6.2% from July and was reduced with no activity included for the Coventry Urgent Treatment Centre. UHCW remained below the benchmarked position for England and the Midlands. The Referral to Treatment (RTT) incomplete position remained below the 92% national target and stood at 53.5% for July. The average weeks wait was 20.5. The Trust had seen an increase in the number of RTT 52 Week wait patients which occurred as a result of service changes required in response to Covid-19. There were 4,811 for July, an increase of 586 from June. This compared to a national average of 2,147. RTT 78 week waits were reducing with 127 reported for July, a decrease of 19 on June. Diagnostic waiters performance was 10.28% in August, a deterioration in performance of 0.21% on the previous month. This was due to performance in cardiology and audiology. Three national cancer standards were achieved in July. Cancer 31 day subsequent drug (100%) and radiotherapy (95.03%) standards and the Faster Diagnosis Breast Symptomatic (94.55%) standard were met. GH stated that the Trust was currently in T2. JG asked how many tiers there were and was then informed that there were sub tiers to the main tiers, these were due to different services being provided. The Two Week Wait suspected cancer standard was reported as 75.25% for July. This was driven by inadequate capacity to	

	see patients within 14 days for Head and Neck, Gynaecological and Lower GI referrals. 62 day performance was reported as 62.13% for July, due to the delays in first outpatient appointment, delays to diagnostic investigation in some specialties and overall treatment capacity. GH further reported that some delays in this group were being experienced due to 104 week waiters being given precedence particularly in the neurology department. JG asked whether the 104 week waiters who we were treating from other Trusts counted against our figures. GH confirmed this, however if UHCW commenced treatment within 28 days then they were not considered as a breach. The Trust failed to achieve the 62 Day National Screening Programme standard in July at 86.49% due to diagnostic delay and treatments. The overall 28 Day Faster Diagnosis Standard reported 71.95% against the 75% target. 19.5 breaches (26 patients) were treated after the 104+ day target. The average number of long length of stay patients for August was 199, an increase of 17 from July. In relation to the target to eradicate 72-week waiters, the figure currently stood at 72, of which 55 were available for operation. GH said that by the end of September there was confidence that the Trust would be very close to achieving the target. Cancer had been focused on but now hard to hit specialities were being targeted. JMG said that the reductions in 78 week targets in average wait for electives were very good but asked if this had affected other wait lists. GH said that this was not the case and work was being undertaken to reduce the other lists. JW asked a question on the cancer pathway and whether this was affecting elective targets. GH explained that pathology and urology were challenging but the Trust was managing the waiters well and it was not affecting the figures significantly. JG asked for a report in future as how the numbers in relation to mutual aid being provided to Leicester were made up and whether these were due to patients not being able to be treated until much later. GH said that some figures were available through the Emergency Care update, which split between medically fit and non-medically fit patients. The Committee **RECEIVED ASSURANCE** from the report.	
FPC/22/149	**EMERGENCY CARE UPDATE** JL presented the report giving the following highlights for Urgent and Emergency Care performance in August.	

ITEM	DISCUSSION	ACTION
	UHCW 4-hour performance was 64.38%, although it was noted some data was missing due to a malware incident with Adastra software. Adult attendances for this period exceeded those for August 2021. Bed occupancy had remained more than 96% across both sites, representing significant pressure on occupancy rates. In August 2022 Emergency Department attendances exceeded levels seen in August 2021; but were broadly in line with average expectations. Opportunity existed to improve key points within the emergency pathway, linked to time to see a senior decision maker, which was linked to overcrowding within the Emergency Department. Following investment there had been increased patient streaming to Minors, and this could be seen as an upward trajectory. In August 2022 there had been an increase in long length of stay, across 7, 14 and 21-day metrics. This was a direct consequence of increases in numbers attending the ED during August as 50% of these were deemed medically fit. JG asked whether this was linked to issues with Community Health. GH responded that this was probably more due to the summer holidays as the main factor. She stated that this had felt like the worst summer for attendances over a number of years. JG asked how many beds the hospital had in place, GH stated this was 1000 and these were divided into 30/40 bed wards. There were still 202 beds occupied. A skew in the numbers of patients not being able to be discharged in the SWFT area was reported. JMG asked how the Trust was dealing with this. GH stated that the Trust was working with a number of agencies to achieve a higher discharge rate into the community and was meeting weekly with partners. There were two areas of focus for the months ahead: - Reducing length of stay by driving next steps in patient level care and ensuring every day in hospital was value added - Increasing discharges to reduce the number of medically fit patients The above actions would impact directly on reducing ambulance handover times, associated with poor hospital flow. Partnership working across the system to drive targeted improvement schemes continued. In particular working with CWPT had seen better understanding and more responsive support leading to improved discharge performance. Improving Lives work had been completed and taken to the ICB which had been supported by them. This had now been	

ITEM	DISCUSSION	ACTION
	taken to NHSE for their approval and the Trust was awaiting a response. Mental health remains a significant issue particularly with placements. JG asked how many patients were in beds at the moment. JL replied that on 28 September the Trust had five, of which two were situated in ED. This caused problems due to the length of time they remained in acute beds. SR reported on the Mental Health budget, where there was a significant underspend due to the inability to recruit staff in this area. The ED expansion plan was now ahead of schedule which would change the flows through the department. JMG asked when the expansion was due for completion and was told January 2023. JG asked how the reception desks were organised in the temporary area. GH stated that the ambulance desk was much smaller than the walk in desk. JW noted that there was little discussion concerning Emergency Care and Prevention working with partners including local GPs. GH stated that the Urgent Community response was for admission avoidance and this was a national initiative. The coming winter was expected to be particularly challenging so every element that could be worked on would assist in reducing the pressure. There was early information showing a reduction in numbers being admitted. Following a question by JW, GH stated that there would be a measurable response and increase in discharges. GH lacked confidence that local community organisations understood the issue due to the outcomes seen over the summer period. JW felt that this was a system issue rather than a Trust issue. JL stated that the numbers presenting in August were roughly what the Trust would expect in winter. JG asked what was the barrier to senior decision making to help address this. GH stated that this was bed occupancy. JG further asked about the problems with malware in Adastra. It was reported that there had been national issues with the software, the system had now been restored and also that our EPR would further improve the system. JG felt that the committee should flag up the cyber security issue to the Audit and Risk Assurance Committee. It was agreed that this would be included in the Chair's report to Board. JG asked for an explanation as to why 0-15 minute handovers were so high compared to others. GH described the patient journey and how they were measured from coming on to the site. The HALO system was also a factor in the handovers.	**DW**

ITEM	DISCUSSION	ACTION
	The Committee **NOTED** the report and **RECEIVED ASSURANCE** in the measures in place to support improvement in Urgent and Emergency Care.	
FPC/22/150	**WINTER PLAN** GH presented the paper noting that it was the high level Winter Plan for 2022/23 and was linked to the Trust's Operational Delivery Plan. It was noted that the NHS entered winter 2022/23 facing significant challenges, and at UHCW, the winter period had the potential to place significant pressure on elective, cancer and urgent and emergency care pathways. Eight national priorities for winter, focusing on urgent and emergency care, had been defined. The UHCW Winter Plan focuses on delivery of these priorities together with maintaining and further restoring elective and cancer pathways. The plan focused on both improving efficiency and using capacity as well as further opportunities that could be achieved with financial investment. The committee was advised that behind the document was a detailed operational plan, informed by each of the Clinical Groups. It was proposed that governance of operational delivery was via Operational Clinical Group and Chief Officers Group for assurance. GH noted that the Trust had bid for schemes totalling £5m which underpinned the plan. External assurance was given in the Plan by the completion of a winter BAF which was a multi tabbed spreadsheet giving assurance to the Trust. JG asked whether this BAF would give external assurance, GH replied that this was for internal use only. JG also asked that updates be provided to ensure risks had been properly managed. JG asked a question relating to the assurance process through the winter as it was noted that external bodies were discussing the plan (CWPT and Coventry City Council) together with a response being awaited from the ICB. SR stated that governance was still being transferred from the CCG to the ICB so the Trust was awaiting clarification of the final governance. The Committee **RECEIVED ASSURANCE** of the plan prior to submission for approval at Trust Board.	
FPC/22/151	**RESEARCH AND DEVELOPMENT INCOME AND EXPENDITURE AND COMPLIANCE** SR presented the report stating that the Trust was currently maintaining its research self-funding business model, so that research was maintained in line with income.	

ITEM	DISCUSSION	ACTION
	There was a risk around commercial income, so the Trust was seeking to prioritise and pursue activities that were 100% (or more) funded. A Clinical Research Network external audit demonstrated compliance with funding arrangements. Research Income and Expenditure was forecast to balance in 2022/23. Funding values were not received uniformly therefore this could appear out of line with the overall plan, however the Trust had balanced the income and expenditure in previous years. Commercial income was reliant on support from radiology and pharmacy and therefore was a risk factor in the Plan. It was noted that the Research & Development Strategy had been approved by the Trust Board. JG questioned the number of vacancies in the West Midlands Clinical Research Network and whether this was a risk to the funding. SR stated that this was a risk and the strategy was not only to fill vacancies but to also expand the numbers of researchers working to increase income. The Committee **NOTED** the contents of the report.	
FPC/22/152	**CORPORATE RISKS REPORT** LC was welcomed to the meeting to present the Corporate Risks Report. It was reported that there were twelve open corporate risks under the FPC portfolio. Nine of the risks were graded as moderate or below and three risks were graded as high. A summarised version of the nine risks graded as moderate or below was provided to the Committee. The three highest rated risks (15-20) were noted below Risks 4088 (22/23 Inflation Pressure), 4089 (22/23 Waste Reduction Delivery) and 4084 (22/23 Contract Income - Elective Recovery Fund) LC advised that there had been no change since the last meeting of the Committee. JG asked what assurances the committee could take that the matter was being managed. DW and SR noted that the high risk item 4089 was being brought before the next meeting of this committee and had been mentioned during the course of this meeting. This item could therefore be updated in line with those reports. AH stated that the risk may disappear to be replaced with a recovery risk in the future. AH further noted that the inflation risk 4088 was reducing as the financial year progressed. At this point LC left the meeting. The Committee **RECEIVED ASSURANCE** from the report**.**	

ITEM	DISCUSSION	ACTION
FPC/22/153	**BOARD ASSURANCE FRAMEWORK** DW noted that the BAF presented to the Committee in their papers was the version correct prior to the meeting, but the dynamic nature of the BAF meant changes arising in the meeting would be reflected. DW presented the report showing the updated BAF as this was a live document and was currently correct. Updates that had been provided during the meeting, gaps identified by the committee and actions requested were featured in the live version of the document. The committee agreed these be adopted into the document as well as the ratings proposed. The majority of the changes were as a result of updates made in SR's report and also JL's report on contract values, agency expenditure and UTC assurance. DW recommended that the winter plan remain 'green' assurance. The final change was in the region of delayed discharge and the actions being taken. AH noted that the financial sustainability comments were being presented to the appropriate committee which would present further risk assurance. DW asked the committee if the changes presented gave sufficient assurance to move the first line of assurance rating from amber to green, given the majority of sources of assurance detailed within that line were now green. The Committee resolved to leave the line as amber for the present. The Committee **RECEIVED** the BAF, considered assurances received during the meeting and how these would reflect on the existing document, and **AGREED** the assurance ratings. The Committee was further asked to **NOTE** and **ENDORSE** a decision taken by the Audit and Risk Assurance Committee requesting that it be provided with and monitor a new BAF risk relating to Cyber Security.	
FPC/22/154	**DRAFT AGENDA FOR NEXT MEETING** The draft agenda for the next meeting was verbally given and was accepted. Discussion ensued on the timing of items to allow enough time for consideration.	
FPC/22/155	**ANY OTHER BUSINESS** There was no other business to consider.	
FPC/22/156	**CHAIR'S REPORT TO TRUST BOARD** The Chair stated that he would report the main issues of the Finance reports to the Board. He further stated that he would report on the Winter Plan and Emergency Care Report.	

ITEM	DISCUSSION	ACTION
FPC/22/156	**MEETING REFLECTIONS** JW said that she would be able to reflect properly after a few meetings. DW said that it had been a good productive meeting. JMG noted that the Committee had managed to catch up with the timings of the agenda items so may need to consider these for a future meeting. The Chair thanked the members for their attendance and participation. The Chair declared the meeting CLOSED at 15.05	

MINUTES END

University Hospitals Coventry and Warwickshire NHS Trust

MINUTES OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE HELD AT 13:30 ON THURSDAY THE 27 OCTOBER 2022 VIA MS TEAMS

ITEM	DISCUSSION	ACTION
FPC/22/157	**PRESENT** Jerry Gould (JG), Non-Executive Director – Chair Janet Williamson (JW), Non-Executive Director Gaby Harris (GH), Chief Operating Officer Su Rollason (SR), Chief Finance Officer	
FPC/22/158	**IN ATTENDANCE** Paul Davies (PD), Associate Director of Financial Management for Item **FPC/22/166** Lincoln Dawkin (LD), Director of Estates and Facilities for Items **FPC/22/172&173** Andy Smith (AS), Head of Programme Management Office for Item **FPC/22/167** David Walsh (DW), Director of Corporate Affairs	
FPC/22/159	**APOLOGIES FOR ABSENCE** Jenny Mawby-Groom (JMG), Non-Executive Director	
FPC/22/160	**CONFIRMATION OF QUORACY** The Chair confirmed the quoracy of the meeting and declared the meeting open in accordance with Standing Orders. Following discussion, Item 11 Performance Benchmarking was stood down to be brought back at the November meeting.	**DW**
FPC/22/161	**DECLARATIONS OF INTEREST** There were no declarations of interest made.	
FPC/22/162	**MINUTES OF THE MEETING 29 SEPTEMBER 2022** The minutes of the Finance and Performance Committee held on 29 September 2022 were **APPROVED** as a true and accurate record.	
FPC/22/163	**ACTION MATRIX** It was agreed that 22/069 deadline be amended to 24 November. It was agreed that 22/072 deadline be amended to 26 January 2023. Item 22/149 had been reported to Board and was now under Audit and Risk Assurance Committee so could be closed on this Action Matrix.	
FPC/22/164	**MATTERS ARISING** There were no matters arising.	

ITEM	DISCUSSION	ACTION
FPC/22/165	**INTEGRATED FINANCE REPORT**	

SR introduced the report and noted that the revised plan showing a £14.8m deficit was going through a process and the revised figure would not show until that had been completed.

Financial Position

- The Month 6 year to date position showed a £13.4m deficit compared to the NHSE deficit plan of £7.3m. The forecast position showed a £20.4m deficit compared to the NHSE deficit plan of £14.8m deficit.
- YTD WRP performance was £9.2m against a target of £12.7m, an improvement of £3.6m from month 05 with a forecast delivery of £38.8m.
- Agency expenditure was £12.3m at Month 6, which was (£1.9m) above the year-to-date agency ceiling of £10.4m. Forecast expenditure was £22.5m at Month 6, which was (£1.7m) above the agency ceiling of £20.8m.
- NHSE had indicated there would be no financial adjustments related to under-delivery against the 104% target in H1. The way ERF was to work in the second half of 2022/23 was under review by NHSE, we expect an announcement shortly.
- Capital expenditure was £14.1m at Month 6 compared to a £13.3m plan, with forecast expenditure of £46.2m against a plan of £46.1m.
- Capital funding associated with the EPR programme continued to be a significant risk. Whilst the UHCW programme assumed digital funding would be secured in year to a value of circa £9m. At point the report was written the allocation had not been secured. A regional process had been running since July 2022 and should come to a conclusion over the next month or so.

Income Position

- The forecast was based on delivering plan for the rest of the year for emergencies, critical care and other.
- The forecast for elective was based on 104% delivery from October. For August and September, the following forecasts had been used:
- Women's and Children's Services – 103%
- Surgical Services - 102%
- Emergency Medicine - 102%
- Medicine - 102%
- Trauma and Neuro Services - 98%
- Others - 104%

JG noted that we were projecting to exceed the original deficit by £5.6m, the Trust was currently running at £6.1m with agency figures worse than prediction. SR stated that there were mitigations against the agency costs and also current level of spend. The Trust had some certainty of winter funding, SR noted that she was confident of achieving the figures. She stated that she had some concerns about the next financial year due to non recurrent savings in the WRP. These concerns were shared with other Chief Financial Officers around the country, particularly in view of rising pay rates and inflation. JG queried an issue with forecasts that had changed in this month’s report compared with the same forecasts in the previous

ITEM	DISCUSSION	ACTION
	report, e.g. the forecast deficit position for M7 where the forecast had improved between the two reports but to be achieved would require a significant improvement over the next month. He requested that where there are such substantial adjustments to forecasts between monthly reports, in future the report provide an explanation of the change and the justification behind it. SR noted that some of these specific questions could be explained better in the pre-meet before the Board meeting. JW asked for further detail concerning the region's acceptance of the Trust's financial position, SR stated that the region understood that the Trust had to show operational planning guidance of zero Covid alongside the emergency planning undertaken. This was in line with other trusts. Both the regional finance director and the finance director for the ICB had seen the figures and given feedback.	
	JG further asked a question on the ERF performance shown against the ICS , SR stated that this was the independent sector figures and that they received a number of referrals directly . JG asked for an explanation on cost and volume pricing. SR said that there was a conflict due to methodologies not being accepted and some trusts would benefit, some would not. The Committee raised concerns over the numbers presented and asked for additional assurance at the next meeting.	**SR**
	JG asked that in future the IFR includes a standard bullet giving the month end cash position against the original forecast.	
	The Committee **CONFIRMED** their understanding of the Month 6 financial position for 2022/23 and **RECEIVED ASSURANCE** from the report.	
FPC/22/166	**FINANCIAL SUSTAINABILITY**	
	PD was welcomed to the meeting and presented the report as follows.	
	The Sustainability exercise was a requirement for receiving additional funding in the revised plan made in June and was part of the Trust receiving additional monies towards covering the inflationary pressures facing the Trust. It took the form of a self assessment highlighting nay areas of weakness in financial governance and the Trust was required to produce an Action Plan for any remedial actions. • Assessment had been completed by Finance for the period 30 September 2022 and had been approved by the CFO & CEO. • The self-assessment did not have any areas scoring 3 or less, which would had required remedial actions. • Internal Audit would review in depth 12 of the 72 questions to agree/disagree with the scoring to report to Audit Committee. • Final scoring, including internal report and any agreed actions, were required to be submitted to the region by 31 January 2023.	
	PD further explained the scoring and noted that most of the scoring was actually between 4 and 5. He stated that even though the Trust had scored a 5 in some areas there was still room to improve. JG asked about the evidence that had been gathered and SR stated that	

ITEM	DISCUSSION	ACTION
	there was a full portfolio of evidence to support the internal scoring of each question and she had forwarded JG a copy of some of that evidence. At this point PD left the meeting. The Committee **NOTED** the requirement to undertake the NHS Improving NHS Financial Sustainability self-assessment. **NOTED** the self-assessment scoring for the 8 Domains set out in Table 1 of the report. **NOTED** the next stage of the review by Internal Audit and the Audit Committee before final submission to the regional team by 31January 2023.	
FPC/22/167	**WASTE REDUCTION PROGRAMME** SR presented the report the highlights of which were. **Month 6 Reporting** • As at month 6, YTD delivery was £9.23m which was 73% of YTD target • Forecast delivery had been externally reported as £38.79m with £13.94m forecast from clinical groups and corporate departments • Recurrent YTD delivery was £2.53m (38% of YTD target) • Non-Recurrent YTD delivery was £6.7m (112% of YTD target) **2023/24 Forward Planning** • £2.34m identified for 23/24 in PM3 so far, £1.94m of which was recurrent. At this point AS joined the meeting to assist the presentation. There had been another round of Star chamber groups who all had a number of actions to perform. It was noted that there had been a loss of productivity nationally. The Trust was struggling to achieve full productivity. The full pipeline had not yet been fully quantified so other ideas were still coming forward. Deloitte support was well received. Star chambers were focussing on drug wastage for cost control. Problems with robots were being resolved, the CEO had asked for star chambers to continue to the point of forecast delivery. Theatres had an action plan to improve productivity, Alex Monahan had been brought in to assist and there were showing big improvements in this area for specific disciplines. Outpatients were also showing improvements during the last month, particularly in the areas of agency or bank staff. JG asked for further clarification of the QIA figures, there were 37 schemes but only 30 appeared to be subject to QIA's. AS stated that all 37 were subject to QIAs and headings would be amended to give greater clarity. JG asked for a presentation from someone with responsibility for the theatre's productivity WRP as the Committee needs to look at key elements of the programme with some depth. Following that presentation in November then to have another presentation in January to look at cost control. It was agreed that Alex Monahan would present at the November meeting and either Richard De Boer or Wendy Bowes to present at the January meeting. At this point AS left the meeting.	**DW/GH**

ITEM	DISCUSSION	ACTION
	JG asked that a report go to People Committee on the staffing implications of the WRP	
	The Committee **RECEIVED ASSURANCE** from the report.	
FPC/22/168	**PROCUREMENT UPDATE**	
	In the absence of Amar Bhagwan, Director of Procurement, on leave SR presented the report as follows.	
	The trust had introduced ATOMIST which enabled the trust to produce a series of dashboards to give clarity. There were a number of expired contracts of which £3.9m were covered by T&O, Pathology and Radiology. These were moving over to the NHS Supply chain process. The new ATOMIS programme was giving the Trust greater visibility. Work was progressing on validating expired contracts to look for better value. Due to the national funding model a number of very tight timeframes had been undertaken where funding had been granted within a financial year.	
	The procurement team were working with other Trusts of which one was outside of our ICB area, in relation to LIMS and the South Midlands Pathology Network. There was a neutral vendor ICT project underway. The procurement team were currently supporting a number of very complex procurements as well as their normal work. There was increasingly a move towards procurement projects working in a Collaboratory way across the ICB.	
	The GHX system updates were given and a reminder of how the system integrates with different areas across the Trust. The project was expected to close by September 2023 and be handed over to customer support.	
	All waivers and procurement forms were now on Docusign which increases transparency, security and the availability of information.	
	JG asked that future reports include key points from it in the Executive Summary.	**AB**
	The committee **NOTED** the progress to date of the Procurement Transformation Plan.	
FPC/22/169	**INTEGRATED QUALITY, PERFORMANCE AND FINANCE REPORT** GH presented the report for September and gave the following detail.	
	The Trust delivered performance of 62.7% for September for the four hour standard, below the national standard of 95%. Performance deteriorated by 1.7% from August and was reduced with no activity for the Coventry Urgent Treatment Centre for a second month, this being due to the cyber attack on the Adastra system. This was reported as being back on line so the next months figures would be showing an improvement. UHCW remained below the benchmarked position for England and the Midlands.	

ITEM	DISCUSSION	ACTION

The RTT incomplete position remained below the 92% national target and stood at 53.6% for August. The average weeks wait was 20.6. The Trust continued to see an increase in the number of RTT 52 Week wait patients which occurred as a result of service changes required in response to Covid-19. There were 4,941 for August, an increase of 130 from July. This compared to a national average of 2,199.

RTT 78 week waits were reducing with 93 reported for August, a decrease of 34 on July.

Diagnostic waiters performance was 9.32% in September, an improvement in performance of 0.96% on the previous month.

Four national cancer standards were achieved in August. Cancer 2 week wait breast symptom (94.69%), 31 day diagnosis to treatment (96.77%), 31 day subsequent drug (100%) and the faster diagnosis breast symptomatic (100%) standards were met.

The Two Week Wait suspected cancer standard was reported as 79.75% for August. This was driven by inadequate capacity to see patients within 14 days for Head and Neck, Gynaecological and Lower GI referrals.

62 day performance was reported as 57.48% for August due to the delays in first outpatient appointment, delays to diagnostic investigation in some specialties and overall treatment capacity.

The Trust failed to achieve the 62 Day National Screening Programme standard in August at 65.52% due to diagnostic delay and treatments.

The overall 28 day faster diagnosis standard reported 72.48% against the 75% target.
30.5 breaches (35 patients) were treated after the 104+ day target.

The average number of long length of stay patients for September was 195, a reduction of 4 from August.

Reason to reside data collection compliance for eligible areas was 85%.

The Trust had delivered 94,345 Covid-19 vaccinations (as at 17/10/2022).

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

GH further reported on the staffing shortages reported in emergency care and also delays in ambulance handovers. There were no trolly waits for over 12 hours. Patients remaining in hospital for longer than 21 days was still high and had impacted on other areas of the service. JW asked about the redesign work occurring in the emergency department. GH noted that Kaizen events and value

ITEM	DISCUSSION	ACTION

stream work had commenced and were ongoing. The completion date was the end of November and a report would be generated in early December. Early indications were that some significant improvements were being made. JW further asked about the impact of winter. GH stated that there were some improvements but winter would only be mitigated not covered off. JG asked for clarity over the Adastra system. GH stated that this system would had recorded the fact that the majority of patients had flowed through the system within the four hour reporting limits but that had not been picked up by the paper based emergency system.

GH then drew the Committee to the 30 day readmission rate which had slightly deteriorated.

The Committee **RECEIVED ASSURANCE** from the report

FPC/22/170 ELECTIVE UPDATE

GH presented this report outlining the Trusts position for Elective Care.

It was noted that the 104 week position had been held steady for a six month duration at zero and the Trust had plans in place to continue to hold this position through until January 2023 with rolling improvements to treatment schedules.

From a 78 week perspective the Trust were working hard to eliminate 78 week waiters. Internal targets had been put in place and most specialities had achieved this. GH reported that the numbers had fallen currently to around 50 with issues in Dermatology, Gynaecology, specialised Plastics and specialised Orthopaedics.

Work was continuing on addressing the 52 week waiters. It was reported that numbers were slowly reducing with current numbers in the region of 5500 a piece of work was currently being undertaken on linking performance to ERF and ADP activity.

Outpatient numbers were greatly reduced from 19,000 to 11,500 with numbers being impacted by Dermatology and Gynaecology. Work ongoing to help patients achieve healthy outcomes.

Diagnostic performance was also improving with September 10.28%, the current position at 9.7% and the DMO1 target of 5%. Challenges remain in the Audiology department which was a recruitment issue. Cardiology ECHO was another challenge , the Trust was working with an outsourcing company towards resetting capacity back to pre Covid levels. It was reported that the numbers of waiters were improving. JW asked for reassurance on the expected reductions in 78 week waiters, this was given noting that poor uptake or industrial action were risks to non achievement of the target. Similar reassurance was given for the 52 week waiters particularly around non-admitted pathways. JW asked if there was any ICB monies available to assist the Trust achieve these targets, SR noted that there was none available at the moment however the Trust may be able to bid for further funding in the next financial year.
JG asked what collaboration was happening with system partners and the independent sector. GH noted that there were ongoing

ITEM	DISCUSSION	ACTION
	challenges with the BMI around Gynaecology over routine treatments and this work was being better spread around the three providers. This would improve the Trusts DMO1 performance.	
	The Committee **NOTED** the Elective Care Update.	
FPC/22/171	**CANCER CARE UPDATE** GH presented the Cancer Care Update, at the start of the report she noted that in June 2022 the Trust had been placed in Tier 2b for Cancer Care by NHS England, the Trust had worked hard to improve the ranking and were now expecting an improved grade shortly.	
	The Board had to self certify and there was a deadline for the submission of papers. This means that there would be a presentation to the Finance Committee at the November meeting.	**DW**
	It was reported that, following the pandemic, there was an increased demand of the service. The Two Week Wait standard had improved for the month of August to 79.8% for suspected cancer and 94.7% for breast symptomatic. The breast team had also achieved a 100% rate for Faster Diagnosis. There had also been improvements in 31 day surgery and radiotherapy standards. Recruitment for specialised staff was assisting in delivering improvements to the standards although there was slippage seen in 62 day first treatment and the 62 day national screening programme. GH reported that the backlog was now improving.	
	The position remained challenged as there was an increase to 125% of the 2019/20 position.	
	Patients were being referred from George Eliot and SWFT in Urology. Pathology was still driving delays in the pathway and the CEO and GH were meeting the diagnostic teams to seek improvements. JW asked whether the problems were with the numbers of vacancies in pathologists. GH confirmed this position.	
	JG asked for improved detail in the improvement plan section to gain a better understanding. GH said that would be done.	
	JW asked whether there were any opportunities to outsource the service. GH stated that all neighbouring Trusts were in the same position as this Trust.	
	The Committee **NOTED** the Cancer Care Update Paper.	
FPC/22/172	**SUSTAINABLE DEVELOPMENT UPDATE**	
	LD joined the meeting to present this report, the highlights included: • Governance – progress continued against targets in the new UHCW Green Plan and the Net Zero Delivery Group set up to monitor progress. • Travel – Travel arrangements between sites and improved cycle routes to the Hospital of St Cross. • Waste Management – Waste segregation work continues to align with national profile.	

ITEM	DISCUSSION	ACTION

- Energy – Increased electrical load allows full usage of CHP generated electricity.
- Hospital of St Cross Decarbonisation – The Trust received £4,034.960 for energy saving at St Cross.
- Carbon Trading – Increased costs from change to UK carbon trading following Brexit; a target increase had been requested and agreed for the CHP. Which meant increased gas use from the CHP incurs less carbon tax.

Cycle routes were to the edge of the St Cross site and would be completed shortly.

LD gave further detail on the waste management work and improvements to incineration.

Overall running the CHP gives reduced carbon use and lower running costs but increased gas charges were skewing the figures. The new heat pump at St Cross and solar panels were commencing operation shortly.

The Committee **NOTED** and **APPROVED** the progress in relation to sustainable development issues.

FPC/22/173 ESTATES AND FACILITIES UPDATE

LD reported the quarterly update on current issues in relation to the Estates and Facilities Department.

Fire Dampers – issue relating to defective dampers had progressed well with remedial work being completed by the end of November.

Fire Stoppers – The Trust had raised some concerns and was waiting for further clarification following the receipt of documentation of the completed remedial works.

Fire Audit – the fire audit commenced in October 2022 and the Fire Service were visiting the hospital on a monthly basis. The audit should take six months to complete.

ISS/Soft FM – there were 12 service failure events and 21 quality failures resulting in penalties of £6282.70 being applied.

Healthcare Cleaning – average audit scores were disclosed to the Committee with no areas of concern.

Security Service – the service continued to fall below required standards and compliance. Increased monitoring arrangements had been formalised.

Vinci/Hard FM – Project Co and the Trust continued to engage with Vinci following performance concerns. Statutory and asset survey compliance was rated at 84%. Monthly performance meetings had been recommenced and to agree a framework to resolved the long term plan. A standstill agreement had been entered into. Vinci staffing levels in relations to Approved and Responsible Persons was causing

ITEM	DISCUSSION	ACTION

concerns. Vinci had not produced an updated PPM plan, the 21/22 plan had been rejected.

An update to the Estates Capital Programme was disclosed to the Committee.

Detail of the Trust's art programme was disclosed noting the new loan collection from Painting in Hospitals situated along the ground floor central and east wing.
Some years ago, the Trust had agreed with ISS that it could move away from its obligation to pay ISD staff NHS pay rates which had resulted in a significant saving in costs charged to the Trust. The resulting reduction in pay and conditions for ISS staff was now resulting in recruitment challenges and the Trust is in discussions regarding potential solutions. JG asked a question around the contractual obligation with ISS, LD stated that the Trust had financially benefited from the agreement but to improve the service the Trust would have to pay more out of the £2.1m savings the Trust was making and this is going to be negotiated in the future.

JG asked for further detail around the Approved and Responsible staff at Vinci. LD noted that these were staff who had been properly trained and authorised to work on hospital systems such as medical gas.

JG further asked about the key issues relating to preventative maintenance and lifecycle plans and whether Vinci were suffering monetary deductions for failure to comply. LD stated that the issues related to quality of work undertaken on statutory and mandated maintenance. He noted that they were being financially penalised for these failures. LD left the meeting.

The Committee **NOTED** and **APPROVED** the progress in relation to Estates & Facilities issues.

FPC/22/174 CORPORATE RISKS REPORT

DW presented the report giving the following detail:

Total No. of Open Risks:
There were twelve open corporate risks under the FPC portfolio.

Since the last meeting:
Three risks had their risk level downgraded from 'HIGH':

- **Risk ID 4084 – 22/23 Contact Income Risk – ERF Recovery Fund**
- **Risk ID 4088 – 22/23 Inflation Pressure**
- **Risk ID 4089 – 22/23 Waste Reduction Delivery**

Two of the risks had their risk level upgraded to 'HIGH':

- **Risk ID 4085: 22/23 Contact Income Risk – High Costs Drugs and Devices Block**
- **Risk ID 4086: 22/23 Emergency Pressures**

There was one risk pending approval at risk committee in November 2022 prior to being shared at FPC:

- **Risk ID 4209: 22/23 Recurrent Waste Reduction Delivery**

ITEM	DISCUSSION	ACTION

DW stated that there had been a lot more movement in the risks since the last report.

JG asked whether risk 2357 should remain with this committee. DW stated that this would move to the new BAF being developed for Audit and Risk Assurance Committee.

JG noted that risk 4209 scored differently in the BAF and asked for an explanation. It was reported that the Corporate Risks report and the BAF were produced at different times and the details would match later.

The Committee **RECEIVED ASSURANCE** from the report.

FPC/22/175 BOARD ASSURANCE FRAMEWORK

DW presented the BAF noting that the version seen by the Committee was correct a week before the meeting. He exhibited the updated version to the Committee explaining the differences between the two versions, amendments had been made due to Board meetings including changes occurring during the meeting happening at this point in time. After explanation the Committee agreed the amendments and these were adopted into the new documents. The Committee accepted that the overall Financial Stability Report could now be changed from a red to an amber level.

The Operational Performance document was further considered with amendments and additions to the first line of assurance. The overall rating for this line could now be made green. With additions to the third line made the Committee agreed that the overall rating for the third line of assurance now be made amber.

The Committee **RECEIVED** the BAF, considered assurances received during the meeting and how these reflected on the existing document. The Committee **AGREED** the assurance ratings

FPC/22/176 DRAFT AGENDA FOR NEXT MEETING

The draft agenda for the next meeting was accepted. It was noted that the Committee would also receive an Item on theatres utilisation in respect of the Waste Reduction Programme and would also bring back Item 11 which had been stood down from this meeting. Finally it was also agreed to bring back an item on Cancer Care Update to receive assurance on the change from Tier 2 status.

FPC/22/177 ANY OTHER BUSINESS

There was no other business to consider.

FPC/22/178 MEETING REFLECTIONS

GH felt that it was a productive meeting. JW reflected that there was a lot of pressure on the Chief Officers to present their material. She agreed that a deep dive into some topics would prove very useful to the Committee.

ITEM	DISCUSSION	ACTION

The Chair declared the meeting closed at 4.00pm

MINUTES END

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 1 DECEMBER 2022

Report of the Finance and Performance Committee following its meeting held on 24 November 2022

Committee Chair:	Jerry Gould
Quoracy:	The meeting was quorate.
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.
Recommendations:	The Board is asked to: 1. Confirm assurance received from the business discussed at the meeting; 2. Raise any questions in relation to the same; 3. Give consideration to any matters highlighted for escalation.

Key highlights of discussions held during the meeting

ISSUE	DETAILS
6. Next Steps on Elective Care, Cancer Care – Self Certification	The committee gave consideration to a detailed update setting out ongoing improvement work relating to the actions set out in the letter notifying UHCW that it had been placed in Tier 2 in relation Elective and Cancer Care by NHSE. Productivity and efficiency programmes in relation to elective care were described, along with the metrics showing the current position and trajectory. In relation to cancer, current performance was outlined with a focus on 31-day, 62-day and 104-day targets, including progress that had been made in relation to the objectives described in the Tier 2 letter. The committee took assurance from the report and was able to endorse it to Trust Board for consideration at today's meeting.
7. Theatre Productivity	This was the first of two WRP deep dives which the committee determined it would take at its previous meeting, the second focusing on cost control in January 2023. The committee received a report detailing work being undertaken to drive increases in productivity along with associated theatre and outpatient metrics. The presentation included detail of the Theatre and Outpatients Producing and Efficiency Programme which had been established to focus on this. The committee noted areas requiring further focus, including the average late starts being off track, but also noted evidence of where the improvement programme was shifting this positively, with an example from with Neuro described. The committee took assurance from the report.
8. Integrated Finance Report	A report setting out the latest financial position was received. It included that the month 7 year to date position showed a £14.8m deficit against a £9.2m plan. In terms of capital, this stood at £18.2m compared to a £16.7m plan, while agency expenditure was £13.6m compared to a year-to-date ceiling of £12.1m. The waste reduction position had improved since the last month, showing £10.3m performance against a £15m plan.
9. Overseas Patient Access – Elective Treatment – Policy	The committee approved a policy setting out the requirements for charging overseas visitors in line with legislation. A key part of this was that non-urgent care (defined as care which could await the overseas visitor departing the UK) would need to be paid for in full prior to it being provided. It was confirmed that no such provision would exist for urgent care, although an invoice would be sent in advance. The committee approved the policy.

15. Virtual Wards Business Case	This is included as an agenda item on the Private Board agenda and is presented with the endorsement of the committee.

ITEMS FOR ESCALATION, WHY AND TO WHERE		
Item or issue	Purpose for escalation	Escalated to
Adastra malware attack affecting Urgent Treatment Centre	To ensure triangulation against other cyber threat risks being monitored by the committee	Audit and Risk Assurance Committee

OTHER AGENDA ITEMS
Item 10 National Cost Collection Post Submission Report Item 11 IQPFR Item 12 Performance Benchmarking Report Item 13 Emergency Care Update Item 14 Specialing Report Item 16 Corporate Risks Report Item 17 Board Assurance Framework

TERMS OF REFERENCE: Did the meeting agenda achieve the delegated duties? Yes	
Item from terms of reference	State which agenda item achieved this
Advise the Trust Board on the strategic aims and Objectives of the Trust	
Review risks to the delivery of the Trust's strategy as delegated by the Trust Board	Item 17 Board Assurance Framework Item 16 Corporate Risks Report
Review the financial strategy	Item 8 Integrated Finance Report
Review outline and final business cases for capital investment the value is above that delegated to the Chief Officers	
Receive assurance on the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and recommend modifications	Item 13 Emergency Care Update Item 14 Specialing Report
Receive reports from the Chief Officers relating to organisational performance within the remit of the Committee	Item 11 Integrated Quality, Performance and Finance Report
Receive assurance on the delivery of strategic objective and annual goals within the remit of the Committee	
Review performance against financial and operational indicators and seek assurance about the effectiveness of remedial actions and identify good practice	Item 8 Integrated Finance Report Item 10 National Cost Collection Post Submission Report
Review the capital programme	

TERMS OF REFERENCE: Did the meeting agenda achieve the delegated duties? Yes	
Item from terms of reference	State which agenda item achieved this
Receive assurance about the effectiveness of arrangements for; • Financial management • Operational performance • Recruitment, employment, training and workforce management • PFI arrangements • Organisational development • Emergency preparedness • Insurance and risk pooling schemes (LPST/CNST/RPST) • Cash management • Waste reduction and environmental sustainability	Item 8 Integrated Finance Report Item 11 Integrated Quality, Performance and Finance Report Item 14 Specialing Report
Receive reports from the Chief Finance Officer on actual and forecast financial performance against budget and operational plan	Item 8 Integrated Finance Report
Review proposals for the acquisition, disposal or change of use of land and/or buildings.	
Review the terms of reference for the Committee and recommend approval to the Trust Board	
Other	

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

ATTENDANCE LOG											
		Apr	**May**	**Jun**	**Aug**	**Sep**	**Oct**	**Nov**	**Jan**	**Feb**	**Mar**
Was the meeting quorate?		**Yes**	**Yes**	**Yes***	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Non-Executive Director (Jerry Gould)	Chair	✓	✓	✓	✓	✓	✓	✓			
Non-Executive Director (Jenny Mawby-Groom)	Member	✓	✓	✓	✓	✓	×	✓			
Non-Executive Director (Janet Williamson)	Member					✓	✓	✓			
Chief Finance Officer	Member	✓	✓	×	✓	✓	✓	✓			
Chief Operating Officer	Member	✓	✓	×	×	✓	✓	×			

*In accordance with paragraph 4.3 of the Committee Terms of Reference, the Chair gave approval for deputies attending the meeting to count towards the quorum.

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 1 DECEMBER 2022

Subject Title	Integrated Quality, Performance & Finance Report – Month 7 – 2022/23
Executive Sponsor	Kiran Patel, Chief Medical Officer
Author	Daniel Hayes, Director of Performance & Informatics
Attachment(s)	Integrated Quality, Performance & Finance Report – Reporting period: October 2022
Recommendation(s)	The 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 31st October 2022.

The Trust has achieved 10 of the 35 indicators reported within the Trust's performance scorecard.

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

The Trust delivered performance of 61.8% for October for the four hour standard, below the national standard of 95%. Performance deteriorated by 0.9% from last month and is reduced with no activity for the Coventry Urgent Treatment Centre included for a third month. UHCW remains below the benchmarked position for England and the Midlands.

The RTT incomplete position remains below the 92% national target and stands at 52.7% for September. The average weeks wait was 20.8.

The Trust continues to see an increase in the number of RTT 52 Week wait patients which occurred as a result of service changes required in response to Covid-19. There were 5,117 for September, an increase of 176 from August. This compares to a national average of 2,281.
RTT 78 week waits are continuing to reduce with 67 reported for September, a decrease of 26 on August.

Diagnostic waiters performance was 6.49% in October, an improvement in performance of 2.83% on the previous month.

Cancer performance for September 2022 was:

- Cancer TWW: 78.86% (target 93%)
- Cancer 31 day diagnosis to treatment: 95.67% (target 96%)
- Cancer 62 day referral to treatment: 57.10% (target 85%)
- Cancer 104+ days wait: 30.5 breaches, 40 patients (target 0)
- Cancer 62 day screening: 83.87% (target 90%)
- Cancer 28 days Faster Diagnosis Overall: 73.38% (target 75%)

The average number of long length of stay patients for October was 189, a reduction of 6 from September.

Reason to reside data collection compliance for eligible areas is 84%.

The latest reported HSMR figure is 152.08 for July 2022 and is outside Dr Foster's calculated relative risk range.

A Never Event has been reported for October. Further details are included in this report.

Complaints Turnaround time <= 25 days was 97%.

The Trust has delivered 95,713 Covid-19 vaccinations (as at 14/11/22).

In addition to the above – using Statistical Process Control charts the Trust has identified the following KPIs which are showing a statistically significant variation in their trends:

- Emergency Care 4 Hour
- Emergency Care 12 Hour
- RTT Incomplete %
- Cancer 62 Day Standard
- Cancer 104 Day
- Mandatory Training
- Average number of Long Length of Stay Patients
- Friends & Family Test – Recommender Targets Achieved

A separate commentary has been provided for these measures in the Appendix B

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

Workforce	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: October 2022





Contents

Executive Summary

The Trust has achieved 10 of the 35 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.

Our current position continues to reflect the ongoing challenge of restoring both elective care services, and delivering non elective services at a scale not seen before, whilst striving to achieve a financial balance without impacting the care we give our patients. I am proud that we continue to have no patients waiting in excess of 104 weeks for elective care at the Trust, and we continue to see improvements in those waiting over 78 weeks, whilst focusing next on those waiting over 52 weeks. Our cancer services continue to deliver excellent care, in terms of quality and waiting times, despite an ongoing increase in demand. On the emergency side we continue to monitor performance against the 4 hour standard, although nationally this is no longer being used in the same way, and we have seen a reduction in the number of patients waiting the longest time. We have seen an increase in the demand for emergency care this month, and our teams are working to safely manage this in collaboration with those in the elective services to ensure we maintain a steady flow throughout the hospital. Operationally, our teams are working to improve the patient experience across all areas, balanced against an increasing level of staff sickness absence and an increase in Covid-19 cases (both among staff and patients) as the winter months approach. We continue to have a significant focus on staff well-being and efforts to engage and listen to staff are at a level beyond our conventional approach as we strive to make staff engagement, learning and well being central to our business as usual. This is demonstrated by our improvements to medical and non-medical appraisals as well as a return to high levels of mandatory training.
Whilst we review and learn from the challenges and improvements demonstrated, we remain focused on those areas we need to improve as we move into the future.

Professor Andrew Hardy, Chief Executive Officer

10 KPIs achieved the target in October

	Indicators achieved	Indicators in exception	Indicators in watching status	Total indicators
Safest care and excellent experience	4	5	0	9
Leader in operational performance	2	12	0	14
Model employer	2	1	2	5
Achieve financial sustainability	0	2	0	2
Frontrunner in research innovation and education	2	3	0	5
All domains	10	23	2	35

KPIs categorised based upon SPC methodology*

	Consistently Achieving Target	Consistently Failing Target	Hit and Miss Target
Safest care and excellent experience	2	2	0
Leader in operational performance	0	7	1
Model employer	0	3	1
Achieve financial sustainability	0	0	0
Frontrunner in research innovation and education	0	0	0
All domains	**2**	**12**	**2**

* Not all KPIs are suitable for SPC analysis

Performance Trends – Trust Overview

NHS University Hospitals Coventry and Warwickshire NHS Trust

Please note: Areas listed below as showing a Special Cause Improvement or Common Cause Variation may show as Failing against Target. Areas of Special Cause Concern are statistically the areas that should be the focus of attention.

Mandatory - KPIs with a National Target

Special Cause Concern

Measure	Annual Target	Target Assurance	Latest Position
Emergency Care 4 Hour Wait	95%	F	61.8%
Cancer 62 Day Standard plus 31 Day Rare Cancers (1 month in arrears)	85%	F	57.10%
18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears)	92%	F	52.7%
A&E 12hr Total Wait Time	2%	F	8.3%

Special Cause Improvement

Measure	Annual Target	Target Assurance	Latest Position

Common Cause Variation

Measure	Annual Target	Target Assurance	Latest Position
Breaches of the 28 Day Readmission Guarantee	0	F	8
Diagnostic Waiters - 6 Weeks and Over (National Target)	95%	F	93.51%

Non Mandatory (Local or Regional Targets)

Special Cause Concern

Measure	Annual Target	Target Assurance	Latest Position
Mandatory Training Compliance	95%	F	94.59%
Cancer 104+ days wait (treated) - (1 month in arrears)	0	F	30.5
Average Number of Long Length of Stay Patients	109	F	189
Friends & Family Test - Recommender Targets Achieved	7	F	0

Special Cause Improvement

Measure	Annual Target	Target Assurance	Latest Position

Common Cause Variation

Measure	Annual Target	Target Assurance	Latest Position
Sickness Rate	4%	F	5.77%
Appraisal - Non-Medical	90%	F	80.09%

Quality and Safety | Headlines October 2022

NHS University Hospitals Coventry and Warwickshire NHS Trust

INFECTION CONTROL

This month 0 MRSA and 9 CDiff cases were reported.

Infection Rates
Cumulative

53 CDiff
YTD target 38
Annual Target 65

0 MRSA
0 YTD target
Annual Target 0

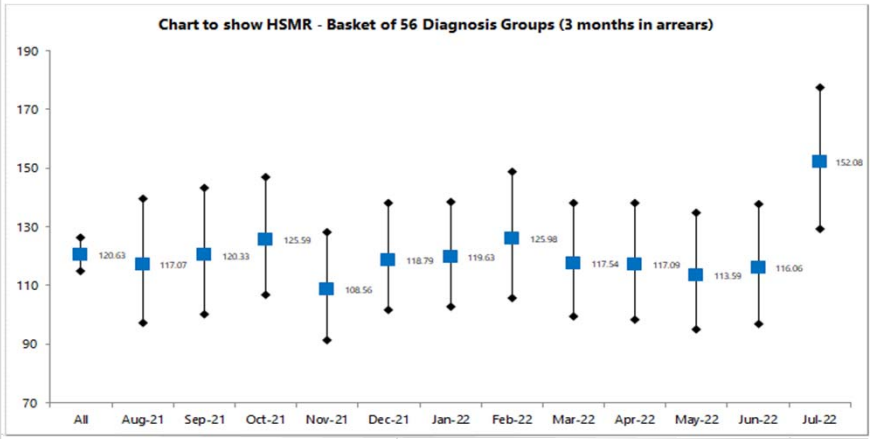
- **CDiff 21 RCAs** carried out and reviewed. 1 deemed avoidable. No further RCAs held.
- **MRSA** High Risk Elective Inpatient Screening: **98.2%**
- **MRSA** High Risk Emergency Screening: **91.5%**

MEDICINE RELATED SERIOUS INCIDENTS

No medication errors causing serious harm have been reported.

HSMR

The latest HSMR score reported from Dr Foster is 152.08



Summary

RIDDOR – There were three reported incidents in October, all related to staff.

The average number of patients with a length of stay of 21 days is 189, a decrease of 6 against the Trusts target of 109.

A Never Event was reported in October, details are included in this report.

The latest HSMR score reported is 152.06 for July and is outside Dr Foster's calculated relative risk range

4 - 12 hour trolley waits

UIGGRU

6 Iqflghqw#hsruwhg# iru#R fwrehu

No urgent operations have been cancelled for a second time

Never Events **1**

3 YTD performance against target of 0

4hr Achievement Overview - as at 14/11/2022

Stream	Last Month	Current Month	Last Year	This Year
Type 1 Majors	30.35%	30.99%	38.78%	28.80%
Type 1 Resus	30.21%	26.02%	36.40%	27.24%
Type 1 Paediatrics	56.82%	60.90%	69.32%	61.89%
Local Health Economy	61.80%	63.31%	73.87%	66.89%

97% Complaints turnaround in <= 25 days
Last month 98%
Target 90%

Urgent Clinic Letters sent in 7 calendar days

66.1%

Last month: 67.4%
Target 100%

LLOS

Average number of patients with a length of stay 21 days and over
189

Reason to Reside
Data Collection compliance for eligible areas: 84%

Incomplete RTT pathways

52 Weeks

5,117 (September)

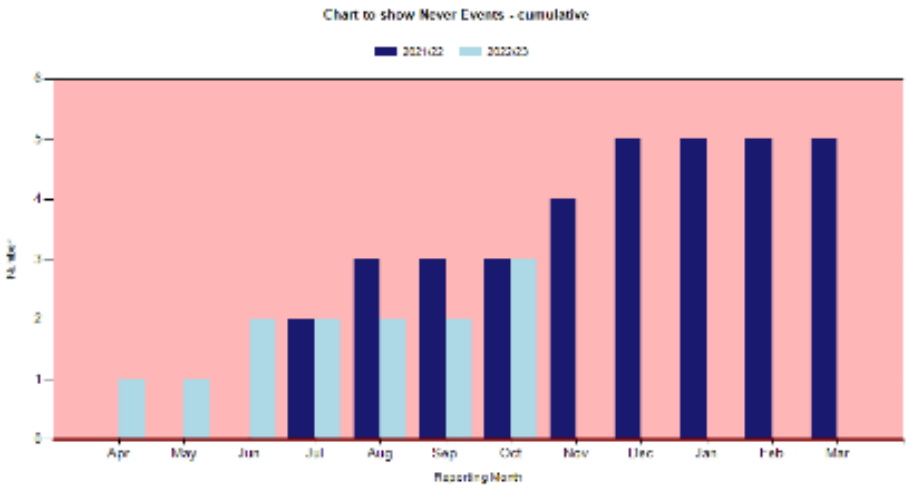
Previous month 4,941
Target 0

Integrated Quality, Performance and Finance Reporting Framework

Quality and Safety Summary

Area of underperformance – Never Event

A Never Event has been reported in October – Invasive procedure performed at the wrong site



Retained foreign object.
A patient was admitted to UHCW for left lower limb angiography and angioplasty. The patient was consented for a left lower limb angioplasty following discussion with the consultant vascular surgeon and was transferred to the angioplasty room. The patient was then handed over to the consultant interventional radiologist performing the procedure.

Following this, the WHO checklist was commenced however the side of the surgery was not discussed. The plan was to approach the patient's left leg from the right side therefore the team were stood on the right-hand side of the patient. On completion of the procedure to the patient's right leg, the consultant interventional radiologist noted the procedure should have been completed on the left leg. This was discussed and the procedure was then repeated on the patient's left leg. This meets the Never Event criteria for an invasive procedure performed at the wrong site.

Immediate actions:
A serious incident investigation has been instigated to identify the cause of this never event and put in place learning to prevent such an incident from occurring again.

Operational Performance | Headlines October 2022

University Hospitals Coventry and Warwickshire NHS Trust

Operational Summary

Emergency 4 hour wait:
October 2022 - 61.8%

Latest benchmarked month:
England – October 69.3%
Midlands – October 72.7%

4hr Achievement Overview - as at 14/11/2022

Stream	Last Month	Current Month	Last Year	This Year
Type 1 Majors	30.35%	30.99%	38.78%	28.80%
Type 1 Resus	30.21%	26.02%	36.40%	27.24%
Type 1 Paediatrics	56.82%	60.90%	69.32%	61.89%
Local Health Economy	61.80%	63.31%	73.87%	66.89%

Diagnostic Waiters 6 Weeks and Over

6.49% : 1,106 breaches across all areas

Ambulance Handover

Within 30 minutes : **71.3%**
Within 60 minutes : **89.4%**

Summary

Emergency 4 hour wait was 61.8% for October, a deterioration of 0.9% from last month. Performance is reduced with no activity for the Coventry Urgent Treatment Centre included for a third month. UHCW remains below the benchmarked position for England and the Midlands.

Cancer 2 week wait breast symptom (97.98%), 31 day subsequent drug (100%) and radiotherapy (94.37%) and 28 day faster diagnosis breast symptomatic (100%) standards were met. Two week wait (78.61%), 31 day diagnosis to treatment (95.67%) and 62 day (57.10%) standards were not achieved in September.

Covid-19 Vaccinations

95,713
as at
14/11/2022

Urgent Clinic Letters sent in 7 calendar days

66.1%

Last month: 67.4%
Target 100%

Incomplete RTT pathways

Submitted Position	Inc %	Backlog (Over 18 Weeks)	Latest Benchmarked Month	UHCW	NHS England
Sep 2022	52.7%	30,474	01/09/2022	52.7%	59.0%
Sep 2021	58.0%	22,539	01/09/2021	58.0%	65.8%
YTD UHCW Change	-5.3%	7,935	Benchmark Change	-5.3%	-6.8%

5,117 (September)
Previous month 4,941
Target 0

LLOS

Average number of patients with a length of stay 21 days and over
189

4 - 12 hour trolley waits

Reason to Reside

Data Collection compliance for eligible areas: 84%

Cancer standards - September

	Mth	Qtr	YTD
TWW:	78.61%	77.96%	77.8%
31 day:	95.67%	95.37%	95.96%
62 day:	57.1%	58.64%	59.24%
FD Overall:	73.38%	72.72%	74.14%
31 Day Sub Surg	93.62%	93.33%	95.68%
62 day Screening	83.87%	79.38%	76.06%
TWW Breast Symp	97.98%	89.03%	87.4%
31 Day Sub Radio	94.37%	93.59%	92.31%

30.5 breaches (40 patients) treated over 104 days

Last minute Non-Clinical Operations – Elective

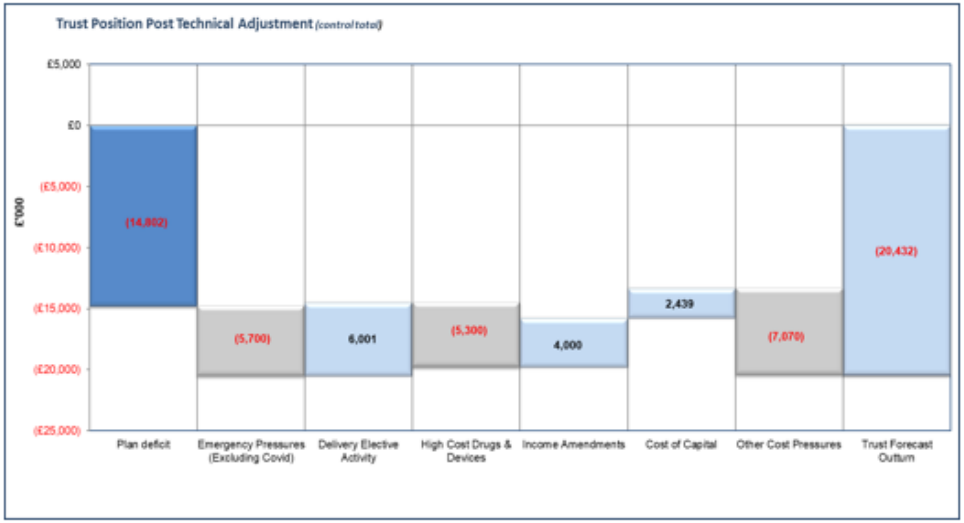
1.3%
of elective admissions – 92 Patients
Last month – 64 Patients

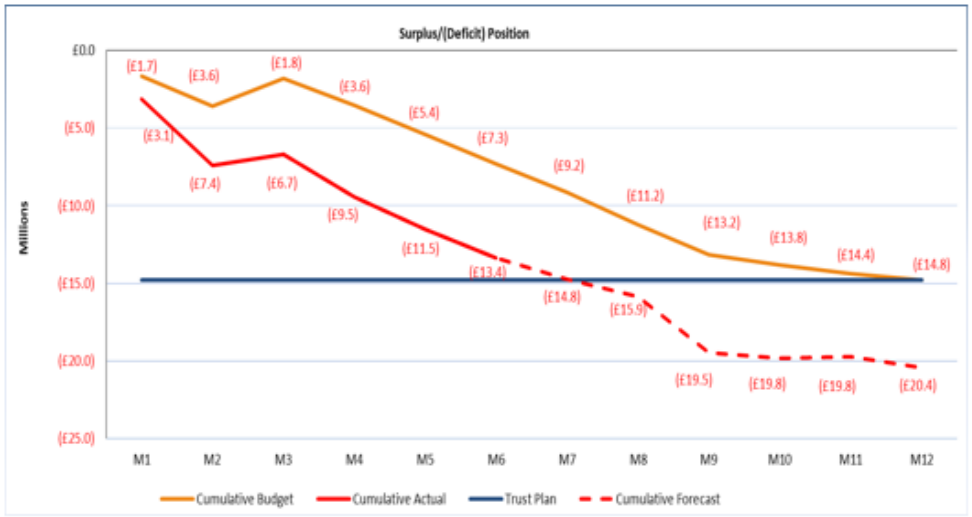
Integrated Finance Report | Finance Headlines

NHS University Hospitals Coventry and Warwickshire NHS Trust

Reporting Month: October 2022

The month 7 year to date position shows a (£14.8m) deficit compared to (£9.2m) deficit plan, an unfavourable variance of (£5.6m). The forecast position at Month 7 shows a (£20.4m) deficit compared to (£14.8m) deficit plan, an unfavourable variance of (£5.6m).





Movements on the waterfall shows a (£5.6m) forecast deficit position compared with the Trust plan. Largely driven by Managing Emergency pressures (£5.7m), Delivery of elective activity £6.0m, High-cost drugs & devices (£5.3m), Income changes £4.0m, Cost of Capital £2.4m and other cost pressures (£7.1m) which include CW Pathology Network, PFI costs and the additional bank holiday costs being the main drivers.

The Trust submitted a revised plan of a deficit position of (£14.8m) in month 3.

ERF Income Assumption:

- Internal monitoring to month 07 indicated delivery of 96.4%, it is expected that the official delivery will be around 99-100%, when figures are finalised.
- This represents an improving trajectory but is some way short of the target of 104%. Current forecasts showing achievement of 104% from November with no loss of income at this stage.

CONTRACT & ACTIVITY INCOME

£1.1m surplus

The Trust reported £1.1m surplus compared to plan at Month 7.
The forecast position is £6.4m surplus compared to plan at Month 7.

Waste Reduction Programme

£10.3m has been delivered against a YTD £15.0m target

£38.8m has been identified against a full year target of £38.8m

Capital

Capital Plan £46.1m

Capital Expenditure of £18.2m at Month 7.

YTD £13.6m Agency Spend

Agency expenditure at Month 7 is £13.6m compared to a target of £12.1m
Forecast expenditure is £21.7m against a target of £20.8m

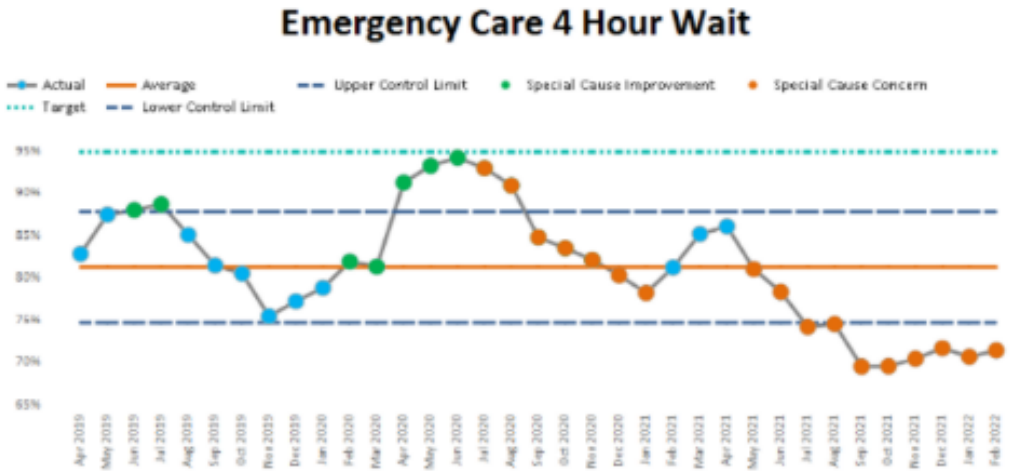
NHS
University Hospitals Coventry and Warwickshire NHS Trust

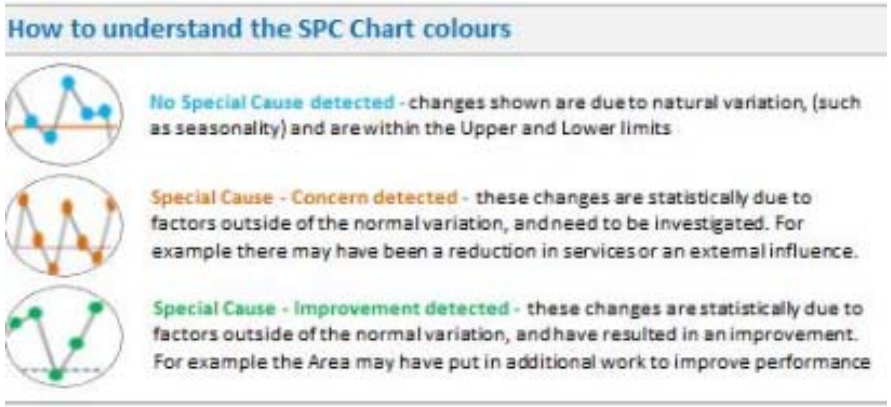
Appendices

Appendix A – SPC explained
Appendix B – Trust scorecards and SPC analyses
Appendix C – Committee scorecards and trends
Appendix D – Financial supporting information
Appendix E – People supporting information

SPC Explained

Variation (Performance Trend)	Trigger
Special Cause Improvement	60% of the last 13 data points showed a statistical improvement
Special Cause Concern	60% of the last 13 data points showed a statistical decline
Common Cause Variation	No pattern of decline or improvement in the last 13 data points
Assurance (Target Trend)	**Trigger**
Consistently Achieving Target	80% of the last 13 data points achieved the KPI target
Consistently Failing Target	80% of the last 13 data points failed the KPI target
Hit and Miss Target	No pattern of achieving or failing KPI target in the last 13 data points





Trust Scorecard

Reporting Month : October 2022

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	ID	Previous Position	Latest Position	DoT	Current Target	Annual Target	Executive Lead	Variation	Target Assurance
Safest care and excellent experience										
	Infection Control									
	Healthcare associated incidents of Clostridioides difficile - Cumulative	1360	44	53	↓	38	65	CNO	N/A	N/A
	MRSA Bacteremia - Trust Acquired - Cumulative	122	0	0	→	0	0	CNO	N/A	N/A
	Safe Care									
	Never Events - Cumulative	848	2.0	3.0	↓	0	0	CMO	N/A	N/A
	Serious Incidents - Number	449	8	12	↓	15	15	CQO		P
	HSMR - Basket of 56 Diagnosis Groups (3 months in arrears)	264	116.06	152.08	↓	RR	RR	CMO	N/A	N/A
	SHMI - Monthly (6 months in arrears)	267	110.46	110.71	↓	RR	RR	CMO	N/A	N/A
	Average Number of Long Length of Stay Patients	1336	195	189	↑	109	109	CNO		F
	Patient Experience									
	Friends & Family Test - Recommender Targets Achieved	1487	0	0	→	7	7	CQO		F
	Complaints Turnaround <= 25 Days (1 month in arrears)	1064	98%	97%	↓	90%	90%	CQO		P
Leader in operational performance										
	Patient Flow									
	Emergency Care 4 Hour Wait	45	62.7%	61.8%	↓	95%	95%	COO		F
	A&E 12hr Total Wait Time	1511	9.1%	8.3%	↑	2%	2%	COO		F
	Bed Occupancy Rate - KH03 (3 months in arrears)	1065	96.6%	98.0%	↓	93%	93%	COO	N/A	N/A
	Breaches of the 28 Day Readmission Guarantee	16	13	8	↑	0	0	COO		F
	Diagnostic Waiters - 6 Weeks and Over (National Target)	1507	90.68%	93.51%	↑	95%	95%	COO		F

Appendix B – Trust Scorecard

Trust Scorecard

Reporting Month : October 2022

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	ID	Previous Position	Latest Position	DoT	Current Target	Annual Target	Executive Lead	Variation	Target Assurance
			RTT							
	RTT 52 Week Waits Incomplete (1 month in arrears) (National Target)	1508	4941	5117	↓	4060	4060	COO	N/A	N/A
	RTT 78 Weeks Wait Incomplete (1 month in arrears) (National Target)	1509	93	67	↑	213	0	COO	N/A	N/A
	RTT 104 Weeks Wait Incomplete (1 month in arrears) (National Target)	1510	0	0	→	0	0	COO	N/A	N/A
	18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears)	480	53.6%	52.7%	↓	92%	92%	COO		F
	Last Minute Non-clinical Cancelled Operations - Elective	14	0.9%	1.3%	↓	0.8%	0.8%	COO		?
			Cancer							
	Cancer 62 Day Standard plus 31 Day Rare Cancers (1 month in arrears)	73	57.48%	57.10%	↓	85%	85%	COO		F
	Cancer 104+ days wait (treated) - (1 month in arrears)	860	30.5	30.5	→	0	0	COO		F
	Cancer Faster Diagnosis Overall - Group	1491	72.64%	73.38%	↑	75%	75%	COO	N/A	N/A
	National Cancer Standards Achieved (1 month in arrears)	1290	4	4	→	12	12	COO	N/A	N/A
Model employer										
	Mandatory Training Compliance	384	94.41%	94.59%	↑	95%	95%	CPO		F
	Appraisal - Non-Medical	641	82.26%	80.09%	↓	90%	90%	CPO		F
	Appraisal - Medical	642	93.81%	94.38%	↑	90%	90%	CMO		?
	Sickness Rate	385	5.13%	5.77%	↓	4%	4%	CPO		F
	Vacancy Rate Compared to Funded Establishment	650	6.50%	6.54%	↑	10%	10%	CPO	N/A	N/A

Appendix B – Trust Scorecard

Trust Scorecard

Reporting Month : October 2022

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	ID	Previous Position	Latest Position	DoT	Current Target	Annual Target	Executive Lead	Variation	Target Assurance
Achieve financial sustainability										
	Forecast Income & Expenditure	477	£-20432k	£-20432k	→	-14802	-14802	CFO	N/A	N/A
	WRP Delivery	478	£12.360m	£10.349m	↓	14998	38788	CFO	N/A	N/A
Frontrunner in research innovation and education										
	Patients Recruited into NIHR Portfolio-Cumulative (2 months in arrears)	297	1884	2348	↑	2159	5213	CMO	N/A	N/A
	Commercial Income Invoiced - Cumulative (1 month in arrears)	684	£270k	£489k	↑	450	900	CFO	N/A	N/A
	NIHR Research Capability Funding (3 months in arrears)	1332	£302k	£302k	→	500	1000	CMO	N/A	N/A
	Trial Recruitment Income (3 months in arrears)	1344	£506k	£842k	↑	1062.5	2125	CMO	N/A	N/A
	All Grant Income (3 months in arrears)	1345	£1.730m	£736k	↓	1000	2000	CMO	N/A	N/A
Enhanced Performance										
	Diagnostic Waiters - 6 Weeks and Over (Local Target)	33	9.32%	6.49%	↑	1%	1%	COO		F
	RTT 52 Week Waits Incomplete (1 month in arrears) (Local Target)	416	4941	5117	↓	0	0	COO	N/A	N/A
	RTT 78 Weeks Wait Incomplete (1 month in arrears) (Local Target)	1503	93	67	↑	0	0	COO	N/A	N/A
	RTT 104 Weeks Wait Incomplete (1 month in arrears) (Local Target)	1504	0	0	→	0	0	COO	N/A	N/A

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

Trust Heatmap

NHS University Hospitals Coventry and Warwickshire NHS Trust

Appendix B – Trust Heatmap

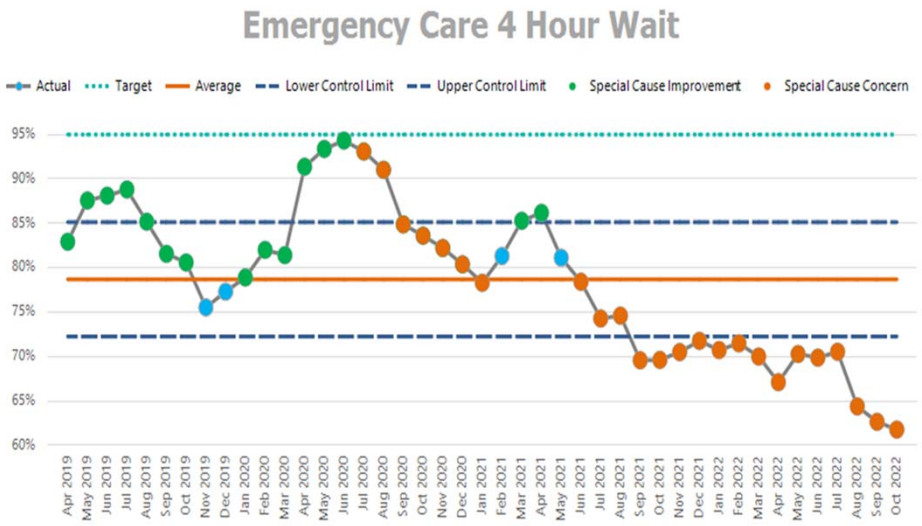
Measure	Emergency Medicine	Medicine	Trauma and Neuro Services	Surgical Services	Women and Children's Services	Clinical Diagnostics Services	Clinical Support Services	Trust	Trust Target
Reporting Period:								**October 2022**	
Group Level Indicators									
Safest care and excellent experience									
Healthcare associated incidents of Clostridioides difficile - Cumulative	3	16	4	6	0		0	53	38
MRSA Bacteremia - Trust Acquired - Cumulative	0	0	0	0	0		0	0	0
Never Events - Cumulative	0	0	0	0	1		1	3	0
Serious Incidents - Number	0	8	0	1	0	1	1	12	15
HSMR - Basket of 56 Diagnosis Groups (3 months in arrears)	76.46	163.5	174.38	46.3	488.5			152.08	100
Average Number of Long Length of Stay Patients	0	98	56	18	1	1	15	189	109
Friends & Family Test - Recommender Targets Achieved	0	0	0	0	1		0	0	7
Complaints Turnaround <= 25 Days (1 month in arrears)	100%	100%	100%	75%	100%	100%	100%	97%	90%
Leader in operational performance									
Emergency Care 4 Hour Wait	57.80%			99.90%	87.50%			61.80%	95%
Breaches of the 28 Day Readmission Guarantee			6	1	1		N/A	8	0
Diagnostic Waiters - 6 Weeks and Over (Local Target)		10.28%	10.96%	6.28%		6.01%		6.49%	1%
18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears)		54.60%	56.80%	49.40%	50.70%	62.20%	53.20%	52.70%	92%
RTT 52 Week Waits Incomplete (1 month in arrears) (Local Target)		1830	583	2021	670	3	10	5117	0
Last Minute Non-clinical Cancelled Operations - Elective	0.00%	0.00%	5.00%	2.90%	0.70%	0.00%	0.00%	1.30%	0.80%
Cancer 62 Day Standard plus 31 Day Rare Cancers (1 month in arrears)		73.28%	N/A	47.06%	47.06%			57.10%	85%
Cancer 104+ days wait (treated) - (1 month in arrears)		6.5	0	22.5	1.5			30.5	0
Cancer Faster Diagnosis Overall - Group		81.24%	61.11%	71.29%	59.80%			73.38%	75%
National Cancer Standards Achieved (1 month in arrears)		3	6	4	4			4	12
Model employer									
Mandatory Training Compliance	92.53%	93.99%	93.48%	94.54%	91.88%	94.96%	96.07%	94.59%	95%
Appraisal - Non-Medical	81.03%	73.81%	77.72%	87.86%	85.29%	83.54%	89.57%	80.09%	90%
Appraisal - Medical	97.50%	95.76%	95.45%	91.45%	94.55%	97.01%	95.79%	94.38%	90%
Sickness Rate	6.36%	5.38%	6.40%	6.01%	5.91%	5.45%	6.15%	5.77%	4%
Achieve financial sustainability									
WRP Delivery	£871k	£2.020m	£648k	£591k	£559k	£768k	£1.125m	£10.349m	14998
Frontrunner in research innovation and education									
Patients Recruited into NIHR Portfolio-Cumulative (2 months in arrears)	10	958	112	295	845	0	128	2348	2159

Trust SPC - Areas of Concern - Mandatory

University Hospitals Coventry and Warwickshire NHS Trust

Appendix B – Trust Trends

Special Cause Concern



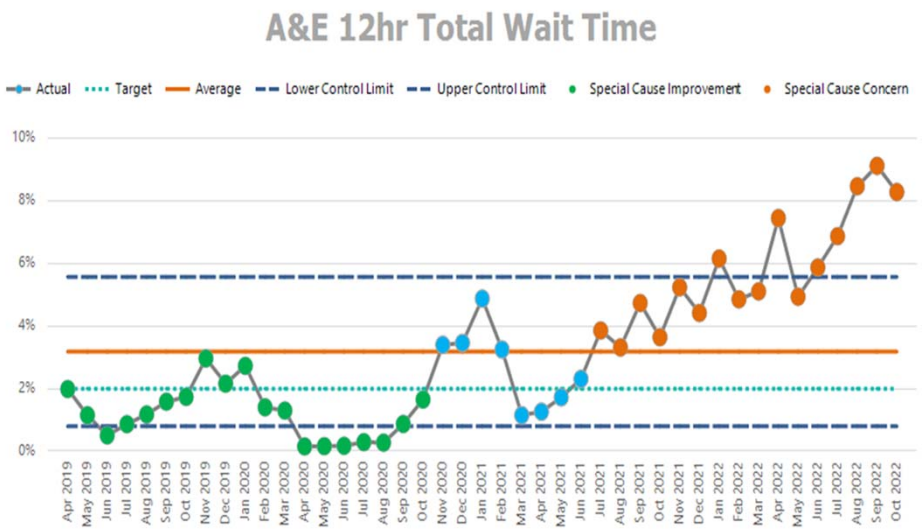
Urgent and Emergency care pathways remain challenged, reflecting the National position.

The statutory 95% target has not been achieved this financial year, remaining the case in October 22. None compliance with this target is directly linked to high occupancy (~98%), LLOS and discharge delays. The rapid deterioration since August is due to data relating to UTCs being unavailable due to the cyber attack on Adastra software.

Overall ED activity remains at 104% of 19/20 for the same period.

Actions ongoing include streaming patients away from ED to assessment areas, providing timely specialist care. Pathway reviews and improvement events are being led by Groups. Locally partnership working is progressing to promote admission avoidance and timely discharges. Nationally the Winter Collaborative work has commenced with a view to reducing Ambulance handover delays and time spent in ED.

Commentary Provided by the Deputy Chief Operating Officer – Elective and Cancer Care



This performance metric is directly linked to the challenges described for the performance in the 4 hour wait – in particular the challenges experienced in the majors stream which is impacted by increased occupancy and LOS in the medical bed base.

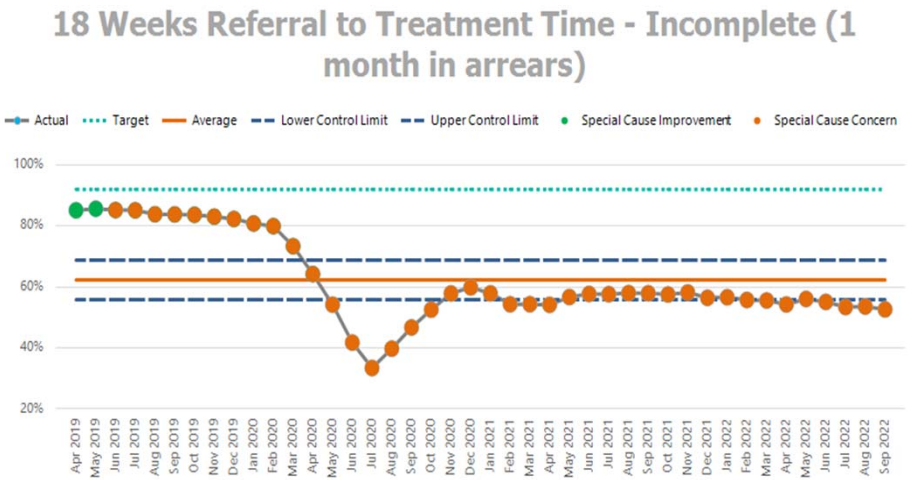
Commentary Provided by the Deputy Chief Operating Officer – Elective and Cancer Care

Trust SPC - Areas of Concern - Mandatory

University Hospitals Coventry and Warwickshire NHS Trust

Appendix B – Trust Trends

Special Cause Concern



The Trust continues on the journey of elective recovery. The maintenance of the 18wks position, whilst below the lower control limit masks the smoothing of the waves in the underlying waiting lists.

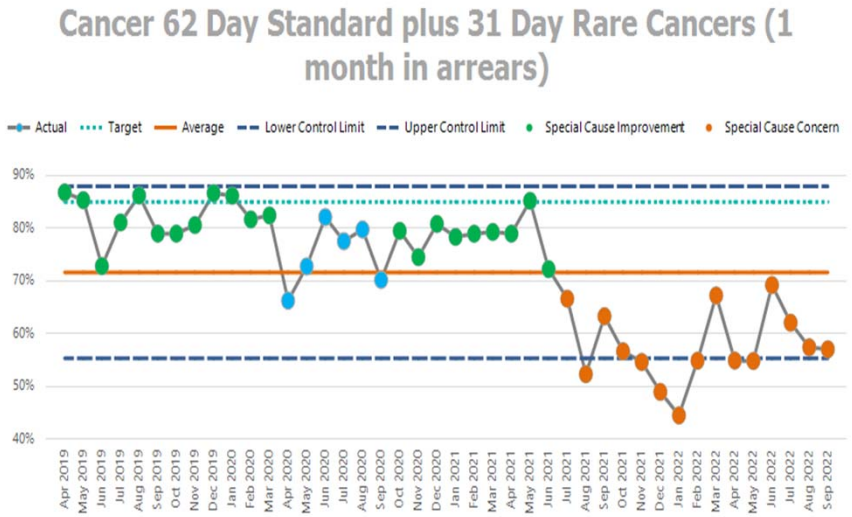
The Trust continues to focus on the reduction in long waits, maintaining the elimination of 104wks since 1st August 2022 and sustaining that position . The number of patients waiting over 78wks has also reduced significantly to less than 100 which equates to 0.15% of the total waiting list.

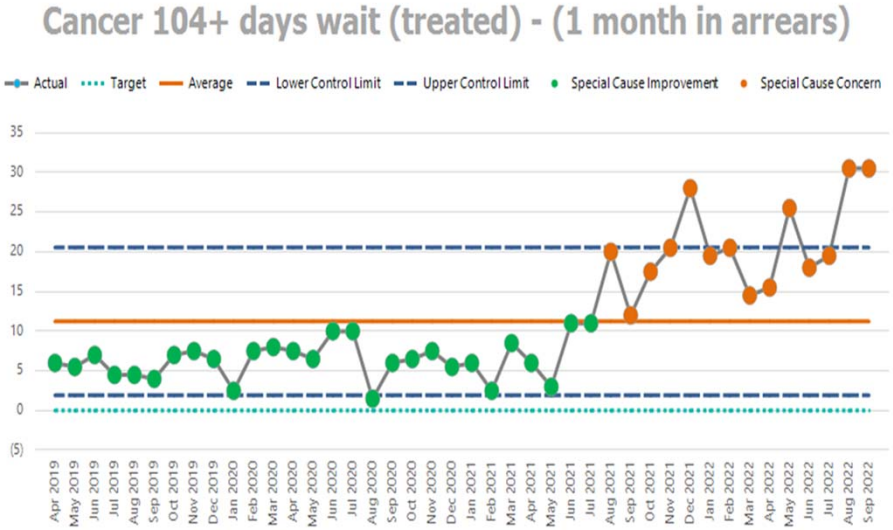
The next phase of our elective recovery and the improvement of this metric is the work on validating the whole waiting list and the improvement in the wait for first appointment, since September 2022 the Clinical Groups have been focused on reducing the wait for first appointment to under 26wks which will have an impact on this metric over the course of the autumn months.

Commentary Provided by Chief Operating Officer

Trust SPC - Areas of Concern – Mandatory/Non Mandatory

Special Cause Concern





The Trust continues to prioritise diagnosis and treatment of all patients on a Cancer pathway.
Daily tracking and validation of patients continues across all tumour sites, alongside:
- Weekly review of all patients with a decision to treat to ensure treatment within timed pathway standard
- Weekly DCOO led confirm and challenge for patients at 104+ days and patients due to tip over to support backlog reduction at both a weekly DCOO Recovery meeting and Senior Huddle.
- Weekly senior operational meeting with all tumour site leads to understand service challenges and ensure plans are in place to support referral demand and backlog clearance
- Working with C&W System ICB and West Midlands Cancer Alliance to support transformation of diagnostic pathways and to determine additional funding to support delivery of 28 Faster Diagnosis Standard for all tumour sites
- Exceptional operational planning to understand re-baseline capacity required due to increased cancer referrals in 2022
- Seeking mutual aid and utilisation of independent sector for cancer pathways where practically viable
- Reducing the waiting time for patients on a Cancer pathway continues to be a key priority for the Trust to ensure that as many patients as possible could receive their treatment.

The Trust is working towards reducing the number of patients treated at 104 days or more to zero by March 2023 in line with NHS England National Operational Planning Guidance for 2022/23. In addition we are currently meeting our H2 target, agreed with the ICS, for our 62 Day Backlog.

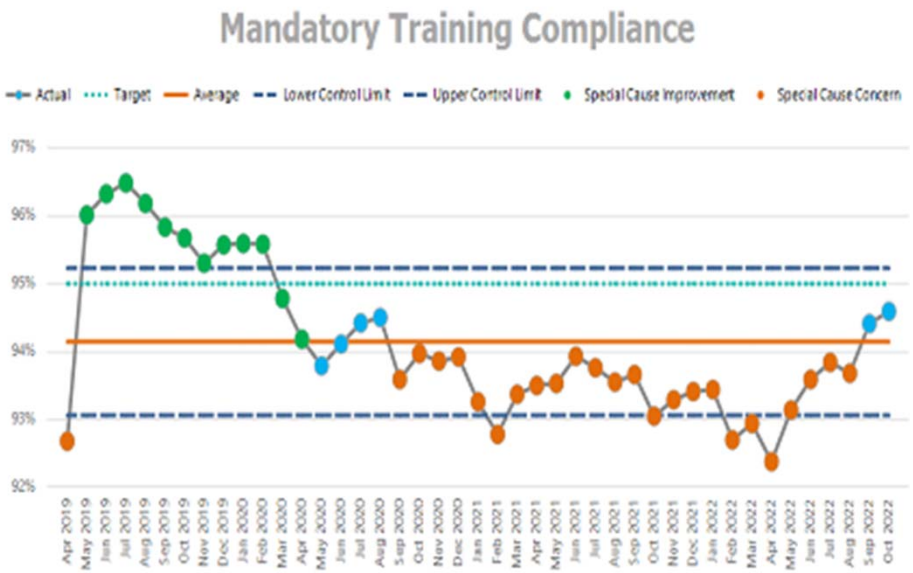
Commentary Provided by Chief Operating Officer

Trust SPC - Areas of Concern – Non Mandatory

NHS University Hospitals Coventry and Warwickshire NHS Trust

Appendix B – Trust Trends

Special Cause Concern



Overall Mandatory Training compliance for substantive staff remains in a stable and slightly improved position. There was an increase of 0.91% through September & October 2022 to 94.59%.
Staff compliance rates continue to be affected by unforeseen and sporadic Covid-19 related absences and the operational pressures of the Trust. All Clinical Groups are achieving over 94% compliance.

The Trust-wide awareness campaign entitled 'Check/Book/Attend' commenced in July 2022 highlighting the importance of mandatory training compliance across the Trust in an informative, friendly and supportive way. This campaign is intended to motivate all staff to consider their own accountability to mandatory training and the role we all have to play.

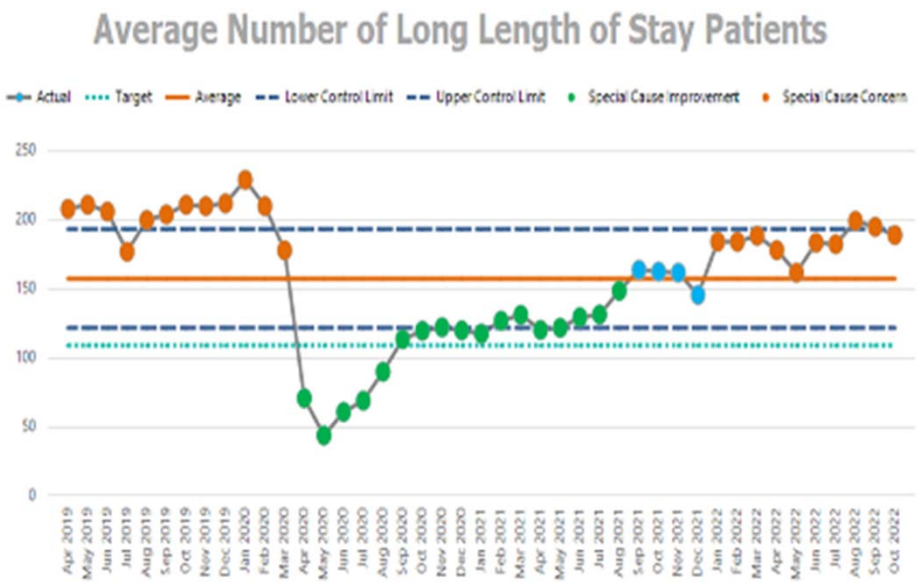
Commentary Approved by the Chief People Officer

Trust SPC - Areas of Concern – Non Mandatory

University Hospitals Coventry and Warwickshire NHS Trust

Appendix B – Trust Trends

Special Cause Concern



External challenges

- Patients referred to care homes refused on more than one occasion due to complexity
- Sourcing out of area – dementia care / behavioural unit placements – delays
- Patients waiting for Neuro rehabilitation placement for specialist care – CERU / Oswestry

Actions

- Daily 'Bronze' calls reviewing each patient in delay – with health, MH and social care partners / capacity review with system
- Confirm and challenge with Groups weekly – granular detail by patient
- Weekly long length of stay reviews with CEO/CNO – escalations to Gold (system)
- Medium / Long Term – Hospital at Home expansion / Improving Lives for Older People (system transformation)

Internal focus / flow

- Alignment of Ward View / Progress Chase (data flows)
- Discharge timeliness focus boards – medicine
- Kaizen event with Care of the Elderly Therapy Team
- Standard work – Ward / Board Rounds and Manager of the Day training
- Discharge before 5pm / 12MD – focus
- Discharge Lounge – early pull supported by Flow Rota (winter)
- Criteria Led Discharge (CLD) programme of work

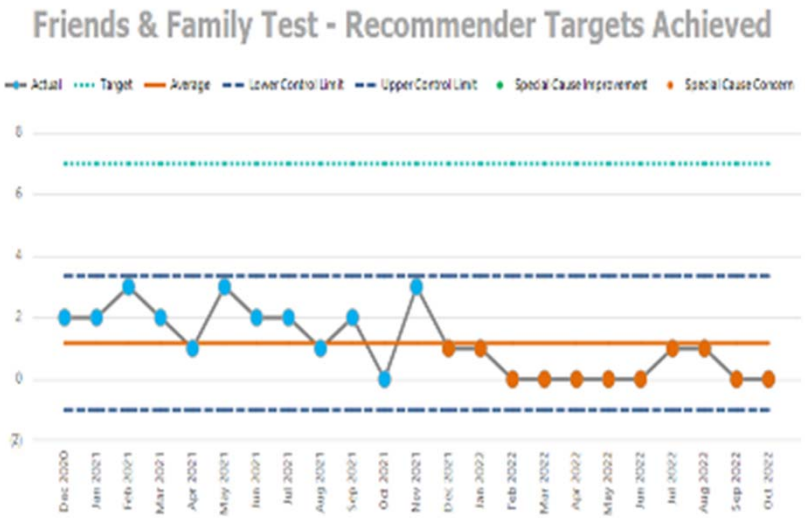
Commentary Provided by the Chief Nursing Officer

Trust SPC - Areas of Concern – Non Mandatory

University Hospitals Coventry and Warwickshire NHS Trust

Appendix B – Trust Trends

Special Cause Concern



The attached SPC chart reflects the aggregated performance of all seven Friends and Family Test (FFT) touchpoint recommender rates for UHCW combined. Reporting for FFT is monitored monthly for the seven FFT touchpoints. Since December 2021 there has been a reduction in the Trust's performance against the internal FFT recommender target, below the average across all seven touchpoints. This means that the percentage of patients who would recommend the service has reduced over the past nine months and for the previous two months, no FFT touchpoint has achieved the Trusts recommender target.

FFT performance is monitored via the Patient Experience and Engagement Committee (PEEC), and monitoring has been identified that there are data discrepancies between the data the Trust sends, (and receives), from Healthcare Communications who manage the process of text messaging patients on behalf of the Trust for FFT. The Performance and Informatics Team (P&I) and Healthcare Communications, with oversight from the Patient Insight and Involvement Team, are investigating the issue. The ongoing updates regarding this recognised issue are shared with PEEC monthly.

The Patient Insight and Involvement Team continue to promote FFT across the Trust and have made a number of improvements to achieve the Trust internal target including:

- Commenced FFT text messaging within maternity services.
- Trial commenced in the Children's Emergency Department (CED) to use iPads to collect patient feedback.
- #FFTFriday Patient Experience twitter account campaign continues, prompting positive feedback from patients, increasing awareness of FFT for both staff and patients.
- Patient instruction on how to leave FFT feedback is being rolled out on all new patient information leaflets.
- The Post COVID-19 FFT survey is live, collecting feedback from patients using this service.
- Volunteers supporting the collection of FFT feedback on Wards and Outpatients.

Commentary Provided by the Chief Quality Officer

Quality and Safety Committee Scorecard

Reporting Month : October 2022

University Hospitals Coventry and Warwickshire NHS Trust

DoT
Improving
No change
Falling

Target Type
National Target
Regional Target
Local Target

Quality & Safety Scorecard

Type	Measure	ID	Previous Position	Latest Position	DoT	Current Target	Annual Target	Executive Lead	Variation	Target Assurance
Excellence in patient care and experience										
	Patient Outcomes									
	MRSA Bacteremia - Trust Acquired - Cumulative	122	0	0	→	0	0	CNO	N/A	N/A
	Healthcare associated incidents of Clostridioides difficile - Cumulative	1360	44	53	↓	38	65	CNO	N/A	N/A
	E. Coli - Trust Acquired - Cumulative	162	61	71	↓	80	137	CNO	N/A	N/A
	Pseudomonas - Trust Acquired - Cumulative	1497	15	18	↓	22	40	CNO	N/A	N/A
	Klebsiella - Trust Acquired - Cumulative	1499	19	25	↓	38	63	CNO	N/A	N/A
	MRSA High Risk Elective Inpatient Screening	1280	97.5%	98.2%	↑	95%	95%	CNO		P
	MRSA High Risk Emergency Screening	1281	91.4%	91.5%	↑	90%	90%	CNO		P
	Serious Incidents - Number	449	8	12	↓	15	15	CQO		P
	Serious Incidents - Overdue	475	17	25	↓	0	0	CQO		F
	Medicine related serious incidents	435	0	0	→	0	0	CQO	N/A	N/A
	Reported Harmful Patient Safety Incidents (1 month in arrears)	649	35.7%	36.4%	↓	24.94%	24.94%	CQO		F
	CAS Alerts - Overdue	437	0	0	→	0	0	CQO	N/A	N/A
	NCE POD Categorised E Deaths - Cumulative (3 months in arrears)	850	4	4	→	3	10	CMO	N/A	N/A
	Never Events - Cumulative	848	2.0	3.0	↓	0	0	CMO	N/A	N/A

Appendix C – QSC Scorecard

Quality and Safety Committee Scorecard

University Hospitals Coventry and Warwickshire NHS Trust

Reporting Month : October 2022

DoT
Improving
No change
Falling

Target Type
National Target
Regional Target
Local Target

Quality & Safety Scorecard

Type	Measure	ID	Previous Position	Latest Position	DoT	Current Target	Annual Target	Executive Lead	Variation	Target Assurance
	Mixed Sex Accommodation Breaches	135	0	0	→	0	0	COO	N/A	N/A
	HSMR - Basket of 56 Diagnosis Groups (3 months in arrears)	264	116.06	152.08	↓	RR	RR	CMO	N/A	N/A
	SHMI - Monthly (6 months in arrears)	267	110.46	110.71	↓	RR	RR	CMO	N/A	N/A
	Pressure Ulcers Cat 3 - Reportable - Cumulative (1 month in arrears)	1512	0	0	→	12	12	CNO	N/A	N/A
	Pressure Ulcers Cat 4 - Reportable - Cumulative (1 month in arrears)	1513	1	1	→	0	0	CNO	N/A	N/A
	Pressure Ulcers Unstageable - Reportable - Cumulative (1 month in arrears)	1514	19	21	↓	24	24	CNO	N/A	N/A
	Falls with Moderate Harm or Above per 1000 Occupied Bed Days	1063	0.34	0.09	↑	0.08	0.08	CNO		?
	Eligible Patients Having VTE Risk Assessment (1 month in arrears)	1373	96.2%	96.1%	↓	95%	95%	CNO		P
	Average Number of Long Length of Stay Patients	1336	195	189	↑	109	109	CNO		F
	Reason to Reside	1490	85%	84%	↓	95%	95%	CNO		F
	Transfer of Patients at Night (UH to Rugby)	1343	7	19	↓	0	0	COO		F
	Friends & Family Test Inpatient Recommenders (Inc. Day Cases)	1482	86.6%	87.1%	↑	95%	95%	CQO		F
	Friends & Family Test Inpatient Coverage (Inc. Day Cases)	1014	22.3%	21.3%	↓	26%	26%	CQO		F

Appendix C – QSC Scorecard

Quality and Safety Committee Scorecard

NHS University Hospitals Coventry and Warwickshire NHS Trust

Reporting Month : October 2022

DoT
Improving
No change
Falling

Target Type
National Target
Regional Target
Local Target

Quality & Safety Scorecard

Type	Measure	ID	Previous Position	Latest Position	DoT	Current Target	Annual Target	Executive Lead	Variation	Target Assurance
	Friends & Family Test A&E Recommenders	1480	73.4%	70.5%	↓	87%	87%	CQO		F
	Friends & Family Test A&E Coverage	398	15.4%	14.3%	↓	15%	15%	CQO		F
	Friends & Family Test Outpatient Coverage	1178	6.38%	6.05%	↓	8%	8%	CQO		F
	Maternity FFT Recommenders - 36 weeks	1483	96.12%	92.02%	↓	97%	97%	CQO		F
	Maternity FFT Recommenders - Labour / Birth	1484	95.60%	93.98%	↓	97%	97%	CQO		?
	Maternity FFT Recommenders - Postnatal Hospital	1485	89.13%	94.00%	↑	97%	97%	CQO		F
	Maternity FFT Recommenders - Postnatal Community	1486	95.16%	85.19%	↓	97%	97%	CQO		?
	Maternity FFT No of Touchpoints Achieving a 15% Response Rate	467	3	3	→	4	4	CQO		F
	Number of Registered Complaints (1 month in arrears)	373	40	30	↑	32	34	CQO		?
	Complaints per 1000 Occupied Bed Days (1 month in arrears)	1068	1.23	0.95	↑	0.99	0.99	CQO		?
	Complaints Turnaround <= 25 Days (1 month in arrears)	1064	98%	97%	↓	90%	90%	CQO		P
	Theatres									
	Surgical Safety Checklist - WHO	442	100.00%	100.00%	→	100%	100%	CMO		P
Excellence in patient care and experience										
	National Quality Requirements									
	Valid NHS Number - Inpatients - Cumulative (2 months in arrears)	644	99.8%	99.9%	↑	99%	99%	COO		P

Quality and Safety Committee Scorecard

University Hospitals Coventry and Warwickshire NHS Trust

Reporting Month : October 2022

DoT
Improving
No change
Falling

Target Type
National Target
Regional Target
Local Target

Quality & Safety Scorecard										
Type	Measure	ID	Previous Position	Latest Position	DoT	Current Target	Annual Target	Executive Lead	Variation	Target Assurance
	Valid NHS Number - A&E - Cumulative (2 months in arrears)	645	94.6%	98.8%	↑	95%	95%	COO		P
	12 Hour Trolley Waits in Emergency Care	646	0	4	↓	0	0	COO	N/A	N/A
	Ambulance Handover within 15 minutes	129	15.7%	22.8%	↑	65%	65%	COO		F
	Ambulance Handover within 30 Minutes	131	63.8%	71.3%	↑	95%	95%	COO		F
	Ambulance Handover within 60 Minutes	405	85.8%	89.4%	↑	100%	100%	COO		F
	Urgent Operations Cancelled for the Second Time	414	0	0	→	0	0	COO	N/A	N/A
	RTT 52 Week Waits Incomplete (1 month in arrears) (Local Target)	416	4941	5117	↓	0	0	COO	N/A	N/A
Leading research based health care organisation										
	Patients Recruited into NIHR Portfolio-Cumulative (2 months in arrears)	297	1884	2348	↑	2159	5213	CMO	N/A	N/A
	Performance in Initiating Trials - Quarterly	421	7.0%	8.0%	↑	80%	80%	CMO	N/A	N/A
	Performance in Delivery of Trials - Quarterly	422	85.7%	55.6%	↓	80%	80%	CMO	N/A	N/A
	Research Critical Findings and Serious Incidents - Quarterly	681	0	0	→	0	0	CQO	N/A	N/A
	Peer Reviewed Publications - Calendar Year Cumulative (2 months in arrears)	682	191	199	↑	120	246	CMO	N/A	N/A

Appendix C – QSC Scorecard

QSC – KPI Performance Trends

NHS University Hospitals Coventry and Warwickshire NHS Trust

Please note: Areas listed below as showing a Special Cause Improvement or Common Cause Variation may show as Failing against Target. Areas of Special Cause Concern are statistically the areas that should be the focus of attention.

Mandatory - KPIs with a National Target

Special Cause Concern

Measure	Annual Target	Target Assurance	Latest Position
Ambulance Handover within 30 Minutes	95%	F	71.3%
Ambulance Handover within 60 Minutes	100%	F	89.4%

Special Cause Improvement

Measure	Annual Target	Target Assurance	Latest Position

Common Cause Variation

Measure	Annual Target	Target Assurance	Latest Position
Ambulance Handover within 15 minutes	65%	F	22.8%

Non Mandatory (Local or Regional Targets)

Special Cause Concern

Measure	Annual Target	Target Assurance	Latest Position
Friends & Family Test A&E Coverage	15%	F	14.3%
Maternity FFT No of Touchpoints Achieving a 15% Response Rate	4	F	3
Serious Incidents - Overdue	0	F	25
Reported Harmful Patient Safety Incidents (1 month in arrears)	24.94%	F	36.4%
Friends & Family Test Outpatient Coverage	8%	F	6.05%
Average Number of Long Length of Stay Patients	109	F	189

Special Cause Improvement

Measure	Annual Target	Target Assurance	Latest Position
Maternity FFT Recommenders - 36 weeks	97%	F	92.02%

Common Cause Variation

Measure	Annual Target	Target Assurance	Latest Position
Friends & Family Test Inpatient Coverage (Inc. Day Cases)	26%	F	21.3%
Transfer of Patients at Night (UH to Rugby)	0	F	19
Friends & Family Test A&E Recommenders	87%	F	70.5%
Friends & Family Test Inpatient Recommenders (Inc. Day Cases)	95%	F	87.1%
Maternity FFT Recommenders - Postnatal Hospital	97%	F	94.00%
Reason to Reside	95%	F	84%

Finance & Workforce Committee Scorecard

NHS University Hospitals Coventry and Warwickshire NHS Trust

Reporting Month : October 2022

DoT
Improving
No change
Falling

Target Type
National Target
Regional Target
Local Target

Finance and Workforce Scorecard

Type	Measure	ID	Previous Position	Latest Position	DoT	Current Target	Annual Target	Executive Lead	Variation	Target Assurance
Excellence in patient care and experience										
				Emergency care						
	Emergency Care 4 Hour Wait	45	62.7%	61.8%	↓	95%	95%	COO		F
	12 Hour Trolley Waits in Emergency Care	646	0	4	↓	0	0	COO	N/A	N/A
	A&E 12hr Total Wait Time	1511	9.1%	8.3%	↑	2%	2%	COO		F
	Ambulance Handover within 15 minutes	129	15.7%	22.8%	↑	65%	65%	COO		F
	Ambulance Handover within 30 Minutes	131	63.8%	71.3%	↑	95%	95%	COO		F
	Ambulance Handover within 60 Minutes	405	85.8%	89.4%	↑	100%	100%	COO		F
	30 Day Emergency Readmissions (1 month in arrears)	447	8.4%	7.8%	↑	8.2%	8.2%	COO		?
	Number of Medical Outliers - Average per Day	950	30.5	47.6	↓	50	50	COO		?
	Length of Stay Acute - Average	951	7.0	7.1	↓	6.9	6.9	COO		F
				Non emergency care						
	Last Minute Non-clinical Cancelled Operations - Elective	14	0.9%	1.3%	↓	0.8%	0.8%	COO		?
	Breaches of the 28 Day Readmission Guarantee	16	13	8	↑	0	0	COO		F
	Urgent Operations Cancelled for the Second Time	414	0	0	→	0	0	COO	N/A	N/A
	18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears)	480	53.6%	52.7%	↓	92%	92%	COO		F

Finance & Workforce Committee Scorecard

NHS University Hospitals Coventry and Warwickshire NHS Trust

Reporting Month : October 2022

DoT
Improving
No change
Falling

Target Type
National Target
Regional Target
Local Target

Finance and Workforce Scorecard

Type	Measure	ID	Previous Position	Latest Position	DoT	Current Target	Annual Target	Executive Lead	Variation	Target Assurance
	RTT 52 Week Waits Incomplete (1 month in arrears) (Local Target)	416	4941	5117	↓	0	0	COO	N/A	N/A
	RTT 78 Weeks Wait Incomplete (1 month in arrears) (Local Target)	1503	93	67	↑	0	0	COO	N/A	N/A
	RTT 104 Weeks Wait Incomplete (1 month in arrears) (Local Target)	1504	0	0	→	0	0	COO	N/A	N/A
	E-referral Appointment Slot Issues – National data (1 month in arrears)	260	4.1%	4.6%	↓	4%	4%	COO		?
	Diagnostic Waiters - 6 Weeks and Over (Local Target)	33	9.32%	6.49%	↑	1%	1%	COO		F
	Bed Occupancy Rate - KH03 (3 months in arrears)	1065	96.6%	98.0%	↓	93%	93%	COO	N/A	N/A
	Cancer									
	Cancer 2 Week Wait GP Referral to OP Appointment (1 month in arrears)	59	79.75%	78.61%	↓	93%	93%	COO		F
	Cancer 2 Week Wait Breast Symptom (1 month in arrears)	61	94.69%	97.98%	↑	93%	93%	COO		?
	Cancer 31 Day Diagnosis to Treatment (1 month in arrears)	63	96.77%	95.67%	↓	96%	96%	COO		?
	Cancer 31 Day Subsequent Surgery Standard (1 month in arrears)	67	93.88%	93.62%	↓	94%	94%	COO		?
	Cancer 31 Day Subsequent Drug Standard (1 month in arrears)	65	100.00%	100.00%	→	98%	98%	COO		P
	Cancer 31 Day Subsequent Radiotherapy Standard (1 month in arrears)	69	91.48%	94.37%	↑	94%	94%	COO		?
	Cancer 62 Day Standard plus 31 Day Rare Cancers (1 month in arrears)	73	57.48%	57.10%	↓	85%	85%	COO		F
	Cancer 62 Day Screening Standard (1 month in arrears)	75	65.52%	83.87%	↑	90%	90%	COO		F
	Cancer 62 Day Consultant Upgrades (1 month in arrears)	77	52.0%	60.0%	↑	85%	85%	COO		F

Appendix C – FPC Scorecard

Finance & Workforce Committee Scorecard

NHS University Hospitals Coventry and Warwickshire NHS Trust

Reporting Month : October 2022

DoT
Improving
No change
Falling

Target Type
National Target
Regional Target
Local Target

Finance and Workforce Scorecard										
Type	Measure	ID	Previous Position	Latest Position	DoT	Current Target	Annual Target	Executive Lead	Variation	Target Assurance
	Cancer 104+ days wait (treated) - (1 month in arrears)	860	30.5	30.5	→	0	0	COO		F
	Cancer Faster Diagnosis 2WW - Group	1421	74.05%	72.27%	↓	75%	75%	COO	N/A	N/A
	Cancer Faster Diagnosis Breast Symptomatic Referral - Group	1422	100.00%	100.00%	→	75%	75%	COO	N/A	N/A
	Cancer Faster Diagnosis Screening - Group	1423	47.83%	73.95%	↑	75%	75%	COO	N/A	N/A
	Cancer Faster Diagnosis Overall - Group	1491	72.64%	73.38%	↑	75%	75%	COO	N/A	N/A
Excellence in patient care and experience										
	Theatre Productivity									
	Theatre Efficiency - Main	423	59.8%	60.3%	↑	85%	85%	COO		F
	Theatre Efficiency - Rugby	424	68.0%	70.0%	↑	85%	85%	COO		F
	Theatre Efficiency - Day Surgery	425	55.5%	58.5%	↑	85%	85%	COO		F
	Theatre Utilisation - Main	369	78.1%	78.9%	↑	85%	85%	COO		F
	Theatre Utilisation - Rugby	370	80.7%	81.8%	↑	85%	85%	COO		F
	Theatre Utilisation - Day Surgery	371	73.1%	77.4%	↑	85%	85%	COO		F
	Surgical Safety Checklist - WHO	442	100.00%	100.00%	→	100%	100%	CMO		P
	Theatre Lists Started within 15 mins of Start Time	1319	28.8%	29.3%	↑	75%	75%	COO		F

Finance & Workforce Committee Scorecard

University Hospitals Coventry and Warwickshire NHS Trust

Reporting Month : October 2022

DoT
Improving
No change
Falling

Target Type
National Target
Regional Target
Local Target

Finance and Workforce Scorecard

Type	Measure	ID	Previous Position	Latest Position	DoT	Current Target	Annual Target	Executive Lead	Variation	Target Assurance
Deliver value for money										
	Forecast Income & Expenditure	477	£-20432k	£-20432k	→	-14802	-14802	CFO	N/A	N/A
	WRP Delivery	478	£12.360m	£10.349m	↓	14998	38788	CFO	N/A	N/A
	YTD Income & Expenditure Trust	986	£-13384k	£-14756k	↓	-9157	-14802	CFO	N/A	N/A
	Agency Expenditure	1315	£1.886m	£1.317m	↑			CPO		?
Leading research based health care organisation										
	Submitted Research Grant Applications - Quarterly - Cumulative	683	40	38	↓	76	152	CMO	N/A	N/A
	Commercial Income Invoiced - Cumulative (1 month in arrears)	684	£270k	£489k	↑	450	900	CFO	N/A	N/A
	NIHR Research Capability Funding (3 months in arrears)	1332	£302k	£302k	→	500	1000	CMO	N/A	N/A
	Trial Recruitment Income (3 months in arrears)	1344	£506k	£842k	↑	1062.5	2125	CMO	N/A	N/A
	All Grant Income (3 months in arrears)	1345	£1.730m	£736k	↓	1000	2000	CMO	N/A	N/A

Appendix C – FPC Scorecard

FPC – KPI Performance Trends

NHS University Hospitals Coventry and Warwickshire NHS Trust

Please note: Areas listed below as showing a Special Cause Improvement or Common Cause Variation may show as Failing against Target. Areas of Special Cause Concern are statistically the areas that should be the focus of attention.

Mandatory - KPIs with a National Target

Special Cause Concern

Measure	Annual Target	Target Assurance	Latest Position
Emergency Care 4 Hour Wait	95%	F	61.8%
Cancer 62 Day Standard plus 31 Day Rare Cancers (1 month in arrears)	85%	F	57.10%
Cancer 62 Day Consultant Upgrades (1 month in arrears)	85%	F	60.0%
Ambulance Handover within 30 Minutes	95%	F	71.3%
Ambulance Handover within 60 Minutes	100%	F	89.4%
18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears)	92%	F	52.7%
A&E 12hr Total Wait Time	2%	F	8.3%

Special Cause Improvement

Measure	Annual Target	Target Assurance	Latest Position

Common Cause Variation

Measure	Annual Target	Target Assurance	Latest Position
Breaches of the 28 Day Readmission Guarantee	0	F	8
Cancer 62 Day Screening Standard (1 month in arrears)	90%	F	83.87%
Ambulance Handover within 15 minutes	65%	F	22.8%

Non Mandatory (Local or Regional Targets)

Special Cause Concern

Measure	Annual Target	Target Assurance	Latest Position
Cancer 2 Week Wait GP Referral to OP Appointment (1 month in arrears)	93%	F	78.61%
Cancer 104+ days wait (treated) - (1 month in arrears)	0	F	30.5
Length of Stay Acute - Average	6.9	F	7.1

Special Cause Improvement

Measure	Annual Target	Target Assurance	Latest Position
Theatre Utilisation - Main	85%	F	78.9%
Theatre Utilisation - Day Surgery	85%	F	77.4%
Theatre Efficiency - Main	85%	F	60.3%

Common Cause Variation

Measure	Annual Target	Target Assurance	Latest Position
Theatre Utilisation - Rugby	85%	F	81.8%
Theatre Efficiency - Rugby	85%	F	70.0%
Theatre Efficiency - Day Surgery	85%	F	58.5%
Theatre Lists Started within 15 mins of Start Time	75%	F	29.3%

Integrated Finance Report | Trust Financial Position

NHS University Hospitals Coventry and Warwickshire NHS Trust

Reporting Month: October 2022

07 Months Ended 31st October 2022	YTD Budget £'000	YTD Actual £'000	YTD Variance to Budget £'000	Annual Budget £'000	Forecast Actual £'000	Forecast Variance to Budget £'000
Total Income From Patient Care Activities	462,210	463,307	1,097	791,778	798,192	6,414
Adjusted Top Up Income	2,210	2,187	(23)	3,647	3,227	(420)
Total Other Operating Income	27,387	34,575	7,188	50,452	59,347	8,895
Total Operating Income	491,807	500,069	8,262	845,877	860,766	14,889
Total Medical and Dental - Substantive	(83,396)	(81,678)	1,718	(141,836)	(136,948)	4,888
Total Agenda for Change - Substantive	(171,993)	(183,778)	(11,785)	(288,156)	(317,435)	(29,279)
Total Medical and Dental - Bank	(7,778)	(6,184)	1,594	(13,318)	(9,558)	3,760
Total Agenda for Change - Bank	(18,614)	(14,492)	4,122	(32,637)	(26,653)	5,984
Total Medical and Dental - Agency	(5,693)	(6,760)	(1,067)	(9,233)	(10,116)	(883)
Total Agenda for Change - Agency	(7,611)	(6,849)	762	(12,911)	(11,555)	1,356
Other gross staff costs	(1,035)	(709)	326	(1,775)	(1,358)	417
Total Employee Expenses	(296,120)	(300,450)	(4,330)	(499,866)	(513,623)	(13,757)
Total Operating Expenditure excluding Employee Expenditure	(162,720)	(170,475)	(7,755)	(284,693)	(293,752)	(9,059)
Total Operating Expenditure	(458,840)	(470,925)	(12,085)	(784,559)	(807,375)	(22,816)
Operating Surplus/Deficit	32,967	29,144	(3,823)	61,318	53,391	(7,927)
Total Finance Expense	(38,386)	(37,804)	582	(65,677)	(63,238)	2,439
PDC dividend expense	(3,975)	(3,975)	0	(6,814)	(6,814)	0
Movements in Investments & Liabilities	0	0	0	0	0	0
Net Finance Costs	(42,361)	(41,779)	582	(72,491)	(70,052)	2,439
Surplus/Deficit For The Period	(9,394)	(12,635)	(3,241)	(11,173)	(16,661)	(5,488)
Control Total adjustments						
Donated assets (income)	0	(2,358)	(2,358)	(4,035)	(4,177)	(142)
Donated assets (depn)	238	237	(1)	408	406	(2)
Impairments	0	0	0	0	0	0
Impact of consumables from other DHSC bodies	0	0	0	0	0	0
Control Total	(9,157)	(14,756)	(5,600)	(14,800)	(20,432)	(5,632)

Forecast Total Operating Income has increased by £8.0m from month 6. This is due to £6.1m additional contract income for winter pressures, Severe Intestinal Failure (SIF) and high cost drugs and devices. Additional income within clinical group forecasts has also increased by £1.9m due to education and research, CWPS activity and stakeholder income, and reproductive medicine.

Year to date Financial Performance:

Income from Patient Care: Activities (including Adjusted Top Up: £1.0m favourable

- Overseas Patients £0.5m
- Private patients (£0.3m); Injury Cost Recovery Scheme (£0.4m); BMI Income (£0.4m)
- Contract income additional to block contract £1.6m

Other Operating Income: £7.2m favourable:

- Donated Asset Income £2.4m
- Education & Research Income £3.5m
- Charitable funds £0.3m
- Recharges £1.0m

Expenditure: (£12.1m) adverse

- Unidentified WRP (£4.6m)
- Pass-through drugs (£2.3m)
- Education & Research (£3.2m)
- Managing Emergency Pressures (£2.1m)

Forecast Financial Performance:

Income from Patient Care Activities (including Adjusted Top Up £6.0m favourable:

- Overseas Patients £0.5m
- Private patients (£0.4m); Injury Cost Recovery Scheme (£0.7m); BMI Income (£0.7m)
- Contract income additional to block contract £7.3m

Other Operating Income: £8.9m favourable:

- Education, Training & Research £6.6m
- Charitable Funds £0.4m
- Recharges £1.9m

Expenditure: (£22.8m)

- Pass-through drugs (£4.2m); Excluded Devices (£2.1m)
- Education, Training & Research (£6.2m)
- Managing Emergency Pressures (£10.3m)

ERF Income Assumption

NHSE has indicated there will be no financial adjustments related to under-delivery against the 104% target in H1. The way ERF is to work in the second half of 2022/23 is under review by NHSE, we expect an announcement shortly.

Integrated Finance Report |Statement of Financial Position

Reporting Month: October 2022

Statement of Financial Position 7 months ended 31 October 2022	Full Year Plan (£'000)	Full Year Forecast Outturn (£'000)	Full Year Variance (£'000)	Year To Date Plan (£'000)	Year To Date Actual (£'000)	Year To Date Variance (£'000)
Non-current assets						
Property, plant and equipment	472,661	480,943	8,282	447,584	451,626	4,042
Intangible assets	16,592	13,644	(2,948)	14,448	12,817	(1,631)
Investment Property	12,080	12,080	0	12,080	12,080	0
Trade and other receivables	35,060	38,702	3,642	34,258	39,147	4,889
Total non-current assets	**536,393**	**545,369**	**8,976**	**508,370**	**515,670**	**7,300**
Current assets						
Inventories	17,183	17,360	177	16,843	17,005	162
Trade and other receivables	50,232	55,728	5,496	69,897	70,357	460
Cash and cash equivalents	19,291	19,291	0	9,426	30,255	20,829
	86,706	**92,379**	**5,673**	**96,166**	**117,617**	**21,451**
Non-current assets held for sale	0	0	0	0	0	0
Total current assets	**86,706**	**92,379**	**5,673**	**96,166**	**117,617**	**21,451**
Total assets	**623,099**	**637,748**	**14,649**	**604,536**	**633,287**	**28,751**
Current liabilities						
Trade and other payables	(78,322)	(92,249)	(13,927)	(89,949)	(117,785)	(27,836)
Borrowings PFI obligations	(2,904)	(2,904)	0	(3,423)	(4,465)	(1,042)
Borrowings leases	(5,914)	(4,450)	1,464	(5,914)	(4,450)	1,464
DH Capital loan	(899)	(898)	1	(903)	(904)	(1)
Provisions	(2,548)	(3,536)	(988)	(2,665)	(4,036)	(1,371)
Total current liabilities	**(90,587)**	**(104,037)**	**(13,450)**	**(102,854)**	**(131,640)**	**(28,786)**
Net current assets/(liabilities)	**(3,881)**	**(11,658)**	**(7,777)**	**(6,688)**	**(14,023)**	**(7,335)**
Total assets less current liabilities	**532,512**	**533,711**	**1,199**	**501,682**	**501,647**	**(35)**
Non-current liabilities:						
Trade and other payables	0	0	0	0	0	0
Borrowings PFI obligations	(222,526)	(222,526)	0	(223,252)	(222,193)	1,059
Borrowings leases	(32,898)	(38,049)	(5,151)	(31,515)	(35,781)	(4,266)
DH Capital loan	(890)	(890)	0	(1,335)	(1,335)	0
Provisions	(4,029)	(4,029)	0	(4,029)	(4,029)	0
Total assets employed	**272,169**	**268,217**	**(3,952)**	**241,551**	**238,309**	**(3,242)**
Financed by taxpayers' equity:						
Public dividend capital	249,876	251,413	1,537	229,479	229,479	0
Retained earnings	(77,644)	(83,133)	(5,489)	(75,865)	(79,107)	(3,242)
Revaluation reserve	99,937	99,937	0	87,937	87,937	0
Total Taxpayers' Equity	**272,169**	**268,217**	**(3,952)**	**241,551**	**238,309**	**(3,242)**

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.

IFRS16 accounting standard for leases was implemented in April, with a significant value of contracts previously expensed through I & E now being "capitalised", with a "right of use" lease asset being recognised within property, plant and equipment and a corresponding lease liability within borrowings. The impact is an approximate £36m of additional assets.

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

Year to Date variances

- Property plant and equipment is higher than Plan due to phasing of this year's capital programme;
- Receivables balances are higher than Plan due to additional income accruals with the local commissioner;
- Payables balances are significantly higher than Plan due to high levels of accrued pay expenditure and deferred income at month 07;
- Retained earnings reflect the year-to-date increased deficit position;
- The above variances, particularly increased payables balances, in turn are the main contributing factors to the increased cash balance month end.

Full Year variances

- Property plant and equipment balance is higher than Plan due to the additions made to the capital programme, especially around the CDH scheme;
- Receivables balances are forecast to be higher than Plan due to addition year-end accruals with the newly formed ICB;
- Payables balances are forecast to be higher than Plan in anticipation of additional expenditure accruals and capital creditor accruals reflecting the likely phasing of the capital programme towards year-end;
- Lease borrowing is greater than planned due to the addition of the Paybody lease to the CDH capital scheme;
- Additional PDC funding is required for the increased capital programme;
- Retained earnings reflect the revised forecast outturn, which is currently showing an overspend against the planned deficit position.

Workforce Information | Headlines for October 2022

University Hospitals Coventry and Warwickshire NHS Trust

This report provides a summary overview of workforce data for the month.

Agency Spend
£ 1,317,187

Headcount
10103 Headcount
8928.89 WTE
(Inclusive ISS/ROE)
Bank not included

Training
94.25%
(Substantive Employees only)

Target ≥ 95%

Vacancy Rate
6.54%
605.33 WTE

Target ≤ 10%

Medical
94.38%

Non-Medical
80.09%

Target ≥ 90%

Turnover
10.80%
(12 months rolling average this data)

Target ≤ 10%

Sickness
5.77%

Target ≤ 4%

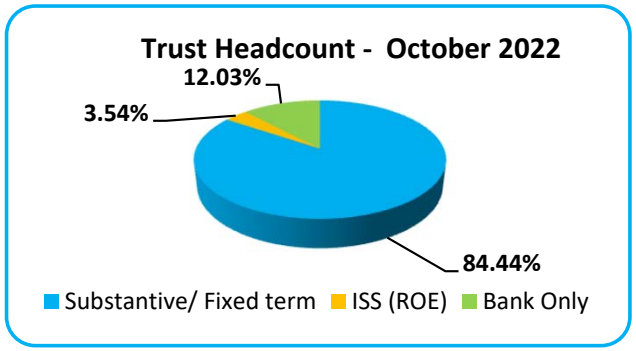
Workforce Information | October 2022

NHS University Hospitals Coventry and Warwickshire NHS Trust

Staff Headcount | Monthly Variation

The tables below shows the primary headcount and WTE for UHCW and ISS staff.

Staff Headcount Breakdown	Aug-22	Sep-22	Oct-22
Substantive/Fixed Term	9591	9620	9697
ISS (ROE)	418	407	406
Trust Total	**10009**	**10027**	**10103**
Bank Only	1241	1269	1381



Staff WTE Breakdown	Aug-22	Sep-22	Oct-22
Substantive/Fixed Term	8522.62	8542.35	8611.49
ISS (ROE)	317.40	317.40	317.40
Trust Total	**8840.02**	**8859.75**	**8928.89**

Staff in Post by Staff Group | Monthly Variation

Staff Group	Sep-22 (WTE)	Oct-22 (WTE)	Starters Oct-22 (WTE)	Leavers Oct-22 (WTE)
Add Professional	299.47	309.72	8.23	0.93
Add Clinical Services	1901.18	1904.65	68.47	16.97
Admin & Clerical	1522.83	1538.43	28.32	12.75
Allied Health Professional	523.53	531.8	11.41	5.60
Estates & Ancillary	1.00	1.00	0.00	0.00
Healthcare Scientists	381.80	385.76	7.48	2.00
Medical & Dental	1223.90	1219.52	31.54	26.70
Nursing & Midwifery	2741.59	2765.36	29.45	15.06
Students	0.00	0.00	0.00	0.00
Total	**8595.31**	**8656.03**	**184.90**	**80.01**

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.*

Starters (excluding bank staff)

There were **184.90 WTE** (**196** headcount) new starters of which **37%** (**73** headcount) were **Additional Clinical staff** with **21** Healthcare Assistants, **20** Support Workers, **9** Healthcare Science Assistants, **8** Phlebotomists, **13** Other Assistants, and **2** Technicians. **Medical staff** had **31.54** WTE (**32** headcount) **25** Specialty Registrars (rotational) , **2** Specialty doctors and **5** consultants. **Nursing and Midwifery** had **14.71** WTE (**17** Headcount) new starters including **4** Band 5 Nurses, **8** Band 6 Nurses,**2** Band 7 Nurses, **2** Midwives and **1** Pre-reg Nurse.

Leavers (excluding bank staff)

There were **80.01 WTE** (**94** headcount) leavers in October. **Medical Staff** had **26.70 WTE** (**28** Headcount) of which **15** were rotational doctors, **7** trust grade doctors, **2** specialty doctors and **4** consultants (2 of which were on fixed term contracts).
Additional Clinical staff had **16.97 WTE** (**22** Headcount).

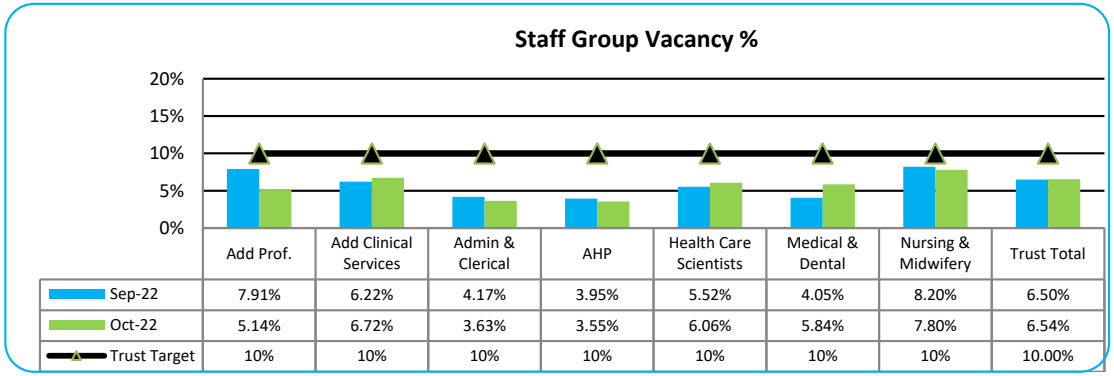
Leaving Reasons

35.80% (**35** Headcount) of staff voluntary resigned with no reason recorded,
26.25% (**22** Headcount) were on end of fixed term contracts including rotational doctors,
10.51% (**10** Headcount) cited child dependency, **10.06%** (**9** Headcount) relocated, and **7.95%** (**9** Headcount) retired.

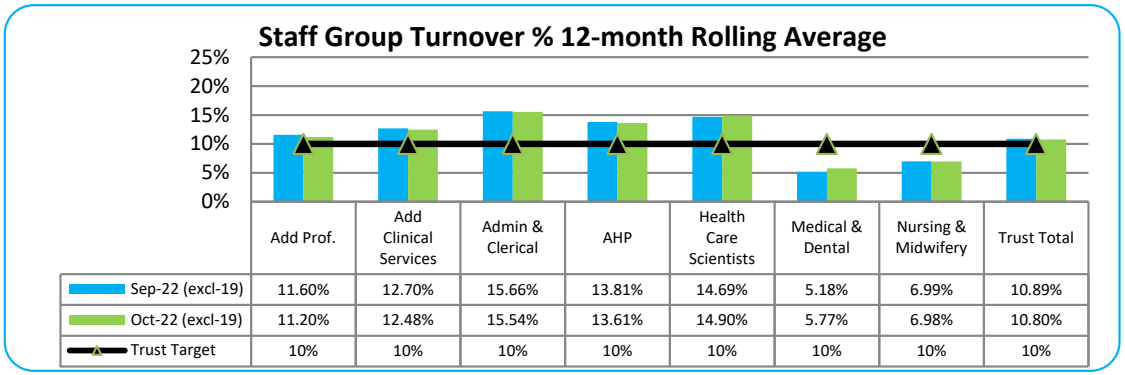
Workforce Information | October 2022

NHS University Hospitals Coventry and Warwickshire NHS Trust

Vacancy | by Staff Group



Staff Group	Sep-22			Oct-22		
	Funded (WTE)	Staff In Post (WTE)	Funded Vacancies (WTE)	Funded (WTE)	Staff In Post (WTE)	Funded Vacancies (WTE)
Add Prof Scientific and Technic	325.20	299.47	25.73	326.58	309.79	16.79
Additional Clinical Services	2027.34	1901.18	126.16	2041.84	1904.65	137.19
Administrative and Clerical	1589.10	1522.83	66.27	1596.45	1538.43	58.02
Allied Health Professionals	545.08	523.53	21.55	551.37	531.80	19.57
Healthcare Scientists	404.09	381.80	22.29	410.35	385.47	24.88
Medical and Dental	1275.54	1223.90	51.64	1295.19	1219.52	75.67
Nursing and Midwifery Registered	2986.34	2741.59	244.75	2999.42	2765.36	234.06
Estates and Ancillary	1.96	1.00	0.96	1.96	1.00	0.96
Students	38.20	0.00	38.20	38.20	0.00	38.20
Grand Total	**9,192.85**	**8,595.31**	**597.54**	**9,261.36**	**8,656.03**	**605.33**



Vacancy| by Staff Group

The Trust's overall vacancy rate has increased marginally by **0.04%** from **6.50%** in September to **6.54%** in October.

Our key recruitment campaigns are for the following staff groups:

Band 5 nurses – 140.65 WTE/9.40% vacancy rate
In addition to our local recruitment campaigns, the second programme of international recruitment has a target of 159 nurses by Dec 2022. In October, 106 nurses have arrived with a further 26 appointed but not yet in the country, leaving an additional 27 WTE to be recruited. By the end of 2022, the Trust will have recruited 440 International nurses.

Midwives–42.06 WTE/24.91% vacancy rate.
We have a recruitment pipeline of 5.4 WTE in pre-employment checks. We have confirmed start dates for 1 WTE for November 2022 and 3 WTE for January 2023.

HCSW – 93.13 WTE/9.87% vacancy rate
We have a recruitment pipeline of 9.35WTE in pre-employment checks. We have confirmed 20.55WTE for November. Our recruitment pipeline remains strong as work to achieve our 1% vacancy rate target. Our next assessment day is in early December 2022.

A&C – 58.02 WTE/3.63% vacancy rate
We are making good progress with our A&C vacancy rate with 14.46 WTE within the pre-employment stage of the recruitment pipeline. There was a high level of interest from potential candidates following our system wide A&C recruitment event in late October.

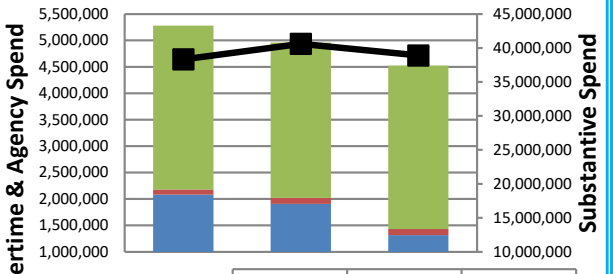
Turnover| by Staff Group

This month's turnover has decreased slightly to 10.80%. The planned focus of staff retention during 2022/23 should see this start to reduce in the future. Activities include a review of our exit interview process to enable full analysis and trend review and enhancements to our Total Reward Packages for staff.

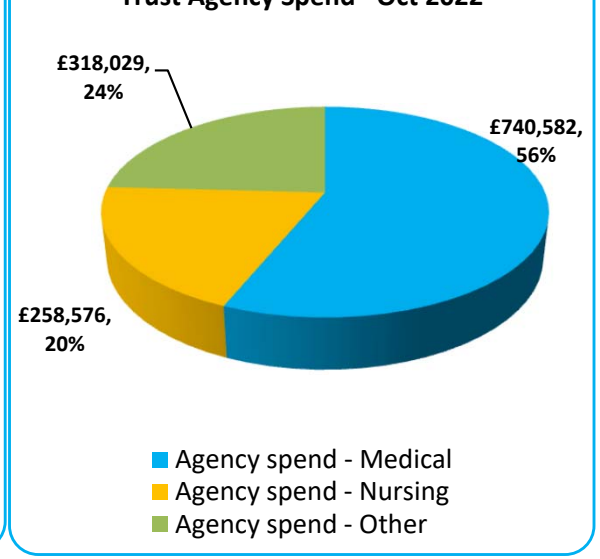
Workforce Information | October 2022

NHS University Hospitals Coventry and Warwickshire NHS Trust

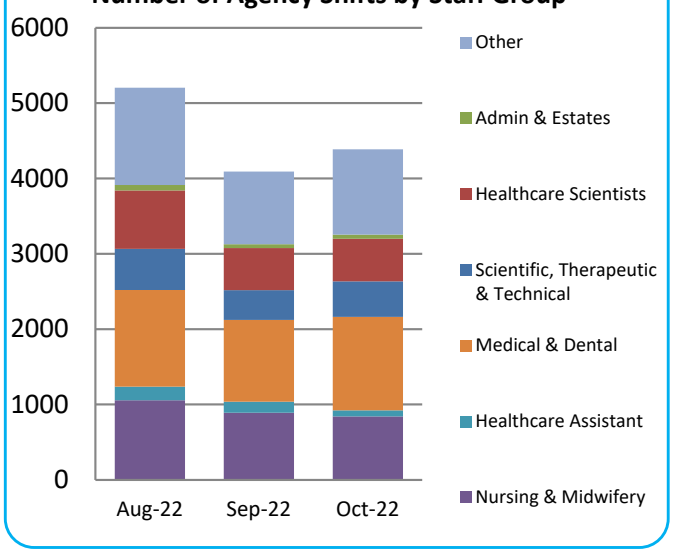
Pay Costs | Provided by Finance



	Aug-22	Sep-22	Oct-22
Bank Spend	3,099,896	2,937,728	3,094,153
Overtime Spend	96,495	115,503	112,134
Total Agency Spend	2,082,153	1,906,773	1,317,187
Substantive Spend	38,341,661	40,611,356	38,903,111



Agency | Number of Shifts Booked



Agency Shifts Booked | Reasons for Shifts Booked

The number of agency shifts booked for the month of October (4387) has slightly increased compared to last month (4091) but the overall agency spend has decreased in October as compared to last month. We have also seen a slight increase in bank spend.

Even though the Trust remains under sustained operational pressures, the management of agency spend is decreasing throughout the majority of staff groups as individual clinical groups focus on waste reduction schemes, recruitment activity and as we encourage uptake of bank shifts from our staff.

Staff Group	Aug-22	Sep-22	Oct-22
Nursing & Midwifery	1056	891	842
Healthcare Assistant	181	145	80
Medical & Dental	1283	1086	1241
Scientific, Therapeutic & Technical	545	396	471
Healthcare Scientists	775	557	566
Admin & Estates	72	52	54
Other	1293	964	1133
Total Shifts Booked	**5,205**	**4,091**	**4,387**

Workforce Information | October 2022

University Hospitals Coventry and Warwickshire NHS Trust

Absence | by Group

Overview

Trust Group	Covid-19 Absence% (FTE)	Sickness absence % excluding Covid-19 (FTE)
218 Clinical Diagnostics	0.71%	4.74%
218 Clinical Support Services	1.08%	5.06%
218 Core Services	0.50%	4.52%
218 Emergency Medicine	0.79%	5.57%
218 Medicine	0.52%	4.86%
218 Surgical Services	1.34%	4.67%
218 Trauma and Neuro Services	0.79%	5.61%
218 Women and Children	0.49%	5.48%
Grand Total	**0.77%**	**5.00%**

ABSENCE

The overall Trust sickness absence rate has increased by **0.64%** from September **5.13% to** October **5.77% .** Both Covid-19 and non Covid-19 absence levels have increased from September 2022.

Clinical groups continue to proactively manage sickness absence and all groups use monthly production boards, check and challenge meetings with People BPs and managers to ensure appropriate plans are in place. There is also the support of the People Support Group which includes health and wellbeing, engagement and equality, diversity and inclusion.

Work continues on reviewing and refining our health and wellbeing offer available to staff and our annual Flu and Covid-19 booster programme is underway.

Our key area of focus is to explore all other opportunities to support staff with the current cost of living crisis which affects health and wellbeing. Our new “Money Matters” campaign planned for December includes a food hub voucher scheme, meal cards for staff restaurants, direct access to financial advice, free sanitary products for staff and an act of kindness pay-it-forward scheme.

Group Rolling Sickness Absence Rate % (including Covid 19 sickness)	Aug-22	Sep-22	Oct-22
218 Clinical Diagnostics	4.56%	5.38%	5.45%
218 Clinical Support Services	5.55%	5.39%	6.15%
218 Core Services	3.98%	3.95%	5.02%
218 Emergency Medicine	5.45%	5.41%	5.36%
218 Medicine	4.32%	4.67%	5.38%
218 Surgical Services	4.41%	4.92%	6.01%
218 Trauma and Neuro Services	5.70%	5.79%	6.4%
218 Women and Children	6.35%	6.37%	5.97%
Trust Total %	**4.95%**	**5.13%**	**5.77%**

Absence | Reasons

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

Top Five Absence Reasons	Total WTE Days Lost	Absence %
Infectious diseases	3796.49	24.81%
Mental Health Issues	*3191.62*	20.86%
Muscoloskeletal Problems	2010.93	13.14%
Gastrointestinal problems	1250.73	8.17%
Pregnancy related disorders	933.33	6.10%
Overall All Absence Trust Totals	**15299.95**	**5.77%**

Workforce Information | October 2022

University Hospitals Coventry and Warwickshire NHS Trust

Mandatory Training | by Group

Group Mandatory Training %	Aug-22	Sep-22	Oct-22
Clinical Diagnostics	94.94%	95.17%	94.96%
Clinical Support Services	95.98%	96.13%	96.07%
Core Services	93.45%	94.44%	94.32%
Emergency Medicine	91.35%	93.20%	92.53%
Medicine	92.26%	93.57%	93.99%
Surgical Services	94.24%	94.64%	94.54%
Trauma and Neuro Services	92.37%	93.76%	93.48%
Women & Children	91.29%	91.81%	91.88%
Substantive Staff Only	93.48%	94.30%	94.25%

Mandatory Training

Overall Mandatory Training compliance for the trust remains stable at **94.25%** in October 2022.

All groups are over **91%** with one being above **95%** target.

The Learning and development team have increased their number of available clinical trainers to increase the training availability and access for all staff groups. Improvements have also been made with administration support to assist with timely system updates at the point of training.

The Trust-wide awareness campaign entitled 'Check/Book/Attend' which commenced in July 2022 highlights the importance of mandatory training compliance across the Trust in an informative, friendly and supportive way. This campaign is intended to motivate all staff to consider their own accountability to mandatory training and the role we all have to play.

Appraisals | by Group

Appraisal % by Group	Non-Medical Appraisals			Medical Appraisals		
	Aug-22	Sep-22	Oct-22	Aug-22	Sep-22	Oct-22
Clinical Diagnostics	82.67%	84.51%	83.54%	97.01%	98.53%	97.01%
Clinical Support Services	86.44%	91.07%	89.57%	94.25%	92.47%	95.79%
Core Services	74.41%	68.27%	65.16%	100.00%	100.00%	100.00%
Emergency Medicine	86.47%	79.15%	81.03%	92.59%	96.55%	97.50%
Medicine	77.00%	76.43%	73.81%	95.54%	97.58%	95.76%
Surgical Services	88.74%	89.35%	87.86%	87.61%	85.83%	91.45%
Trauma and Neuro Services	84.45%	84.83%	77.72%	92.06%	93.08%	95.45%
Women & Children	84.68%	87.82%	85.29%	93.62%	92.45%	94.55%
Trust Total	82.41%	82.26%	80.09%	91.93%	93.81%	94.38%

Non Medical Appraisals

There has been a **2.17%** decrease in compliance of non-medical appraisals across the Trust. Completion of appraisals whilst balancing operational pressures remains a challenge.

This metric will be a key focus in November's Accountability Reviews.

Medical Appraisals

Performance is good with attainment of the **90%** across all groups.

Medical appraisals is a focus and core requirement for GMC's revalidation.

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 1 DECEMBER 2022

Subject Title	Emergency Preparedness Core Standards and Annual Report
Executive Sponsor	Gaby Harris, Chief Operating Officer
Author	Luke Peachey, Emergency Planning Manager
Attachment(s)	2022 Emergency Preparedness Core Standards and Annual Report
Recommendation(s)	The Board is asked to **NOTE** that the Trust is partially compliant with the requirements of the Civil Contingencies Act 2004 and the NHS EPRR Framework as outlined in the Emergency Preparedness Annual Report 2022. This is pending validation.

EXECUTIVE SUMMARY

1. The Department of Health guidelines set out a requirement that all NHS Boards receive regular reports, at least annually on emergency planning.

2. This report outlines the activity and work of the Emergency Planning Team undertaken during the year 2021/2022.

3. The report details Trust partial compliance with the requirements of the Civil Contingencies Act (CCA) (2004) and the newly revised NHS Emergency Preparedness Response & Resilience (EPRR) Core Standards Framework (2022) following self-assessment and pending formal confirmation.

4. Each year NHSE request a submission against a set of Core Standards that provides guidance on the Emergency Planning Work Programme. The standards set out the minimum EPRR standards which NHS organisations and providers of NHS-funded care must meet.

5. In July 2022 these standards were revised and released with a self-assessment against them required by 7th September 2022.

6. Following submission of self-assessment against these standards confirm and challenge has been underway with ICB and NHSE.

7. The self-assessment has shown that UHCW is 'Partially Compliant' overall.

8. UHCW awaits confirmation of the self-assessment score and formal feedback. However in order to comply with reporting deadlines the EPRR submission has had to be issued to Trust Board unratified.

9. The submission and compliance level remain subject to a further review by NHSE and the ICB before it can be formally ratified.

10. In the event of changes to the overall compliance a summary will be provided to Trust Board.

11. An improvement plan is in place to ensure compliance with all core standards is met within the next 12 months.

12. Comprehensive plans are in place to ensure the Trust is able to respond to a range of incidents and emergencies.

13. As a Major Trauma Centre the Trust is heavily involved in local and regional planning and exercising aimed at testing the resilience and preparedness of not only UHCW NHS Trust, but partner organisations.

The work undertaken and response in 2021-22 has ensured the Trust has robust, tested plans and has trained and able staff to respond to incidents.

PREVIOUS DISCUSSIONS HELD

N/A

KEY IMPLICATIONS	
Financial	Financial arrangements to be in place to provide equipment and staff to safely respond to incident.
Patients Safety or Quality	Patient safety, and business continuity in the event of incident.
Workforce	Training of all relevant staff / communication of plans.
Operational	Appropriate preparedness and ability to respond to NHS England Emergency Preparedness, Resilience and Response Framework, 2022.

University Hospitals Coventry and Warwickshire NHS Trust

Emergency Preparedness Core Standards Return and Annual Report 2022

Report by:

Luke Peachey, Head of Emergency Planning and Operational Resilience

On behalf of

Gaby Harris, Chief Operating Officer

Contents

1.0 Introduction

The Department of Health guidelines set out a requirement that all NHS Boards receive regular reports, at least annually on emergency planning.

This report outlines the activity and work of the Emergency Planning Team undertaken during the year 2021/2022. The report details Trust self-assessed compliance with the requirements of the Civil Contingencies Act (CCA) (2004) and the newly revised NHS Emergency Preparedness Response & Resilience (EPRR) Core Standards Framework (2022), pending formal confirmation.

1.1 Civil Contingencies Act 2004

The CCA (2004) provides a framework for all emergency preparedness activities undertaken across the public sector. As part of this legislation, the Trust is classed as a Category 1 Responder along with the emergency services, local authority and other frontline NHS organisations.

As a Category 1 Response, the Trust is responsible for a number of civil protection duties. These include a requirement to:

- Assess the risk of emergencies occurring and use this to inform contingency planning
- Put in place emergency plans
- Put in place Business Continuity Management arrangements
- Put in place arrangements to warn, inform and advise the public in the event of an emergency
- Share information with other local responders to enhance co-ordination, and
- Co-operate with other local responders to enhance co-ordination and efficiency.

The work that is undertaken by the Head of Emergency Planning and Operational Resilience focuses on ensuring that the Trust, is compliant with the duties placed upon it by the (CCA) (2004), along with the associated guidelines, Emergency Preparedness, Emergency Response and Recovery and the NHS Emergency Planning Guidance.

1.2 NHS Emergency Preparedness Framework

This is a strategic national framework containing principles for health emergency planning for all NHS funded organisations including Integrated Care Boards (ICBs), GPs, Acute Trusts, primary and community funded organisations.

This Framework describes how the NHS in England should go about its duty to be properly prepared for dealing with emergencies. It provides the framework and principles for effective Emergency Preparedness, Resilience and Response (EPRR), to help all NHS-funded Organisations in England meet the requirements of the Civil Contingencies Act 2004 (CCA 2004), the NHS Act 2006, the Health and Care Act 2022 and the NHS Standard Contract.

1.3 NHS Emergency Preparedness, Resilience and Response Core Standards

The newly revised NHS England Core Standards Framework for EPRR was released in July 2022 and sets out the minimum EPRR standards which NHS organisations and providers of NHS-funded care must meet. All health organisations are being assessed against these new standards, with the self-assessment submission deadline of 7 September 2022.

The Core Standards enable agencies across the country to share a common purpose and to co-ordinate EPRR activities in proportion to the organisations size and scope. The also provide a consistent cohesive framework for self-assessment, peer review and assurance processes. The EPRR assurance process uses the NHS England Core Standards for EPRR. Due to the changes in the NHS Core Standards for EPRR it will not be possible to directly compare year on year compliance scores, and with new standards added and amended it is anticipated that there will be reduced compliance in some areas.

The deep dive focuses this year on evacuation and shelter arrangements. The outcome of the deep dive process is used to identify areas of good practice and further development for future guidance from national teams. It should also guide individual organisations in the further

development of their shelter and evacuation arrangements. The deep dive questions do not count towards the Trust's overall core standards compliance rating.

Following submission of self-assessment against the core standards there has been a period of confirm and challenge from the ICB and NHSE. This has concluded with an unconfirmed position that the Trust is partially compliant with the standards. Of the 64 applicable standards assessed, the Trust has self-assessed as fully compliant with 50 and partially compliant with 14. Of the 13 deep dive questions, 6 are considered to be fully compliant, and 7 to be partially compliant. As a result, the Trust has self-assessed and categorised itself as Partially Compliant as it is 77-88% compliant with the core standards.

Details of partially compliant core standards are detailed below.

Overall assessment:	Partially compliant

Areas Partially complaint are as follows:

Core Standards	Action	Owner	Deadline
5. EPRR Resource	Business case in development for approval	Head of Emergency Planning	Feb 23
6. Continuous Improvement	Amendment to EPRR Policy required	Head of Emergency Planning	Sept 23
9. Collaborative planning	EPRR portfolio to feature as standard agenda item in new governance structure meetings within operations	Deputy COO	Jan 23
16. Evacuation and Shelter	Revise Evacuation and Shelter SOP	Head of Emergency Planning	May 23
17. Lockdown	Revise Lockdown SOP	Head of Emergency Planning	Sept 23

Core Standards	Action	Owner	Deadline
19. Excess fatalities	Mortuary Team to adopt document control procedures	Clinical Diagnostics Group triumvirate	Jan 23
28. Management of business continuity incidents	Develop process to ensure learning and policy amendment following BCP incident	Head of Emergency Planning	Feb 23
33. Warning and informing	Communication Team to ensure documents have version control	Director of Communications	Feb 23
34. Incident communication plan	Review and revise Handbook for Communication Team	Head of Emergency Planning / Groups	March 23
39. Mutual Aid arrangements	Review and amend incident response plans	Head of Emergency Planning	March 23
47. Business Continuity Plans	Review all BCPs and ensure up to date and fit for purpose	Head of Emergency Planning / Groups	April 23
50. BCMS monitoring and evaluation	Revise process for BCP audits and ensure documented review, learning and actions.	Head of Emergency Planning	April 23
51. Business Continuity Audit	Undertake audit and ratification of groups/services BCPs	Head of Emergency Planning	Aug 23
52. BCMS continuous improvement process	Develop a programme to audit BCPs and revise process for learning from incidents, ensuring appropriate governance and oversight	Head of Emergency Planning	May 23

Deep Dive	Action		
1. Up to date plans	Review and revise Evacuation and Shelter SOP	Head of Emergency Planning	May 23

Deep Dive	Action		
6. Patient transportation	Draft plan in place to transport patients to another hospital or site requires regional and WMAS agreement	Head of Emergency Planning / Region	Sept 23
8. Patient receiving	SOP for the receiving of patients and staff following the evacuation from another organisation, to be updated	Head of Emergency Planning	Sept 23
9. Community evacuation	SOP to support partners in a community evacuation to be updated	Head of Emergency Planning	Sept 23
10. Partnership working	SOP to support partner organisations during incidents requiring their evacuation to be updated	Head of Emergency Planning	Sept 23
12.Equality and Health inequalities	Patient vulnerability risk score to be reviewed to demonstrate evidence that all equality and heath inequalities have been considered, including BME.	Head of Emergency Planning	Sept 23
13. Exercising	Undertake evacuation exercise	Head of Emergency Planning	June 23

For each core standard and deep dive scored partially compliant, an action plan has been created to meet compliance within the next 12 months.

UHCW is awaiting confirmation of agreed positions for the final agreed results. However, in order to remain compliant with tight reporting arrangements submission to Trust Board is required before 30 December 2022 when NHSE will submit regional assurance ratings to the National team.

It should be noted that the submission and compliance level remain subject to a further review by NHSE and the ICB before it can be formally ratified. In the event of changes to the overall compliance a summary will be provided to Trust Board.

2.0 Emergency Planning Overview

2.1 Accountabilities

The Chief Executive has overall responsibility and accountability for ensuring the organisation has tried and tested processes to manage the response to any major incident.

The Chief Operating Officer is the Executive Director Lead [*Accountable Emergency Officer - AEO*] for Emergency Planning within the Trust with responsibility for setting the strategic direction.

The requirements under the Framework previously required a nominated Non-Executive board member, however this requirement has since been removed in light of national review of NED Champions. EPRR sits with the whole board and all NEDs should assure themselves that requirements are being met via the appointed AEO.

The Head of Emergency Planning and Operational Resilience is the Trust Lead for Emergency Planning providing the day-to-day operational input into emergency planning.

The Trust Clinical Lead for Emergency Planning is undertaken by an Emergency Medicine Consultant. This role provides a clinical perspective on all emergency planning activities.

2.2 Resources

2.2.1 Staffing

The staffing resource for the Emergency Planning Unit is currently 1 WTE Band 8b in the form of the Trust Head of Emergency Planning and Operational Resilience, and 1 Part time (0.8) Personal Assistant of which responsibilities are split with the wider Operational Management Team.

A business case is in development for the Emergency Planning Unit to obtain funding to recruit a substantive EPRR Professional and an EPRR Support Officer. It is proposed that this will enhance arrangements to ensure that the organisation is better prepared and establishes a robust, resilient

service providing full coverage to all sites, managing business as usual as well as incidents when they occur.

2.2.2 Equipment

The Head of Emergency Planning and Operational Resilience manages, on behalf of the Trust, a range of equipment which includes decontamination equipment for patients who are contaminated by chemical, biological, radiological or nuclear material, the Mass Casualty Stock, and the Trust Radio equipment.

The Head of Emergency Planning and Operational Resilience ensures that the Major Incident Control Room is prepared for use and is able to function appropriately as a control centre.

2.2.3 MTPAS – Mobile Telephone Privileged Access Scheme

To ensure that there are resilient communications within the Trust, there is access to a number of mobile telephones that are registered with the Mobile Telephone Privileged Access Scheme. These details can be obtained from the Head of Emergency Planning upon request.

2.2.4 Decontamination Equipment

The Trust has 34 operational decontamination suits (Powered Respirator Protective Suits – PRPS) out of 24 of the required number to be held. The suits are stored within the Emergency Department that were procured by NHSE but are maintained by UHCW under an annual service programme. 6 of the suits are coming to the end of their life cycle in 2023, and a further 4 in 2027. All Trusts are required to have finance in place to revalidate (extend) or replace suits that are reaching their expiration date as these will no longer be funded by NHSE. 12 of the operational suits will expire in 2028, 5 in 2029, and 7 in 2031, all of which will require replacing before the expiry date in order to maintain the minimum 24 required operational suits. A capital proforma is being created with corporate finance team to ensure costing is captured for 2027/28.

The Trust also has a two-lane articulating frame decontamination tent which is light weight and easy to erect. This tent is also equipped with a conveyor to deal with non-ambulatory patients. The

tent is inspected on an annual preventative maintenance contract to ensure it is in good working order by an external company.

2.3 Emergency Planning Steering Committee

The Emergency Planning Steering Committee is a multi-disciplinary group established to monitor and guide the work of the Emergency Planning work stream. This group reviews the work of the Head of Emergency Planning and provides opportunity to influence ongoing planning within the Trust.

During 2021/22 the committee met on:

- 21 July 2021
- 10 December 2021
- 11 July 2022

The next scheduled meeting is planned for 30 November 2022

The committee reports directly to the Risk Committee via the Head of Emergency Planning on a quarterly basis which feeds the Quality Standards Committee and Trust Board.

2.4 Multi-Agency Forums

The Trust is usually represented on various multi-agency forums, working with partners across the health economy and the region to ensure plans and responses to incidents are integrated. Due to COVID-19 these meetings were temporarily suspended but have since been reconvened. These include:

- Local Health Resilience Partnerships in both West Midlands and Warwickshire
- Coventry and Warwickshire Emergency Planning Action Group
- Town and County Council Emergency Planning and Safety Advisory Groups
- Coventry Resilience Forum.

2.5 Risk Register

The Emergency Planning Risk Register is maintained by the Head of Emergency Planning and Operational Resilience with an update to the Risk Committee on a quarterly basis.

3.0 Major Incident and Business Continuity Planning

The Trust must be able to respond to Critical and Major Incidents, as one of its core capabilities and responsibilities. These incidents may be from either an external or internal stimuli, the end result being the same, essential services must continue. This can be achieved through an effective Major Incident Plan, and Business Continuity Plan which are in place.

3.1 Business Continuity Plan

The review of the Business Continuity Management System is one of the main priorities of the Head of Emergency Planning and Operational Resilience to ensure continuity in the delivery of core services through an incident or business interruption at each group level. This ensures the Trust is aligned to best practice and the requirements of the NHS EPRR Core Standards.

The Trust corporate Business Continuity Plan remains in place and currently under review capturing the recent changes to the EPRR Framework.

3.2 Major Incident Plan

The Trust Major Incident Plan remains in place and current.

3.3 Incident Declarations

During the last twelve month period, there have been no activations of the Major Incident Plan however the Head of Emergency Planning and Operational Resilience, and Operational Team have supported in a number of business continuity incidents to minimise the impact to the organisation as listed below.

3.3.1 Critical Incidents

Nil

3.3.2 Business Continuity Incidents

Incidents have included the following:

- Leaks caused by Girpi Pipe work failure
- ICT system failures
- Bleep and telephony System failures
- Adverse weather notifications
- Supply chain disruptions

3.3.3 On Call Manager and Executive Training

All on Call Managers and Executives are required to have undertaken Incident Management Training in order fulfil the requirements of the role under the National Occupation Standards for on call commanders. Internal training has been provided to all staff on a 3 yearly basis on the management of incidents at UHCW. 100% of on call staff have completed the internal training within the last 3 years. In addition to this regional training was also provided by Coventry and Warwickshire emergency planners in an open forum with all health economy partners enabling multi-partner training in testing incident management knowledge. NHSE have taken responsibility for all regional training moving forwarded and this previous course has been replaced with Principles of Health Command, with an expectation that all on call staff will complete within the next 12 months and maintain competency every 3 years.

3.3.4 Internal –Major Incident and Business Continuity Training

The training for the Emergency Department Nursing staff continues being delivered successfully by the appointed Emergency Department link nurses. This specific training focuses on the Major Incident Plan and the associated Standard Operating Procedures to cover specific threats the Emergency Department is likely to encounter. Training compliance with nursing staff in the ED

continues to be a challenge due to operational pressure, vacancies and sickness. As of September 2022, compliance remains at 73%, however strategies ae in place to improve this position to 95% compliant by the end of 2022.

Training for Emergency Medicine Consultants, and Registrars continues to be delivered by the Head of Emergency Planning and Operational Resilience, and the Clinical Lead for EPRR.

Major Incident and Business Continuity Training has also been extended to junior doctors during 2022 to raise awareness.

3.3.5 Loggist Training

The Loggist role is essential in the response to any Critical or Major Incident to capture decisions and actions made by the Incident Management Team. The Head of Emergency Planning and Operational Resilience is able to deliver Loggist training within the Trust which is accredited with UK Health Security Agency (UKHSA). Administrative staff from around the trust continue to be invited to attend one of the many Loggist course dates scheduled throughout the year.

3.4 Exercises

The CCA requires Category 1 responders to include provision for carrying out exercises and for the training of staff in emergency plans. As a minimum requirement, NHS organisations are required to undertake a minimum of a ‘live’ exercise every three years, a ‘tabletop’ exercise every year, and a communication cascade every six months. As UHCW was involved in the response to the COVID-19 pandemic requiring the Incident Command Centre to be opened UHCW is exempt from a live play exercise which should take place every three years based on regulations as outlined in the CCA (2004).

Limited activity has taken place with offsite multiagency exercises compared to pre pandemic, however UHCW participated in a command post exercise to prepare for the Commonwealth Games hosted by NHSE titled ‘Exercise OVERLORD II’ on 26 April 2022. The exercise tested the

regional health economy response should a major incident occur during the games. A number of lessons were identified which have featured in this year's EPRR work plan.

A number of other internal exercises/drills continued to run as summarised below:

3.4.1 Internal - Communications

Two communication exercises for the Trust throughout 2022 have tested Pharmacy group and On Call Executives, and Managers through the use of the automated telephone call out system – Rapid Reach with success.

3.4.2 Internal Exercise Switchboard switchover 'monthly occurrence'

The purpose of this regular exercise is to ensure if the main switchboard in the FM Building failed or required evacuation, and or the main bleep system failed the staff were able to deliver a service from the Fall-back Switchboard based in the Clinical Science Building. This exercise continues to be delivered on a monthly basis testing all equipment and keeping staff familiar with their role, responsibilities, and processes should this be required.

3.4.3 Internal Exercise Lockdown

The purpose of this regular exercise is to ensure ISS Security can quickly respond safely, and effectively locking down the hospital site whatever the need may be. A full lockdown is the process of preventing entry to and exit from the entire site and or building. This exercise continues to be delivered on a regular basis testing all security teams and keeping staff familiar with their role and responsibilities.

4.0 Summary

UHCW continues to deliver against the requirements of the CCA (2004) and the NHS EPRR Framework. Whilst is it noted that compliance against the Core Standards has been self assessed as 'partially compliant' this is reflective of revised standards and is an opportunity for ongoing improvement. Rectification plans are in place. Compliance level remains subject to a further review by NHSE and the ICB before it can be formally ratified.

Comprehensive plans are in place to ensure the Trust is able to respond to a range of incidents and emergencies. Working both internally and externally with partner organisations, the Trust has tested these plans in the response to the COVID-19 pandemic and will continue to embed learning into future plan revisions/developments along with disseminating training to staff involved in the management of incidents.

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 1 DECEMBER 2022

Subject Title	Update on Next Steps for Elective Care
Executive Sponsor	Gaby Harris, Chief Operating Officer
Author	Alex Monahan, Deputy Chief Operating Officer – Elective and Cancer Care John Elliot, Head of Cancer Services
Attachment(s)	Next Steps on Elective Care Self Certification Update Paper Cancer Care Self Certification Update Paper Tier 1 and Tier 2 Letter and Self Certification Document
Recommendation(s)	The Board is asked to **APPROVE** the Update on Next Steps for Elective Care

EXECUTIVE SUMMARY

The two papers enclosed outline the Trust Elective and Cancer performance and the ongoing improvement work taking place in response to the Next Steps on Elective Care Self Certification letter received from NHS England on the 25 October 2022, the letter was for Tier 1 and Tier 2 providers of which UHCW is currently a Tier 2 provider.

The Elective paper outlines the current elective position for 78wks and 52wks RTT along with the Theatre productivity and the Outpatient productivity and transformation programme updates. Both productivity and efficiency programmes have been launched with workstreams in place for a number of metrics and the programme Boards are in place to monitor and support progress.

The Cancer paper outlines current cancer performance for the key metrics with a focus on 31 Day and 62 Day, 104 days and details the progress made against key objectives highlighted in the Tier 2 letter, namely, Lower GI FIT Testing, Prostate mpMRI and Tele dermatology. All tumour sites have recovery action plans in place and are being monitored weekly in both Deputy Chief Operating Officer recovery meetings and Senior Cancer Huddle with Group Directors of Operations.

PREVIOUS DISCUSSIONS HELD

Discussions held at COG 22/11/22 and FPC 24/11/22

KEY IMPLICATIONS	
Financial	No financial implications highlighted via the papers

Patients Safety or Quality	Improved waiting times for our patients would mean more timely treatments.
Workforce	No workforce implications highlighted via the papers.
Operational	There is an impact to operational teams as close management of waiting lists and performance against metrics is monitored through weekly meetings with DCOO.

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

REPORT TO PUBLIC TRUST BOARD

Next Steps on Elective Care Self Certification Update

1. INTRODUCTION

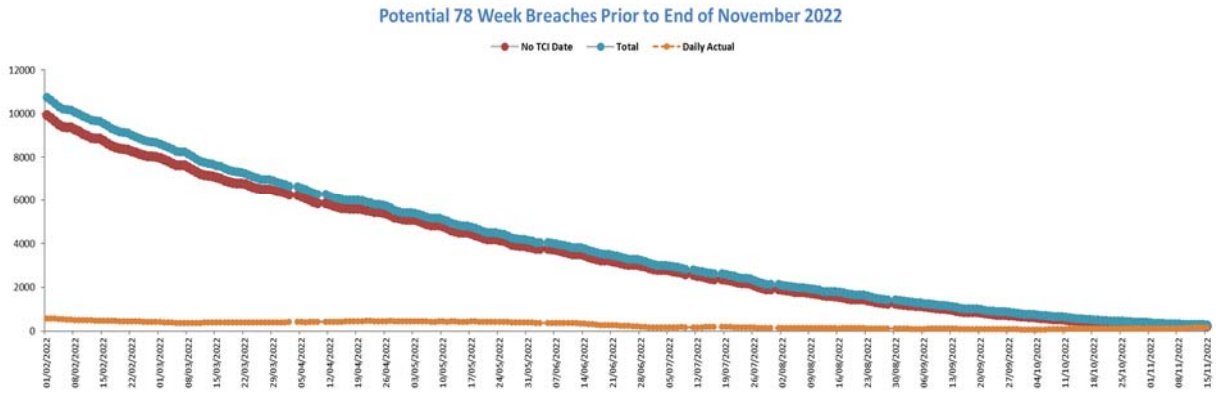
1.1 On the 25 October 2022 the Trust, UHCW, received a letter from NHS England outlining the next steps on elective care. The Trust received this letter as a current Tier 2 provider and as part of the letter an Elective Recovery Self Certification was requested to be signed by the Chair and CEO to confirm the Board has assurance on actions being taken.

1.2 This paper will outline the current Elective position and steps to improve in line with the letter and self-certification requirement from NHS England. A separate paper is provided that details the Cancer position and next steps.

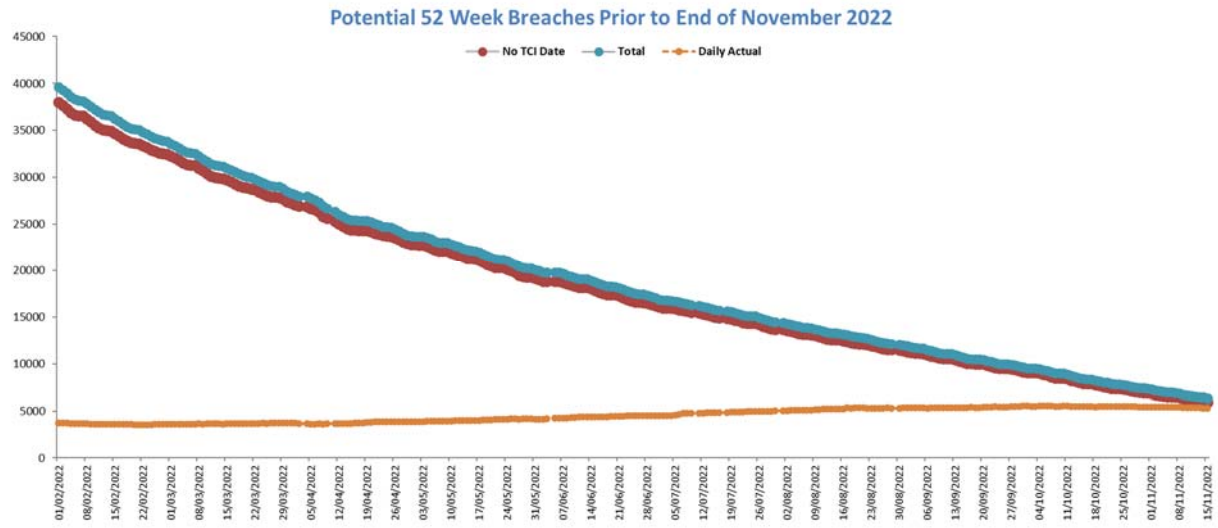
2. ELECTIVE CARE

2.1 The Trust continues to work hard to transform Elective Care and is focussed on reducing the number of patients on waiting lists, specifically 78 and 52 weeks. We continue to maintain our 1 August 2022 position of zero patients waiting over 104 weeks.

2.2 The National target is to reduce the maximum wait for elective treatment to 78 weeks by 31 March 2023. The following chart shows the number of patients the Trust has on its waiting list that will breach 78 weeks wait as of 30 November 2022. This stood at 8,384 patients on 01 February 2022 that would breach the 78 weeks wait by the end of October 2022, the Trust is working hard to reduce waiting lists and the number of weeks patients have to wait for care. Without further intervention the Trust currently has 248 patients that would breach 78 weeks by 30 November 2022.



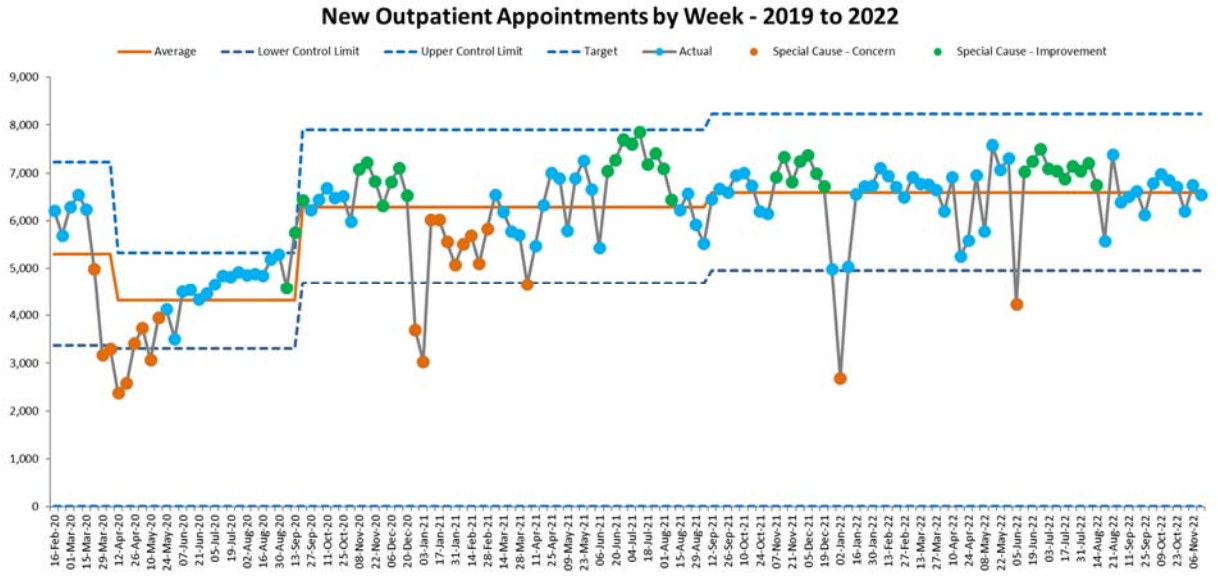
2.3 The following chart shows the number of patients the Trust has on its waiting list that will breach 52 weeks wait as of 30 November 2022. This stood at 31,862 patients on 1 February 2022 that would breach the 52 weeks wait by 31 October 2022, the Trust has made significant progress for the patients within this cohort. Whilst the clinical groups focus on the 78 week metric, there is also focus on those patient between 52 weeks and 78 weeks and the 'tip overs' from under 52 weeks to over 52 weeks.



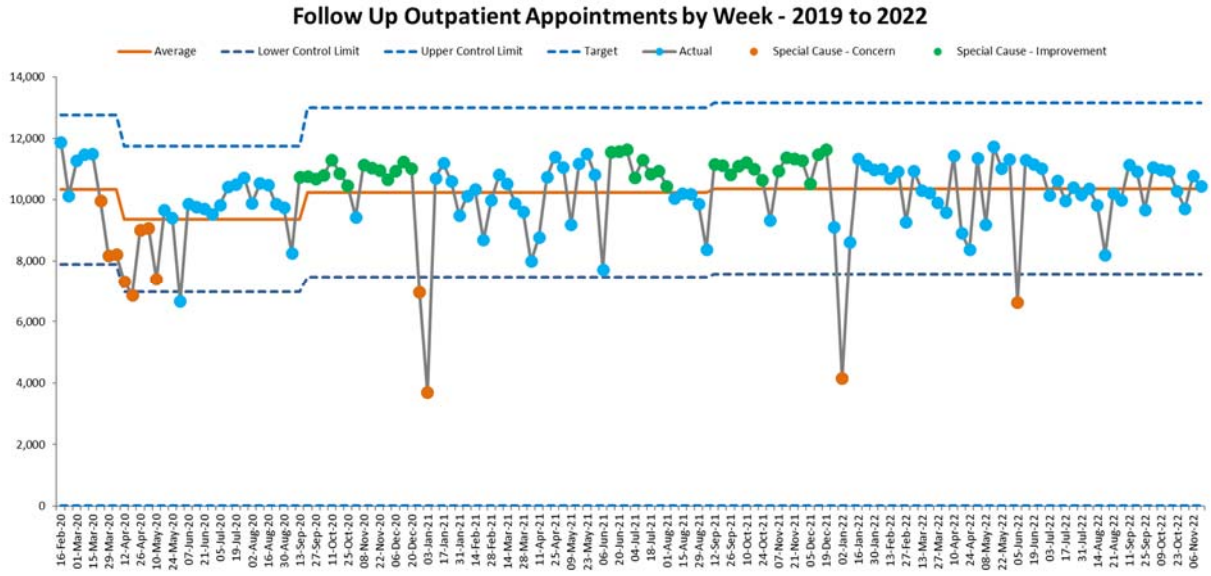
2.4 The Trust continues to focus on key Elective metrics and there are a number of workstreams in place to drive performance and deliver patient care, including micromanagement of Theatre lists to ensure that capacity is maximised, a weekly Theatre Planning meeting to ensure effective utilisation, as well as weekly Waiting List and Cancer Access meetings.

2.5 The Deputy Chief Operating Officer for Elective and Cancer Care has also introduced, from November, Elective and Cancer recovery meetings. This meeting is held with each group weekly to go through their Elective and Cancer activity, performance, recovery plans and in-week actions. This meeting will also support the Groups to focus on delivery of ERF/ODP activity targets and the productivity targets agreed through the Theatres and Outpatient PEP. With a "Confirm and Challenge" approach the DCOO will support the Groups to meet targets, unblock issues and escalate or resolve risks.

2.6 The following chart shows the performance and trajectory of new Outpatient appointments. As of week ending 13 November 2022 the Trust had 6,544 new appointments which is within the upper/lower control limits and only just below the average and is therefore no cause for concern.



2.7 The following chart shows the performance and trajectory of follow up Outpatient appointments. As of week ending 13 November 2022 the Trust had 10,441 follow up appointments which is again within the upper/lower control limits and only just below the average and is therefore and no cause for concern.



2.8 An area of focus for the Groups is the 26 weeks wait outpatient target that has been set for all patients waiting on a non-admitted outpatient waiting list to have their first appointment within 26 weeks. Teams have been working on this since the beginning of September 2022, where we had around 19,000 patients waiting over 26 weeks for an appointment, this has now reduced to around 11,000 with teams still focussed on improving month on month.

2.9 Validation and the clinical review of patients on a non-admitted waiting lists (outpatient PTLs) is a key function that must be undertaken routinely which ensures clean visible waiting lists and is used to measure appropriate use of outpatient capacity. As part of the Next Steps letter from NHS England there was a requirement for each Trust to meet three deadlines by the end of April 2023 in terms of validation of the waiting lists.

All three deadlines are for any patients, who have not been validated and who haven't been contacted in the previous 12 weeks to be contacted. The deadlines are all over 52 weeks (as of 31 March 2023) by 23 December, all over 26 weeks (as of 31 March 2023) by 23 February and all over 12 weeks (as at 20 April 2023) by 28 April 2023.

All Clinical Groups with non-admitted RTT waiting lists have been asked to review against the deadlines and to feed back on the December target by 21 November 2022.

3. THEATRE PRODUCTIVITY

3.1 The Theatre Productivity and Efficiency Programme (PEP) was launched in August 2022 with several workstreams in place covering areas of waste reduction such as: Late Starts and On the day cancellations. New metrics have been agreed by the Chief Operating Officer and the Deputy Chief Operating Officer which focusses on: Booked and Actual Utilisation, Turnaround Times, Late Starts, Cancellations and Closure Rates.

The metrics for each of these workstreams focusses on reducing waste and improving the utilisation of the available theatre capacity in the most efficient way. Metrics for utilisation are supported by national benchmarking and targets and utilising data and recommendations from Model Hospital and the GIRFT High Volume Low Complexity programme.

3.2 The Theatre PEP has a fortnightly board meeting attended by clinical group representation, including the Clinical Directors, and the workstream leads with support from the PMO and

Deloitte. The Senior Responsible Officer (SRO) for Theatre Productivity is Alex Monahan, Deputy Chief Operating Officer – Elective and Cancer Care. With Dr Clare Ingram, Clinical Director for CSS, as Clinical SRO.

3.3 With the upcoming Theatre Lifecycle works, we are using this as an opportunity to ensure we are maximising those specialties and procedures that can be done at Rugby St Cross and our Ground Floor Day Case theatres as well as the usage of Treatment Rooms both at UH and Rugby, but also at our City of Coventry locations. This will also give us the opportunity to review specialities against the British Association of Day Surgery (BADS) recommendations and metrics with a view to improve.

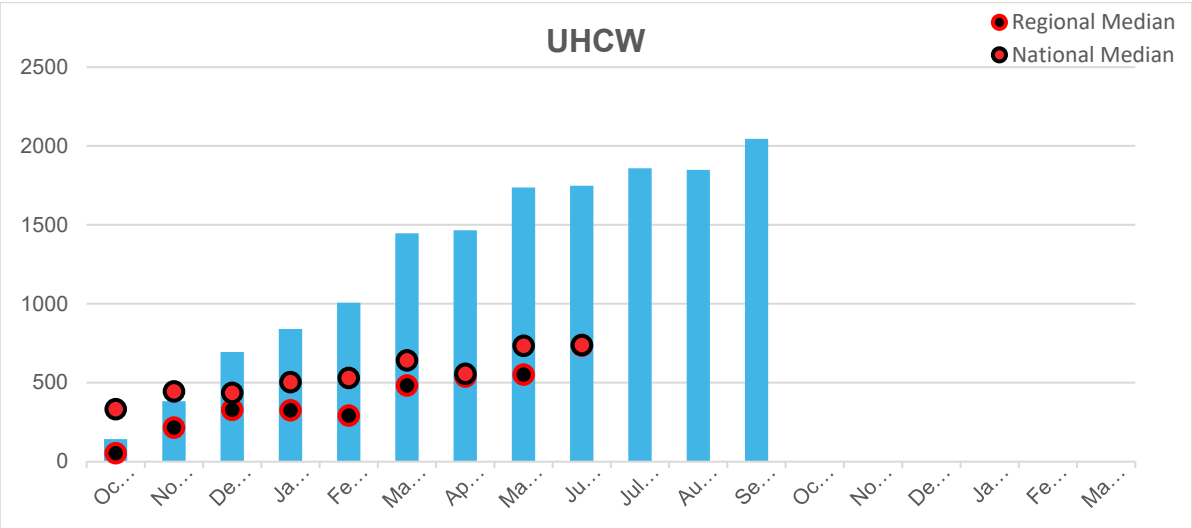
3.4 The Utilisation workstream will also focus on the scheduling and booking processes of lists and the further embedment of 642. Actions from this workstream will focus on improving the booking horizon for our theatre sessions and ensuring patients are given sufficient notice of a date for surgery.

4. OUTPATIENT TRANSFORMATION

The Outpatient Productivity and Efficiency Programme (PEP) was launched in 2022. As with Theatres, metrics have been agreed by the Chief Operating Officer and the Deputy Chief Operating Officer which focusses on: Booked and Actual Utilisation and DNAs. Due to the cross-working and impact from strategic outpatient transformation the Outpatient PEP Board has been joined with the Outpatient Transformation Board to create the Outpatient Transformation and Productivity Board, which is co-chaired by Alex Monahan and Kara Marshall, Director of Corporate Delivery. The new combined board launched in November 2022.

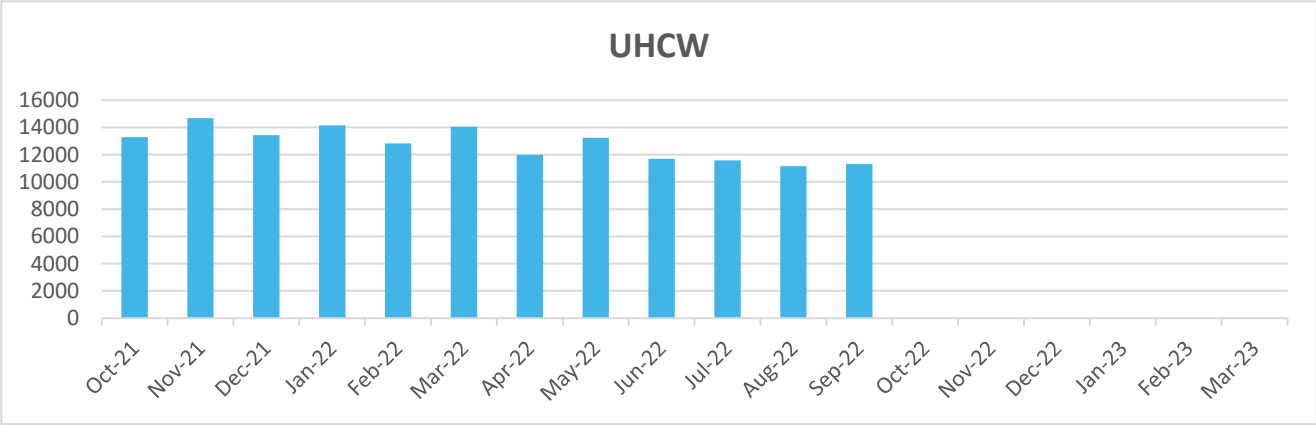
This combined approach will link the strategic work around patient initiated follow up (PIFU), Virtual and Advice and Guidance with the productivity work around utilisation and DNAs. This approach lends itself to outlining the benefits across all these workstreams to the clinical groups e.g. if you move patients to virtual and PIFU it releases physical capacity to increase new outpatient appointments, and clinics can be managed more effectively thus improving utilisation.

4.1 As part of the strategic work we continue to expand Patient Initiated Follow-Ups (PIFU) across the Trust, we are currently exceeding the National average with 32 specialties utilisation PIFU pathways at UHCW. We have seen a month on month increase in patients moved or discharged to PIFU and we remain the top performing Trust in the system. The below graph shows our position to September 2022.



4.2 Through the Outpatient Transformation and Productivity Board data is being sought to enable targets to be given to the groups by speciality for Virtual, PIFU and Advice and Guidance. This is to provide them with a tangible number rather than the overall percentages to have them focussed on working towards something and for the OTP Board to monitor.

4.3 We continue to support a personalised approach for outpatients with the move of appointments being delivered via telephone or video as a virtual clinic appointment. We have seen a reduction in appointments being delivered virtually with the September 2022 position being only 16% against the target of 25% as can be seen in the graph below. Clinical teams have expressed a clinical need to see patients waiting for a longer period of time to require a face-to-face appointment at this time but through the OTP board we will continue to support specialities to move back to a virtual first approach where appropriate.



4.4 Nationally Tier 1 providers were asked to take part in Super September, a focussed month on outpatients. Tier 2 providers were recommended to take part and UHCW decided on Outpatient October. This was a month-long event with a focus on Healthy Lifestyles to continue to develop the approach to population health management, prevent ill health and address health inequalities with the aim of improving the uptake of lifestyle services with a particularly important focus on healthy eating, weight management, smoking cessation, and alcohol prevention to support patients get 'fit' for surgery.

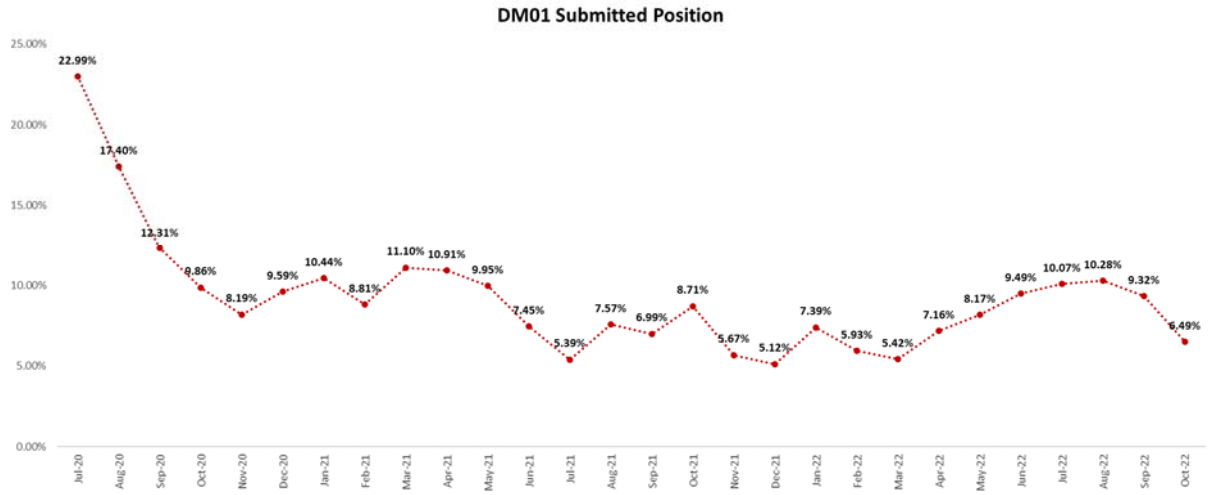
During this month the Groups focussed on ensuring increased booked and actual utilisation of clinic capacity. We saw an increase in the booked utilisation of our clinics across the hospital of 84.3% which is the highest it has been since May 2022, we also saw an actual utilisation 73.4% which is a maintained position over the last three months. We also saw the DNA rate remain static at around 12% for the Trust overall.

5. DIAGNOSTICS

5.1 The Trust reported an October 2022 month end performance of 6.49%. This was a decrease of 3.79% from Sept-2022 when 10.28% was reported, which was the highest it had been since April 2021.

5.2 Audiology and Cardiology Echo are the Trust's focus areas to improve this position. Both areas are showing improvements in performance from September to October, however further work is required to improve the position further.

5.3 In line with the letter from NHSE, the Diagnostics Group are reviewing current utilisation against the optimal standards set by NHS England.



6. CONCLUSION

6.1 UHCW has provisional information that we will be taken off Tier 2, however the focus on Elective and Cancer care remains a priority. We are committed to and have formalised Governance to regularly review and deliver transformational Elective and Cancer Activity.

6.2 UHCWs focus continues to minimise long waits patients on all pathways and to embed and evolve pathway developments such as Virtual and PIFU.

6.3 UHCWs focus continues to improve Theatre productivity and efficiency and increase utilisation of capacity.

6.4 The Trust will continue to ensure that patients are cared for in clinical priority and within Infection Prevention Guidelines.

Author Name: Alex Monahan
Author Role: Deputy Chief Operating Officer – Elective and Cancer Care
Date report written: 15 November 2022

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

REPORT TO PUBLIC TRUST BOARD

Next Steps on Elective Care Self Certification – Cancer Update

Introduction

On the 25 October 2022 the Trust, UHCW, received a letter from NHS England outlining the next steps on elective care. The Trust received this letter as a current Tier 2 provider and as part of the letter an Elective Recovery Self Certification was requested to be signed by the Chair and CEO to confirm the Board has assurance on actions being taken.

This paper will outline the current Cancer position and steps to improve in line with the letter and self-certification requirement from NHS England. A separate paper is provided that details the Elective position and next steps.

The Trust continues to prioritise delivery of Cancer care. Performance against the national cancer waiting times standard remains extremely challenged due to a combination of factors; increase in overall referral volumes, sustained recovery of activity to pre-pandemic levels and workforce to meet service demand.

Alongside the performance measures set out in the National Cancer Waiting Times Standard, the Trust is working toward reducing the number of patients on a cancer pathway awaiting treatment, beyond 62 day standard; referred to as '62 day backlog'. The Trust remains on a national NHS England escalation level 'Tier 2' with respect to the number of patients at day 62 or greater as a proportion of the overall cancer waiting list. This report describes the actions taken to reduce or mitigate this position.

The Trust reported Cancer performance for September 2022 and year to date is provided below.

September 2022, Year to date (April-September 2022)

Standard:	Sep-22	2022/23 YTD	DoH Tolerance
TWW suspected cancer	78.6%	77.8%	**93%**
TWW breast symptomatic	98.0%	87.4%	**93%**
31 day - 1st treatment	95.7%	96.0%	**96%**
31 day - subsequent treatment -chemo	100.0%	99.7%	**98%**
31 day - subsequent treatment -surgery	93.6%	95.7%	**94%**
31 day - subsequent treatment - radio	94.4%	92.3%	**94%**
31 day - rare cancers	100.0%	80.0%	No tolerance set
62 day - 1st treatment	57.1%	59.2%	**85%**
62 day – national screening programme	83.9%	76.1%	**90%**
62 day - consultant upgrade	60.0%	65.6%	CCG tolerance = 85%

62 day - treated after day 104	30.5	139.5	0
Faster diagnosis: TWW	72.1%	73.1%	**75%**
Faster diagnosis: Breast symptomatic	100.0%	97.1%	**75%**
Faster diagnosis: Screening	73.9%	52.9%	**75%**
Faster Diagnosis: ALL	73.3%	72.4%	**75%**

The 62 Day standard was not met for September 2022 (57.1%). The breakdown of performance and reasons is provided as:

September-22	**62 day Performance**	**Contributing Factors**
Lung	22.2%	Increase in referral volumes associated with Targeted Lung Health Check programme
Gynaecology	47.1%	Capacity in outpatients for first appointment and diagnostic delay
Head & Neck	9.5%	Capacity in outpatients for first appointment and diagnostic delay
Colorectal	80%	Complex pathways requiring multiple investigations
Urology	14.3%	Overall diagnostic and treatment capacity
Upper Gastrointestinal	61.5%	Complex pathways requiring multiple investigations
Breast	82.6%	Delays to diagnostic investigation

28-Day Faster Diagnosis Standard

UHCW performance year to date for this measure (for all of 2WW, Breast Symptomatic and Screening) is 72.4% against the 75% standard. For patients referred on a 2WW pathway, the breakdown of performance for the month of September 2022 by tumour site is shown below:

CANCER SITE	0-28 days	after day 28	Total	% Pathway end within 28 Days
Brain	2	0	2	100.0%
Breast	342	17	359	95.3%
Colorectal	288	94	382	75.4%
Gynaecology	66	77	143	46.2%
Haematology	0	4	4	0.0%
Head and Neck	71	184	255	27.8%
Lung	19	11	30	63.3%
Other	7	0	7	100.0%
Paediatric	10	0	10	100.0%
Sarcoma	10	7	17	58.8%
Skin	626	134	760	82.4%
Upper GI	163	13	176	92.6%
Urology	86	105	191	45.0%
Total TWW Suspected Cancer	1690	646	2336	72.3%

The individual breakdown highlights the variation in performance for each pathway. This variation is representative of a number of factors. including:

- Progress of implementing the National Best Practice Timed pathway
- Overall workforce required to diagnose patients within the 28 day standard
- Fluctuation in monthly referral volumes

Delivery of the 28 Day Faster Diagnosis standard is a priority for all cancer services. Clinical Groups are working alongside the West Midlands Cancer Alliance to transform pathways and improve delivery of the standard.

Progress against priorities set out by NHS England (25 October 2022)

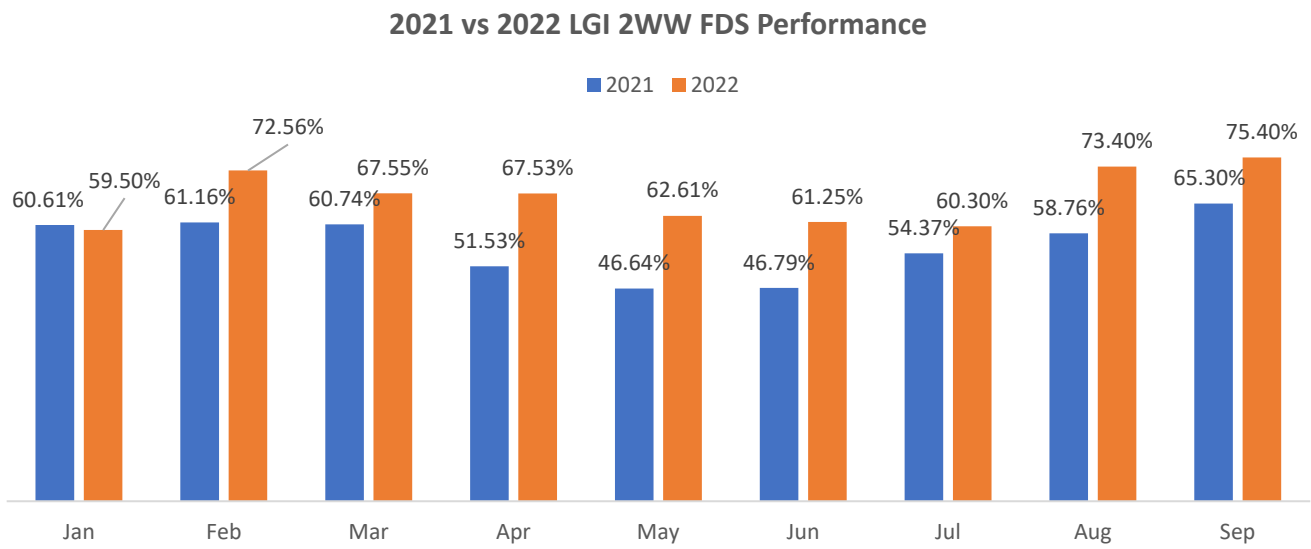
As part of the NHSE letter to Tier 2 providers actions were set out for Cancer Care in support of improving 62 day cancer waiting times. These included the following three priorities:

1. Full implementation of FIT (Faecal Immunochemical Test) as part of the Lower GI 2WW pathway
2. Full implementation of Best Practice Timed Pathway for Prostate Cancer
3. Implementation of tele-dermatology in the suspected skin pathway

The request also described the expectation for all cancer diagnostic investigations to be undertaken within 10 days, from request to report. The delivery of this standard is monitored weekly by existing Cancer governance and escalated where required to ensure compliance and the Diagnostic Clinical Group is reviewing their capacity to deliver this target currently.

1. Implementation of FIT (including Straight to Test Pathway)

UHCW implemented Straight to Test in January 2022, which forms part of the Lower GI National Best Practice Timed Pathway. Following a 2WW referral, patients are triaged for a diagnostic colonoscopy based on an agreed clinical criteria. As of September 2022, between 15-20% are triaged directly for a coloscopy procedure. As a result of implementing Straight to Test, UHCW have consistently improved performance against the Faster Diagnosis Standard, shown as below comparing January-September 2021/2022. UHCW have been recognised by the West Midlands Cancer Alliance as a leader in the region in operational delivery of the pathway, with regards to this National Best Practice Standard.



The implementation of FIT as part of the pathway is being led by the Coventry & Warwickshire Integrated Care System. UHCW are working closely with C&W ICB to support the actions required to fully implement FIT. This includes the set up of a Task & Finish Group, incorporating clinical oversight of the pathway provided by Upper and Lower GI teams alongside senior operational colleagues. FIT is planned to be implemented fully across Coventry & Warwickshire in December 2022. Implementation, delivery and evaluation of FIT is governed locally by UHCW Cancer Board and Coventry & Warwickshire Cancer Board.

2. Full implementation of Best Practice Timed Pathway for Prostate Cancer

The Trust have undertaken a detailed review of the Urology pathway to assess position against the National Best Practice standard and understand actions required to achieve the standard. The progress against implementing this pathway, by milestone is shown below:

National Best Practice Pathway Step	UHCW delivery against the pathway item
Nurse-led triage within 0-3 days	All patients who are referred into Urology on a 2WW pathway have a clinical triage. This is typically undertaken by a Urology Consultant within the 0-3 standard. Although the standard describes this as a nurse-led triage, the service does not currently have nurse-led triage in place. The Trust are exploring options to increase the substantive nursing workforce to support nurse-led triage.
mpMRI for appropriately triaged patients (day 3-9)	The Trust implemented rapid access mpMRI for appropriately triaged patients in June 2022. This includes provision of ring-fenced MRI slots weekly to support service demand and within day 3-9 of the pathway. As of November 2022, 68 patients on a 2WW prostate pathway were triaged within the timed pathway. Of the 68 patients: - 14 patients were recorded as receiving confirmation of the diagnostic investigation (cancer / not cancer) within the 28 Day standard

	- 18 patients were recorded as not receiving confirmation of the diagnostic investigation (cancer/ not cancer) within the 28 day standard - 36 patients had not yet had a diagnostic outcome
Prostate Biopsy (LATP) (day 3-9)	Operational capacity for LATP is a significant contributor to the performance of the Urology 28 Day Faster Diagnosis Standard. The current wait time for LATP procedure is beyond pathway standard at between 4-5 weeks. Determining additional sustained LATP capacity is a Trust priority. The clinical and operational team are working to establish increased biopsy provision as part of the local Coventry & Warwickshire CDC, which includes increased workforce and capital.
Outpatient clinic review (by day 14)	Outpatient clinic review following diagnostic investigation does not routinely occur within the timed pathway standard due to capacity for biopsy (as above), though is also contributed to by histopathology reporting delay. There is significant variation in histopathology turnaround times following LATP is between 4-5 weeks.

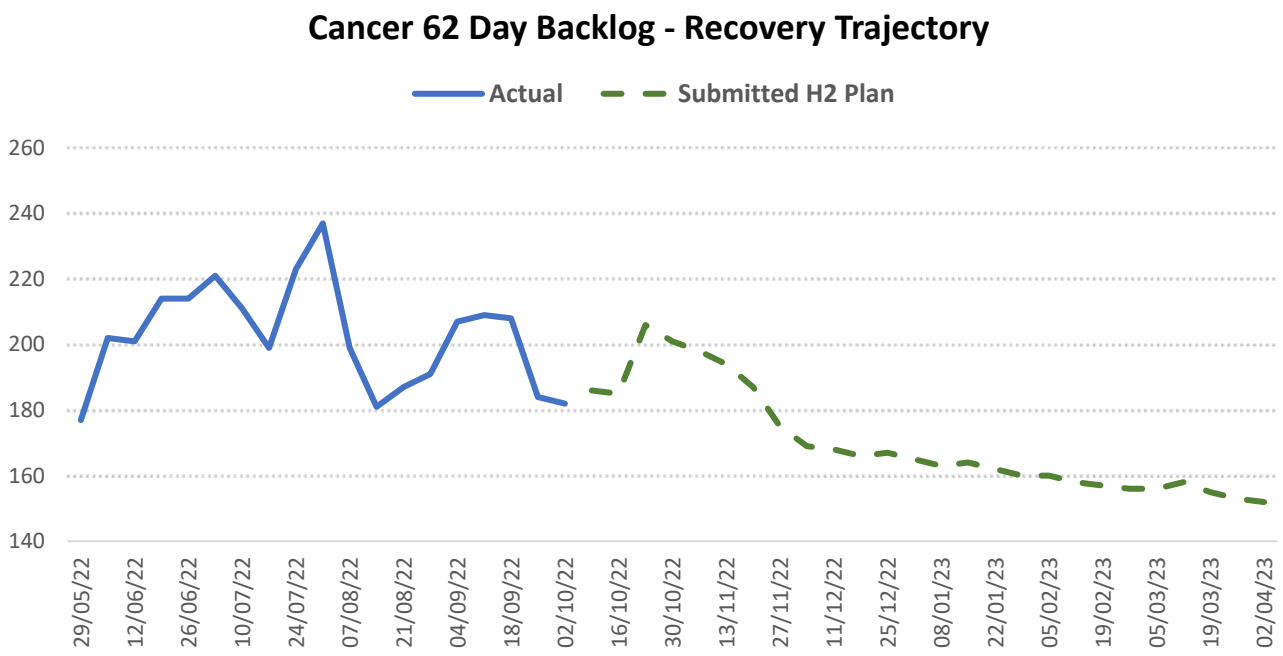
3. Implementation of tele-dermatology in the suspected skin pathway

The Trust are proactively working with Coventry & Warwickshire ICB to fully implement tele-dermatology across primary care. Historically, tele-dermatology had been deployed to the local population that UHCW serves, however the implementation was not consistent and could not be relied upon to support in reducing unnecessary hospital attendances. Tele-dermatology was fully implemented for non-cancer pathways in October 2022, with a plan to further roll out to include cancer pathways in the coming months.

Where we are not meeting performance or recommendation targets, the Groups have in place Cancer Recovery Action Plans which are reviewed weekly by both the Deputy Chief Operating Officer – Elective and Cancer Care and the Head of Cancer Services.

Patients on a cancer pathway waiting greater than 62 days for treatment (>62 day backlog)

The Trust are working closely with clinical and operational teams to treat all cancer patients within the 62-day pathway standard. The 2022/23 Operational Planning Guidelines described a requirement for all providers to reduce the >62 day backlog. The performance against this measure is shown below, alongside the submitted recovery trajectory through to March 2023. The Trust reported 184 patients at >62 days in October 2022, with a plan to reduce this to no greater than 152 patients by end March 2023. The delivery of improvement plans to achieve this measure is monitored on a weekly basis with oversight from Chief Operating Officer.



4. CONCLUSION

UHCW has provisional information that we will be taken off Tier 2, however the focus on Elective and Cancer care remains a priority. We are committed to and have formalised Governance to regularly review and deliver transformational Elective and Cancer Activity.

UHCWs focus continues to improve Cancer Care through weekly monitoring at administration, management and group director level.

The Trust will continue to ensure that patients are cared for in clinical priority and within Infection Prevention Guidelines.

Author Name: John Elliot
Author Role: Head of Cancer Services
Date report written: 15 November 2022

To: NHS Trust and Foundation Trust chief executives and chairs

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

25 October 2022

Dear colleague,

Next steps on elective care for Tier One and Tier Two providers

On 18 October, NHS England wrote to the NHS outlining further plans to boost capacity and resilience for services over the coming challenging winter period. This letter now sets out immediate next steps for tier one and tier two of the elective recovery programme to ensure that our phase two objectives around 78 week waiters and 62 day cancer waits are met.

The NHS has delivered a massive reduction in patients waiting two years and is also now steadily reducing the number of people waiting more than 18 months and 62 days respectively. Activity levels compared to pre-pandemic are increasing but we can still do more. There is no one silver bullet, but through a combination of getting the basics right and data-led management and innovation, particularly on outpatient and diagnostic activity, we firmly believe that we can continue to make genuine progress.

We realise that there are a lot of asks on providers and that each of you will know best your local circumstances and what works well. However, through each wave of Covid over the past two years, hospitals have got better and better at protecting elective and cancer care. There are significant learnings from individual organisations across the country that can make a huge difference if adopted collectively. That is why we are now asking all colleagues to step up efforts on all of the measures outlined below. With this in mind, we ask that you complete the Board self certification, (see appendix A) to allow us to support you where you are having the greatest challenges. The fundamentals that we have, collectively, proven to work are:

Excellence in the Fundamentals of Waiting List Management

Ensuring operational management and oversight of routine elective and cancer waiting lists aligns with best practice as outlined/directed within the national programme and current Cancer Waiting Times guidance. All patients past 62 days for cancer and 78

weeks for wider elective care should be reviewed and the actions required to progress them to the next step in their pathway prioritised.

Validation

The validation and review of patients on a non-admitted waiting list is important for the appropriate use of outpatient capacity and to provide clean visible waiting lists to ensure timely and orderly access to care. There are three phases to validating waiting lists that providers are required to undertake routinely – technical, administration and clinical and, following on from guidance sent out on 16 August available here, we expect providers to meet this timeline:

a) By 23rd December 2022
   Any patient waiting over 52 weeks on an RTT pathway (at 31 March 2023) who has not been validated* in the previous 12 weeks should be contacted

b) By 24th February 2023
   Any patient waiting over 26 weeks on an RTT pathway (at 31 March 2023) who has not been validated* in the previous 12 weeks should be contacted

c) By 28th April 2023
   Any patient waiting over 12 weeks on an RTT pathway (at 20 April 2023) who has not been validated* in the previous 12 weeks should be contacted

Appropriate surgical and diagnostic prioritisation

We know that 85% of patients waiting longer than 62 days from their referral for urgent suspected cancer are waiting for a diagnostic test. For cancer in particular, the significant demand for additional diagnostic capacity means that Trusts need to adhere to the maximum timeframes for diagnostic tests within each tumour-specific Best Practice Timed Pathway, but should at all times have a maximum backstop timeframe of 10 days from referral to report. Trusts should undertake a comprehensive review of current turnaround times and what further prioritisation of cancer over more routine diagnostics would be required to meet this backstop requirement.

Trusts should ensure that existing community diagnostic centres (CDCs) capacity is fully utilised by ringfencing it for new, additional, backlog reducing activity, and working with their wider ICS partners to use a single PTLs across the system. Trusts should work across their systems to accelerate local approval of business cases CDCs, additional acute imaging and endoscopy capacity; and expedite delivery of those investments once approved, and should continue to explore partnerships with the independent sector to draw on or build additional diagnostic capacity.

Surgical prioritisation should continue to follow the guidance set out in the letter of 25 July, providing ringfenced elective capacity for cancer patients (particularly P3 and P4 urology and breast patients) and 78ww patients. Performance against the 31 day standard from decision to treat to treatment should be used to assess whether the first of these objectives is being met.

Cancer pathway re-design for Lower GI, Skin and Prostate

There are three pathways making up two-thirds of the patients waiting >62 days and where increases over the past year have been the largest: Lower GI, Skin and Urology. Service Development Funding was made available to your local Cancer Alliance to support implementation of these changes and additional non-recurrent revenue funding has also been made available nationally.

Lower GI: Full Implementation of FIT in the 2ww pathway

As set out in the joint guidance on FIT issued by the British Society of Gastroenterology and Association of Coloproctology of Great Britain and Ireland (ACPGBI), and reinforced in this letter, most patients with suspected colorectal cancer symptoms but a FIT of fHb <10 µg Hb/g, a normal full blood count, and no ongoing clinical concerns should not be referred on a LGI urgent cancer pathway. Where referred, teams should not automatically offer endoscopic investigation but consider alternative, non two week wait, pathways as set out in the letter.

Full implementation of teledermatology in the suspected skin cancer pathway

All Trusts should work with their ICS to implement teledermatology and digital referral platforms to optimise suspected skin cancer pathways and reduce unnecessary hospital attendances to tackle the backlog and meet increasing demand. NHS England's guidance on the implementation of teledermatology pathways is endorsed by the British Association of Dermatologists and supports a Best Practice Timed Pathway for skin cancer which has been published this week.

Implementation will require provision for dermoscopic images to be taken for Urgent Suspected Cancer Skin cancers. This could be delivered by primary care, a separately contracted service delivered by primary care, in a community image taking hub setting, or by medical illustration departments in secondary care. Capacity must be in place for daily dermatologist triage of images, as either additional activity or as part of existing job plans. Following triage, the consultant or a member of their team should communicate with the patient (via telephone, video or face-to-face consultation) and be booked directly for surgery and receive appropriate preoperative advice and counselling if required.

Full implementation of the Best Practice Timed Pathway for prostate cancer
All provider Trusts should implement the national 28-day Best Practice Timed Pathway for prostate cancer, centred on the use of multiparametric MRI (mpMRI) before biopsy. Using pre-biopsy mpMRI means patients can be triaged towards a biopsy so at least 25% can avoid it, over 90% of significant cancers can be diagnosed on imaging and fewer insignificant cancers are diagnosed. Use of local anaesthetic transperineal biopsy where clinically indicated provides increased accuracy and reduced risk of infection, without the resource intensity of procedures done under general anaesthetic.

Implementation will require all patients to be booked in for both mpMRI and biopsy at the point of triage, with triage taking place no later than 3 days from the date the referral is received. Ring-fenced mpMRI slots should be in place – weekly demand analysis from radiology requesting systems should be used to inform the level at which this is set, with frequency of mpMRI slots sufficient to support delivery of timely biopsy. Maximum use of local anaesthetic transperineal prostate biopsy should also be ensured, with general anaesthetic biopsy used only where clinically indicated or for patient preference. Pre-biopsy mpMRI and biopsy procedures should take place no later than 9 days from the date the referral is received.

Outpatient transformation
Outpatients make up around 80% of the total waiting list and it is crucial that, over the winter period, providers continue to keep a strong operational focus on providing these services. Providers are asked to continue their work to deliver a 25% reduction in outpatient follow up appointments by March 2023.

a) As part of this, trusts are asked to continue the expansion of patient initiated follow up (PIFU) to all major outpatient specialties, especially increasing the volume of PIFU activity in specialties where it is now well established.
b) Continue to deliver at least 16 specialist advice requests per 100 first outpatient appointments. Providers are asked to focus efforts on pre-referral advice models.
c) Further initiatives to support outpatient follow-up (OPFU) reduction should also include improved and standardised discharge procedures and more effective administrative processes – including focusing on reducing DNAs in outpatient settings
d) In order to enable a personalised approach for outpatients and where it is clinically appropriate to do so, outpatient appointments should continue to be delivered via video and telephone, at a rate of 25% of all outpatient appointments. Remote consultation guidance and implementation materials can be found on NHS Futures here.

Surgical and theatre productivity

It is essential that we make best use of available surgical capacity, to drive productivity improvements and protect elective activity through winter. As such we expect providers to:

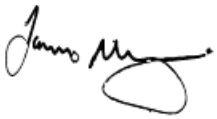
a) Review the senior responsible officer(s) (SROs) and oversight arrangements in relation to theatre productivity and strengthen these if necessary. Ideally, it should consist of a senior manager working ‘shoulder-to-shoulder’ with a senior clinician – to succeed we need both groups working together.
b) Drive up theatre utilisation to 85%, underpinned by the cases per list standards set out within the GIRFT high volume low complexity (HVLC) programme.
c) Make elective surgery daycase by default, delivering daycase rates across all surgery of 85%, and helping to free up valuable inpatient beds for complex work.
d) Maximise Right procedure right place, taking simple surgical procedures out of theatre into procedure rooms, eg hand surgery, cyctoscopy, hysteroscopy
e) Adopt best practice pre & peri-operative medicine pathways to reduce issues of under booking of lists, on the day cancellations, and pro-longed length of stay, as well as providing better care for patients.
f) Optimise the booking & scheduling processes, ensuring that patients are ready for surgery prior to being offered a surgery date, with an embedded data driven, clinically led approach.
g) Not performing those interventions identified as ‘must not do’ on EBI lists 1 and 2 and following the stated process for those List 1 and 2 interventions that should only be performed after applying the specific criteria.

Board Self-certification

As part of the above priorities, we are asking each provider to undertake a Board self certification process and have it signed off by Trust Chairs and CEOs by November 11, 2022. If you are unable to complete the self certification process then please could you discuss next steps with your Regional team. The details of this self certification can be found at Appendix A.

Thank you for all of your continued hard work in addressing what are two critical priorities for the NHS over the winter period. Please share this letter with your Board, key clinical and operational teams and relevant committees, and do email england.electiveopsanddelivery@nhs.net should you have any questions.

Yours sincerely,



Sir James Mackey
National Director of Elective Recovery
NHS England

Dame Cally Palmer
National Cancer Director
NHS England

Elective Recovery Self certification **Appendix A**

The Chair and CEO are asked to confirm that the Board:

a) Has a lead Executive Director(s) with specific responsibility for elective and cancer services performance and recovery.

b) That the Board and its relevant committees (F&P, Safety and Quality etc) receive regular reports on elective, diagnostic and cancer performance, progress against plans and performance relative to other organisations both locally and nationally.

c) Has an agreed plan to deliver the required 78ww and 62 day trajectories for elective and cancer recovery, and understands the risks to delivery, and is clear on what support is required from other organisations.

d) Has received a report on the current structure and performance of Lower GI, Skin and Prostate cancer pathways (including the proportion of colonoscopies carried out on patients who are FIT negative or without a FIT; the proportion of urgent skin referrals for whom a face to face appointment is avoided by use of dermoscopic quality images; and a capacity/demand analysis for MRI and biopsy requirements on the prostate pathway), and agreed actions required to implement the changes outlined in this letter.

e) Is pursuing the opportunities, and monitoring the impacts, presented by Outpatient transformation and how this could accelerate their improvement, alongside GIRFT and other productivity, performance and benchmarking data and opportunities.

f) Have received a report on Super September and have reviewed the impact of this initiative for their Organisation.

g) Have received reports on validation, its impact and has a validation plan in line with expectations in this letter.

h) Have challenged and received assurance from the lead Executive Director, and other Board colleagues, on the extent to which clinical prioritisation (of both surgical and diagnostic waiting lists) can help deliver their elective and cancer objectives. This should include receiving a review of turnaround times for urgent suspected cancer diagnostics and agreeing any actions required to meet the backstop maximum of 10 days from referral to report.

i) Discuss theatre productivity at every trust board; we suggest with the support of a non-executive director to act as a sponsor.

j) Routinely review Model Health System theatre productivity data, as well as other key information such as day-case rates across trusts.

k) Confirm your SROs for theatre productivity.

l) Ensure that your diagnostic services reach at least the minimum optimal utilisation standards set by NHS England.

Signed by CEO Date:

Signed by Chair Date:

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 1 DECEMBER 2022

Subject Title	Palliative and End of Life Care Annual Report 2021-2022
Executive Sponsor	Tracey Brigstock, Chief Nursing Officer
Author(s)	Rebecca Bourton, Strategy Delivery Lead Jon Tomas, Consultant Hazel Coop, Consultant Julie Glover, Modern Matron
Attachment(s)	End of Life Care - Annual Report (2021 - 2022)
Recommendation(s)	The Board is asked to: **NOTE** the areas of outstanding practice in EOLC **NOTE** the workforce challenges in EOLC and proposed changes to stabilise the service **NOTE** the Place and system activities and Operational alignment actions

EXECUTIVE SUMMARY

The attached annual report for End of life care (21/22) outlines the work that has been undertaken by the clinical team during the past 12 months and further builds on the update provided to the Board in December 2021

The report reflects the changes in system architecture and outlines the trust's priorities as well as those developed at both system and place. The emerging strategy for Palliative and End of Life Care for Coventry and Warwickshire will be a driving force for co-ordinated development across the system, with Place Steering Groups working across organisational boundaries to set key priorities and drive further improvement for this patient group locally.

The continued challenges in Specialist Palliative Care workforce at the Trust are detailed throughout the report. Despite these challenges the team have worked hard to make plans to restructure the workforce over the coming 6 months to add increased sustainability to the team as well as to implement a 7-day service model. This development will seek to resolve a long standing CQC recommendation, bring the trust in line with current practice, provide an improved patient experience, reduce unnecessary inpatient stays and align its services more favourably with neighbouring trusts.

PREVIOUS DISCUSSIONS HELD

Annual Report 2020/21

KEY IMPLICATIONS	
Financial	None
Patients Safety or Quality	Proposed development of 7-day service Identified priorities to improve patient care
Workforce	Current staffing challenges Proposal to restructure team across 7 days
Operational	Working pattern Cross system working (system and place priorities)

University Hospitals Coventry and Warwickshire NHS Trust

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

REPORT TO PUBLIC TRUST BOARD

1st December 2022

End of Life Care – Annual Report (2021-2022)

1. Purpose

The purpose of this report is to provide an update on the work of the UHCW End of Life Care (EOLC) Committee since the last report to Trust Board.

2. Background and Links to Previous Papers

This report is the eighth report to Trust Board for EOLC and builds on that provided in December of 2021.

3. Summary

3.1 CQC Definition

End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, as well as chaplaincy and bereavement support and mortuary services.

3.2 UHCW

End of life care (EOLC) is delivered by ward staff throughout the Trust and is core to the work of all health care professionals. The dedicated Palliative Care Team (PCT) provide advice to healthcare clinicians and support the wider adult care team who provide direct care level palliative care to patients with life limiting illnesses and / or in the last stages of life.

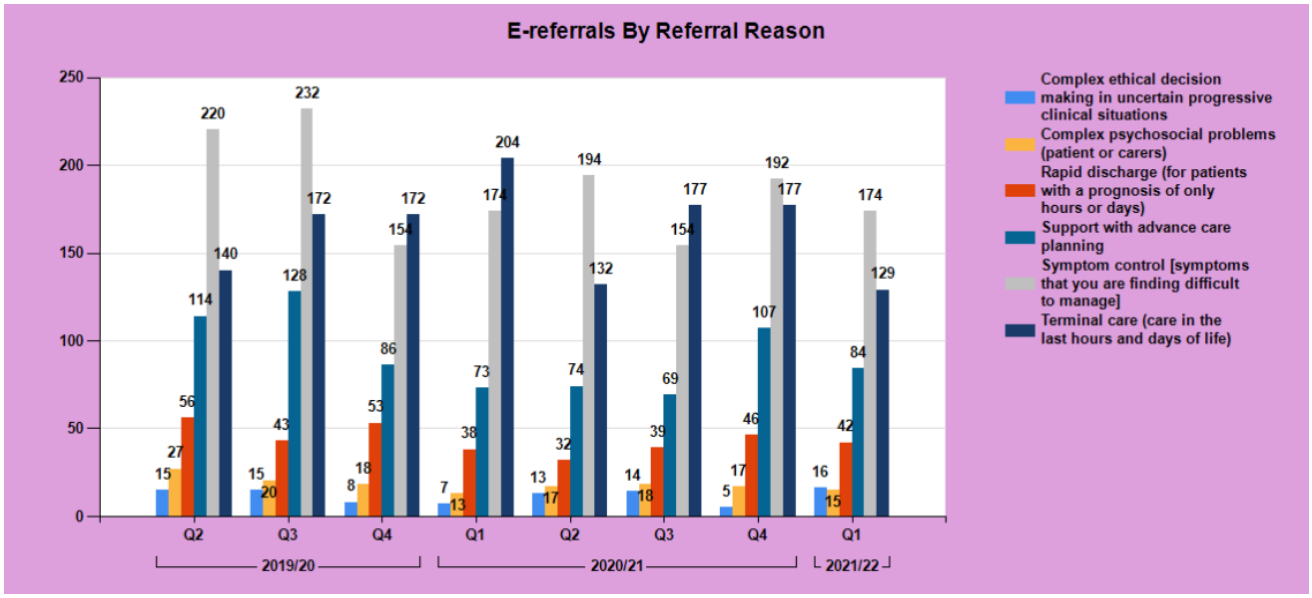
The Palliative Care Team leads on quality improvements related to EOLC and provides education and training for Trust staff in palliative and EOLC. It is a multi-professional team with qualifications, expertise, and experience in care for this patient group.

The Palliative Care Team provides advice to patients who have complex care needs or are in their last days of life. They support patients to live as well as possible during life limiting illness, ensuring comfort and dignity is maintained as they come to the end of their lives, by undertaking assessments and management of physical, psychological, and spiritual symptoms to:

- reduce symptoms, suffering and distress
- support complex clinical decision-making
- apply relevant ethical/legal reasoning with clinical assessment
- provide care and support to those important to the person receiving care, including facilitating bereavement care.
- train other clinicians in Palliative Care/Medicine as much as possible so that they too can reduce symptoms, suffering and distress.

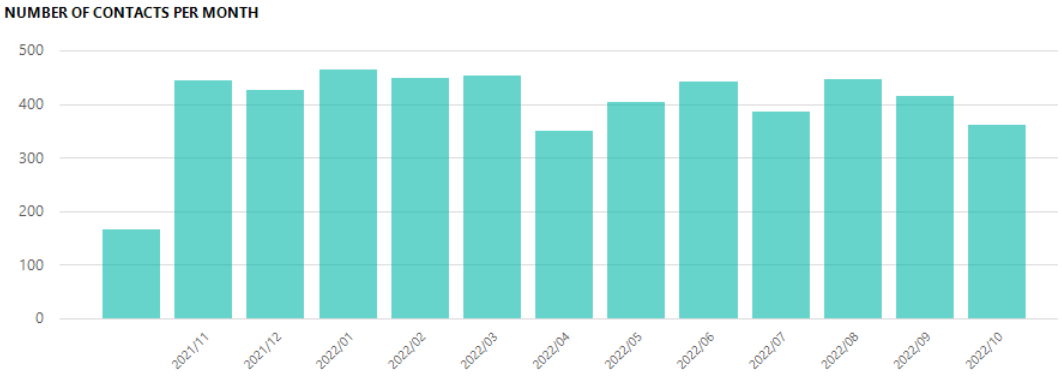
Patients are referred to the Specialist Palliative Care Team from across adult services. The graph below demonstrates the reason for referral for the team, and clearly illustrates the specialist nature of this team offering both support for patients but also to other clinicians.

Figure 1: E-Referrals by Reason



The graph below details the number of patient contacts (per month) for the past 12 months, which averages at around 400 contacts per month.

Figure 2: Number of Patient Contacts Per Month



Advice and support given by the Palliative Care Team is focused on the patient and their wishes, including facilitating rapid discharge to the patient's preferred place of care and death.

A dedicated bereavement team, chaplaincy, and mortuary service work closely alongside the Palliative Care Team.

The vision for the Palliative Care Team is that all adults with a life-limiting condition at UHCW have access to the best possible palliative care, appropriate to their need.

4. Operational Service

Currently the Palliative Care Team offer a face-to-face service at UHCW Monday-Friday 0830-1630. Outside of these hours, specialist palliative care advice is available at all times from the Coventry and Warwickshire Palliative Medicine Consultant on call.

Of note, the Palliative Care Team was able to use COVID-19 funds to temporarily step up to a 7-day face-to-face service April-June 2020 to support the Trust's response to the COVID-19 pandemic.

The team also developed 'Temporary Palliative Care Guidelines for use during the COVID-19 Outbreak', based on published national guidance, these have been recently reviewed and are still active. These reflect the guidelines from West Midlands Palliative Care (WMPCP) and can be found at www.westmidspallcare.co.uk.

As a result of the learning from the changes to service provision through Covid 19, , and the ongoing challenges to establishing sustainable recruitment, the team have worked on developing a new model of care local to UHCW, to support delivery of 7 days services.

5. Place and System EOL Strategy Commencement 2021-2022

At both an ICS and Place level there are dedicated Palliative and End of Life steering groups, which are now well established and have representation from across health and social care partners. Each Place programme within the ICS have used the national ambitions framework reviews to generate key priorities.

National Ambitions framework for palliative care states:

- Each person is seen as an individual
- Each person gets fair access to care
- Maximising comfort and wellbeing
- Care is coordinated
- Staff are prepared to care
- Each community is prepared to help

The system is in the process of developing a 5-year strategy, which is currently being consulted on at place level. The main areas of focus for this strategy have been developed with the results of the system ambitions survey at the heart. Key areas for Coventry and Warwickshire include:

- Every person has a personalised plan, which is reviewed regularly and accessible to all appropriate clinical staff.
- Every person, no matter where they live, what their background is, what their age is, or what their needs are, has access to end of life care
- Ensure Individuals and professionals know what services are available across the system

- Medicines are available to the individual when they need it, with appropriate process and documentation to allow this to happen
- To develop and roll out a communication training plan with certification
- Develop a communication plan help to normalise death and dying

6. Coventry Place Priorities and Progress

7-day Specialist Palliative Care Services

The development of a seven-day service model for Palliative and End of Life Care across Coventry where services co-ordinate to provide efficient and effective care across organisational boundaries.

The development of 7-day services for End of Life Care for UHCW was identified as a "should do" action by the CQC in 2018.
Within the Coventry and Warwickshire system, Coventry is the only location that does not operate a seven-day service for End of Life Care despite being the tertiary cancer centre in the region.

The development of a seven-day service model for Coventry was highlighted as a development need in the National ambitions assessment.

Focusing on developing a coordinated 7 day service across both hospital, community and hospice settings aim to ensure that patients and families have streamlined access to a range of palliative care and end of life services to meet their targeted needs both in the hospital and community setting.

In the community setting there has been progress in designing and initiating recruitment to new staff to deliver a 7 day "Rapid Response" service for patients. The service aims to "go Live" in January 2023. Locally at UHCW, the clinical team has made plans to re-structure its nursing workforce model to provide a seven day clinical service for patients. This work remains ongoing at present and will require a detailed review of plans and authorisation. However, the proposal details a minimal investment requirement to achieve a valuable service change and is intended for implementation during 2023.

Compassionate Communities Bereavement Directory

As part of a wider programme of delivery to secure compassionate communities accreditation for Coventry and to improve the experience of patients and their families facing the end of life, the Coventry team has been working on the development of a dedicated bereavement directory. This will signpost recently bereaved to help and support which is available across the city.

A working group has been set up and in progress in setting this directory up on the compassionate communities' website

Fast track discharges

Providing an effective process for discharging patients either home or to another care environment during the last days and hours of life is a priority area for improvement across Coventry. Working together as a place team across organisational boundaries to seek opportunities to improve flow for this patient group aims to improve the quality and patient / family experience during a difficult time.

The EoLC team is working closely as a part of the Trust discharge working group A working group across place partners is in progress to improve patient flow and enable patients to be in their preferred place of care and death. To date a regular daily call to Myton Hospice, progress chasing call has been established between care providers to identify patients awaiting fast track discharge and to take steps to expedite discharge / transfer wherever possible.

EPaCS

Electronic Palliative Care Coordination Systems, or EPaCCS, is a means to capture and share information from people's discussions about their care. The aim of this is to ensure that any professional involved in that person's care has access to the most up to date information, including any changes to their preferences and wishes and personalised care plans.

Across Coventry the team will be prioritising the implementation of EPaCCs as a system to share essential clinical information safely. This work will require the development of data sharing agreements for all organisations.

This workstream is being reviewed at ICS level for implementation across the wider system. The Coventry Place group are tracking progress of this development and working to support this development as required

Transition Services (Paediatric to Adult Services)

The implementation of a dedicated pathway to support patients who are transitioning from paediatric to adult specialist palliative and EoL Care services has been identified as a key development area to improve patient care for a specialised group of patients. Palliative and EoL clinicians and colleagues from both adult and paediatric will be working across organisational boundaries to develop this key pathway.
Our Specialist Palliative Care Consultant Lead has reached out to colleagues and is keen to develop relationships further.

To date the Coventry Place EoLC steering group is in the process of implementing a dedicated working group and designing the key parameters and scope of the project.

7. Rugby Place based priorities

Enhance delivery of end of life care within the prison

The team has been working alongside the prison service at Rye Hill Prison to develop dedicated palliative care suites to support palliative care inmates, and to reduce the need for lengthy inpatient stays within the acute care sector which has resourcing implication for both health and prison services.

Review of bereavement services locally.

The SPCT has been working closely with Compassionate Community team to review bereavement services locally within the Rugby Borough. This is feeding into the wider Compassionate Communities workstream. In addition the team has been working closely with the Maple Unit at the Hospital of St Cross to provide a service for families of patients visiting the Rugby Myton Hub to provide cancer, bereavement and information services.

Review of end of life care provision within Rugby community.

Evidence has been captured illustrating a frequent use of Home First to deliver evening end of life support visits, impacting on the capacity of the Home First Team to facilitate hospital discharge. A regular meeting has been established between hospice, hospital and community palliative care services to ensure access to hospice at home is equitable and easy.

8. UHCW work progress 2021-2022

8.1 CQC Actions

Following a CQC inspection in 2018, the end of life care domain had a number of actions. A CQC relationship meeting was held on 13/06/19, where these actions were discussed, alongside potential areas of outstanding practice. The end of life care domain was not inspected during the CQC inspection of UHCW in late 2019. However, a summary of responses to actions from 2018 are listed below:

Must do actions: Completed; See Previous report (Dec 2021).

Should do actions:

1. To prioritise action to improve mandatory training achievement

All established members of the UHCW Palliative Care Team achieved 100% compliance in mandatory training. At present the palliative care team are compliant with all mandatory training, however x1 Long term sick staff member is not compliant in all areas of mandatory training this will impact on overall score for the department No actions required for this at present Mandatory training is covered at the Palliative Care Team education meeting to ensure ongoing compliance.

2. To continue to address the improvement of facilities for having difficult conversations with relatives in clinical areas.

Completed

Quiet areas for difficult conversations were reduced throughout Covid due to having to increase space for staff breaks etc.

Emails have been sent out to ward Mangers to ensure that these rooms are now available and in working order for the facilitation of difficult conversations

Ward 25 has x 2 relative rooms that were not used throughout covid for relatives to use when loved ones are nearing EOL.

These are now clear and will be used again, charitable funding application to be submitted for refurbishment

JG will complete this

3. To prioritise the use of accurate and complete activity data that demonstrates the responsiveness of the specialist palliative care team in relation to referrals.

Data on the responsiveness of the Palliative Care Team is collected. The previous system has ceased to be used and has been replaced with a superior system utilising Pathway and Dashboard, since September 2021.

Our Specialist Palliative Care Consultant lead and Modern Matron are working with the performance and informatics team to look at referrals and clinical need so able to support further areas across the trust

4. To continue to develop plans to provide a seven-day face to face service to support the care of patients at the end of life, with clear action and timelines identified.

There is recognition of the need for a 7-day face-to-face Palliative care service at UHCW as per CQC recommendation since 2017 and the need for a 7-day face-to-face Palliative care service has been National recommendation since 2004.

The development of a 7 day service is being driven as a Coventry Place priority (see section 6) A workforce plan to deliver this change has been developed. It is expected that a management of change exercise will need to be conducted to consult current staff on this change

8.2 Potential Areas of Outstanding Practice:

Compassionate Communities

Compassionate Communities is expanding beyond Coventry and Rugby into the whole of Warwickshire with the continued aim of improving wellbeing and tackling social isolation within individuals and groups in the community who have been diagnosed either with a long-term and life-

limiting health or palliative condition and beyond into supporting loved ones in bereavement. The services have been created around valuing and treating individuals with appropriate compassion and dignity and providing a listening ear to give our clients a voice that they may not otherwise have at each stage of life and at all points in their care.

During the pandemic, all face to face home visits to our Compassionate Communities clients were re-provided virtually, to every person referred into our services during that time. In addition, the Chaplains, with a couple of Compassionate Communities volunteers provided bereavement support to families, during the pandemic.

Post covid, the recruitment of new volunteers, predominantly in Coventry and Rugby, but also out as far as the very south of Warwickshire and beyond continues. Home visits have been resumed.

This movement of Compassionate Communities now comprise of the following elements:

- We currently have 62 trained or in training volunteer befrienders covering this service across Coventry and Warwickshire who since May this 2021 have and are supporting 99 families who are at the end of life, following a bereavement or who are frail-elderly and socially isolated.
- Bereavement Point Groups. There are now 4 Bereavement Point Support Groups across Coventry and Rugby, one each week for a wide-reaching arm. These are open to the public as well as families of deceased patients. Since its launch, this initiative has seen about 130 individuals attend.
- Support for the Dying Companions
- A new Bereavement Course is now available online and for in-person training which is being offered to all our volunteers and to external organisations who are seeking to provide bereavement support in-house by their employees for their employees.
- Death Cafes are being hosted as public events in Coventry and Warwickshire to shift the culture of silence around death.
- RIPPLE and Take a Breath (TAB) in Rugby offer weekly support groups that address major issues of social isolation and low mental wellbeing related to living with a long-term condition – particularly COPD (Chronic Obstructive Pulmonary Disease). Groups directly address issues of self-management, confidence in communicating with healthcare providers about their condition, fear of physical exertion, positive social interactions with each patient's communities and peer-to-peer support. These groups create resilience within patients with long term conditions and have demonstrably indicated in the first 5 years of existence, a 20% decrease in unplanned admissions, as well as a noted improvement in quality of life, demonstrated by patient's increased confidence as well as new involvement in their communities."
- The Heart Failure Group project initiated in January 2022.

  GP Listening is now being delivered by trained volunteers based in GP surgeries offering "good neighbour" listening for those who are referred by their GPs who just need a space to share.
- A Compassionate Rugby website is now established to support the ongoing services of Compassionate Communities and it's Town Charter, generated by the town itself is anticipated in the future through public declaration of support for this movement.

DOVE Academy

The DOVE academy recommenced in April 2021.

The DOVE academy is a training course dedicated to improving the care of dying patients at UHCW. The programme is for Health Care Support Workers to develop their skills and knowledge and to champion what they have learnt with others, empowering them in practice.

At present, follow up evaluation to this course is minimal, so evidence of improvement to EOL care in ward areas is sparse. The Palliative care team have committed to relook at how to deliver training with a view to expand their teaching capacity and include more staff at all levels)

The course involves spending a week with a palliative care nurse and visiting/talking to patients and their loved ones, attending meetings and supporting ward staff. There are optional visits to Coventry Myton hospice and the mortuary at UHCW. Following the week there are twice yearly catch ups to disseminate new information plus follow up visits to the ward to offer support when required.

In order to complete the weeks training, those attending have a competency book that will need to be signed off by the palliative nurse supporting them. There is also some e-learning training to develop their skills further.

There has been very positive feedback from the DOVE champions that have attended and there have been some positive changes seen in last days care on the wards where DOVE champions are working. Some of the DOVE champions have also developed posters, booklets and teaching packages to use on their ward.

The DOVE Academy was presented to the public at the UHCW 'We Care' Event.

Cross-Coventry Working

Specialist Palliative Care services in Coventry are provided by three separate organisations: UHCW (hospital), Coventry and Warwickshire Partnership Trust (community services) and The Myton Hospices (hospice). There is recognition of the importance of joined up working.

A daily Coventry-wide daily teleconference (Monday-Friday) continues between all three teams. This allows appropriate data sharing to ensure patients' care is well handed over, and services are well appraised of patients' needs on an individual basis.

The lead consultant for Community Palliative Care in Coventry works two weekly sessions at UHCW. This helps to provide continuity of care.

A weekly virtual meeting with all Palliative Medicine Consultants in Coventry & Warwickshire also continues. This meeting includes representatives from: Coventry Community (CWPT), South Warwickshire Community (SWFT), Warwick Hospital (SWFT), George Eliot Hospital, North Warwickshire Community and The Myton Hospices.

Trustwide Education

A Trust-wide education plan has been developed. This is a multi-pronged approach that will allow staff within the Trust to access and receive education around palliative and end of life care. The plan comprises three elements:

- e-ELCA (end of life care for all) via ESR. Bespoke learning paths for different staff groups (doctors, registered nurses, healthcare support workers, allied health professionals, other staff) have been developed, utilising this national e-learning programme. Sessions were selected that were of high relevance to each particular staff group.
- Ward nurse champions. This group of individuals are a key link between the wards they represent and the Palliative Care Team. These nurses have received training in palliative care through QELCA© training, and they disseminate their expertise to their ward areas. They also act as a link to highlight teaching sessions available from the Palliative Care Team.

The Ward Nurse Champion Programme has recently been updated and this has started in July 2021.

- Rotational ward visits. The Palliative Care Team used to attend Rugby St Cross and delivered two sessions to each ward, at board rounds, to:
  - Increase the visibility of the Palliative Care Team in UHCW
  - Recap contact details for the Palliative Care Team
  - Help staff identify patients who may require palliative or end of life care in the near future
  - Offer the chance for reflection for recent cases for staff
  - Utilise a mobile board for teaching purposes.
  - Visit Rugby St Cross on a weekly basis and review patients on an ad hoc basis.

The Palliative Care Team regularly contributes to both undergraduate and postgraduate medical education at the Trust. The team is routinely assigned students from Warwick Medical School throughout the year. There are regularly scheduled teaching sessions for F1, F2, and IMT doctors in the education centre. The team also contributes to the regular medical teaching at St. Cross Hospital in Rugby. Plans are currently underway to offer, in conjunction with community and hospice partners, a more formal, immersive education programme for IMT doctors and specialty trainees in Geriatrics. These efforts do not include numerous bespoke education sessions delivered by senior medics of the team upon request (e.g. to Trust pharmacists).

Alongside this, the Palliative Care Team offer an educational programme with a variety of planned sessions. They also support departmental teaching and education of staff groups such as preceptorship nurses. They support education of the Oncology Nurses.

Previously, the Specialist Palliative Care Team have supported education around Dying Matters week. This is something that the team will engage in again when staffing stability improves and the training can be facilitated by the direction of a lead nurse.

9. UHCW EOLC Committee Priorities

Related issues since the last EOLC Committee 2020-2021:

9.1 Sustainability of the UHCW Specialist Palliative Medicine and Care service; Monday to Friday and develop a 7-day face-to-face service

At present the palliative care team are seeing upwards of 5000 contacts annually, the aim was to see 5500 with a seven-day working service. The number of contacts now being achieved is sustainable with the workforce in place, however it will be greatly increased with the provision of 7 day working and a lead nurse.

9.1.1 Medical Workforce

Since the last update, the Trust has recruited a new clinical lead. The consultant workforce now consists of: a) one whole time substantive consultant who is also the clinical lead (1.0WTE), b) one substantive consultant with two weekly sessions at UHCW (0.2WTE) who is also the

community palliative care lead for Coventry (Coventry & Warwickshire Partnership Trust, 0.7WTE), and one bank locum consultant who typically works four sessions each week (0.4WTE).

The shared post between hospital and community allows for continuity of care, liaison, partnership working and improving the experience of patients being admitted via the emergency department.

There remains a significant consultant recruitment gap, and ongoing recruitment efforts have not realised substantiation. This is indicative of a dearth of palliative medicine consultants, as well as trainees, nationally. Accordingly, the team is now seeking to recruit a full-time specialty doctor in Palliative Medicine to support continuity of care.

Since July 2022, the team has a specialty trainee in Palliative Medicine. The clinical lead is their supervisor. Given the aforementioned shortage of palliative medicine trainees, there is no assurance that this post will be filled beyond next year.

Since August 2022, the team supports a F1 doctor in Palliative Medicine. The clinical lead is their supervisor. This is a tremendous learning opportunity for said trainee and will increase exposure to the specialty amongst junior doctors at UHCW.

9.1.2 Nursing Workforce

The Palliative Care Team is without a dedicated Nursing Lead, this role is presently part of a wider Matron role, encompassing Oncology/Haematology/Anti-coagulation. Similar teams in the UK have a dedicated Palliative Care Nursing Lead, which enables them to participate in wider ICS strategic working.

Currently, there is 1 Non-Medical Prescriber in the nursing team. The nursing workforce needs another 3.0 WTE CNS to provide 7-day services.

9.1.3 Pharmacy:

A Band 8 Specialist Palliative Care Pharmacist is in post, role shared between UHCW and Myton Hospices, in training to become a Non-Medical Prescriber.

9.1.4 Administrative:

The team benefits from an enthusiastic team MDT Co-ordinator who supports the UHCW Palliative Care MDTs which have been operational in a new format since November 2021.

The End of Life and Palliative Care Service aligns to National Ambitions (#1-8) and these are referenced as throughout the following section.

9.2 UHCW participation and engagement with NACEL (National Audit for the Care at the End of Life)

The palliative care team participated in the Nacel audit year 2022. A total of twenty five sets of notes were audited across a 2-week period in April and again in May.

All sections of the audit were completed including the bereavement section and the staff survey. These sections were excluded from the previous Audit.

The bereavement section was completed with the assistance of bereavement services and a staff survey was completed by the team with a good response of over 160 staff

9.3 Implementation of Trust EOLC Education & Training Strategy and Plan

See Potential Areas of Outstanding Practice point 4 above.

9.4 Improving communication

Advanced communication training has been offered via funding received by the Trust Cancer Team, this has been offered to a total of eight members of staff across the trust.

The palliative care team have trainers available for advanced communication skills and as a team have identified this as a priority for support as a part of the wider education and training offer with in the future vision of palliative care and has been identified as being advantageous to all members of staff across the trust

9.5 Partnership working

a. CASTLE Working groups

The CASTLE working groups comprise of those across Coventry and Warwickshire working within Specialist Palliative care across different settings to share learning and experience.

The CASTLE Expert Advisory Group (EAG) meeting takes place on a three-monthly basis and is attended by specialists in palliative care from across Coventry and Warwickshire. Representatives from UHCW regularly attend this.

The education sub group meets quarterly and is represented by UHCW representatives. This group supports and delivers education to the system. Sessions have been delivered virtually on symptom management topics.

There has been a working group reviewing the individual plan for the dying person across the system that UHCW have had representation at.

There are also early discussions about a system wide authorisation chart to support patients transferring with settings, this work is in the early stages but has initial buy in from all organisations in the system.

UHCW have now implemented the updated CASTLE anticipatory guidelines at the end of life guidelines, this means that the trust now is aligned with the rest of the system.

b. Continue the success of local Compassionate Communities through ongoing collaborative work with the voluntary sector and groups within the community.

See Potential Areas of Outstanding Practice point 1 above.

c. Link in with the Coventry and Warwickshire Directors/Leads End of Life & Palliative Care Meeting (to drive the configuration of Specialist Palliative Care Services)

The Coventry & Warwickshire Collaborative EOLC Committee has been replaced by System ICB meetings. UHCW representatives regularly attended.

One consultant has been participating in meetings to help to develop the Coventry and Warwickshire ICS Data and Digital Strategy, of note this will look at Electronic Patient record, Integrated Care record and EPaCCs.

9.6 Optimal patient discharge

Fast track discharge data is collected by IDT including monitoring delays/ identifying/acting on themes impacting on patient flow from hospital in last weeks of life.

The UHCW Integrated Discharge Team (IDT) have presented data regarding this at End of Life Care Committee meetings. The IDT continue to produce regular reports.

Literature to support fast-track discharges has been completed by the UHCW integrated discharge team and has been uploaded to e-library.

Data collection continues and is reviewed by the Palliative Care Team every 3 months.

10. Governance & Risk

The End of Life Care Committee manages the Trust's annual priorities for end of life care. This Committee reports to the Quality Governance Committee via the Patient Safety & Effectiveness Committee.

The Trust has a regulatory obligation to ensure that we are meeting the CQC standards in end of life care.

The Trust is sponsoring a workstream for Palliative and EoL Care service improvement for Coventry Place, working alongside place partners to develop services as a part of the Integrated Care Programme. Progress and governance for this scheme is managed through the trust's Integrated Care Programme Board.

There are two risks specific to Specialist Palliative Care and End of Life on the Medical Group risk register.

(a) Impact of medical staffing vacancy for the Specialist Palliative Care team.

(b) Risk of not having an operational 7 day service for Specialist Palliative and End of Life Care

Through this report details have been provided to demonstrate steps being taken by the team to mitigate these risks and move towards a seven day service with increased staffing resilience.

11. Responsibility

Chief Officer with responsibility for End of Life Care is Tracey Brigstock, Chief Nursing Officer

12. Recommendations

The Board is invited to:

NOTE the areas of outstanding practice in EOLC

NOTE the workforce challenges in EOLC and proposed changes to stabilise the service

NOTE the Place and system activities and Operational alignment actions

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 1 DECEMBER 2022

Subject Title	Maternity Safety Improvement Plan
Executive Sponsor	Tracey Brigstock, Chief Nursing Officer
Author	Gaynor Armstrong, Director of Midwifery
Attachment(s)	Appendix 1 – Ockenden first report action plan Appendix 2 – Ockenden Insight visit action plan Appendix 3 – East Kent Gap Analysis
Recommendation (s)	The Board is asked to receive the Maternity Safety Report and plan for **ASSURANCE** and to **NOTE**: • The performance and compliance updates for quarter 2 of 2022/23 and receive assurance around the CNST Maternity Incentive Scheme standards, national recommendations and PMRT and ATAIN action plans all of which are on track. • The midwifery vacancy position and the progress with the trajectory for pipeline recruitment. • The outstanding actions and action plan for the Ockenden report, Insight visit and gap analysis for the East Kent report 2022.

EXECUTIVE SUMMARY

This paper aims to share the Maternity Safety report and plan for quarter two of 2022/23:

- Current activity including births, deliveries and bookings highlighting a slight increase compared to the same period in 2021/22.
- Induction of labour and caesarean section updated information following the changes in the reporting requirements as requested by NHS England.
- Perinatal Mortality including reviews and Perinatal Quality Surveillance Model. The department are on track with all nationally agreed timescales for multi-disciplinary reviews including patient involvement in all investigation and review processes.
- The stillbirth rate for the Trust is at 7.57 per 1000 births for the reporting period and 6.75 per 1000 births for the rolling 12-month period. A local assurance review on the governance of stillbirth cases was presented to PSEC in September 2022.
- There have been six cases referred to HSIB during the reporting period including one maternal death.
- Midwifery Continuity of Carer is on hold for the Trust in line with recommendations from the final Ockenden report. All national target dates to deliver MCoC have now been removed.

However, a high level Implementation plan is in development for when appropriate staffing levels can be achieved and MCoC can be introduced safely.

- The current Midwifery vacancy from funded posts is 28wte with a further 15.5wte in the pipeline to commence in the next 2 months. Midwifery recruitment continues including International Recruitment.
- Midwifery staffing including national reporting requirements such as Midwife to Birth ratio, one to one care in established labour, supernumerary status of the labour ward coordinator and red flags. For the period reported one to one care in labour was achieved and supernumerary status of the coordinator was achieved 99% of the time. There were red flags reported however there were no adverse outcomes or clinical harm because of these.
- National reporting including the Trust progress against the Ockenden Immediate and Essential Actions and NHS Resolution Maternity Incentive Scheme (CNST) Year Four and East Kent (2022) report.
- Service user feedback is sought through the Maternity Voices Partnership and patient surveys. The department continues to receive positive feedback and were the recipients of both OSCA and Daisy nominations during this reporting period.

The Committee is asked to receive the Maternity Safety Report and the following recommendations:

- Note the performance and compliance updates for quarter 2 of 2022/23 and receive assurance around the CNST Maternity Incentive Scheme standards, national recommendations and PMRT and ATAIN actions all of which are on track.
- The midwifery vacancy position and the progress with the trajectory for pipeline recruitment.
- The outstanding actions and action plan for the Ockenden report, Insight visit and gap analysis for the East Kent report 2022.

PREVIOUS DISCUSSIONS HELD
COG October 2022, QIPS October 2022 Public Board June 2022, PSEC November 2022

KEY IMPLICATIONS	
Financial	Risk of Litigation, additional cost for recruitment of midwives and medical staffing to meet workforce assessments.
Patients Safety or Quality	To maintain patient safety, improving outcomes in line with national ambition.
Workforce	Recruitment and retention of midwives to meet Birthrate Plus assessment. Training requirements as outlined within CNST and Ockenden recommendations
Operational	Workforce requirements to meet the acuity of patients who are cared for within the department and increasing complexity. Referral specialist centre for fetal medicine and proposed medicine referral centre. Support is given to trusts within the LMNS and wider for NICU care as part of ODN network.

Maternity Safety Report and Plan

1. INTRODUCTION

1.1 Spotlight on Maternity (2016) national document recommends all Trusts are required to have a Maternity Safety Improvement plan to work towards achieving the national target of reducing stillbirths, neonatal deaths and intrapartum brain injuries by 50% by 2025. The Trust first developed their improvement plan in 2018 considering further national documents such as Safer Maternity Care (2016) Saving Babies Lives (2016 & 2019) and MBRRACE perinatal and maternal mortality & morbidity reports.

1.2 The Maternity Safety Report incorporates all Trust national reporting such as NHS Resolution Maternity Incentive Scheme (CNST), Ockenden Report (2020/ 2022), East Kent report (2022) and dashboard compliance for quarter 2 2022/23. The information is detailed within the report for compliance against the proposed February 2023 CNST submission and ongoing assurance will feature within future reports.

1.3 The Maternity Safety Report is presented quarterly at the Trust Patient Safety and Effectiveness Committee, Quality Safety Committee and was last presented at Trust Board in June 2022.

2. CONTENT

2.1 Activity/outcome data within the maternity unit:

Month – 2022/23	Deliveries	Births
July	501	509
August	473	479
September	455	465
Total	1429	1453

Month – 2022/2023	Bookings
July	469
August	513
September	507
Total	1489

The number of deliveries/births has shown a slight ***increase of 12 deliveries and 2 births*** compared to the same period in 2021/2022. There is ***a decrease of 62 bookings*** during the same period.

Maternal Clinical outcome data

As part of the national reporting for caesarean sections NHS England have asked that caesarean section rates are no longer reported against a national benchmark but use the WHO Robson criteria as detailed below.

Group	Description
1	Nulliparous, single cephalic, ≥37 weeks, spontaneous labour
2A	Nulliparous, single cephalic, ≥37 weeks, induced labour
2B	Nulliparous, single cephalic, ≥37 weeks, caesarean before labour
3	Multiparous (excluding previous caesareans), single cephalic, ≥37 weeks, spontaneous labor
4A	Multiparous (excluding previous caesareans), single cephalic, ≥37 weeks, induced labor
4B	Multiparous (excluding previous caesareans), single cephalic, ≥37 weeks, caesarean before labor
5	Previous caesarean, single cephalic, ≥37 weeks
6	All nulliparous breeches
7	All multiparous breeches (including previous caesareans)
8	All multiple pregnancies (including previous caesareans)
9	All abnormal lies (including previous caesareans)
10	All single cephalic, ≤36 weeks (including previous caesareans)

Data for the 6-month reporting period demonstrates that the most common reason for caesarean section was from Group 2 and Group 5 with over 50% of caesarean sections undertaken for these reasons.

The induction of labour rate at the Trust averages as a percentage of all deliveries for Quarter 2 is currently at 30.97% which is just below the national average of 31.6%. This rate will be influenced by the number of high-risk pregnancies where an increased risk of poor outcome is well evidenced, including those transferred for tertiary level care. The Trust are a referral centre for maternal and fetal medicine cases for Coventry and Warwickshire providing care to women with complex pre-existing medical conditions and those requiring enhanced support including interventional radiology, cardiology, renal and vascular support.

2.2 Perinatal Mortality: Stillbirths and Perinatal/Neonatal deaths

According to MBRRACE (2021) the extended perinatal mortality rate for 2020 across the UK as a whole was 4.85 per 1,000 total births (5.13 in 2018), comprising ***3.33 stillbirths per 1,000 total births*** (3.51 in 2018) ***and 1.53 neonatal deaths per 1,000 live births*** (1.64 in 2018). (Stillbirths are related to babies born without signs of life at more than 24 completed weeks of pregnancy.)

The rate of Stillbirths for the Trust is currently 6.74 per 1000 births for the period reported and 6.75 per 1000 births for the rolling 12 month period. Stillbirths are related to babies born without signs of life at more than 24 completed weeks of pregnancy.

As a Local Maternity and Neonatal System (LMNS) the stillbirth and neonatal death rate is 4.2 per 1000 births and 1.2 per 1000 births respectively:

All stillbirths had a Patient Safety Response review within 72 hours and any early themes and learning are identified and acted upon. Using decision making tools (Appendix 1) the following cases within the reported period were allocated for review as follows:

Reason(s) for admission	Referral for HSIB investigation	Internal RCA Investigation	PMRT review	Other
Vaginal bleeding (APH)	Yes	No	Yes	No fetal heartbeat on admission meets HSIB referral criteria
Twin pregnancy (IUD during pregnancy of one baby)	No	No	Yes	
Twin pregnancy (spina bifida and fetocide)	No	No	Yes	
Attended in labour, ruptured membranes – meconium-stained liquor	Yes	No	Yes	No fetal heartbeat on admission, meets HSIB referral criteria
Abdominal pain/placental abruption diagnosed on admission	Yes	No	Yes	37+5 contracting meets HSIB referral criteria
Breech presentation declined intervention	Yes	No	Yes	
No fetal movements with diagnosed trisomy 13	No	Yes	Yes	
No fetal movements 25 weeks gestation	No	No	Yes	PM requested
Admitted in labour, no fetal heartbeat on admission	Yes	No	Yes	PM requested, meets HSIB referral criteria
Known bilateral cleft palate, small for gestational age baby 31+6 weeks gestation	No	No	Yes	
Attended with no fetal movements for 5 hours overnight	No	No	Yes	
Admitted with abdominal pain, ruptured ovarian cyst identified during caesarean	No	No	Yes	29 weeks gestation
Admitted for sliding scale and steroids planned caesarean section. No Fetal heartbeat during routine observations	Yes	No	Yes	Labour 37 weeks meets HSIB referral criteria

As part of our ongoing commitment to patient safety and the national ambition to reduce poor outcomes an internal deep dive into the governance, investigations and national reporting of perinatal mortality cases for 2020-2022 has been completed and was reported to the Patient Safety Effectiveness Committee (PSEC) in August 2022. Local actions from this review have now been completed. The actions included PSR reviews to be undertaken for all eligible incidents, to include a review into health inequalities of the women and their families and monitoring of all actions identified during the PMRT process through the Trust incident reporting/monitoring system (Datix). There was also a Trust wide action to review the Incident Management policy (GOV-POL-005-07) with regards to stillbirths and unavoidable neonatal deaths.

The national average for neonatal deaths is 1.53 per 1000 live births. As the only Level 2 and Level 3 provider in the local area the unit receive transfers from neighbouring trusts during pregnancy and the early neonatal period for intensive support. The rate of Neonatal deaths for the Trust is currently 1.97 per 1000 births for the rolling 12 month period.

There were 7 neonatal deaths for the period reported, 5 of these were due to extreme prematurity (between 22+5 and 23+3 weeks gestation) and 2 due to known fetal anomalies. None of the cases were eiligible for HSIB referral and all had a local review.

2.3 Neonatal

Women with pregnancies less than 32 weeks gestation with threatened preterm labour are received into the Trust from within the system and Clinical Network. There were 8 intrauterine and 7 neonatal transfers within the department during the reported quarter.

Any women who are unable to be accepted due to capacity on the Labour Ward or in the Neonatal Unit (NNU) are discussed as part of the bi-weekly Maternity Safety Champion meeting for oversight and assurance. There were a total of 78 requests during this timeframe, this was an increase on the previous quarter.

The Term admission rate at the Trust is consistently below the national reported average rate (5%) at 2.8%. The Avoiding Term Admission into Neonatal Unit (ATAIN) for all unplanned term admissions are reviewed as part of multi-professional review and decided whether the admission was avoidable or unavoidable. Any learning identified is shared within an action plan and disseminated via a staff newsletter. Recent learning identified and shared include:

- calling 2222 for a baby emergency if the neonatologists are not in attendance following the first bleep,
- ensuring all appropriate babies receive delayed cord clamping for at least one minute after birth,
- raised lactate in isolation is not a reason for admission to the Neonatal unit

In regard to neonatal nursing workforce, the neonatal nurse staffing business case is currently being updated to reflect the funding received from the Clinical ODN and AHP support funding. The action plan submitted for Maternity Incentive Scheme in 2021, these risks continue to be monitored through the governance reporting structure and this will be updated to reflect the improved position prior to the submission date in February 2023.

2.4 Continuity of Carer

In accordance with the recommendations of the final Ockenden Report (March 2022) and following the letter sent to all Trusts by Ruth May, NHSE Chief Nursing Officer on April 1st 2022, the Trust has previously confirmed that Midwifery Continuity of Carer (MCoC) is not currently in place and women are cared for within traditional models of maternity care. This position is reflected across the LMNS.

A further letter sent by Ruth May and Jacqueline Dunkley-Bent, NHSE Chief Midwifery Officer on September 21st 2022 confirmed that all national target dates to deliver MCoC have been removed and this will remain in place until sufficient staffing levels can be demonstrated.

The Trust remains committed to delivering the critical components of the model to women with health inequalities such as those from black, asian and minority ethnic groups and those living in high social deprivation and continues to work towards this.

2.5 Healthcare Safety Investigation Branch (HSIB) and Maternity Serious Incidents

Cases to date	
Current active cases	8
Exception reporting	1 exception on case (MI-009297). Likely to exceed 6 month timeframe

All learning and safety recommendations from incidents are shared within the weekly Quality of Care multi-professional learning meetings, weekly departmental training sessions (MS Teams) and monthly Quality Meetings to inform practice and embed learning identified. To support wider learning all findings and safety recommendations are also shared within the monthly LMNS Board meetings as part of the Perinatal Clinical Quality Surveillance requirements.

There are 'Good Governance Boards' in clinical areas which are discussed at the daily huddles to share learning. These have been identified as best practice during our recent NHS England insights visit.

National themes and learning from HSIB cases are disseminated quarterly within a HSIB newsletter.

2.6 Staffing/red flag events/Birthrate + acuity

A bi-weekly meeting with Recruitment and Workforce is in place to discuss challenges and updates relating to pipeline starters and leavers. This works well to ensure that there is timely response to all aspects of recruitment detailed below.

Staffing has remained challenging during the period reported. As a result of the support with the enhanced bank rate we have had continued support in covering some available shifts, however to maintain safe staffing all specialists and ward managers have continued to be utilised.

Community Midwifery caseloads have been reviewed and re-aligned with further work ongoing to streamline the workload in community such as centralised booking clinics.

Additional measures taken include Agency nursing shifts for Labour ward and ward 25, although these cannot be included within the midwife to birth ratio, this model has been shared regionally as good practice for enhanced safety whilst midwifery staffing remains a national challenge.

The introduction of a Matron of the Day has also supported safe staffing and escalation within the department with senior oversight and opportunity for referral.

2.7 Vacancy

The ***current midwifery vacancy*** is **28 WTE** against the 2021/022 baseline. Additional funding has been received from NHSE from Ockenden funds for **8.57 WTE** midwives to be added to the baseline establishment. Within the department there are also currently **11 WTE** staff on maternity leave. A Midwifery Workforce plan is in place to review current position, trajectory, and future workforce plans.

As part of our Workforce Improvement Plan, we have received executive support to reintroduce the Golden Hello incentive which was previously successful and an enhanced bank rate for midwifery shifts until the end of October 2022. We continue to advertise various roles to attract Band 5/6 midwives including community only posts and have planned recruitment events. There are 15 WTE midwives in the recruitment pipeline that will commence in practice over the next 1-2 months (all pipelines) leaving a residual **vacancy of 13 WTE**.

Recruitment Pipeline

Band 5/6	Sept 22	Oct 22	Nov 22
Vacancies WTE	41.52	28	14.9
Vacancy %	22%	16.5%	8.8%
New Starters profiled WTE	5	15.5	
Projected Pipeline Leavers	6	2.4	1
Pipeline New Starters		15	-

By the end of November 2022, the projected vacancy will be 8.8% for band 5/6 Midwives.

International Recruitment

Funding from NHS England to recruit as part of a collaborative bid 14 WTE International Recruitment (IR) Midwives has been fully utilised. 12 midwives have successfully completed their training, 1 more is in the process of training and awaiting completion of their OSCE and an additional 1 is yet to arrive in the UK. We have two IR Practice Educators appointed on secondment for 12 months to implement their OSCE training and provide essential pastoral support. A further bid has been supported by NHSE/I to continue with further International Recruitment for the next 12 months for a further 7 midwives. We are looking to increase this to 14 with funding from within the existing budget.

Return to Practice (RtP)

Within the maternity department we have supported three RtP Midwives, two of whom have been appointed into substantive roles, the remaining is our professor of Midwifery.

Heath Education England (HEE) is offering financial support to the Trust for 3 places within the current financial year. Interviewing is scheduled in November with 6 applicants, it is our intention to support all applicants.

Education programmes

During 2021 the Trust agreed to support an increase in the number of midwifery students on the pre-registration midwifery course at Coventry University from 23 (2019/20) to 45 (2021/22) and 35 (2022/2023). Unfortunately, due to the admissions process this was not achieved in 2022/23 with 27 students being allocated to UHCW for 2022/23.

Retention of existing / new staff is an essential area of focus, and we are currently piloting the Retention Toolkit developed in the Midlands Region – with a focus on leadership for successful retention and actively reviewing career pathways and opportunities for our staff. We have our second midwifery student on the Developing Aspiring Leaders course sponsored by the Director of Midwifery.

We are also funded for a Retention Midwife in post who is showing successful results with supporting staff and improving retention and recruitment being the link person following interview until commencement in post.

Furthermore, we have developed an SLA for the shortened programme (18 months) with Birmingham City University and have received funding for an additional five placements to commence in January 2023, we are currently recruiting into these posts.

Maternity Support Worker training

A shortened training programme is being developed with funding support from NHSE/I to prepare band 2 Healthcare Support Workers to progress to band 3 Maternity Support Workers to meet workforce requirements. The programme will be fully mapped to HEE's Maternity Support Worker framework and UHCW are a pilot site.

Midwife to Birth ratio:

The Midwife to Birth ratio has been maintained between 1:30 and 1:33, this is largely dependent on the number of births each month and sickness rates.

The supernumerary status of Labour Ward coordinator is essential for a helicopter view of the service and to provide supervisory support and continuous senior presence. This has been maintained at 99% for the period reported, an action plan is in place to ensure that we achieve the 100% required standard in addition to the one to one care in labour standard.

With the support of the specialist midwives and management team, one to one care in established labour has been maintained at 99% during the period reported. The department currently has the nationally agreed 10% specialist roles as detailed within the most recent Birthrate Plus assessment.

There were 4 categories for 'Red Flags' as per NICE Safe Staffing guidance reported during the period with no adverse outcomes or clinical harms because of these. The delays were considered necessary due to ensuring that one to one care in labour could be maintained and supernumerary status of the coordinator.

As part of the regional Maternity OPEL escalation any delays are shared with the W&C Manager of the Day and the trust Site Manager, with the ability to escalate any unresolved staffing gaps to region.

There were 4 categories for 'Red Flags' as per NICE Safe Staffing guidance reported during the period. These include:

- delay between admission for induction and beginning of the process

- delay in starting Syntocinon/ ARM of more than 20 minutes. This red flag is being changed to 48 hours in line with Birthrate Plus and national recommendations.

Audits around compliance within the Labour Ward Triage BSOTS reviews have been added to the audit plan as part of local learning identified to ensure that there is timely escalation for medical review.

There were no adverse outcomes or clinical harms identified because of the delays detailed above. The delays were considered necessary due to ensuring that one to one care in labour could be maintained and supernumerary status of the coordinator.

As part of the regional Maternity OPEL escalation any delays are shared with the W&C Manager of the Day, Control room and any requests for support escalated within the LMNS and region.

The Trust are committed to working towards the recent Birthrate Plus assessment and a business case for Maternity Staffing is in the Trust review and approval process.

2.7 Staffing oversight

Staffing rosters are published 6 weeks in advance, signed off by Matrons and authorised by the Deputy DoM. or Director of Midwifery (DoM).

Rosters are subject to change, for example, to respond to unplanned short term sickness absence, or unexpected patient acuity or demand, requiring a high level of responsiveness.

Staffing has remained challenging during the reporting period. The enhanced ‘bank rate’ in place until the end of October, has been effective in helping to cover some of the available shifts, with specialists and ward managers being rostered to support essential shifts, where necessary.

Community Midwifery caseloads have been reviewed and re-aligned with further work ongoing to streamline the workload in community such as centralised booking clinics.

The introduction of a Matron of the Day in maternity, has further strengthened staffing oversight linking closely into established safer staffing / escalation processes within the trust.

Further additional measures taken include Agency nursing shifts for Labour ward and ward 25, although these cannot be included within the midwife to birth ratio, this model has been shared regionally as good practice for enhanced safety whilst midwifery staffing remains a national challenge.

2.8 Culture and Communication

A revised communication strategy, (dissemination of information) was launched in March 2020 with the introduction of a closed Facebook Group for all Maternity staff including the multi-professional team (theatre staff, Midwives, Sonographers, HCSW, MSW, admin staff medical staff and medical secretaries) there are currently 359 members. The Director of Midwifery/ Deputy Director of Midwifery shares a video update each week with key messages for staff, these include recruitment, trust updates and any learning from incidents/feedback. The group also offers the staff the opportunity to ask questions at any time – these are responded to within 48 hours of being raised, along with direct access to the Director of Midwifery through messenger.

Human factors are built into all aspects of multi-professional training and safety culture training to build on the PROMPT and CTG multi-professional workshops.

The number of Professional Midwifery Advocates (PMAs) continues to grow to support restorative practice, service, and staff development. The Lead PMA was appointed in 2021 and led on the Civility Toolkit survey, which was completed in February 2022, with restorative meetings, feedback to staff and drop-in sessions to help improve health and wellbeing continuing. A newly locally developed App (COMPASS) for direct access to PMA support is currently being trialled with all our 2022 new starter midwives before roll-out across the department.

The Chief Nursing Officer completes leadership rounding meetings within maternity services with a different area of focus weekly including Community staff to discuss any concerns or assistance needed. This is in addition to the bi-weekly meeting attended by the Chief Nursing Officer and Non-Executive Director Maternity Safety Champion to discuss maternity safety, together with the senior clinical leadership team and wider clinical body, to focus on progress with key quality metrics.

The results of the previous staff survey have been shared with all staff and a compass event held for staff to contribute to the action plan. Staff are currently being encouraged to contribute to this year's staff survey, the current completion rate is 20%.

The Non-Executive Director Maternity Safety Champion is planned to visit the department in November and meet with both the Maternity Voices Partnership chair and attend a focus group with service users.

2.9 CNST Maternity Incentive Scheme

The trust received notification in February that the department was successful in achieving all ten safety standards for 2020/21. The department are working on the actions to achieve all standards, and these are scheduled to be submitted for Trust Board approval for year four and submission to NHS Resolution by 5 February 2023.

2.10 Regulatory issues (Quarterly):

Progress with Ockenden action plan

5 of the 7 Immediate and Essential Actions from the Ockenden first report have been fully completed with 2 actions in progress:

- relates to medical staff undertaking wards rounds on the antenatal/ postnatal wards this is being addressed through a workforce business case.
- soundproofing of a Labour Ward room and designation of a separate bereavement facility. Currently solutions are being costed, business case has now been shared with the Chief Officers and support confirmed for progression.

Whilst the action plan shares the outstanding actions it offers assurance around the mitigation in place to strengthen the measures required to ensure that all recommendations are being met. (Appendix 2)

The department welcomed an Insight visit in August 2022 led by the Regional Midwifery Officer for NHSE/I to gain assurance with the immediate and essential actions from the first Ockenden report. Positive feedback was given following this meeting with some points for consideration to strengthen the assurance given. The report was shared with the Quality and Safety Committee in September 2022 and the department is currently working on the action plan following the visit. (Appendix).

The final Ockenden report was published on March 30, 2022, with 15 new Immediate and Essential Actions with 88 specific components in each. The department has assessed itself against the 88 components whilst awaiting further guidance from the national team and established the following progress:

- 76 of the components are complete, 55 of these having a full level of assurance.
- 3 components are in progress.
- 9 components not applicable as awaiting national guidance.

Bi-weekly meetings are being held with the Chief Nursing Officer, Chief Medical Officer and Director of Quality to review progress against the IEAs.

The department have developed a local gap analysis against the five East Kent report (2022) recommendations (Appendix 4) with dates and leads to be identified:

Perinatal Mortality reviews (PMRT/MBRRACE)

The department are working towards all of the measures outlined within the year four Maternity Incentive Scheme and hold regular weekly multi-disciplinary team mortality review meetings. Parent perspectives are obtained for all cases to ensure that any questions that they may have around the care is incorporated into the review. Some recent learning from PMRT includes:

- The use of interpreters for non-English speaking patients instead of using family members,
- women attending with antepartum haemorrhage should be admitted for 24 hours in line with RCOG guidance,
- if a woman is delayed for any reason, and in theatre there should always be one midwife and one support worker in attendance in case of an emergency.
- Delays in commencing cases within two months where the case is co-assigned with another organisation – raised with MBRRACE and this will be shared within our CNST submission.

Perinatal Quality Surveillance Model (PQSM)

Board level safety champions attend the bi-weekly Maternity Safety Champion production board meeting, and the Chief Nursing Officer has conducted rounding on Ward 25, Community and Antenatal Clinic (July & October 2022), ward 24 and Labour ward (September 2022).

The Non-Executive Board Level Maternity Safety Champion attended the department in July 2022 and a further visit has been arranged for November 2022.

The triumvirate prioritise and attend all LMNS board and Workstream meetings each month to ensure that there is UHCW representation and learning is disseminated to the wider team.

The ICB are involved in the monthly perinatal quality surveillance regional meetings to represent UHCW, George Eliot and South Warwickshire Foundation Trust.

The OPEL escalation policy has been adopted within the department with daily reporting to the site team and national team to highlight the challenges within the department and escalation for support. The Director of Midwifery is on working groups to develop and improve these reporting processes.

Governance Processes

A local assurance review on the governance, investigations and national reporting of stillbirths was commissioned by the Chief Nursing Officer and Chief Officer for Quality and the report was presented at PSEC in August 2022.

The review found that all the SI and HSIB criteria were reported and investigated appropriately, and the duty of candour process was followed in all cases. Actions for

the department from the review included the use of Datix for documenting the outcomes and actions from investigations and the duty of candour process.

2.11 Training Compliance against trajectory for Multi-Professional Training

Speciality specific training has been prioritised within the department, in particular for multidisciplinary Obstetric emergency training and fetal monitoring training. Compliance remains above 90% for Midwives, Obstetric Consultants, Maternity Support Workers. Anaesthetic Consultants and trainees will have achieved the 90% requirement by 30 November 2022. NLS training is incorporated into the Multi-professional training day and will also be above the 90% requirement by 30 November 2022.

2.12 Compliments and Complaints

The department regularly receives positive feedback from the women directly on the ward, by email, through PALS and Daisy award nominations. This is shared with the team involved and on the Maternity closed Facebook page to celebrate the team's successes with the introduction of 'Feedback Friday'.

There have been 14 formal complaints during the period reported. All complaints have been formally investigated and reported back to the complainant. No themes/ trends have been identified within this reporting period.

Learning from complaint actions include:

- A multi-disciplinary task and finish group has been set up to review wound care, including sourcing new wound dressings.
- A multi-disciplinary task and finish group has identified an area to develop a bereavement suite, funding has now been given to develop plans for this and a business case is in progress.
- From previous complaints regarding the induction of labour process a multi-disciplinary task and finish Group has been set up to review and implement the new Induction of Labour guideline alongside the Maternity Voices Partnership Chair to ensure that the opinions of our service users are taken into consideration. The recruitment of an identified Induction of Labour Flow midwife is also in process.
- During the COVID pandemic the commissioned support provided by George Eliot Hospital for frenulotomy (tongue tie division) was removed for women of Coventry and Warwickshire leaving them with the opportunity to access private care only. The department have since supported staff to undergo accredited training with University of Wolverhampton and commenced a dedicated clinic in October 2022.

2.13 Service User Feedback/Maternity Voice Partnership

The department has received the results of the 2022 National Maternity survey led by Picker. Although the report remains embargoed the department are working on an action plan to improve the 5 areas where improvement is most needed.

Regular quarterly meetings have been held with the Maternity Voices Partnership (MVP) chairs, many of the team attend this including the Patient Experience midwife. A 15 Steps review, (where several service users walk through the department with fresh eyes) was undertaken by the MVP in early July with positive feedback received from this visit. An action plan is underway to address any improvements identified.

A Whose Shoes event took place on June 14th involving service users, the MVP and staff as a joint interactive engagement event looking at the impact of Covid-19 on patient experience.

2.14 Risk register/additional items for the attention of Board

There are two high risk items on the risk register for Maternity. These include the inability to achieve the nationally recommended midwifery staffing in accordance with the Birthrate plus assessment. Current action to reduce this risk includes the ongoing recruitment with bi-weekly recruitment meetings. International recruitment with all 14 Midwives recruited and the agreement to continue with international recruitment. The enhanced bank rate for all clinical midwifery shifts was supported until the end of October. Specialist midwives/ managers are working weekly clinical shifts. The Matron of the day was introduced to provide daily senior oversight and ensure that staff had relief for meal breaks. A funded Retention Midwife is in post successfully supporting staff to remain in post.

The business case requesting additional support to achieve the Birthrate Plus assessment is currently going through the Trust review and approval process.

The second high risk relates to the Trust compliance with the National Bereavement Care Pathway to have a dedicated bereavement facility with a separate entrance from the Labour ward. Board approval has been received to progress to a PFI variation, once approved detailed plans and drawings can be commenced.

3. IMPLICATIONS

The department continue to focus on the following workstreams in order to achieve all national recommendations and requirements:

3.1 Review of the Maternity workforce business case to ensure that the Trust have a plan to meet the Birthrate Plus assessment undertaken in 2021 and workforce requirements as outlined in Section 2 of the Ockenden recommendations. This has been further updated following the NHSE/I insight visit.

3.2 Improved focus through the Maternity Safety Champion board meeting to include vacancy rate for midwives, compliance with QIS trained neonatal nurse, mandatory training compliance and sickness rates.

3.3 A task and finish group has been established to look at the risk around the separate area for dedicated bereavement care in maternity to meet the national requirements and is meeting bi-weekly as a minimum to progress this work. An area has been identified to convert into a bereavement suite, further funds have been agreed via the Chief Officer's forum to progress with plans.

3.4 Continuous review of perinatal mortality and morbidity and reporting to appropriate committees, all future reporting to include associated contributory factors, learning identified and escalation.

3.5 To ensure that there is continued commitment to multidisciplinary attendance at training sessions for PROMPT and the full day fetal monitoring training to maintain the 90% compliance. These have been prioritised as mandatory training to meet the needs of the Ockenden report and the CNST Safety Standard 8. This will improve safety along with improving working relationships which is critical within maternity safety.

4. CONCLUSIONS

4.1 The report aims to provide assurance that the department are on track with national reporting requirements and recommendations and that there is strong evidence of governance processes in place and that the organisation are well sighted on any improvements and progress.

4.2 The department are listening and actively seeking patient views in partnership working to provide strong evidence of working towards a strong inclusive leadership culture within all areas of maternity services.

4.3 Midwifery staffing continues to be closely monitored through the Senior Nurses Production Board, performance review meetings and Trust Board reports. The workforce business case has been re-drafted following the confirmation of financial support from NHS England and midwifery and medical recruitment is in progress. Bi-weekly vacancy control meetings are in place and well-attended monitoring recruitment.

4.4 The maternity team continue to prioritise patient safety and share their learning with the Board level maternity Safety Champions and offer staff the opportunity to share any concerns regarding patient safety at the bi-weekly production board.

4.5 Work is ongoing to achieve the ten Maternity Incentive Scheme safety standards by February 2023 submission date, with action plans in place and monitoring through the bi-weekly Maternity Safety Production Board.

5. RECOMMENDATIONS

5.1 The Trust Board are asked to note the performance and compliance updates for quarter 2 of 2022/23 and receive assurance around the CNST Maternity Incentive Scheme standards, national recommendations and PMRT and ATAIN action plans all of which are on track.

5.2 The Trust Board is asked to note the midwifery vacancy position and the progress with the trajectory for pipeline recruitment.

5.3 The Trust Board is asked to acknowledge the outstanding actions and action plan for the Ockenden report and the Insight visit.

Author Name: Gaynor Armstrong

Author Role: Director of Midwifery

Date report written: 10/11/2022

Table of abbreviations

Abbreviation	Meaning
ATAIN	Avoiding Term Admissions into Neonatal Units
CNST	Clinical Negligence Scheme for Trusts
CO	Carbon Monoxide
CoC	Continuity of Carer
GIRFT	Getting it Right First Time
IEAs	Immediate Essential Actions
LMNS	Local Maternity and Neonatal System
MIS	Maternity Incentive Scheme
MSDS	Maternity Services Dataset
PMRT	Perinatal Mortality Review Tool
PROMPT	Practical Obstetric Multi-Professional Training
RCOG	Royal College of Obstetricians and Gynaecologists
SOP	Standard Operating Procedure
UA	Uterine Artery
WTE	Whole time equivalent

Appendix 1 – Decision Tool for HSIB & PMRT referral(s):

HSIB referrals:

Incident(s) involving	Criteria for referral
Babies	**Term babies** (at least 37 completed weeks of pregnancy) who have one of the following outcomes: • Intrapartum stillbirth (thought to be alive at the start of the labour); • Early neonatal death (occurring within 7 days); • Potential severe brain injury (moderate or severe HIE, therapeutically cooled, had decreased tone, comatose and had any seizures). **Note: This does not include cases where health issues or congenital conditions (present before or at birth) have led to the outcome for the baby.** The definition of labour used by HSIB includes: • Any labour diagnosed by a health professional, including the latent phase (start) of labour at less than 4cm cervical dilatation. • When the mother called the maternity unit to report any concerns of being in labour, for example (but not limited to) abdominal pains, contractions, or suspected ruptured membranes (waters breaking). • Induction of labour (when labour is started artificially). • When the baby was thought to be alive following suspected or confirmed pre-labour rupture of membranes. HSIB do not investigate neonatal cases where the mother has not gone into labour. For example, when a caesarean section was performed before the mother had started having contractions or ruptured her membranes
Maternal deaths	Within 42 days of the end of a pregnancy, however HSIB do not investigate cases where suicide is the cause of death. These are reviewed by MBRRACE.

	Direct deaths - Direct deaths include those resulting from obstetric complications of the pregnant state (pregnancy, labour and after the birth), from interventions, omissions, incorrect treatment or from a chain of events resulting from any of the above. **Indirect deaths** - Indirect deaths include those from previous existing disease or disease that developed during pregnancy, and which was not the result of direct obstetric causes but was aggravated by the physiological effects of pregnancy in the perinatal period (during or within 42 days of the end of pregnancy).

PMRT referrals:

Incident(s) involving	Criteria for referral
Babies	**Late fetal losses** - where the baby is born between 22^{+0} and 23^{+6} weeks of pregnancy showing no signs of life, irrespective of when the death occurred, or if the gestation is not known, where the baby is over 500g **All stillbirths** - where the baby is born from 24+0 weeks gestation showing no signs of life, or if the gestation is not known, where the baby is over 500g. **All neonatal deaths** - where the baby is born alive from 22^{+0} but dies up to 28 days after birth, or if the gestation is not known, where the baby is over 500g. **Post-neonatal deaths** - where the baby is born alive from 22^{+0} but dies after 28 days following neonatal care; the baby may be receiving planned palliative care elsewhere (including at home) when they die. What is not included within the review: • Termination of pregnancy at any gestation. • Babies who die in the community 28 days after birth or later who have not received neonatal care. • Babies with brain injury who survive.

Appendix 2 Ockenden Report (1) Outstanding Actions

1.3.3 **Findings**	**RAG** **rating**	**Clinical Care and Competency: Management of the Complex Woman** **Evidence to support self-assessment**	**Action required** **Yes**	**Action**	**Action Owner**
f) Complex cases in both the antenatal and postnatal wards need to be identified for consultant obstetric review on a daily basis.		Timings of ward rounds can be compromised due to acuity on labour ward and no dedicated ward cover each day. Additional medical staffing required providing appropriate cover as currently not included within the medical staffing job plans. **Mitigation:** Labour ward Consultant to provide over and ensure that daily ward rounds are completed until dedicated resource is available	Yes	Added to workforce business case for additional Consultant cover to ensure that this is part of job planning. Anticipated date of completion: October 2022	SK/SH
2.0 **Findings**	**RAG** **rating**	**Bereavement Care** **Evidence to support self-assessment**	**Action required** **Yes**	**Action**	**Action Owner**

b) The Lead Midwife and Lead Obstetrician must adopt and implement the National Bereavement Care Pathway.		Following the national Bereavement care pathway, need dedicated bereavement facility with separate and dedicated entrance. **Mitigation:** Room 5 on Labour Ward is used as a bereavement room with further rooms identified on the Postnatal ward for aftercare. A Task and Finish group is meeting bi-weekly to resolve this action.	Yes	Area identified and business case shared with Chief officers, now being progressed through the approval process.	SK/SH

Appendix 3 – **Ockenden Insight Visit** Updated outstanding actions

Insight Visit 7 IEAs Action Plan September 2022

IEA1		RAG	Considerations	Actions	Date	Evidence	Assurance
Q11 – NED	Is there an allocated Non-Executive at Board level who works collaboratively with the maternity safety champions?		Strengthen the interaction between NED safety champion, staff, MVP and service users - little evidence of this seen during visit and when talking to staff. NED in post - little evidence of interaction with staff, none with service users or MVP	8.11.2022 Quarterly meetings planned with CM, MVP chair and DoM. Opportunities during each visit to attend service user focus groups or walkaround in ward areas to gather service user feedback	01.11.2022	champions and attends MSC meetings. First meeting 2.11.2022 attended ward 25 with Patient Experience MW, 15 steps shared and discussed with MVP chair and local action plan	Meetings in place to ensure that there is opportunity to share patient experience in addition to co-production.
Q13 – Service user feedback	What is the mechanism for service user feedback, and how this is obtained through MVP to coproduce maternity services?		MVP stakeholder engagement leadrecently appointed - support with building relationships with key people would be of help, especially the patient experience midwife	Plans to arrange regular service user liaison meetings, including focus groups, meetings and co-production. Chased NLL at ICS to support UHCW as still no local MVP champion appointed (only 1/3 in post currently - no appointment for UHCW or SWFT - needs to be a priority under new model)	31.12.2022	TOR for LMNS MVP saved JW from ICB given details of pt exp midwife to contact. To be escalated again at LMNS Board about MVP champion for UHCW	Sufficient support available for service users to participate in co-production with support of MVP chair nd vice-chair
Q16 – NED	Does the non-executive director support the Board level champion who works collaboratively with the maternity safety champions to bring challenge and ensure all voices are heard?		There was no evidence of co-production seen or described during the visit. Consideration of implementation of true co-production to be given rather than current practice of "ad hoc" requests for women who are still receiving care.	01.09.2022 meeting arranged with SW to discuss plan	03.11.2022	and these are either in person or during the pandemic via Teams. We have had two in the last 12 months and NEDs are part of the team along with a chief officer. Walk around have been completed 3 times by NED during 2022 with opportunity to speak to service users.	February 2022, August 2022 and November 2022. COMPASS event to be arranged with staff, MVP and NED.
Q41 – Inofrmed choice	Can women participate equally in all decision-making processes and to make informed choices about their care?		Little evidence of choice conversations – staff could recall women being "told" they were having induction without any choice – consider a method of recording accurate choice conversations	8.11.2022 Survey being prepared to ask women whether they have been involved in the decision-making process. To be circulated on the postnatal ward by the Patient Experience midwife prior to discharge.	31.12.2022	Survey infomration once available and number of participants each month	Results of survey to indicate compliance
Q42 – Women's choices	Are women's choices respected following informed discussion and decision made?		Decision making and informed consent - find a way of documenting the conversations that take place and then audit	Review of survey findings to ascertain whether the women's choices were respected.	31.12.2022	Survey infomration once available and number of participants each month	Results of survey to indicate compliance

Q43 – Service user feedback	What is the mechanism for service user feedback, and how this is obtained through MVP to coproduce maternity services?		User feedback can be sporadic. Coproduction not documented	Improved mechansisms for collection of feedback including MVP electronic survey, increase in MVP support team (vice-chair and champions), Envoy reports, Feedback Friday QR codes for ward areas, promotion of MVP to engage families to join, patient representatives included within working parties.	31.12.2022	CQC feedback saved Listening clinic information saved, Envoy results for Maternity	Evidence of co-production, minutes from meetings (bereavment T&F group) MVP minutes. COMPASS event to be planned for staff, MVP and NED.
Q49 - Guidelines	Where non-evidenced based guidelines are utilised, is there a robust assessment process before implementation and ensures that the decision is clinically justified.		Still have number of guidelines out of date, no evidence of risk assessment. Need evidence of risk assessments if national guidance not followed.	8.11.2022 number of outstanding guidelines out of date reduced from 57 to 29, 8 to be approved through QIPS November 2022	31.12.2022	Accountability data from QPS team	Evidence of full compliance

Appendix 4 – East Kent report (2022) Gap Analysis

UHCW Kirkup Report Gap Analysis

Gap analyisis of UHCW Maternity service against recommendations detailed in Reading the Signals East Kent Maternity and Neonatal investigation (Kirkup Report)

Theme	Recommendation	Current Status	Status (RAG Rated)	Action(s) Required
Areas for Action	**Recommendation 2 (Part 1):** Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning.	Senior staff attend compassionate leadership training Compassionate working group in place Students receive compassionate training within the universtiy degree programme. Staff and students are expected to adhere to the Trust Values, which are displayed around the Trust and available online		Work with Practice Placement Midwife who provides a link between the trust and the University to ensure compassion and values are aligned [HN/CD] Look into incorporating specific compassion training into the CTG study day and PROMPT training [KS/LT] Development of a decision making proforma [CC/LT]
	Recommendation 2 (Part 2): Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance.	Survey from the Deanery is completed by junior doctors annually Student midwives complete survey annually and have frequent touch point meetings with personal tutors. There is feedback from Labour Ward which is provided quarterly if there are any concerns.		Awaiting direction from professional bodies
	Recommendation 3 (Part 2): Relevant bodies, including Health Education England, Royal Colleges and employers, be commissioned to report on the employment and training of junior doctors to improve support, teamworking and development.	Junior doctors forum meets on a regular basis.		Awaiting direction from professional bodies
	Recommendation 4 (Part 2): Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards.	Regular engagement with the Non Executive Director, Carole Mills who is responsible for patient safety - visits quarterly, speaks to patients and their families and staff. We have 2 board level safety champions.		Development of new debrief pro forma to include questions at the end regarding any concerns or escalation problem [CC/LT]

Theme	Recommendation	Current Status	Status (RAG Rated)	Action(s) Required
1. Not being listened to or consulted with	Indicative behaviour: Not listening to women's concerns or not taking them seriously, resulting in a failure to recognise	Patient experience MW present on wards Matrons perform ward rounds daily Escalation policy in place Rounding by Chief Nursing Officer monthly		Informed consent survey being designed by digital MW [KA]
	Indicative behaviour: Not taking the time to explain to women or their families what was happening or involving them fully in decisions about their care			
	Indicative behaviour: Failing to keep accurate notes about what women themselves were saying and how they were feeling	We encourage and support feedback in a number of ways - the patient experience MW is available on the ward. Encouragement of women to complete the survey regarding all aspects of their care at the point of discharge and the Friends and Family Test.		
2. Encountering a lack of kindness and compassion	Indicative behaviour: Showing a basic lack of kindness, care and understanding to women and their families	Compassionate leadership training is provided to senior staff, the university provides training in compassionate care for midwifery students.		Development of debrief pro forma to include questions at the end regarding the woman's experience of compassion [CC/LT] Incorporate compassionate learning modules into the CTG study day and PROMPT training [KS/LT]
	Indicative behaviour: Making unkind or insensitive comments to women and their partners			
	Indicative behaviour: Showing an indifference to women's pain			
	Indicative behaviour: Failing to ensure or preserve women's dignity or provide for their basic needs			
	Indicative behaviour: Placing women with other mothers and their newborn babies following the loss of their own baby or after a serious event	Bereaved women are placed in side rooms / family rooms as far away as possble from other women with babies.		There is a Task & Finish Group in place to develop a dedicated Bereavement Suite. [HS/GA]
	Indicative behaviour: Putting pressure on families to consent to a post-mortem examination	Training is provided to staff for providing sensitive advice regarding consenting to post mortems.		

Theme	Recommendation	Current Status	Status (RAG Rated)	Action(s) Required
3. Being conscious of unprofessional conduct or poor working relationships compromising their care	Indicative behaviour: Making rude, inappropriate or offensive comments to women and their partners	Mdiwifery staff operate within the NMC code of conduct and all staff are expected to adhere to the Trust Values. Senior staff are provided with compassionate leadership training, and compassionate role modeling is expected. Complaints, including those regarding behaviour are monitored.		
	Indicative behaviour: Behaviours or comments that undermined colleagues, including public disagreements and raising concerns directly with women about their care	There is a clear line of escalating concerns. Senior staff receive compassionate leadership training and		Conflict of clinical opinion guideline under development [LT/CC]
	Indicative behaviour: Disagreements between individuals in the same or different professional groups about women's care, including giving mixed messages			
	Indicative behaviour: Failing to pass on or act on information, including failing to hand over effectively at shift change or to communicate effectively between services	SBAR used for handovers. Huddles for verbal handover to clinical staff		
	Indicative behaviour: Shifting the blame for a poor outcome onto colleagues	Senior staff are provided with compassionate leadership training, and compassionate role modeling is expected. PMAs in place for supporting midwives, supervisors available to support doctors.		
4. Feeling excluded during and immediately after a serious event	Indicative behaviour: Not being told what was happening, or what had happened, when things went wrong	Hot debriefs take place, the neonatal unit staff attend to provide updates / care plans and outcomes / prognosis. Birth listening service is held regularly. Support from the bereavement team alongside the clinical staff is provided.		
	Indicative behaviour: Leaving family members waiting and anxious for news			
5. Feeling ignored, marginalised or disparaged after a serious event	Indicative behaviour: A collective failure to be open and honest or to comply with the duty of candour	Duty of candour pro forma completed at the MDT Patient Safety Reviews which take place within 72 hours of the incident. Face to face meetings are planned to resolve any complaints or answer questions ASAP. If it is an HSIB case, we provide separate compaints meeting to address any concerns that fall outside of the HSIB framework. Psychologist is available for parents with babies in the neonatal unit and one is available for staff where required. Our specialist perinatal mental health midwife is available for long term support to women who require it. There is also a birth listening clinic held		
	Indicative behaviour: A collective failure to act on or respond to concerns, including a poor or inadequate response to complaints			

Theme	Recommendation	Current Status	Status (RAG Rated)	Action(s) Required
5. Feeling ignored, marginalised or disparaged after a serious event	Indicative behaviour: A collective failure to be open and honest or to comply with the duty of candour Indicative behaviour: A collective failure to act on or respond to concerns, including a poor or inadequate response to complaints Indicative behaviour: A tendency for the Trust to fail to take responsibility for errors or to show accountability Indicative behaviour: A failure to provide adequate follow-up support, including appropriate counselling	Duty of candour pro forma completed at the MDT Patient Safety Reviews which take place within 72 hours of the incident. Face to face meetings are planned to resolve any complaints or answer questions ASAP. If it is an HSIB case, we provide separate compaints meeting to address any concerns that fall outside of the HSIB framework. Psychologist is available for parents with babies in the neonatal unit and one is available for staff where required. Our specialist perinatal mental health midwife is available for long term support to women who require it. There is also a birth listening clinic held regularly to provide women with an opportunity to discuss their experiences.		
6. Being forced to live with an incomplete or inaccurate narrative	Indicative behaviour: Blaming women and families, or making them feel to blame, for what had happened to their baby Indicative behaviour: Not giving women and their families answers or reasons for why things had gone wrong	Patient experience MW present on wards and matrons perform a daily ward round for feedback if required. MVP works closely with the Trust staff and the 15 steps report has been co-produced. Feedback is given at the hot debrief regarding incidents and another debrief is also arranged for further discussion in the future with the relevant senior staff. Bereaevement Team privide ongoing support and in cases of, eg. HIE, long term follow up is provided by the neonatal unit with developmental reviews for up to 2 years.		Launch of the national perinatal culture and leadership development event. UHCW will take part as part of the early adopter sites. Dates to be shared November 2022 [SK/SH/GA/PN]. Survey for women to complete on the postnatal ward under development to ask whether the women and families feel that they have been involved in the decision-making process and fully informed about management plans. [LT/CC/KA]

	Compliant
	Work in progress
	Not compliant
	Not applicable

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 1 DECEMBER 2022

Subject Title	Safe staffing report
Executive Sponsor	Tracey Brigstock, Chief Nursing Officer
Author	Paula Seery, Associate Director of Nursing, Workforce Vicky Williams, Deputy Chief Nursing Officer
Attachment(s)	Report
Recommendation(s)	The Board is asked to **NOTE** and **RECEIVE ASSURANCE** from the contents and analysis therein that the organisation has fulfilled its obligations in relation to Nursing and Midwifery safer staffing.

EXECUTIVE SUMMARY

The purpose of this report is provide assurance that the Trust is compliant with its obligations under National Quality Board, National Institute for Health and Care Excellence guidance and Carter report recommendations in relation to safer staffing for Nursing and Midwifery.

The report details safer staffing requirements including standard reporting information with metrics and analysis for the period of April 2022 to September 2022 as part of a bi-annual reporting schedule and demonstrates the utilisation of nationally recognised tools and metrics to ensure effective and robust processes are in place.

There is an overview of recruitment and retention activity including key workstreams and areas of focus across professional as well as specialist groups including Allied health professionals, Paediatrics, Critical care and Maternity services.

Key points of note:

Acuity levels continue to demonstrate increased complexity of patient need as well as continued need for enhanced levels of observation including Registered Mental Health Nurses and Enhanced Care Team

Challenges within paediatrics in managing an increased number of children and young people with mental health or social crisis needs as well as innovative developments to support patients as well as the workforce

No staffing correlations have been identified in Root Cause Analysis investigations for falls and for pressure ulcers

RN vacancy as at September 2022 is 8.65% which is below the ambition of 10%

Bank and agency utilisation due to sickness continues to drive fluctuating demand despite a decrease in vacancies

UHCW are finalists for the second year running for Nursing Times workforce awards including preceptorship programme of the year

UHCW is the first University Hospital in England to achieve Pathway to Excellence ® credentialing which is an internationally recognised framework for nursing and midwifery excellence which is known to have a positive impact on recruitment and retention
PREVIOUS DISCUSSIONS HELD
Report presented to Board 9th June 2022 as part of bi-annual reporting schedule

KEY IMPLICATIONS	
Financial	Robust safer staffing and recruitment processes ensure appropriate and efficient use of available resources
Patients Safety or Quality	Safer staffing and correlation to nurse sensitive indicators provides assurance regarding patient safety events which may relate to nurse staffing
Workforce	Providing a positive experience for new recruits and supporting staff well-being promotes UHCW as an employer of choice
Operational	Safe staffing processes supports operational delivery and patient flow as well as patient experience

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

REPORT TO PUBLIC TRUST BOARD

Safe Staffing report: April 2022 - September 2022 (Q1 & Q2)

1. INTRODUCTION

This report provides assurance that UHCW NHS Trust has met key obligations in relation to safer staffing requirements for Nursing and Midwifery based on National Quality Board requirements (appendix 1), National Institute for Health and Care Excellence guidance (2014) and Carter report recommendations (2016). Information and metrics such as Acuity, Care Hours Per Patient Day (CHPPD) and nurse sensitive indicators are provided. Analysis of information and assurance of robust systems and processes to identify and mitigate any risks are described within the report. The report covers the period from April 2022 to September 2022 (Q1 & Q2). Maternity staffing data has been provided in this report with some narrative however the data will be further detailed and analysed in the next scheduled Midwifery report to Board. The report also highlights key developments in progress supporting the nursing, midwifery and Allied Health Professional workforce.

2. CONTENT: SAFER STAFFING REQUIREMENTS

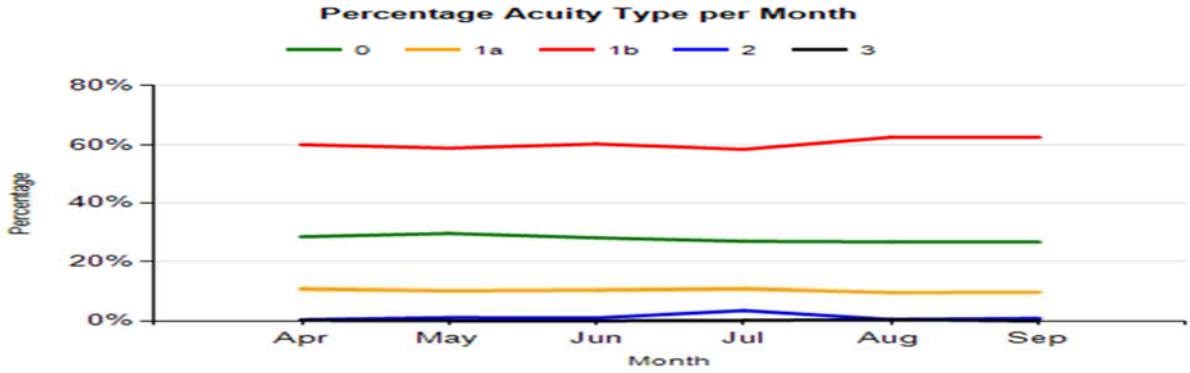
2.1 Daily operational safer staffing process – nursing

Twice daily staffing meetings review data from the Safer Nursing Care Tool (SNCT), contained in the live Health Roster to support decision making for safer staffing. Details of the process and information reviewed can be found in appendix 2.

2.2 Safer Nursing care Tool (SNCT)

The Safer Nursing Care Tool (SNCT) is used to determine the acuity levels (care needs) of patients (appendix 3). Departments are required to input acuity level data twice daily to ensure the sometimes fluctuant care needs of patients can be captured. As demonstrated in table 1, between April 2022 and September 2022 patient acuity levels have remained stable with minor fluctuations, this is comparable to previous report and indicates that the number of patients with greater complexity or dependency continues.

Table 1: acuity levels



2.3 RN to patient ratio

RN to patient ratio data is used alongside acuity and activity levels in real time to support professional judgement decisions. A tolerance of 0.5 RN per patient is an accepted variation in line with NICE guidance and reported ratios are an average across a month. Where there are deviations, mitigations are captured and recorded as part of the safer staffing process. Where areas are consistently below thresholds, a review is undertaken to determine causation to ensure that the worked staffing model is appropriate for the needs of the area including if temporary increases in staffing are required.

2.4 Care Hours per Patient Day (CHPPD)

Care Hours per Patient Day (CHPPD) is a measure of the nursing hours provided to patients and is updated monthly to show staffing levels in relation to patient numbers. The accepted tolerance is 15% between required and actual hours.

Table 3 – CHPPD data: actual and required hours – Trustwide

Entry Month	Actual	Required	Variance
Apr 2022	8.5	9.6	-1.1 (11%)
May 2022	8.7	9.5	-0.8 (8%)
June 2022	8.7	9.6	-0.9 (9%)
July 2022	8.6	9.6	-1.0 (10%)
Aug 2022	8.3	9.6	-1.3 (13%)
Sep 2022	8.5	9.4	-0.9 (9%)

Table 3 demonstrates that the actual care hours provided in total in the organisation from April 2022 to September 2022 were within the 15% tolerance range.

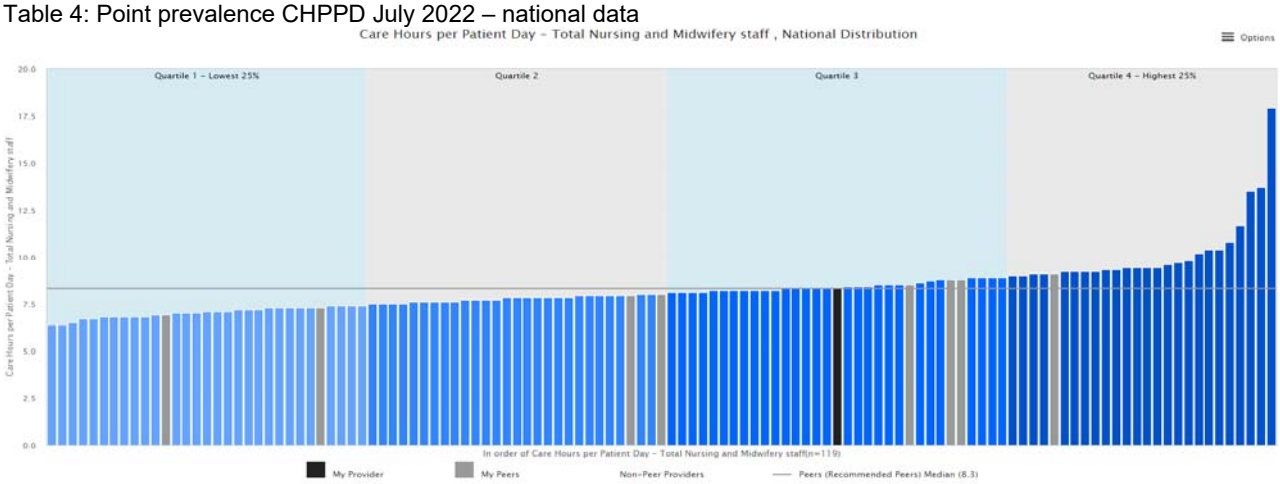
2.4.1 Ward/unit level CHPPD

During the reporting period there was one area noted as below the 15% tolerance range required. This was due to the staffing levels being benchmarked against previous requirements and relates to changes in the functionality of the ward. This has since been corrected and removed from the report.

2.4.2 Model hospital CHPPD – benchmarking against peers (point prevalence July 2022)

Staffing is benchmarked with peers, utilising data from Model hospital as demonstrated below.

Table 4: Point prevalence CHPPD July 2022 – national data



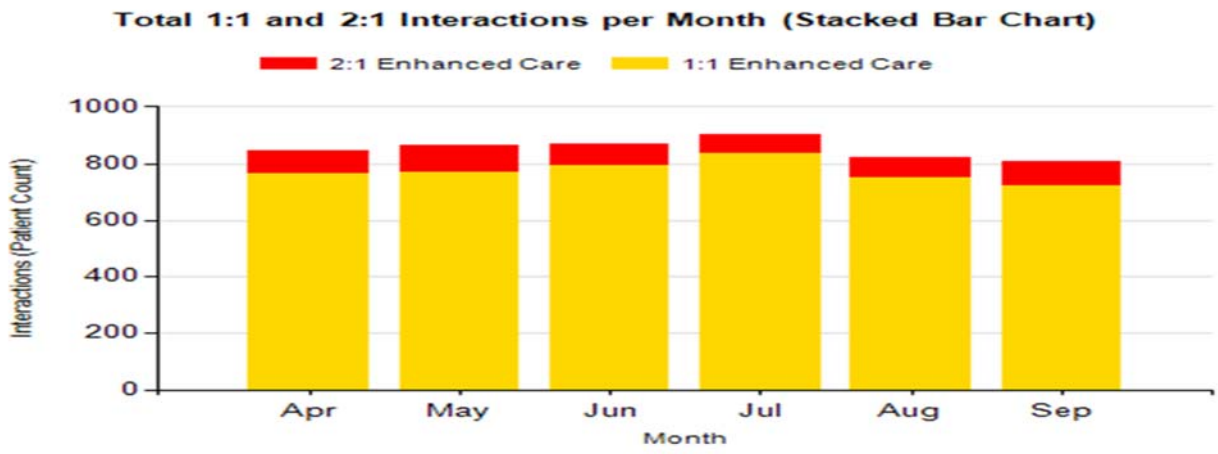
The data from July 2022 point prevalence demonstrated the organisation remains in mid Quartile 3 in line with our recommended peer median average.

2.5 Additional Demand

2.5.1 Increased levels of supervision: Enhanced Care Team demand

One of the factors influencing staffing requirements are those patients where a higher level of supervision is required i.e. Enhanced Care Team (ECT) or Registered Mental Health Nurse (RMN) supervision. Demand for ECT continued to increase until July 2022 and although decreasing slightly thereafter, continues to be at a higher level than previously reported (table 6). Analysis demonstrates an increase in ECT support required due to risk posed by violent and aggressive behaviour or self-harm, reflective of the patient caseload with some patients requiring 2:1 supervision (2 staff per patient, continuously).

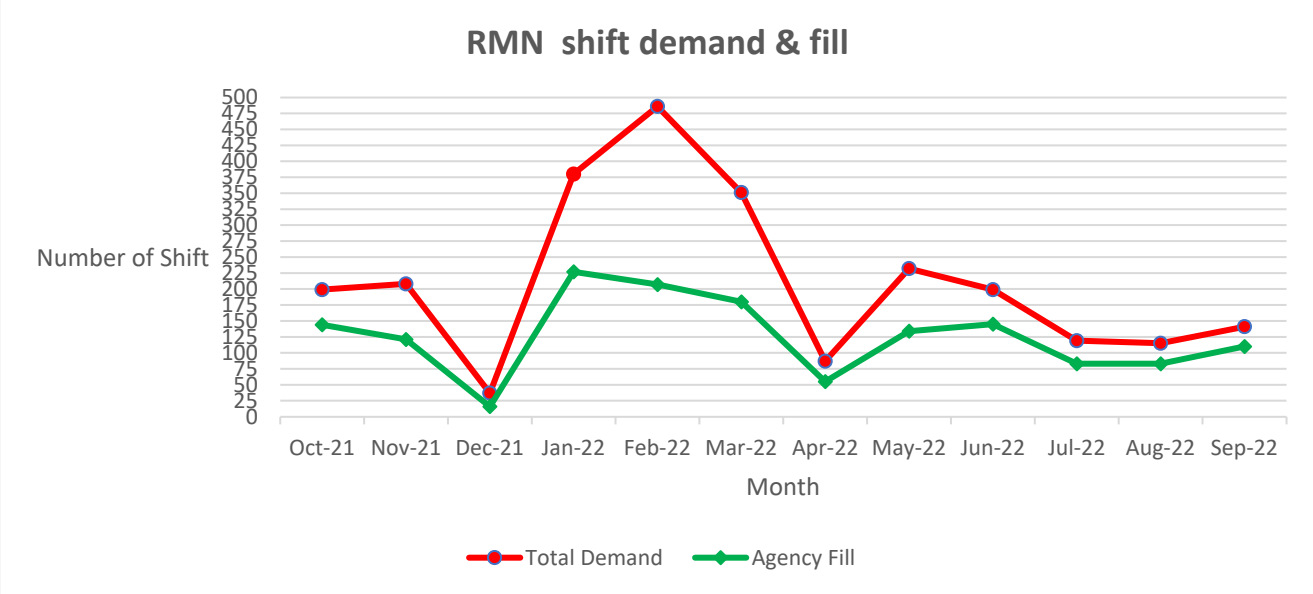
Table 6: Enhanced Care requirements (1:1 and 2:1 level care)



2.5.2 Registered Mental Health Nurse requirements

In April 2022 a review of the process by which patients requiring RMN support across the organisation was reviewed, resulting in an increased focus and evidence for RMN escalations, as well as clarity on the process for requesting RMN cover (appendix 7). There has been a decrease in RMN demand (table 7), with alternative appropriate support being sought i.e. ECT.

Table 7: RMN requests demand and fill Q1/Q2 with comparison to previous reporting period



Patients requiring ECT support for mental health needs is increasing. When RMN support is advised by a psychiatrist or due to imminent risk of safety to self or others and the shift is not filled, a process is in place where this is escalated to the ECT team. These patients assessed, ensuring that cover is provided by ECT and prioritised to those patients at greatest risk of harm. Specialist agencies are utilised for paediatric patients due the specific skills, training and qualifications required to support this patient group.

2.5.3 Bank and agency: sickness

Demand for both RN and HCSW bank and agency shifts notably increased in April, August and September 2022 despite a continued decrease in vacancy levels. This was driven by a marked increase in sickness absence for both RNs and HCSWs in line with increases in Covid-19 prevalence. Bank and Agency requests and escalations continue to be managed through the twice daily safer staffing meetings.

2.6 Specialist Areas

Allied Health Professionals (AHP`s)

There are currently 830 WTE registered AHP`s and support staff working at UHCW. The vacancy rate varies across professional groups with highest vacancies seen in Occupational Therapy (15.5%), Physiotherapy (13%) and Diagnostic Radiography (10.4%). There is an increased demand in services

with the developments in frailty, hospital at home pathways and Community Diagnostic Centres. Work has continued on AHP electronic rosters with 98% of all AHPs at UHCW now on the system, with the remaining due to be in place early 2023. To date we have appointed 17 internationally educated AHPs with plans to recruit a further 45 to support workforce requirements. Re-basing work is in progress to review all establishments within AHP groups to support future workforce planning in line with demand.

Critical Care

Critical care staffing is underpinned by principles outlined in Guidelines for the Provision of Intensive Care Services (GPICS) which are nationally accepted as the standard for staffing in critical care areas. These standards are used as a basis to assess 'Crit Con level' (Appendix 7) which is noted at safer staffing meetings with mitigations recorded on the safer staffing template. Compliance to the GPICS standards for nursing is as per the table below. RN to patient ratios for level 3 (1:1 care) and level 2 (1:2 care) have been maintained throughout the reporting period.

Table 9: GPICS nursing compliance

Month	April	May	June	July	Aug	Sept
Compliance	97%	97%	100%	100%	100%	100%

There are currently no RN or HCSW vacancies in Critical care with the current number of beds being utilised however, supporting increased demand including flexing the bed base will impact on staffing requirements.

Paediatrics

The current vacancy in paediatrics is 25.63wte (25%) and some areas have identified challenges with recruitment. Ward 14, the adolescent ward, has identified that children and young people (CYP) requiring care for challenging behaviours is increasing which in turn is affecting case mix. This is compounded by delays for social care or Child and Adolescent Mental Health Services (CAMHS) support required for discharge. This is monitored and escalated as part of system wide calls daily, with silver and gold escalation where a system response is required. To support recruitment, alternative approaches are being explored such as training Registered Adult and Learning Disability Nurses to work on Ward 14 as part of the skill mix, as well as placements of students on dual registration programmes (CYP and MH). Additional actions and mitigations include moving staff, deployment of Specialist Nurses and Ward Managers and use of specialist agency staff.

Maternity

During the reporting period there has been a reduction in Midwifery vacancies from 58wte to 41wte on current establishment (22%). This is mainly due to the successful international recruitment programme,

supported through funding from NHSE/I. Thirteen Midwives have been recruited with a further bid submitted for an additional six. There are several national opportunities being explored in order to support Midwifery recruitment including return to practice and shortened Masters level training. HEE have developed national Midwifery Support Worker (MSW) competencies. This role supports Registered Midwives to focus on providing more complex care delivery, maximising workforce efficiency and supporting Ockenden (2022) report recommendations. Current training for this programme is 18-24 months. An opportunity to obtain support from NHSE/I in the development, implementation, and evaluation of an in-house training MSW programme was successful and a condensed six-month programme for this role commences in January 2023.

2.7 Quality metrics

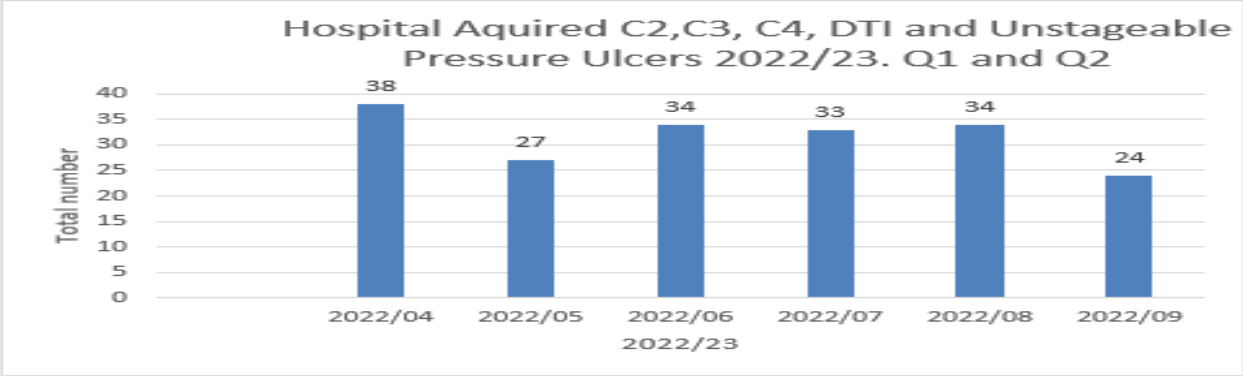
2.7.1 Nurse Sensitive Indicators

Nurse sensitive indicators are used to support the analysis of the quality of care being delivered by triangulating incidences of harm against staffing provision.

Pressure Ulcers

For Q1/2, a total of 190 pressure ulcers were reported of which 44 were moderate harm or above.

Table 10: incidence of all pressure ulcers



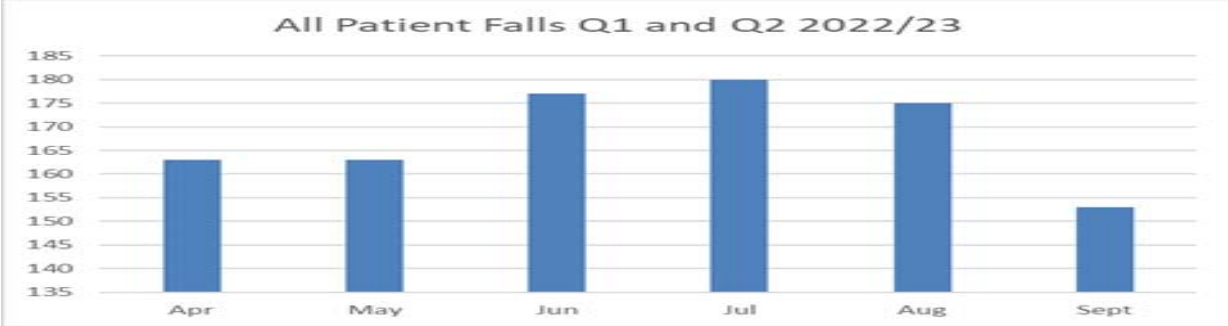
There was a decrease in overall hospital acquired pressure ulcers compared to the previous reporting period, however an increase in those moderate harm or above. Themes identified were lack of repositioning and device related pressure ulcers. The Tissue Viability team have continued to support staff with formal and informal training concentrating specifically on those areas with the highest reporting.

Falls

For Q1/2, there were a total of 1011 falls, of which 29 resulted in moderate harm, an increase in all falls (from 930) and an increase in those which resulted in moderate harm (from 22) from the previous

reporting period. This increase can be attributed to the higher number of frail older patients admitted who appeared more deconditioned or with dementia and acute confusion/delirium with existing mobility issues requiring enhanced observation. Themes identified relate to toileting and unwitnessed falls. A new falls lead commenced in post in July 2022 whose role will be pivotal in driving improvements and learning in practice, as well as delivering training to staff and the implementation of actions to reduce a patient's risk of falling.

Table 11: all falls



There has been no identifiable correlation found between staffing levels and the incidences of pressure ulcers or falls during the reporting period noted during the route cause analysis (RCA) process.

2.8 Nursing recruitment and retention: key developments, activities, and innovations

Registered nurses (RN)

The vacancy rate in September 2022 was 8.65%, a decrease from 12.28% in March 2022. Increases in establishment due to recent service developments are not included and will be reported in subsequent reports. The biggest impact has been the success and continuation of the International Nurse Recruitment programme. 40 WTE newly qualified nurses are due to commence in the organisation over the next three months, a reduction on previous years, mirroring the national picture. There are a number of reasons for this including students taking gap years and relocating back home following training in line with other fee paying students. Project 1000, a plan to recruit 1000 nurses from the local area over the next 5 years has commenced with UHCW leading on the recruitment stream across the system.

Healthcare Support Workers (HCSWs)

The vacancy in September 2022 was 82.60wte (8.75%). Recruitment to target (national target of 1%), is challenged due to changes and increases in budgeted establishments in line with service redesign and developments. However, focussed work has led to over 188wte HCSW`s being appointed to date this year.

2.9 Celebrations and recognition

In August we were awarded Pathway to Excellence accreditation whereby organisations are required to provide evidence of nursing and midwifery excellence which is validated by a staff survey undertaken by the American Nurses Credentialling Centre (ANCC). We are the first University Hospital in England to achieve this designation. There is evidence that those organisations with Pathway to Excellence credentialing have improved recruitment and retention as they attract and retain nursing and midwifery staff.

UHCW are finalists for 2 Nursing Times Workforce awards: Preceptorship Programme of the Year and Best workplace for learning and development.

3. IMPLICATIONS

The report has demonstrated assurance that through robust processes and analysis of key metrics as detailed and correlation of harms; as an organisation we are able to evidence the provision of safer staffing with the resources available. The report identifies where challenges exist and provides assurance of robust processes and the collective leadership required to ensure safer staffing is maintained. The information provided also demonstrates positive progress on our recruitment position, celebrations and recognition of note as well as key developments supporting the wider workforce.

4. CONCLUSIONS AND RECOMMENDATIONS

The Board is asked to note that despite the ongoing national Nursing, Midwifery and Allied Health Professional workforce challenges that UHCW continues to make significant progress in recruiting and retaining staff. The Board is also asked to receive and accept this report for assurance that the organisation has robust processes, systems and prioritised activities to demonstrate that safer staffing has been maintained during the reporting period in line with national and professional obligations as detailed.

Author Name: Paula Seery
Author Role: Associate Director of Nursing for workforce

Reviewer Name: Vicky Williams
Reviewer Role: Deputy Chief Nursing Officer

Date report written: November 2022

Appendix 1: NQB expectations

Triangulated approach to staffing decisions

Expectation 1	Expectation 2	Expectation 3
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Appendix 2: Safer staffing process

- Review of safer nursing care tool and live health roster data
- Any areas of immediate concerns/shortfalls or need for support are discussed (on current shift)
- Any additional requirements not met in establishment numbers i.e. patients requiring 1:1 arms length supervision - aligned to Enhanced Care Team available resources. Patients requiring review and assessment by ECT team to determine levels of supervision required are identified.
- The safe care wheel is reviewed with areas of risk/concern identified for the next 24 hours or over the weekend
- Fully staffed areas are reviewed and decisions made to reallocate staff appropriately to mitigate any areas of risk – initially within group/specialty and then if required across the organisation
- Professional judgement is applied by specialty Matrons regarding their areas using a registered nurse to patient ratio as a benchmark
- Any non-clinical shifts are discussed and if required stood down i.e. management/study days
- Any outstanding shifts (HCSW or RN) required are escalated to appropriate agencies (if not already in place) with the approval of the GDNA/ADN present
- A safer staffing template is completed at every meeting and emailed to the ADN (Workforce) and Deputy CNO and saved onto a shared drive by the hospital bleep holder

- Any mitigations are captured and logged on the safer staffing template
- Any requirement for support outside of clinical groups can be discussed and agreed i.e. support from corporate nursing teams
- The hospital bleep holder then provides an overview of nurse staffing across the organisation as part of the clinical site meetings

Appendix 3: Multiplier criteria for acuity

Table 1: SNCT summary of criteria and associated multiplier Acuity Level

	Multiplier	Criteria
Level 0	0.99	Patient requires hospitalisation Needs met by provision of normal ward care
Level 1a	1.39	Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate
Level 1b	1.72	Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of the activities of daily living
Level 2	1.97	May be managed within clearly identified/designated beds, requiring resources with the required expertise and staffing level OR may require transfer to a dedicated level 2 unit
Level 3	5.96	Patients needing advanced respiratory support and/or therapeutic support of multiple organs

Appendix 4: RN to patient ratio

2022			April	May	June	July	August	September
Unit	required ratio	Number of beds	Actual RN:Patient Ratio	Actual RN:Patient Ratio	Actual RN:Patient Ratio	Actual RN:Patient Ratio	Actual RN:Patient Ratio	Actual RN:Patient Ratio
AMU 1 (Ward 12)	1:6	35	1:5.72	1:5.36	1:5.32	1:5.55	1:5.87	1:5.43
AMU 2 (Ward 2)	1:4	8	1:5.13	1:4.75	1:4.92	1:4.81	1:5.29	1:5.12
AMU 3 (Ward 3)	1:7	26	1:8.54	1:7.49	1:7.55	1:8.43	1:8.99	1:7.58
DSU Ward	1:6	39	1:5.25	1:4.43	1:5.31	1:5.37	1:5.90	1:6.01
Major Trauma ECU	1:4	12	1:4.37	1:4.01	1:3.40	1:3.19	1:3.23	1:3.09
Rugby Cedar Ward	1:7	41	1:5.24	1:5.54	1:5.97	1:6.16	1:6.28	1:6.39
Rugby Hoskyn Ward	1:7	21	1:7.53	1:7.76	1:6.56	1:6.66	1:7.00	1:6.42
Rugby Mulberry Ward	1:8	22	1:3.26	1:3.15	1:4.65	1:4.47	1:3.99	1:4.14
Rugby Oak Ward	1:8	22	1:3.55	1:2.13	1:0.45	1:2.24	1:3.56	1:5.18
Surgical Assessment Unit	1:4	28	1:3.76	1:3.64	1:4.49	1:3.72	1:4.44	1:4.14
Surgical Pathway Wd10	1:6	29	1:4.90	1:4.49	1:4.46	1:5.20	1:6.14	1:5.16
Surgical Wd22 Short Stay	1:6	18	1:6.80	1:6.45	1:5.99	1:5.56	1:5.96	1:5.81
Ward 1	1:8	36	1:8.22	1:6.76	1:5.66	1:7.04	1:8.06	1:7.56
Ward 10 ECU	1:3/4	12			1:3.26	1:3.24	1:3.47	1:3.13
Ward 11	1:6	32	1:5.31	1:5.16	1:4.67	1:5.38	1:5.25	1:5.19
Ward 20	1:6/8	32	1:6.22	1:6.97	1:6.30	1:7.22	1:6.70	1:7.13
Ward 20a	1:6/8	24	1:7.62	1:7.54	1:7.58	1:7.47	1:7.31	1:7.28
Ward 21 Cardiology	1:6	26	1:5.88	1:6.37	1:6.27	1:5.43	1:6.10	1:6.31
Ward 22 SAU New	1:6	12	1:6.14	1:6.12	1:6.21	1:6.38	1:6.86	1:6.27
Ward 22a Vas	1:6	12	1:5.71	1:5.15	1:5.59	1:5.36	1:5.22	1:6.15
Ward 23	1:6	12	1:5.21	1:5.12	1:4.80	1:5.09	1:4.95	1:4.86
Ward 23 H&N - Urology	1:5	16	1:5.51	1:5.24	1:5.52	1:5.60	1:5.77	1:5.51
Ward 30	1:6	18	1:5.43	1:5.61	1:6.56	1:6.02	1:6.16	1:6.57
Ward 30 NIV Area 2	1:4	11	1:3.73	1:2.95	1:3.61	1:3.91	1:3.86	1:4.03
Ward 31	1:6/8	36	1:6.36	1:5.62	1:7.84	1:7.33	1:7.60	1:8.53
Ward 31a	1:6	24	1:6.35	1:6.18	1:6.29	1:6.04	1:6.55	1:6.82
Ward 32 Gastro	1:6	34	1:5.91	1:5.99	1:6.43	1:6.10	1:4.76	1:4.94
Ward 33 ECU Stepdown	1:3/6 change in ward function	12		1:15.41	1:6.26	1:5.73	1:6.25	1:5.82
Ward 33 Medical	1:6	12	1:3.63	1:4.75	1:6.63	1:5.20	1:5.09	1:4.87
Ward 33 Surgery	1:6/7	26	1:5.66	1:5.43	1:5.65	1:5.68	1:5.61	1:5.77
Ward 33/10 ECU & EPOC	1:3	12	1:2.99	1:2.97				
Ward 34	1:4	17	1:4.13	1:4.08	1:3.87	1:3.66	1:4.12	1:3.66
Ward 35	1:6	31	1:7.33	1:7.24	1:7.42	1:6.98	1:7.46	1:7.74
Ward 40	1:8	44	1:6.36	1:7.57	1:7.72	1:7.11	1:8.09	1:7.72
Ward 41	1:6	36	1:6.96	1:6.12	1:5.98	1:5.80	1:5.93	1:4.88
Ward 42	1:6/8	36	1:8.32	1:8.02	1:8.47	1:8.72	1:9.22	1:8.15
Ward 43	1:8	34	1:8.16	1:7.83	1:7.65	1:7.99	1:8.47	1:8.58
Ward 43 NECU	1:4	12	1:4.17	1:4.26	1:4.23	1:4.37	1:4.48	1:4.64
Ward 50 Renal	1:6	22	1:5.92	1:6.85	1:6.77	1:6.97	1:7.35	1:7.61
Ward 52	1:6/NOF 1:4	38	1:7.11	1:7.19	1:6.11	1:5.76	1:6.69	1:6.15
Ward 53	1:7	21	1:6.73	1:6.91	1:7.61	1:7.40	1:7.80	1:7.77

** to note the areas in red can be discounted as are data entry errors

Appendix 5: Local care hours per patient day data

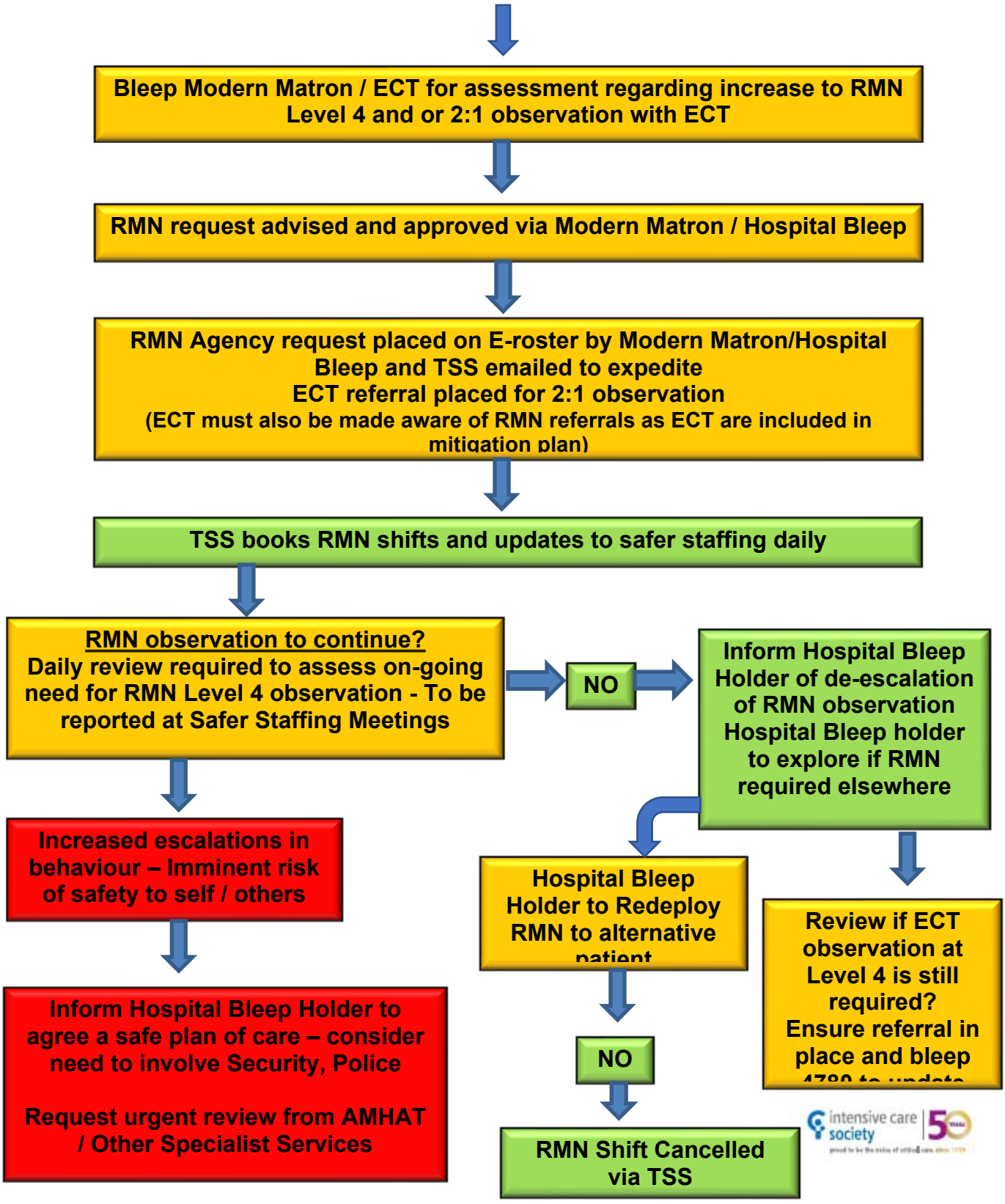
Report shows CHPPD Variance (Expected CHPPD - Actual CHPPD) as a percentage of Expected CHPPD

15% range used (values above this %): red if above 15% less than required, dark green if above 15% more than required

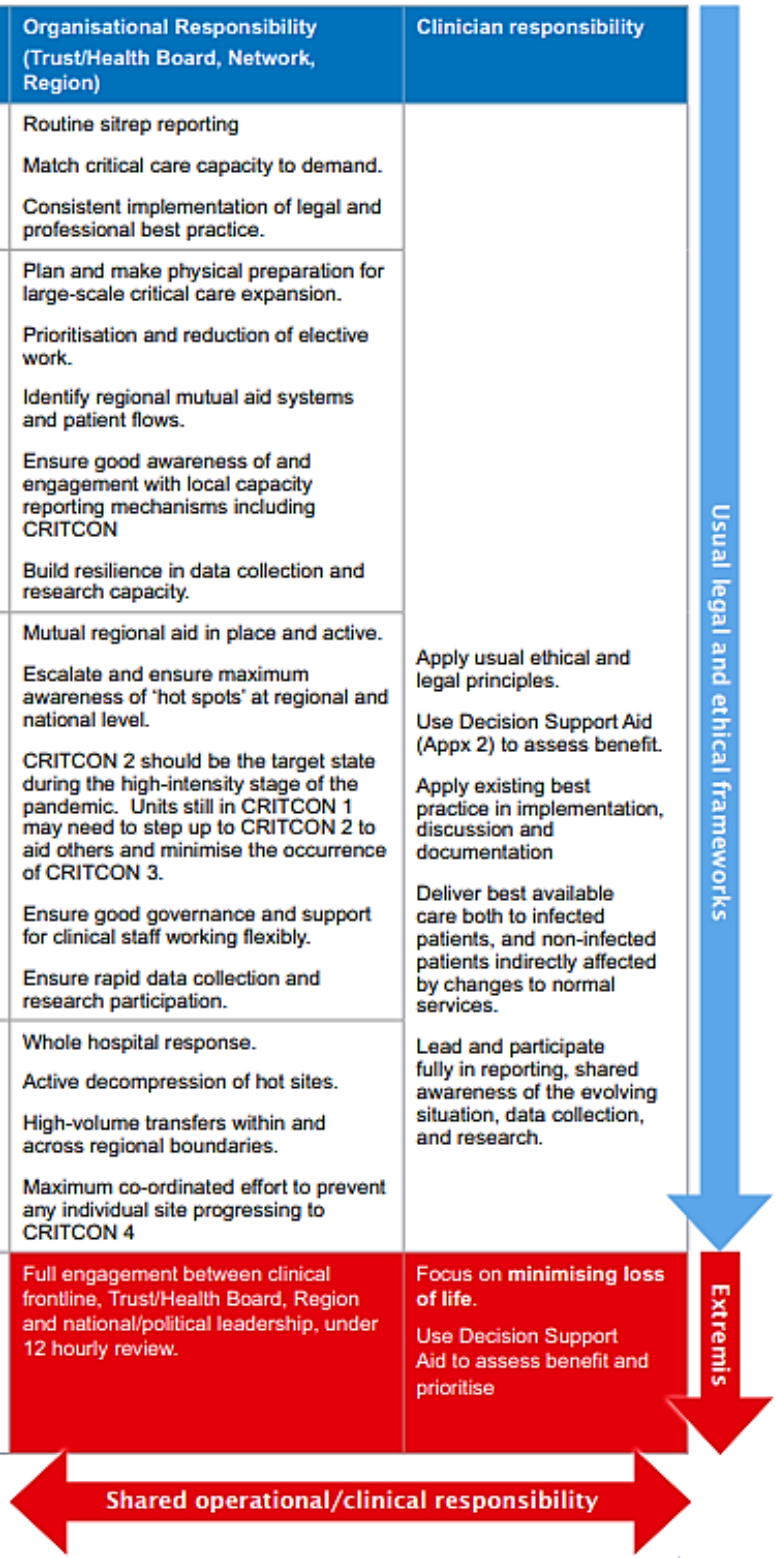
Report Month	2022					
Ward	Apr	May	Jun	Jul	Aug	Sep
AMU 1 (Ward 12)	-12.50 %	-7.14 %	-9.57 %	-10.53 %	-13.19 %	-6.74 %
AMU 2 (Ward 2)	-22.13 %	-10.00 %	-12.50 %	-12.90 %	-17.59 %	-15.74 %
AMU 3 (Ward 3)	-14.93 %	-5.63 %	-11.11 %	-10.96 %	-12.86 %	-11.11 %
Cardiothoracic ITU	3.17 %	4.33 %	2.85 %	1.61 %	-3.13 %	-1.43 %
Coronary Care Unit	0.00 %	-3.74 %	-1.85 %	-7.69 %	-2.91 %	-1.96 %
Critical Care Unit	-8.16 %	-2.78 %	-2.61 %	-3.89 %	-6.27 %	-1.05 %
Labour Ward	-40.98 %	-36.00 %	-39.02 %	-36.97 %	-38.89 %	-38.50 %
Major Trauma ECU	-18.26 %	-14.93 %	-9.88 %	-14.67 %	-10.87 %	-14.00 %
NeoNatal Unit	-16.57 %	-12.11 %	-17.16 %	-18.75 %	-15.58 %	-7.53 %
Paediatric HDU	-15.20 %	-20.00 %	-22.76 %	-17.93 %	-7.44 %	-14.29 %
Surgical Pathway Wd10	-19.15 %	-7.79 %	-7.75 %	-9.27 %	-3.67 %	-6.15 %
Surgical Wd22 Short Stay	-13.16 %	-10.00 %	-3.90 %	-6.25 %	-11.39 %	-14.29 %
Ward 1	-4.69 %	-5.80 %	-3.75 %	-1.59 %	-5.00 %	-1.64 %
Ward 10 ECU						
Ward 11	-12.35 %	-8.00 %	-4.94 %	-8.97 %	-10.39 %	-10.26 %
Ward 14	5.50 %	1.00 %	-11.57 %	-9.92 %	-23.81 %	-17.99 %
Ward 15	-12.86 %	-11.19 %	-12.60 %	-12.03 %	-21.99 %	-3.10 %
Ward 16	-10.77 %	-2.54 %	-1.01 %	-3.88 %	-5.79 %	0.00 %
Ward 20	-10.75 %	-3.75 %	-6.74 %	-9.76 %	-11.39 %	-7.59 %
Ward 20a	-14.77 %	-6.58 %	-9.76 %	-8.33 %	-10.77 %	-13.16 %
Ward 21 Cardiology	-4.48 %	-1.59 %	0.00 %	-2.99 %	-7.25 %	-6.06 %
Ward 22 SAU New	-3.80 %	-2.63 %	-2.53 %	-1.33 %	-5.56 %	-4.00 %
Ward 22a Vas	-7.69 %	-7.45 %	-7.23 %	-4.94 %	-7.32 %	-7.89 %
Ward 23	0.00 %	0.00 %	-2.30 %	1.25 %	-4.88 %	0.00 %
Ward 23 H&N - Urology	-14.14 %	-5.56 %	-8.54 %	-10.84 %	-9.88 %	-6.10 %
Ward 24	-16.39 %	-14.55 %	-16.98 %	-17.74 %	-17.54 %	-20.00 %
Ward 25	-34.92 %	-30.17 %	-33.00 %	-29.81 %	-36.28 %	-29.03 %
Ward 30	-7.06 %	-3.30 %	-1.20 %	-1.11 %	-12.63 %	-8.64 %
Ward 31	-7.69 %	-4.76 %	-5.26 %	-5.08 %	-4.92 %	-3.57 %
Ward 31a	-4.29 %	-4.62 %	-5.88 %	-4.92 %	-7.94 %	-4.76 %
Ward 32 Gastro	-6.85 %	-5.13 %	-5.80 %	-1.37 %	-11.11 %	-6.41 %
Ward 33 ECU Stepdown						
Ward 33 Surgery	-6.17 %	1.28 %	-1.30 %	-8.24 %	-5.19 %	-2.67 %
Ward 34	-5.75 %	-8.24 %	-3.70 %	-7.23 %	-8.54 %	-6.59 %
Ward 35	-7.02 %	-1.72 %	1.75 %	-8.06 %	-10.77 %	-3.51 %
Ward 40	-8.22 %	-5.06 %	-4.05 %	-8.11 %	-7.89 %	-7.79 %
Ward 41	-6.58 %	-9.21 %	-6.58 %	-6.25 %	-6.85 %	-12.75 %
Ward 42	-10.96 %	-7.58 %	-7.14 %	-6.49 %	-8.96 %	-13.33 %
Ward 43	-5.50 %	-6.36 %	-7.62 %	-9.91 %	-11.71 %	-13.68 %
Ward 50 Renal	-11.76 %	-9.86 %	-10.29 %	-11.27 %	-13.04 %	-8.82 %
Ward 52	-14.67 %	-11.84 %	-7.35 %	-13.89 %	-20.25 %	-16.22 %
Ward 53	-20.78 %	-12.99 %	-9.86 %	-11.94 %	-13.24 %	-11.76 %
Rugby Cedar Ward	-24.79 %	-24.14 %	-23.64 %	-25.77 %	-31.63 %	-9.21 %
Rugby Hoskyn Ward	-11.11 %	-11.76 %	-12.50 %	-11.27 %	-13.43 %	-11.43 %
Rugby Mulberry Ward	-12.66 %	-7.04 %	-6.49 %	-11.11 %	-18.75 %	-5.63 %
Rugby Oak Ward	-15.38 %	-11.69 %	-12.86 %	-14.86 %	-18.18 %	-12.82 %
Ward 33/10 ECU & EPOC	9.71 %	24.12 %				

Appendix 6: RMN Escalation Process

Level of risk has potential to exceed that of ECT level 4 observations and indicates the need for RMN Level 4 observations due to high-risk behaviours to self or others or as instructed by AMHAT/Psychiatry


Bleep Modern Matron / ECT for assessment regarding increase to RMN Level 4 and or 2:1 observation with ECT
RMN request advised and approved via Modern Matron / Hospital Bleep
RMN Agency request placed on E-roster by Modern Matron/Hospital Bleep and TSS emailed to expedite
ECT referral placed for 2:1 observation
(ECT must also be made aware of RMN referrals as ECT are included in mitigation plan)
TSS books RMN shifts and updates to safer staffing daily
RMN observation to continue?
Daily review required to assess on-going need for RMN Level 4 observation - To be reported at Safer Staffing Meetings
NO
Inform Hospital Bleep Holder of de-escalation of RMN observation Hospital Bleep holder to explore if RMN required elsewhere
Increased escalations in behaviour – Imminent risk of safety to self / others
Hospital Bleep Holder to Redeploy RMN to alternative
Review if ECT observation at Level 4 is still required? Ensure referral in place and bleep
Inform Hospital Bleep Holder to agree a safe plan of care – consider need to involve Security, Police
Request urgent review from AMHAT / Other Specialist Services
NO
RMN Shift Cancelled via TSS

CRITCON-2020	Definition	Organisational Responsibility (Trust/Health Board, Network, Region)	Clinician responsibility
0 – NORMAL	Able to meet all critical care needs, without impact on other services. Normal winter levels of non-clinical transfer and other 'overflow' activity.	Routine sitrep reporting Match critical care capacity to demand. Consistent implementation of legal and professional best practice.	
1 PREPARATORY	Significant expansion/multiplication of bed capacity, supported by extensive redeployment of staff and equipment from other areas.	Plan and make physical preparation for large-scale critical care expansion. Prioritisation and reduction of elective work. Identify regional mutual aid systems and patient flows. Ensure good awareness of and engagement with local capacity reporting mechanisms including CRITCON Build resilience in data collection and research capacity.	
2 SUSTAINED SURGE	System at full stretch, both in ventilator capacity and/or staffing levels, with staff working outside usual role. but adherence to usual clinical practice goals wherever possible Other resources may be becoming limited e.g. oxygen, renal replacement therapy.	Mutual regional aid in place and active. Escalate and ensure maximum awareness of 'hot spots' at regional and national level. CRITCON 2 should be the target state during the high-intensity stage of the pandemic. Units still in CRITCON 1 may need to step up to CRITCON 2 to aid others and minimise the occurrence of CRITCON 3. Ensure good governance and support for clinical staff working flexibly. Ensure rapid data collection and research participation.	Apply usual ethical and legal principles. Use Decision Support Aid (Appx 2) to assess benefit. Apply existing best practice in implementation, discussion and documentation Deliver best available care both to infected patients, and non-infected patients indirectly affected by changes to normal services. Lead and participate fully in reporting, shared awareness of the evolving situation, data collection, and research.
3 SUPER SURGE	Some resources starting to be overwhelmed. Full use of stretched staffing ratios and cross-skilling. Delivery of best available care but not usual care, for the majority of patients.	Whole hospital response. Active decompression of hot sites. High-volume transfers within and across regional boundaries. Maximum co-ordinated effort to prevent any individual site progressing to CRITCON 4	
4 CODE RED: TRIAGE RISK	Services overwhelmed and delivery of critical care is resource limited. This stage should never be reached at any site unless regionally & nationally recognised and declared.	Full engagement between clinical frontline, Trust/Health Board, Region and national/political leadership, under 12 hourly review.	Focus on **minimising loss of life**. Use Decision Support Aid to assess benefit and prioritise



University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 1 DECEMBER 2022

Subject Title	Mortality (SHMI and HSMR) Update
Executive Sponsor	Kiran Patel, Chief Medical Officer
Author	Duncan Watson, Deputy Chief Medical Officer Hannah Bullock, Associate Director of Quality
Attachment(s)	Mortality Review Report
Recommendation(s)	The Board is asked to **RECEIVE ASSURANCE** from the report.

EXECUTIVE SUMMARY

The enclosed provides an overview of the Mortality portfolio, including key performance indicators such as number of Primary and Secondary/Structured Judgement Reviews (SJR) open for completion and trends presented at the Mortality Review Committee.

A weekly HSMR Intervention group has been established in order to respond to the HSMR data showing an upward trend to 151 in July. This has resulted in a detailed series of actions and due to the lag period of HSMR reporting our HSMR data may take 6 months to show improvement without retrospective data cleansing.

Mortality Profile Performance

1. There are 9 Primary Mortality reviews over 12 months old
2. There have been 1183 primary mortality reviews requested for Covid-19 related deaths. There are currently 84 Primary Mortality reviews pending, of which 55 are over 30 days.
3. There have been 9 inpatient deaths of a person with a learning disability within the last 12 months
4. 7 LeDeR deaths have a completed mortality review which has been shared directly with the LeDeR Deputy and Programme Coordinator at the Clinical Commissioning Group (CCG).

Hospital Standardised Mortality Ratio (HSMR) update and trends

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.

5. Hospital Standardised Mortality Ratio (**HSMR**) for July 2022:
    1. HSMR **151.9** (above expected range)
    2. HSMR August 2021 – July 2022 **120.6** Above Expected Range

6. Summary Hospital Mortality Indicator (**SHMI**) update
    1. SHMI: 1.1046 (within expected range)

2. SHMI Update
3. SHMI Trend

The findings of the review identified

There are five providers within the MTC peer group with statistically significantly high mortality. Of these UHCW has the highest HSMR.

The crude rate is lower than other Major Trauma Centres (MTC), however it has increased during the last year. UHCW's expected rate is below other major trauma centres.

The proportion of non-elective activity with no recorded comorbidity is higher than in peers and this has been increasing over the last two years.

When compared to other Major trauma centres the Trust has fewer episodes where a patient received specialist palliative care, compared to a peer average.

In response to the findings of the HSMR analysis an action plan for the ten diagnosis groups was devised and reported to Mortality Review Committee monthly, as part of the monitoring alerts report.

In addition to the most recent increase in HSMR a weekly task and finish group chaired by the Deputy Chief Medical Officer and attended by the Chief Medical Officer, Chief Quality Officer, Clinical Directors has been set up to drive improvements to positively impact the HSMR retrospectively where possible and going forward. To support this an additional action plan has been created to focus on the Trustwide themes identified.

PREVIOUS DISCUSSIONS HELD

Mortality Review Committee

Patient Safety and Effectiveness Committee

Quality and Safety Committee

KEY IMPLICATIONS	
Financial	Inaccurate clinical coding relating to diagnosis groups reviewed by the committee may have financial implications.
Patients Safety or Quality	Learning from deaths is an opportunity to improve patient safety and experience by improving services or identifying serious incidents for investigation. Reviewing mortality allows compliance with regulated activity and CQC domains for well led domain.
Workforce	N/A
Operational	N/A

Mortality Review Report

Data extracted 1 November 2022

Duncan Watson – Deputy Chief Medical Officer

Hannah Bullock – Mortality and Harm Coordinator

Miguel Valenzuela – Clinical Effectiveness and Assurance Coordinator

1.0 Introduction

The enclosed provides an overview of the Mortality portfolio, including key performance indicators such as number of Primary and Secondary/Structured Judgement Reviews (SJR) open for completion and trends presented at the Mortality Review Committee.

2.0 Mortality Profile Performance

Key Performance Indicator (KPI)	Total Number
Primary Mortality Review Completion Rate %	2021 – 99.4% 2022 – 70.3%
Structured Judgement Mortality Review completion rate %	2021 – 93.7% 2022 – 63.4%

Below is the Primary Mortality Review performance by Clinical Group (01.11.21- 01.11.22)

By Group	Total number of deaths	Total number reviews outstanding	Over 30 days	Over 12 Months
Clinical Support Services	246	51	37	1
Emergency medicine inc. ED	481	50	22	0
Medicine	1398	377	282	7
Surgical Services	131	53	34	1
Trauma &Neuro Services	190	23	1	0
Womens and Childrens	2	0	0	0
Grand Total	**2448**	**554 (22.6%)**	**376 (15.3%)**	**9 (0.4%)**

There are several primary reviews that remain outstanding for 2021 with 9 over 12 months old. Continued support is offered to coordinate medical records and the completion of reviews. The clinical groups have been working particularly hard to complete the oldest reviews as priority. We continue to make progress towards reaching our Trust standard of mortality reviews being completed within 30 days from the date of death.

2.1 Covid-19 related deaths

There have been 1183 primary mortality reviews requested for Covid-19 related deaths. There are currently 84 Primary Mortality reviews pending. Each specialty is notified of any outstanding mortality reviews on a weekly basis.

2.2 LeDeR mortality update

The NHS National Learning from Deaths Guidance (2017) identifies that a case review of deaths of people with a learning disability is undertaken, and oversight is provided via the Learning Disability Mortality Review (LeDeR) program. The purpose of the local reviews of death is to identify any potentially avoidable factors that may have contributed to the person's death and to develop plans of action that individually or in combination, will guide necessary changes in health and social care services in order to reduce premature deaths of people with learning disabilities

There have been 9 deaths of a patient with a learning disability since November 2021, 7 of those with completed mortality reviews have been previously reported within the August report. There are two deaths awaiting the outcome of the mortality review. One from 29.07.22 has been escalated with General Surgery for completion. The other review is within 30 days from the date of death.

3.0 Serious Incident (SI) investigations:

There are 9 ongoing Serious Incident investigations

- 3 were registered as a result of a structured judgement review being completed as per the Trusts mortality review process and graded 2 (poor care)
- 3 were registered as a result of primary mortality reviews being completed and graded as NCEPOD E (less than satisfactory care)
- 3 following a review by Medical Examiner and reported via our Datix Incident Management system

Learning and actions will be shared following the completion of the Serious Incident Investigations.

4.0 Mortality Committee Updates

4.1 General Medicine

It was noted by the committee that there has been staffing shortages with most staff being temporary workers within General Medicine. There is now a stable junior workforce and all of the base 2 patients are now centralised through General Internal Medicine.

4.2 Diabetes and endocrinology

Many Trusts across the UK have gone through a central monitoring system so blood glucose is part of the vital pack, this has not yet been incorporated at UHCW however, this may be something that EPR could implement. The Mortality Review committee support central monitoring via EPR.

It was raised that Diabetes management across the Trust is very different to that from a Diabetes Specialist and the management within the Trust could be improved.

4.3 Sepsis Report

It was noted by the committee that;

- New digital pathway and documentation with the Sepsis dashboard is coming along well
- It is now able to be improved on coding accuracy and optimisation of the pathway
- Senior Analyst has now granted access to project analyst for neonatal system Badger net which allows to include the neonatal information in the audit group which before had to be done manually with ordering notes
- There are still issues around access for NELA database, the access is still awaiting to be granted which is resulting into issues with access to database covering maternity critical care
- EPR work is ongoing, sepsis order sets are going along well and close to finishing
- Encouraging news of ED and neonatal unit have now established their own local audit
- IPC led and clinical lead for sepsis perform further QA assessments of the audits performed by the IPC team
- Post graduate training has now been established and still taking place FY1, FY2, IMT get sepsis teaching with F1's due in November
- Sepsis September held at Grand Round 30/09/2022, the relevant teams presented their challenge and successes

Ongoing work to arrange combined sepsis audit with antimicrobial stewardship/sepsis audit review with microbiology team to look into 50 deaths from high-risk group of dying from sepsis.

4.4 Palliative Care Update

There is ongoing work within the Palliative care service to help with patient flow coming into the hospital. A relaunch of the department is planned for Autumn 2022 when there will be a full team in place. Discussions around palliative care across the Trust will be encouraged to build on skills within other departments.

4.5 Learning Disabilities Update

Emerging themes from completed reviews were access to breast and cervical cancer screening, COVID vaccinations, GPs learning disabilities register, referral to acute liaison nurses and care packages / assessments not up to date.

Recent learning and actions include ambulance service training around learning disabilities, training for care homes and GP practices to promote the role of health advocacy across primary and acute providers. Some of the actions identified to acute settings were late referrals to the learning disability nurse, learning disability awareness training required and ensuring robust procedures when patients are admitted with pressure ulcers. Pressure ulcers has been picked up as a local action also following feedback from the safeguarding team and the CCG.

There has been positive practice relating to early referral to palliative care, there has been appointment of independent advocate at an early opportunity, families have felt supported, there has been holistic and compassionate treatment plans.

4.6 Care of the Elderly Specialty Mortality Profile

The committee noted that inappropriate transfers to Rugby St Cross have been flagged and the referral process is being investigated to improve the patient journey and flow of beds. There are ongoing struggles within the department to discharge medically fit patients to the community due to lack of care placements and delays with sourcing care packages

4.7 Neurosurgery Specialty Mortality Profile

Neurosurgery are supporting with trauma ward rounds to see where they can support and establish a plan.

4.8 Medical Examiner update

There are sufficient Medical Examiners to fulfil the National Medical Examiner's staffing model but not enough to provide 5-day week coverage in the Medical Examiner office. Plans are in place to appoint 3 Medical Examiner Officers to support the current MEs. Their role will be to review notes and support communications with the bereaved families. There is no weekend cover to support the system to enable rapid release bodies for burial in specific religious groups –

The statutory medical examiner system is likely to be commenced in April 2023. This will require positive engagement across all health care systems and UHCW have asked for this item to be on the agenda for the next system Mortality Oversight Group meeting which is due to be chaired by Angela Brady CMO.

The National Medical Examiner software is being tested in the Midlands. The trust now have a database that helps to make reporting easier. More office space is going to be required as the Medical Examiner team expands to achieve full scrutiny.

5. Datix Mortality Module Update

An initial design for the electronic mortality review forms has been shared with the committee and approved. In the initial pilot phase, feedback will be collected for any amendments required.

ICT have confirmed they can provide the link for Datix Cloud to IPM. The implementation of the Datix Module will address some of the actions in place following the Mortality Review Process Audit which was graded as 'Limited Assurance'. The actions rely on the implementation of the Datix module to standardize and improve the currently mortality review process across the Trust.

Once a date has been confirmed the following can continue;

- Profiles and Security Groups will created to grant access to the relevant staff members.
- Roll out with Emergency Medicine and Medical Examiners for 30 days to trial. This will support an opportunity to capture feedback and make amendments before a Trust wide roll out after 30 days.

To provide assurance to the Committee:

- Meetings held and feedback collected from relevant stakeholders showed positive engagement
- Quarterly meetings to be held with key stakeholders (mortality leads) to provide relevant updates
- A Task and Finish Group will be facilitated by the Mortality Co-Ordinator and Quality Information lead to finalise the forms before they are created on the system
- Internal Quality Department team members have received training on Datix to maintain and administrate the system following completion of the Datix Certified Professional (DCP) Course.
- Training packages for key users on Datix has been drafted and will be finalised following completion of the forms to ensure a comprehensive training package
- The medical examiner role to be explored further to ensure appropriate system access to comply with the current process

6.0 Mortality Review Process Audit Action Plan Updates

Please see Appendix 1 (Assurance Action plan) – An interim policy has been approved by the Mortality Review Committee. Following the implementation of the Datix Module the policy will have to be updated to reflect the change in process including the removal of the NCEPOD A-E grading. Progress is being made with majority of the actions and within the agreed timeframes. Incomplete actions are being monitored and escalated where required.

7.0 Hospital Standardised Mortality Ratio (HSMR) update and trends

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.

The HSMR is above the national benchmark of 100, indicating a higher number of deaths than expected. This has been flagged as a high relative risk due to the lower confidence intervals also exceeding the national benchmark.

7.1 HSMR Trend

The most recent month of available data for the HSMR is July 2022.

The most current rolling 12 months of data for HSMR is August 2021 – July 2022 (Table 1).

Month	HSMR Value	Status
July 2022	**151.9**	Above Expected Range
August 2021 – July 2022	**120.6**	Above Expected Range

Table 1: HSMR for the most current data (July 2022). Source: Dr Foster Intelligence

The rolling 12 month HSMR trend is shown below in Figure 1. Since July 2021, the HSMR has been above the national benchmark of 100, indicating a higher number of deaths than expected.

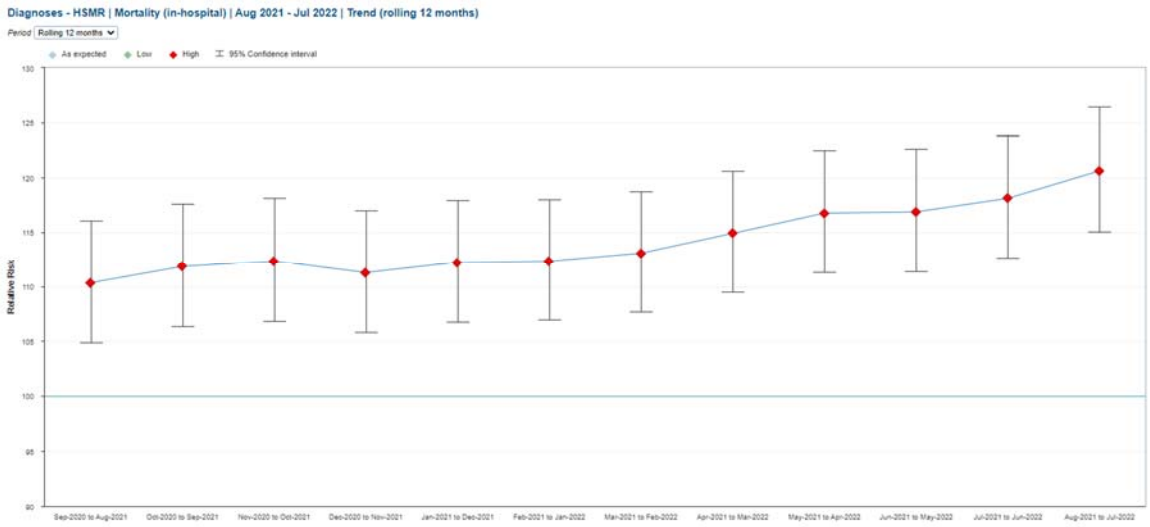


Figure 1. HSMR Rolling 12 Months Trend

7.2 HSMR deep dive

To understand possible reasons for the outlier status in HSMR there has been three deep dives since January 2022 into the diagnosis groups, specific specialties, and a further deep dive into the HSMR. The most recent deep dive was presented to Mortality Review Committee on the 22nd of August 2022. The

review explored casemix factors (comorbidities and admission type), and areas of significance for UHCW. Additional information relating to the themes identified was shared with the senior clinical leadership team during October 2022.

The findings of the review identified:

- There are five providers within the MTC peer group with statistically significantly high mortality. Of these UHCW has the highest HSMR.

- The crude rate is lower than other Major Trauma Centres (MTC), however it has increased during the last year. UHCW's expected rate is below other major trauma centers (UHCW has a 2.5% expected and other MTC's have 3.1% expected rate).

- The proportion of non-elective activity with no recorded comorbidity is higher than in peers and this has been increasing over the last two years. Conversely the proportion of activity with co-morbidity score 10-19 and 20-49 is lower than in peers and this is slowly declining.

- In some diagnosis groups, there is a higher proportion of patients identified with an "unspecified" diagnosis code compared to a peer average.

- When compared to other Major trauma centers the Trust has fewer episodes where a patient received specialist palliative care, compared to a peer average. Furthermore, a notably lower percentage of patient who died were recorded as receiving specialist palliative care, compared to the average for major trauma centers and nationally.

7.3 HSMR Action Plan

In response to the findings of the HSMR analysis an action plan for the ten diagnosis groups was devised and reported to Mortality Review Committee monthly, as part of the monitoring alerts report.

In addition to the most recent increase in HSMR a weekly task and finish group chaired by the Deputy Chief Medical Officer and attended by the Chief Medical Officer, Chief Quality Officer, Clinical Directors has been set up to drive improvements to positively impact the HSMR retrospectively where possible and going forward. To support this an additional action plan has been created to focus on the Trustwide themes identified including: (Appendix 2).

- Improving the documentation of comorbidities in patient notes and electronic discharge summaries
- Improving the access to healthcare records in the bereavement office for coding of deceased patients episodes of care.

- Training for all clinicians and healthcare professionals in documentation and its impact on accuracy of data.
- Completion of all primary mortality reviews to ensure learning from deaths is captures and improvement to clinical care identified in a timely way.

Membership to Mortality Review Committee and the weekly task and finish group has been extended to all clinical governance leads and mortality leads to increase the opportunity for clinical teams to be involves in the improvement plan and share the learning from investigations. A review of primary mortality reviews and patient safety incidents is underway and will be to the task and finish group with further actions added to the action plan.

8.0 Summary Hospital Mortality Indicator (SHMI) update

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. SHMI combines in hospital mortality with mortality within 30 days of discharge.

The SHMI is above the national benchmark of 1, indicating a higher number of deaths than expected. The value, however, is still within the expected range.

8.1 SHMI trend

The most recent SHMI report covers the period of April 2021 to March 2022. The SHMI position has increased since the previous position (1.1046). The SHMI value for UHCW for this publication is within the expected range. There were 2,585 deaths recorded compared to 2,340 ‘expected’ deaths.

Of the 10 diagnosis groups reported by NHS Digital, there were 4 Negative Alerts:

- Septicaemia (except in labour), shock
- Acute Myocardial Infarction
- Pneumonia
- Secondary Malignancies

SHMI and the ten reported diagnosis groups are monitored alongside the HSMR in the Mortality Review Committee and will be considered in the progression of the action plan. Three of the diagnosis groups identified in the SHMI data as higher than expected, are also being monitored through MRC as negative alerts in the HSMR data.

9.0 Improvements/next steps

- Actions from the Mortality Review Process audit to be monitored via MRC. The Mortality Review monitoring policy has been updated to bring in line with current practice and reflect any changes in job roles and responsibilities
- From April 2022 the requirement for a Medical Examiner review became a statutory requirement and rolled out to community deaths as well. We are actively in the process of recruiting more Medical Examiners from both internal clinicians and from general practice.
- To explore process for thematic review and triangulating learning from deaths, as per recommendations from Learning from deaths Guidance for NHS trusts on working with bereaved families and carers 2018
- Quarterly Mortality Lead meetings have been initiated to share learning and updates

Appendix 1 – Internal Audit action plan

Area for Improvement	Action	Person Responsible	Due Date	Status (RAG Rated)	Progress Update/Outcome	Level of Assurance	Evidence
The current generic Medical Examiner Job description does not distinguish between the roles of Medical Examiner and Lead	Produce individual job descriptions for the roles of Medical Examiner and Lead Medical Examiner	Roger Townsend	31/10/2022	Completed	Job description presented to MRC 08.08.22 approved.	Significant	Updated Job Description to include Lead ME role and Responsibilities
The Medical Examiner Process	Continue to recruit to the ME roles to provide full cover to enable all deaths to be screened. Once full cover is in place introduce a rota to ensure that adequate cover arrangements exist. The Lead ME to meet regularly with the team of MEs to share learning and good practice.	Roger Townsend	31/10/2022	In Progress	There is ongoing activity of recruitment for the Medical Examiner roles. Heading towards appointment to ME officer	Moderate	
Mortality Outlier Alerts and how they are communicated	Reintroduce the Outlier response template in line with the policy to support the triangulation of information in relation to mortality. Ensure that action plans in relation to mortality improvements are time bound.	Sharron Salt	31/10/2022	Completed	An updated process for the investigation of mortality outlier alerts has been drafted. This is being documented into a flow chart/SOP. The template has been redesigned and approved by the Mortality Review committee to incorporate a data review before case note review to make the best use of clinicians time when investigating cases. This will go to PSEC to be approved alongside the updated Mortality Review Policy. Mortality alerts are currently shared with specialties via the Specialty Mortality Profiles which are presented to MRC.	Significant	
The Escalation Process	Review current escalation arrangements in place for the completion of PMRs and SJRs to ensure these are effective and can be supported by clear audit trail. Continue to monitor, close off and report on outstanding reviews for 20/21.	Claire Evans / Hannah Bullock	31/10/2022	In Progress	There are now no reviews outstanding for 2020, with a focus on clearing the 14 remaining reviews from 2021. We are aware that although we have now improved the escalation process and updated this in the policy, a clear audit trail will be available once we have a Datix module. Escalations are done via email and reports into the Mortality Review Committee.	Significant	
Trust-wide learning from deaths	The identification and recording of Trust wide learning from deaths should be centralised, ideally through implementation of the Datix module or similar mechanism in order to allow for sufficient reporting through the Trust's governance structure.	Claire Evans / Hannah Bullock	31/10/2022	In Progress	We are still awaiting the Datix Module however, we already have a centralised system for shared learning. Progress has been made towards the implementation of the Datix module and aim to have in place by the agreed deadline.	Limited	
The notification of LeDeR patients that require SJR	Update the ME -1 form to reflect LeDeR requirements.	Roger Townsend - Lead Medical Examiner	31/10/202	Not Started	This is to be linked in with the implementation of the Datix Mortality module.	Limited	
Medical Examiner documentation to support the process	Develop a SOP in support of the Medical Examiner roles and responsibilities	Roger Townsend - Lead Medical Examiner	31/10/2022	In Progress	Due to be presented to MRC on 10th October for approval.	Limited	
The Mortality Review Process	Consider reviewing current practice for reviewing deaths within the Trust with a view to introducing a dovetailed approach whereby a sample of deaths are reviewed at specialty level following review by the Medical Examiner based on specific criteria. Results of the ME reviews could form the basis to highlight deaths for further scrutiny within specialties to complement sample reviews.	Claire Evans / Hannah Bullock	31/10/2022	Not Started	This will be reviewed as part of the implementation of the Datix Module.	Limited	
Training compliance	Consider introducing compliance targets for SJR training completion and monitor performance through MRC.	Sarah Rogers	31/10/2022	In Progress	All consultants are encouraged to complete mortality review training and are not able to review patient deaths until completed. The training is not mandated and on exploration the Trust is unable to add this to mandatory training compliance. A consultant induction pack is in the process of being drafted to include a section around mortality training as a recommendation. We are informed when new consultants join a specialty and contact is made to encourage attendance for Mortality Review training. SJR are usually completed by each specialty Mortality leads - all current mortality leads have completed this training. Target compliance rates will be discussed at the Mortality Review Committee. Following the implementation of the Datix Mortality Module there will be revised training for all staff involved with the mortality review process.	Significant	

Appendix 2 HSMR Action plan

Area of focus	Action	Expected Outcome	Person Responsible	Due date	Status (RAG Rated)	Progress Update/Outcome	Level of Assurance
Clincal Coding	Undertake a coding review of a sample of cases with unspecified sepsis code to identify if more a appropriate code applies	Increase in spells in Sepsis group in line with peers	Hahim Ali- Clinical Coding Manager	25/11/2022	Completed	25/10/2022 More up to date PIDs sent to coding team 4/11/2022- to be continued as part of MRC business	
Clincal Coding	28/10/2022 Review and correct where appropirate the co morbidity recording of patients with a comorbidity score of 0 for this diagnosis group	Correction of comorbidity recording for the diagnosis group and increase in expected mortality rate	Clinical lead for Neurosurgery. Rahim Hussain	18/11/2022	Completed	4/11/2022- to be continued as part of MRC business	
Clincal Coding	24/10/2022 Clarify practice of documenting comorbidities for non elective admissions for head injury patients requiring surgery	clearly defined process for recoring comorbidites for non elective patients	Clinical lead for Neurosurgery. Rahim Hussain	18/11/2022	Completed	4/11/2022- to be continued as part of MRC business	
Clincal Coding	Undertake a coding review of a sample of cases with unspecified pneumonia codes to identify if more a appropriate code applies	correction of unspecified codes and reduction in use of unspecified codes in line with peers	Hashim Ali, Clinical Coding Manager	14/11/2022	Completed	4/11/2022- to be continued as part of MRC business	
Palliative Care	Explore if coding for palliative care can be completed from referral, or if it needs to be from treatment delivery	Identify if practice is reflective of activity recorded	Hashim Ali Clinical Coding Manager	11/11/2022	Not Started	4/11/22 patient must be seen for episode to be coded Z515. local guidance can be created to demonstrate the service delivered at UH. For example, Critical care, Oncology and Care of the Elderly.	
Palliative Care	Identify which clinical scenarios can be identified as delivery of specialist palliative care to be included in local guidance for coding Z515 palliative care where the pallitiave care team are not directly involved.		Hashim Ali Clinical Coding Manager/ Jon Thomas Palliative Care consultant	11/11/2022	Not Started		
Palliative Care	Explore if there is a number of patients being referred for specialist palliative care, but not receiving it before death.	Identify areas of poor patient outcome or experience	Jon Thomas- Palliative Care lead	28/11/2022	Completed	The coding team have investigated the clinical coding of specialist palliative care and there does not appear to be a defecit, in coding. Patients may be referred to sp. Palliative care but pass away before seen. Are these cases captured anywhere and does the code represent referral, or attendance of the team?	
Clincal Coding	Agreement from Chief Officers that that patient notes do not leave the bereavement suite until the coders have completed their duties provided.	Improvement in quality of documentation in medical records. Improvement in depth of coding and comorbidity score. Increase in expected mortatliy rate in line with peers	Mo Hussain/ Kiran Patel	04/11/2022	Completed	Agreement at HSMR action plan meeting 28/10/22 that bereavement notes should not be removed from bereavement office until clinical coding has taken place	

Area of focus	Action	Expected Outcome	Person Responsible	Due date	Status (RAG Rated)	Progress Update/Outcome	Level of Assurance
Clinical Coding	Clinical Coding team to present process of clinical coding bereavement to Group Clinical Directors on Friday	Improvement in quality of documentation in medical records. Improvement in depth of coding and comorbidity score. Increase in expected mortatliy rate in line with peers	Hashim Ali/ Dan Hayes	04/11/2022	In Progress	Date in the diary for Friday 18/11/2022. Also to be presented to all clinical leads on Friday 11/11/22	
Clinical Coding	Clinical Coding team to prepare a communication statement to be shared by the comms team regarding the clinical coding of bereavement notes process	Improvement in quality of documentation in medical records. Improvement in depth of coding and comorbidity score. Increase in expected mortatliy rate in line with peers	Hashim Ali/Keith Bull	04/11/2022	In Progress	13/10/22 Clinical coding consultant pack and posters prepared for distribution.	
Clinical Coding	Clinical Coding team to provide draft email to be distributed to all medical distribution lists w/c 14 November to send from CMO inbox.	Improvement in quality of documentation in medical records. Improvement in depth of coding and comorbidity score. Increase in expected mortatliy rate in line with peers	Hashim Ali	14/10/2022	Completed	4/11/2022 CMO message prpared and shared in CMO bulletin	
Clinical Coding	Coding training to be provided for all consultants (3 or 4 sessions to be delivered via Teams for example) via QIPS	Improvement in quality of documentation in medical records. Improvement in depth of coding and comorbidity score. Increase in expected mortatliy rate in line with peers	Hashim Ali	10/04/2023	In Progress	13/10/22 Clinical coding consultant pack and posters prepared for distribution. 4/11/2022 Explore an opportunity for coding team to attend regular consultant team meetings to share examples of good documentation practice.	
Governance	Monthly meetings for clinical governance and mortality leads in specialties will be scheduled to monitor HSMR attendance will be logged and shared with the GCDs.	Improvement in quality of documentation in medical records. Improvement in depth of coding and comorbidity score. Increase in expected mortatliy rate in line with peers	Duncan Watson/Hannah Bullock	30/11/2022	Completed	1/11/2022 1st meeting in the diary for 8/11/2022. Register to be taken	
Training	Embed clinical coding in junior doctor training through local induction, attendance at QIPS meetings	Improvement in quality of documentation in medical records. Improvement in depth of coding and comorbidity score. Increase in expected mortatliy rate in line with peers	Sarah Rogers/Hashim Ali/Medical Education Workforce	30/11/2022	In Progress	4/11/2022 All consultants at induction should meet with coding All junior doctors at induction meet with coding If Consultant level coding is below standard then a one to one meeting is arranged to discuss	
Training	Explore the options of an eLearning module on documentation and the impact of clinical coding	Improvement in quality of documentation in medical records. Improvement in depth of coding and comorbidity score. Increase in expected mortatliy rate in line with peers	Dan Hayes	25/11/2022	In Progress	4/11/2022 ICT to explore options for eLearning module to be built and possible timescales.	
Training	Invite the Chief Registrar to the actionplan group and MRC to support shared learning to the trainee doctor workforce.	Improvement in quality of documentation in medical records. Improvement in depth of coding and comorbidity score. Increase in expected mortatliy rate in line with peers	Sharron Salt	04/11/2022	Completed	4/11/2022 Invitation sent.	
Clinical Coding	Provide a table of specialties level and consultant level data based on GMC number of the number of all patients recorded with zero comorbidities	Improvement in quality of documentation in medical records. Improvement in depth of coding and comorbidity score. Increase in expected mortatliy rate in line with peers	Dan Hayes	04/11/2022	In Progress	4/11/2022 Table provided by P&I to KP. For review and circulation to CDs and Chief Registrar	
Clinical Coding	Design a pro forma tick list for identifying comorbidities on admission with a view to produce this on CRRS	Improvement in quality of documentation in medical records. Improvement in depth of coding and comorbidity score. Increase in expected mortatliy rate in line with peers	Hashim Ali/ Dan Hayes	11/04/2022	Completed	4/11/2022 Proforma included into existing discharge summary and is ready to go live. Launch at Grand Round today	
Clinical Coding	Explore the addition of a tab on CRRS to record comorbidities, or the inclusion of drop down menus on the discharge summary	Improvement in quality of documentation in medical records. Improvement in depth of coding and comorbidity score. Increase in expected mortatliy rate in line with peers	Penny Kechagioglou	04/11/2022	Completed	4/11/22 Initial review indicates that it is easier to amend CRRS than the discharge summary template. Further investigation needed.	

Area of focus	Action	Expected Outcome	Person Responsible	Due date	Status (RAG Rated)	Progress Update/Outcome	Level of Assurance
Clincal Coding	Confirm the data set for drop down menus for compications and comorbidities on CRRS dishcarge summary	Improvement in quality of documentation in medical records. Improvement in depth of coding and comorbidity score. Increase in expected mortatliy rate in line with peers	Hashim Ali	04/11/2022	Completed	List updated and communicaiton guides available and launched at grand round.Next steps training opportunities with coding team	
Clincal Coding	Investigate the timeline of when coding practice chaged to reflect COVID as primary code over HSMR basket	Improvement in quality of documentation in medical records. Improvement in depth of coding and comorbidity score. Increase in expected mortatliy rate in line with peers	Hashim Ali	04/11/2022	Completed	4/11/2022 Action closed, investgiation complete, no further action required. NHS E guidance during COVID indicated COVID 1st position. Practice changed back in March 2022. Not yet clear of the impact of this on HSMR.	
Clinical Effectiveness	Explore if a list of national registries can be obtained thorugh the clinical audit programme to access to identify if patients have a comorbidity. E.g Diabetes registry	Improvement in quality of documentation in medical records. Improvement in depth of coding and comorbidity score. Increase in expected mortatliy rate in line with peers	Sharron Salt	04/11/2022	Completed	HQIP registry lists only those registries associated with national audit. Not possible to identify all.	
Governance	All Clinical Governance Leads and/Or mortality leads to be invited to attend Weekly HSMR action plan meeting	Increased attendance of clinical representation at mortality meetings	Sharron Salt	04/11/2022	Completed	4/11/2022 Invitation sent	
Governance	All outstanding mortaltiy reviews to be presented by group at Friday HSMR actionplan meeting	To increase completion of mortality reviews to identify concerns in care	Hannah Bullock- mortality coordinator	04/11/2022	Completed	4/11/2022 presented by patient safety team. Further action to complete all outstanding mortality reviews by end of November 2022. 9 reviews from 2021 to be completed by the Clinical Director.	
Governance	Autoemails for outstanding mortality reviews to be sent to Clinical Directors weekly	To increase completion of mortality reviews to identify concerns in care	Hannah Bullock- mortality coordinator	11/11/2022	In Progress		
Governance	All Clinical Governance Leads and/Or mortality leads to be invited to attend Mortality Review Committee	Increased attendance of clinical representation at mortality meetings	Hannah Bullock- mortality coordinator	04/11/2022	In Progress	4/11/2022 Invitation sent, but responses from mortality leads is that they cannot attend regularly.	
Clinical Effectiveness	Investigate and present data demonstrating the relationship between HSMR and SHMI		Miguel Valenzuela	11/11/2022	Completed	4/11/2022- to be continued as part of MRC business	
Governance	Design a process to ensure all consultants are responsible for sign off of discharge summaries	Improvement in quality of documentation in medical records. Improvement in depth of coding and comorbidity score. Increase in expected mortatliy rate in line with peers	Senior medical leadership (Sarah Rogers)	11/11/2022	In Progress	4/11/2022 further exploration required	
Governance	Amend MRC invite to include statement 'if cannot attend please send a deputy'	Increased attendance of clinical representation at mortality meetings	Georgia Finnie/ Sharron Salt	11/11/2022	Completed		
Governance	Chair of Group CD meetings to nominate a representative to attend weekly HSMR meeting and feedback messages	Increased attendance of clinical representation at mortality meetings	Ed Hartley	11/11/2022	Completed	All Clinical Directors invited to weekly meetings	

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 1 DECEMBER 2022

Subject Title	Medical Education Report
Executive Sponsor	Professor Kiran Patel, Chief Medical Officer
Author	Professor Sailesh Sankar, Director of Medical Education
Attachment(s)	Report from Medical Education Directorate
Recommendation(s)	The Board is asked to accept the report for **ASSURANCE**

EXECUTIVE SUMMARY
The Medical Education Directorate manages and delivers education and training to undergraduate medical students, trainee doctors and a full range of health professionals using a range of training facilities and services. In the attached report we will cover the recent progress and challenges faced by each of the departments/services, our Training Leads and the groups we serve
PREVIOUS DISCUSSIONS HELD
This report covers the progress on projects reported in the July 2022 report and introduces any new developments that occurred since that report.

KEY IMPLICATIONS	
Financial	The Directorate has been granted eight grants related to CoVID recovery amounting to £260,000 worth of funding from the Training Recovery 2022-23 Funding process. The Directorate has met it's Waste reduction target, £345K All departments are working on income generated activities.
Patients Safety or Quality	Concerns about the rota cover in ITU have been raised by trainees in their doctors forums and via reports to the Guardian for safe working. These concerns have been escalated via appropriate meetings and are being reviewed by senior management. A number of Quality initiatives are highlighted in the report included work undertaken by the Knowledge and Library team and the Resuscitation team
Workforce	A number of new lead appointments are noted and a change in the recruitment process being used for CTF posts is outlined.
Operational	The core teams of each department are generally strong and morale is good. The Directorate is seeking a couple of appointments to help

	bolster the project management and quality monitoring elements of the overall team

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

REPORT TO PUBLIC TRUST BOARD

Medical Education Report

1. INTRODUCTION

1.1 The Medical Education Directorate manages and delivers education and training to undergraduate medical students, trainee doctors and a full range of health professionals using a range of training facilities and services. In this report we will cover the recent progress and challenges faced by each of the departments/services, our Training Leads and the groups we serve

2. CONTENT

2.1 The Medical Education Directorate has a broad base and a challenging and exciting brief. All the departments are united in their focus on ensuring that medical education at UHCW is accessible, adaptable, responsive, user friendly, integrated and excellent. This report covers the work of the teams supporting our postgraduate doctors both trainees and locally employed doctors, the medical students from WMS and elsewhere, those seeking work experience in medical education from 6th Formers to senior grade doctors seeking clinical attachments, and the work of our departments i.e. the medical education course organising team, our Website and digital learning team and our departments i.e. Clinical Skills, Resuscitation, Simulation centre, Surgical training centre (Warwickshire STC), Knowledge and Library Services and the Grand Round plus working with the Guardian of Safe working

2.2 Postgraduate Medical Education

2.3 *Foundation School update*

- Ensuring that the Educational supervisors maintain their training record in line with accreditation and are fully supported is scheduled into the programme. Dr Rashmi Manjunatha has been promoted to the role of Foundation TPD and Dr Tanya Potter (the previous TPD) has taken on the role of regional training advisor. Following competitive interviews (and subject to CD approval of the change to job plan), Dr Peeyush Kumar has just been offered the role of Foundation Year 1 Tutor.
- Trainees involvement in the shaping of their training and feedback on provision is being promoted via membership of representatives at the Foundation School meetings, encouraging trainees to attend the JDF and promotion of the NETS which is currently live (running between 18th Oct to 30th Nov 22) – all trainees have been encouraged to fill in the survey and currently the UHCW response rate is acceptable when compared to our peers but we are continuing to promote via the Educational Leads (including the Nursing and AHP Leads).
- Feedback from the trainees suggest that in certain specialities they are not getting their SDT/SPA time – Foundation trainees have been advised to exception report. In addition concerns about the staffing levels in ITU (linked to gaps in rotas and difficulties engaging locum cover) has left foundation trainees feeling exposed and unsupported by senior cover. These concerns have been escalated to the senior executive team.
- The Oxford Medical Simulation project continues to be promoted within the Trust and HEEWM has provided the Trust with additional equipment funding to support the project roll out. The simulated clinical scenarios are designed to provide junior grade trainees with grounding in a number of clinical decision making situations and thus support trainees knowledge and confidence. Upto 5 hours of OMS is counted towards foundation core teaching so provides trainees with a flexible training opportunity.

- Foundation posts in South School oversubscribed. Trusts have been asked to explore if new rotations can be created for next year.
- Extended shadowing for IMG FY1s for one week prior to commencement of FY1 post will continue next year.
- Mid-year ARCPs for all foundation trainees will be held in Jan 2023
- ARCP for out of sync trainees – to be conducted on 9/11/22
- 2 monthly local Foundation Meeting (UHCW foundation team) on going – last one in Sept and next one scheduled in Dec 2022.

2.4 ***Locally employed doctors***

2.5 The Lead for Locally employed doctors, Dr Deepak Samson has been working with the Medical Workforce team and senior members of the Medical education team to formally evaluate the on boarding needs of locally employed doctors with a focus on ensuring that any gaps in knowledge and experience that could impact on patient safety and/or the welfare of the doctor are identified early and addressed. In this project the team will be working with the Resuscitation team to address their concern about the gap in cardiac arrest training associated with this group of doctors. The team are currently advertising for a Band 5 project coordinator post to help support this and several other projects.

2.6 ***NETS and GMC survey results and follow up visits from HEEWM***

2.7 Mr Shabin Joshi is currently working with those departments (Neurology, Rugby St Cross trainees and Foundation trainees in surgery) to ensure that the concerns raised in previous GMC and NETS have been fully resolved. The current NETS will be used by HEEWM to evaluate progress against plans and therefore the Leads in these areas are particularly focused on ensuring that a representative sample of trainees complete the survey to avoid outlier bias and ensure a fair evaluation of the training opportunities available.

2.8 ***Enhance programme (Generalist school)***

2.9 Significant progress on the development of the partnerships needed to make this programme successful was achieved via a senior Keystake holder session held in the Innovation hub at UHCW in September. The morning started with a joint presentation to the UHCW Senior Management team and the community leaders by Jonathan Corne and then was followed by a very positive and enthusiastic workshop during which the next steps were explored. Following this Professor Sankar has been working both with staff within the Trust to work through the detailed implications of the programme and how these can be addressed and with the external potential placement providers to establish next steps. The first 3 trainees from the IMT programme will take on this additional workload in August 2023.

2.10 ***Undergraduate Medical Education***

- Various amendments and changes have been made to accommodate the need to allow compliance with Covid restrictions and despite the numerous challenges the team have managed to keep the programme running including providing additional support to the students who need extra support due to loss of confidence and opportunities to access the wards during the pandemic peak.
- Despite last minute cancellations due to medical / Covid positive conditions examiners for 2nd year OSCEs were adequate. FPE examiner recruitment and training is currently in progress under the leadership of the New Exam Lead.

- New CTF structure:
    - New plan has been approved which will see an increase in the number of CTF's to 6 FT and 10 50:50. CTF's will be funded by MedEd completely and provide more flexibility to allocate to educational responsibilities.
    - Introduction of a senior fellow post who will be responsible for the day-to-day management of the fellows.
    - In addition, there will be CTF's designated to a leadership role in each speciality block. Recruitment in progress in next 2 months.
- Medical Education Faculty is working in that it has improved the link between activity and recognition, we are currently reviewing the database with the block leads and appraisals are ongoing including an appraisal template review.
- UHCW has received an approach from Aston Medical School to teach UG students and at this stage we are exploring what the request is and will liaise with Warwick Medical School Dean should any proposal or request materialise as WMS is clearly our primary University partner for medical education and we also have a proposal to deliver with the American Universities of Antigua, so capacity would need to be sought depending upon the request.

2.11 ***Guardian of Safe working***

2.12 The Guardian of Safe working continues to report to the members of the Post graduate medical education committee on concerns raised via Exception reporting. A major area of concern is the failure of Educational supervisors to meet the timescales required in terms of responding to concerns. In addition the lack of senior cover on the ITU and the need for trainees to stay late to cover gaps in staffing leading to breaches has been escalated to the Chief officers.

2.13 ***Grand Round***

2.14 The new programme has been launched and the face to face attendance rates are gradually increasing. The CMO has been very supportive of this weekly opportunity for clinical staff to get together for an hour on Friday lunchtime to share ideas for best practice. The provision of a light lunch and a more reliable high quality programme is helping to spread the message that the Grand round is back.

2.15 The GR will also be a platform for learning from Never Events. The CMO personally requests responsible consultants for clinical never events to present at GR.

2.16 Prof Franco Cappuccio has been appointed as new Chair of the Grand Round committee, which has multidisciplinary membership.

2.17 ***Knowledge and Library Service***

2.18 The staff have supported the National Libraries Week 3-9th October 2022 with this years theme of 'Never Stop Learning'. These included promotion of the library as a 'Living Library, a book lunch with R&D – COVID-19 Stories from UHCW NHS Trust staff, supporting a session with SPOC as it was also the start of Black History Month, CEBIS promotion with talks offering to visit departments and specialities, a Tea party: A 'thank you' promotion for our library users and display of posters submitted for HLG competition

2.19 CEBIS submitted a poster for the Centre for Clinical Excellence Day (18th October 2022) with professor Liz Lees-Deutsch.

2.20 Search Solutions 2022 Innovations in Search & Information Retrieval; Gavin Moore CEBIS Specialist has had an abstract accepted to present at this conference on November 23rd in London.

2.21 Beth Jackson has redesigned the 'Manager's Hub' with Workforce and we are waiting to hear whether further funding is available to make amendments following feedback.

2.22 LKS Website UHCW Library and Knowledge Services

2.23 We have now soft launched the new Library & Knowledge Services website and are in the process of getting user feedback. If you have comments and suggestions, please do feel free to send to library@uhcw.nhs.uk.

2.24 The team have submitted 5 posters for the Health Libraries Group 75th Anniversary Competition. The posters showcase the Library's work.

2.25 Institutional Repository - UHCW has led on a consortium purchase of West Midlands NHS Trusts to purchase an Institutional Repository. This will be Health Libraries Midlands (HeLM) and provides the following benefits users will be able to borrow 16 items for 6 weeks each; automatic renewal for 5 times unless required by another user; return of items to any HeLM library. One self-issue kiosk is now working and waiting for resolution on second one as well as connection for the kiosk at RSX.

2.26 Improvements to the Quality Improvement Outcomes Framework (QIOF) have been made and the new schedule will include a baseline report that will be shared with senior managers and detailed report to be received on 20th September. The Development plan in response to the baseline report will need to be submitted by 16th January 2023. A service improvement plan and annual report will be required every two years thereafter. A full QIOF submission will not be required until 2027/2028. So after a shaky start a more helpful process has been developed to support the work of the Libraries nationally.

2.27 The Library team will be running a campaign to promote HEE nationally funded BMJ Best Practice to comply with HEE Provider Annual Self-Assessment 2022 for NHS Trusts (Section 2 Q.23) and also at request of CMO as part of new process for Clinical Guidelines at UHCW NHS Trust.

2.28 ***Clinical Skills***

2.29 A new lead for the Clinical Skills team, Matthew Fletcher, has been appointed and is leading on the delivery of the comprehensive clinical skills programme for the Warwick medical students. As described in previous reports this is one of the central planks of the teaching provided by the Trust which teaches the medical students the full range of clinical skills ensuring full compliance with national standards.

2.30 This has enabled Linda Crinigan to concentrate on developing the postgraduate medical education curriculum in line with the medical education strategic plan. So far the Multi skills course continues to gain momentum with 10 courses planned for 2023. Candidates have applied from the whole country but mostly the Midlands. Evaluations remain extremely positive; faculty of senior clinicians is building. Dates and time from faculty is being recorded to ensure recognition of contribution. Stand-alone ultrasound guided CVC courses are also running with good uptake – between 7 and 12 candidates per course.

2.31 MCQ pre course –currently candidates complete an MCQ on the day of the course, but the centre plan to build a bank of questions to enable the transition from 'on the day' MCQ to pre course electronic MCQ to take place.

2.32 Discussions are in progress to develop a procedures re-fresher course for consultants

2.33 Discussions also in progress to develop a clinical skills course for medical staff to update them on current practices and equipment within the Trust and nationally. We already have a course in our portfolio for clinical attachés which we should be able to utilise for this with minimum 'tweaks'.

2.34 We are going to investigate joint injection courses for medical staff, but we will also be targeting appropriate GP practices, we will liaise with appropriate medical staff in the first instance from orthopaedics and rheumatology

2.35 First aid courses continue with candidates from various small businesses applying, we have 6 courses booked in for 2023. We have also been asked to deliver a first aid course for the Princes Trust later this month. Plans to develop a brochure for first aid courses and then target local businesses are in progress. This work increases the profile of UHCW as a centre

for training excellence, provides a revenue stream and promotes safe practice in the community thus strengthening our local ties.

2.36 ***Resuscitation***

2.37 Dr James Gaywood , Consultant in Elderly medicine has now been appointed as the Trust Wide Clinical lead for Resuscitation.

2.38 Michelle Hartanto has presented her project on the CPR conversations systematic review nationally and is aiming to publish her work soon.

2.39 The Resuscitation team were nominated for several OSCAs this year, both individual and team nominations were received. The team won the OSCA for UHCWi innovation and improvement for the digitised equipment checklists. The My Kit Check is approximately. 65% operational with the completion of implementation anticipated for end of November. This system is proving effective in reducing risk due to being a more effective audit system compared to the previous manual checking system and the waste reduction in terms of staff time and efficient use of materials is significant

2.40 The ReSPECT e-learning modules are now complete, we have managed IP for the content and licence for reproduction in place and will be going live with this after initial focus group feedback in November 2022. Special thanks to the ReSPECT SDM and UHCW Charity for their hard work and support for this project.

2.41 A recent issue regarding supply of new batteries has been resolved with negotiations resulting in the promise from Zoll to provide new batteries on a rolling supply of 25 batteries per month between now and January. This will remain as moderate risk trust wide for now and will be removed as a risk once all supplies are received. Thanks to the Lincoln Dawkin , GE PFI reps, MEBs and Zoll for assistance this negotiation, intervention and resolution .

2.42 Resuscitation week' wc 10th October was successful including stand up presentations, launch of the ReSPECT E learning, feedback from the My Kit Check roll out, a CPR athon supported by UHCW Charity and also Restart a heart day. The CPR athon was a great success over 200 members of staff (mainly non-clinical) practiced high quality CPR on adults and children and we raised over £400 for our charity pot.

2.43 ***Simulation***

2.44 Dr Laura Harrison has been appointed as the new Lead for Simulation (subject to CD approval and amendment to job plan) following Dr Sarah Ellis stepping down to concentrate on other commitments including her role as TPD for Neonatology. Our sincere thanks to Sarah for all her work and support to build up the Simulation centre and team

2.45 The team are working on their application for accreditation by the Association of Simulated practice for Healthcare (ASPiH). This is the national body and quality standard bearer for simulation based education in the UK. This is a prestigious award is not currently held by many centres so achieving this would be a real boost for the team.

2.46 ***Surgical training (Warwickshire Surgical Training centre)***

2.47 The Centre has been signed off as fully accredited by the Royal College of Surgeons after their follow up audit. The centre has received excellent feedback for the courses it has been running. In addition, the centre has strengthened it's governance structures in line with the recommendations of the Internal audit team with just a couple of minor reassurances now needed to be fully compliant. The Director and manager have these in hand.

2.48 The centre ran the first and last week of August and was closed the middle two weeks and will need to close again over the Christmas period to allow for the installation of the BLOCK virtual reality kit purchased using the large grant from HEEWM to help improve access to the units teaching via remote links. This will not only support international courses but will enable the centre to reach out to groups needing training support for surgical procedures who would otherwise be unable to access them. During the closure the centre will also have alterations made to facilitate the development of a second changing room (to provide a

male and female changing facility) and a material preparation area which will release space in the teaching lab and provide a more respectful facility for handling donor specimens and will allow for back to back teaching rather than needing to have down time for course preparation.

2.49 The new Donor pathway is working well, and the additional paper trail is enabling us to increase body mapping which supports the ethical need to utilise the material donated to teaching as efficiently and effectively as possible and reduces the cost and therefore increases access to this valuable resource.

2.50 The centre needs Trust support to identify a suitable DI for the WMSTC HTA Licence to take up these important responsibilities following Professor Snead s imminent retirement. This is currently being considered by the CMO.

2.51 Centre occupation for the autumn is below the summer period. This may be due to the uncertain financial situation or catch up complete from post Covid training. But despite this the centre expects to turn a significant deficit last year into a break even position this year. Which is a considerable achievement given the investment that has taken place this year to revitalise the centre and bring it back to a top class facility.

3. IMPLICATIONS

3.1 **Financial** - The Directorate has met its Waste reduction target and has attracted a number of significant grants from HEEWM for covid related recovery activity. All departments are working on income generated activities.

3.2 **Patients Safety or Quality** -Concerns about the rota cover in ITU have been raised by trainees in their doctors forums and via reports to the Guardian for safe working. These concerns have been escalated via appropriate meetings and are being reviewed by senior management. A number of Quality initiatives are highlighted in the report included work undertaken by the Knowledge and Library team and the Resuscitation team.

3.3 **Workforce** - A number of new lead appointments are noted and a change in the recruitment process being used for CTF posts is outlined.

3.4 **Operational** -The core teams of each department are generally strong and morale is good. The Directorate is seeking a couple of appointments to help bolster the project management and quality monitoring elements of the overall team.

4. OPTIONS

N/A

5. CONCLUSIONS

5.1 Overall the Directorate and it's departments are functioning well and delivering on their remit.

5.2 The Directorate is continuing to support the overall strategy of the Trust to ensure patient safety and the provision of excellent, innovative care by providing teaching, training and professional support to doctors, nurses, AHPs and those wishing to take up a medical career.

6. RECOMMENDATIONS

6.1 The committee accepts this report for assurance that the medical directorate is fulfilling its function and operating effectively whilst recognising and working on areas requiring further improvement.

Author Name: Professor Sailesh Sankar
Author Role: Associate Medical Director for Education Training and Professional Development
Date report written: 16th November 2022

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 1 DECEMBER 2022

Subject Title	Patient Safety Learning Report
Executive Sponsor	Mo Hussain Chief Quality Officer
Author	Amy Watts, Head of Patient Safety & Risk Claire Evans, Associate Director of Quality – Patient Safety Lisa Cummins, Director of Quality
Attachment(s)	Patient Safety Learning Report
Recommendation(s)	The Board is asked to **REVIEW** and **DISCUSS** the contents of the Patient Safety Learning Report

EXECUTIVE SUMMARY

1.0 Key Performance Indicators

For September 2022 there were two key performance indicators that demonstrated reduced performance over the last three months: the number of overdue Serious Incidents and percentage of Duty of Candour Conversations held within 10 days.

At present the national timeframe for completing SI investigations remains suspended due to the covid-19 pandemic but internally the KPI remains. On review, the reason behind these breaches mostly relates to delays in assigning a lead investigator, delays in obtaining medical records and issues with lead investigator capacity.

In terms of Duty of Candour, there was one case in September 2022 where Duty of Candour was not marked as complete within 10 days; at the time of validating the performance data the incident remained as moderate harm on the system (therefore DOC applied). On review of this incident, it has subsequently been downgraded therefore does not meet the statutory requirement for Duty of Candour. This will be reflected in future reporting (therefore compliance for September will be reported as 100% in future reports).

2.0 Serious Incidents (SIs)

There were eight SIs reported in September 2022 with the highest category of incidents relating to Treatment Delay (although it is recognised that the number of these incidents remains small overall). There were no common themes identified between these treatment delay incidents.

3.0 Never Events

There have been three Never Events registered for this financial year. All Never Events are subject to review via the SI process and the final investigation reports are presented to the Serious Incident Group (SIG) and Quality and Safety Committee as per standard process.

4.0 Safety Alerts

There has been one safety alert received in October 2022 which has been closed. The action plan is included as an appendix to this report.

5.0 Patient Safety Incident Response Framework (PSIRF) update

The framework is currently under review internally and work is ongoing by the Patient Safety Team with support from a dedicated Task and Finish group, and oversight from SIG Governance, to determine the changes that will be required to the Trust's current process for the identification and investigation of Serious Incidents. An options appraisal paper is currently being reviewed to present and explore a number of options for the operational delivery of PSIRF.

PREVIOUS DISCUSSIONS HELD
This report is presented to Trust Board on a three-monthly basis as per the agreed work plan.

KEY IMPLICATIONS	
Financial	N/A
Patients Safety or Quality	To continue to embed learning from near misses and incidents in order to prevent avoidable harm and risk to patients.
Workforce	N/A
Operational	N/A

University Hospitals Coventry and Warwickshire NHS Trust

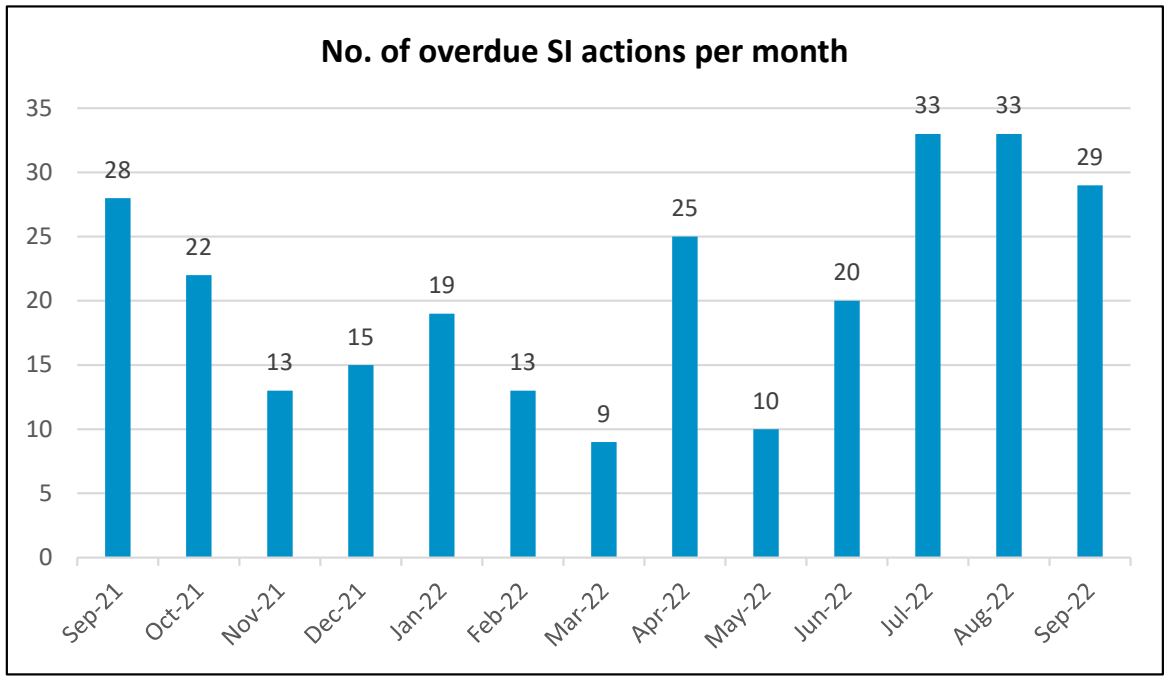
Patient Safety Learning Report

Claire Evans Associate Director Quality – Patient Safety and Risk
Amy Watts – Head of Patient Safety and Risk
Jenna Neale – Patient Safety manager

November 2022

1.0 Key Performance Indicators

Key Performance Indicator (KPI)	Target	June 22	July 22	Aug 22	Sept 22
Duty of Candour conversations to be held with patients and /or their families, within ten days of an incident occurring which resulted in moderate harm or above to the patient	**100%**	100%	100%	100%	92.31%
Serious Incident Investigations to be completed within 60 working days. (Not currently being monitored by the Clinical Commissioning group due to Covid-19)	**100%**	70%	82%	82%	62%
All SIG meetings should be quorate, with regular attendance from members	**100%**	100%	100%	100%	100%



What does the data show?
There were two key performance indicators that did not meet the required KPI as at September reporting; the number of overdue Serious Incidents and the percentage of Duty of Candour Conversations held within 10 days.

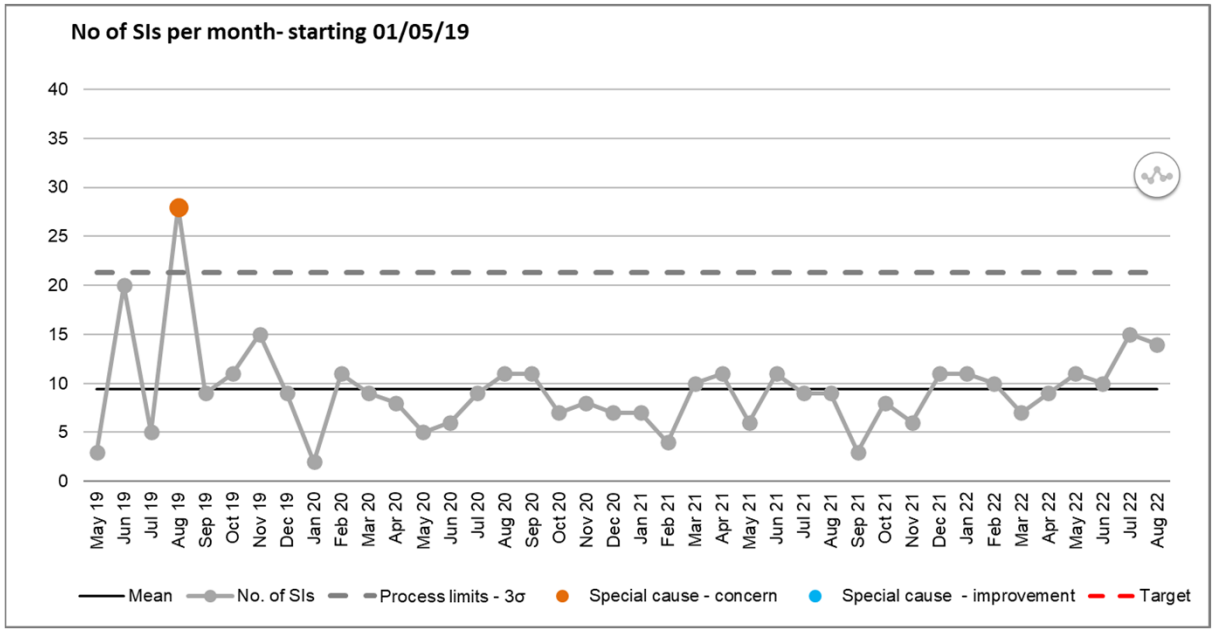
Breached SIs:
As of the 28th October 2022, were 22 out of 58 open Serious Incident investigations that have breached the 60-day timeframe for completion. It should be noted that the 60-day timeframe was stood down by the Integrated Care Board (ICB, formerly Clinical Commissioning Group or CCG), during Covid-19 and the Trust is yet to receive confirmation this has been formally reinstated. However, UHCW has continued to aim to complete cases within this timeframe and an update on all breached cases is provided to the Serious Incident Group (SIG) on a weekly basis.

Learning / Actions:
Review of the 22 breached cases identified that in eight of the cases, lead investigators were assigned late, and in three of the cases there were delays in obtaining the medical records needed for the investigation. In the remaining 11 cases, identified issues related to the capacity of lead investigators and the availability of information from staff involved who had since left the Trust. These issues are discussed at the SIG Governance meetings and actions implemented as required.

Duty of Candour:
There was one incident in September 2022 where duty of candour had not been marked as completed within ten days; at the time of validating the performance data the incident remained as moderate harm on the system (therefore DOC applied). On review of this incident, it has subsequently been downgraded therefore does not meet the statutory requirement for Duty of Candour. This will be reflected in future reporting (therefore compliance for September will be reported as 100% in future reports).

Overdue SI actions: The number of overdue SI actions in September 2022 decreased from 33 (August 2022) to 29. These actions continue to be reviewed and escalated to the action owner and clinical groups and as of the 28th October 2022, the number of overdue SI actions has decreased to 13.

2.0 Serious Incidents



SI Categories	July 22	Aug 22	Sep 22	Total
Accident (not slip / trip / fall)	1	0	0	1
Apparent/actual/suspected Self-Inflicted Harm	0	1	0	1
Diagnostic Incident	1	0	0	1
Maternity Incident – Intrauterine Death	0	2	1	3
Maternity – Baby only	0	1	0	1
Maternity – Maternal death	0	0	1	1
Maternity – Mother and Baby	0	0	1	1
Pending review	0	1	0	1
Pressure Ulcer meeting SI criteria	2	3	0	5
Slips / Trips / Falls	10	3	1	14
Sub-optimal care of the deteriorating patient	1	1	0	2
Surgical / invasive procedure incident meeting SI criteria	0	1	1	2
Treatment delay meeting SI criteria	0	3	3	6
Totals:	15	16	8	39

Background:
Serious Incidents (SIs) are currently identified and reported in line with NHS England's SI Framework and are incidents that have led to serious harm or death of one or more patients, or have a significant potential for learning.

What does the chart show?
The number of SIs reported to the national Strategic Executive Information System (StEIS).
Over the previous two years, the chart shows that the number of registered SIs has remained consistently around the average (Mean = 9) with an observed upward trend in SIs noted from March 2022.

Identified Themes: (September 2022)
The highest number of SIs reported were registered under the category of treatment delay (n=3); all three cases are subject to ongoing RCA's. Two of these cases were identified through the mortality review process where the initial mortality review had been graded as an NCPOD classification "E". On further review of these two cases, there were no common themes identified; the remaining case related to a Paediatric death in which it was identified there may have been opportunity to provide antibiotics and administer blood tests earlier.

Identified Themes: Overall
During the three-month period from July 2022 to September 2022, inpatient falls leading to significant harm or death (n=14), SIs relating to Treatment delay (n=6), and unstageable category 3 and 4 pressure ulcers (n= 5) remain the overall highest reported type of Serious incident category.

4.0 Never Events

Never Event Category	Qtr 1 22/23	Qtr 2 22/23	Qtr 3 22/23
NE - Retained Foreign Object post-procedure	1	0	0
NE – Wrong site block	1	0	0
NE – Wrong Site Surgery	0	0	1
Totals	2	0	1

Background:
There have been three Never Events registered for this financial year (as at 1st November 2022) .

All Never Events are subject to review via the SI process and the final investigation reports are presented to the Serious Incident Group (SIG) as per standard process.

Quarter1:
The review of Never Events registered in Quarter 1 relating to a wrong site block and retain foreign object have now concluded.

Quarter 3:
A further Never Event relating to a wrong site procedure (an angioplasty that was performed on the patient's right lower limb rather than left) was registered in October 2022.

The immediate learning identified included:

- A review of the use of the WHO checklist in Interventional Radiology and exploration of any related audits
- Review of learning from similar incidents in Theatre and whether this could be applied to interventional Radiology e.g., marking the side of the the operation should be performed and introducing a process of 'Stop before you block'

5.0 Safety Alerts

Alert	Due date	Action Plan	Updates on progress
Recall of Targocid 200mg powder for solution for injection/infusion or oral solution, Aventis Pharma Limited t/a Sanofi, due to the presence of bacterial endotoxins	26/10/2022	1. Stop supplying impacted batches immediately. Quarantine all stock and return to supplier 2. Immediately identify whether your organisation has administered any affected batches to patients and put an appropriate action plan in place for clinical assessment / monitoring 3. Immediately identify whether your organisation has supplied any of the affected batches for use at home. Request patients to return for disposal 4. Contact all patients who may be using the impacted batches	Action plan completed and Chief Officer approval sought outside of the Patient Safety and Effectiveness Committee (PSEC) due to timeframe. Action plan shared as an appendix.

Background:
National patient safety alerts (NPSAs) are issued from NHS England and NHS Improvement to raise patient safety issues that require national action

Open Alerts

There has been one safety alert received in October 2022 which has been closed with Chief Officer approval outside of the meeting, due to the deadline being the 26h October 2022.

6.0 PSIRF

The Patient Safety Incident Response Framework (PSIRF) was launched in August 2022. The framework will change the way that patient safety incidents are managed in the NHS across England and all providers are required to transition to this framework by September 2023.

PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement. Some incidents will still require a formal investigation to learn and improve, however PSIRF reduces the rules and thresholds that determine what needs to be learned from to inform improvement and encourages different approaches to learning than just using formal investigations

It is anticipated that organisations will undertake less investigations than is the case currently, however these investigations will be much more in depth and based on intelligence gathered from a range of data sources. Thematic reviews will be used to identify underlying systems issues across common themes and trends to allow a 'deep dive' approach. Leads will also require extensive training and dedicated time to undertake these cases.

Adoption of the framework will require significant changes to the way safety incidents are managed, as well as to training and governance. A proposed implementation timeframe can be seen here.

Phase	Duration	Purpose
PSIRF orientation	Months 1–3	To help PSIRF leads at all levels of the system familiarise themselves with the revised framework and associated requirements. This phase establishes important foundations for PSIRF preparation and subsequent implementation.
Diagnostic and discovery	Months 4–7	To understand how developed systems and processes already are to respond to patient safety incidents for the purpose of learning and improvement. In this phase strengths and weaknesses are identified, and necessary improvements in areas that will support PSIRF requirements and transition are defined.
Governance and quality monitoring	Months 6–9	Organisations at all levels of the system (provider, ICB, region) begin to define the oversight structures and ways of working once they transition to PSIRF.
Patient safety incident response planning	Months 7–10	For organisations to understand their patient safety incident profile, improvement profile and available resources. This information is used to develop a patient safety incident response plan that forms part of a patient safety incident response policy.
Curation and agreement of the policy and plan	Months 9–12	To draft and agree a patient safety incident response policy and plan based on the findings from work undertaken in the preceding preparation phases.

Source: NHS England Patient Safety Incident Response Framework Preparation guide

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 1 DECEMBER 2022

Subject Title	Corporate Risks Report
Executive Sponsor	Mo Hussain, Chief Quality Officer
Author	Amy Watts, Head of Patient Safety and Risk
Attachment(s)	Claire Evans, Associate Director of Quality Lisa Cummins, Director of Quality
Recommendation(s)	The Board is asked to **RECEIVE ASSURANCE** from the report

EXECUTIVE SUMMARY

- There are currently 37 open corporate risks which have been approved by the Trust's Risk Committee (full details attached).
- Fourteen of these risks are graded as high (≥15); summary details, (movement since previous Trust Board), are included in the table below.
- The remaining 22 risks are graded as moderate or below.
- The Risk Committee review all corporate risks monthly and are also reported to any relevant sub-committees as per their work plan. Any newly reported or corporate risks listed for closure also require approval by Risk Committee to ensure appropriateness.

PREVIOUS DISCUSSIONS HELD

Corporate risks are discussed at the Risk Committee monthly.

KEY IMPLICATIONS	
Financial	This may be dependent on the individual risks included in the paper.
Patients Safety or Quality	Demand and capacity in services resulting in potential patient safety incidents
Workforce	Risks articulate workforce suitable/establishment concerns
Operational	This may be dependent on the individual risks included in the paper.

Risk ID	Title	Risk rating (current)	Risk Description	Latest Updates	Movement (since last meeting)
Risk 2646	Cyber security threats and vulnerabilities to the Trust.	20	If a cyber-attack was successful it could lead to loss or deletion of confidential patient or Trust data and significantly affect the IT infrastructure and availability of key clinical systems. If this occurs then it would impact on clinical operation and the availability of business-critical systems in the Trust, which could result in reputational damage, a risk of fines but ultimately affect staff welfare and the delivery of timely, effective, and safe patient care.	Investment in a cyber technology monitoring tool (IT Health Dashboard) has been made.	↔
Risk 3779	Lack of permanent Mortuary Fridge/Freezer Space (HTA inspection major finding)	20	IF the Trust does not address the shortfalls identified in the Human Tissue Authority report, THEN this may lead to the HTA determining that the major shortfalls identified cumulatively in the report give rise to a critical shortfall leading to regulatory action.	Capacity and demand paper to be completed as verification of effectiveness of FD charging.	↑
Risk 4085	22/23 Contract Income Risk - High Costs Drugs and Devices Block	20	IF the Trust is unable to control the level of expenditure for high costs drugs and devices for the Coventry and Warwickshire ICB, THEN there is a risk that the Trust will exceed the block allocation value and incurring costs without any funding, RESULTING in the failure to meet the financial plan position (which is not sustainable).	Performance monitored through the Integrated Finance Report to F&P Performance monitored through CFO updates to COG	**NEW**
Risk 4145	Failings in Theatre infrastructure	20	If the physical infrastructure of the theatres is not life-cycled in a timely manner, then it will be subject to repeated failings leading to closures of theatres whist awaiting repairs. these closures impact on patient care.	Plans for refurbishment of Theatres is under review	**NEW**
Risk 107	Storage on Hospital Corridors	16	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	Teams from estates supported by clinical team are undertaking weekly inspections of back corridors to drive down the number of incorrectly stored items and drive up a positive housekeeping culture for these areas.	↑
Risk 1858	Capacity, statutory, and reputational impact of cold/hot water pipe failure)	16	There is a concern that the water system at UHCW may release water (hot /cold) in an uncontrolled manner. This will cause potential harm and damage to people and infrastructure. Resulting in a) Loss of Services, b) Harm to patients, contractors, and others. In addition, a catastrophic failure may result in statutory breaches.	Project Co have agreed to change out the pipework in CSSD, Critical care and Pathology for copper as these are seen as the initial high risk failure areas. Time plan for this work is in development	↑
Risk 3816	Inability to keep CAMHS patients safe	16	If we are unable to provide enhanced support to complex CAMHS patients, then there is a high risk of self-harming on the unit, suicide by misadventure due to patients with escalating behaviours and aggressive and violent behaviours towards staff. Which could impact on the quality of care on other medical patients resulting in delay in care and discharges.	Business case in progress to establish a Paediatric specific Enhanced Care Team	↔
Risk 3975	Inability to deliver a sustainable Dermatology service	16	If a suitable location for the delivery of Dermatology services cannot be identified then the patients (Adults, Children, and patients on a cancer pathway) who require access and treatment to this service may experience delay in their care, which could result in patient harm.	Regular dialogue with NHSIE and the CCG with regard to a forward plan and alignment of the service with the service specification provided.	↔

Risk 4086	22/23 Emergency Pressures	16	IF the Trust is not able to deliver the Emergency activity within the block funding allocation, THEN then the Trust may either exceed its planned budget or redirect resources from Elective delivery, RESULTING in the failure to meet the financial plan position by either overspending or a reduction in ERF income, (which is not sustainable).	Performance monitored through the Integrated Finance Report to F&P Performance monitored through CFO updates to COG	↔
Risk 2540	Potential Risk of Major Fire Incident	15	IF the Trust does not deliver the fire compartmentation remediation plan and maintain our current high levels of control and risk mitigation THEN the risk of a fire incident developing might increase RESULTING IN potential patient harm and/or consequent risks to the Trust's ability to deliver effective and safe services	39 dampers across site are still inaccessible due to other services and infrastructure that were installed during the construction phase of the hospital. Access to these dampers is still under review and needs to be factored against disruption to hospital operations	↔
Risk 2658	Clinical evaluation may not be recorded in Patient Records for Plain film imaging Examinations not reported by Radiology	15	IF a clinical evaluation of an imaging examination is not recorded within the patients records THEN a diagnosis is will not be seen or recorded appropriately WHICH could result in delay to treatment and will be a breach of IRMER 17 legislation.	Draft business case for radiology to recruit and train staff to report 27000 ward based plain film images currently not formally reported by Radiology in progress.	↔
Risk 3030	Violence and Aggression against staff	15	IF staff are not well equipped to deal with violence and aggression by patients and visitors THEN an occurrence of such violence and aggression could RESULT in harm to either party or other patients.	Violence and Aggression (V&A) policy has been reviewed by union's and will be re-submitted to H&S cttee for approval. V&A task group continue to meet.	↑
Risk 3810	Inability to meet the demand for Breast Imaging/screening services within the capacity	15	IF the Trust is unable to meet the demand within its capacity for Breast Imaging services, THEN patients' treatment pathways may be delayed which could RESULT IN harm to patients and impact on operational performance.	Weekly Accountability Meetings through the CDG are taking place to identify how best the screening backlog can be cleared and normal screening activity resumed	↔
Risk 4151	Registered Midwife Vacancies	15	If there are high levels of Registered Midwife vacancies, THEN this could lead to insufficient numbers of skilled and experienced midwives to care for our patients which may RESULT in a risk to safe and effective patient care.	A workforce plan is in place to monitor vacancies and pipeline starters and leavers.	**NEW**

Key

No change in risk rating	↔
Risk rating increased and escalated as a corporate risk	↑
Risk rating downgraded/reduced	↓

University Hospitals Coventry and Warwickshire NHS Trust

Corporate Risks Report

December 2022

1.0 High Corporate Risks

ID	Date Identified	Date Risk logged on Datix	Title	Risk Type	Risk Subtype	Specialty	Specialty Group	Description	Risk level (initial)	Rating (initial)	Executive Lead	Person Accountable	Person Responsible	Responsible Committee/s	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	Target Date
2846	8-Nov-2016	24/11/2016	Cyber security threats and vulnerabilities to the Trust.	Corporate	Information Technology	Information & Communications technology	Core Services	If a cyber-attack was successful it could lead to loss or deletion of confidential patient or Trust data and significantly affect the IT infrastructure and availability of key clinical systems. If this occurs then it would impact on clinical operation and the availability of business-critical systems in the Trust, which could result in reputational damage, a risk of fines but ultimately affect staff welfare and the delivery of timely, effective and safe patient care.	HIGH	20	Mo Hussain	Miss Jackie Weager	Mr David Baynton	Audit and Risk Assurance Committee/Information Governance Committee/Risk Committee	Security systems are in place to help protect our IT infrastructure and monitoring of security alerts received via NHS Digital, the National Cyber Security Centre (NCSC) and other relevant intelligence sources are in place. There are robust internal processes followed when remedial action is necessary. Annual penetration tests are completed and action plans are monitored via a working group within ICT. A Cyber Security Plan has been drafted to ensure a work plan is maintained Annual data security and information governance training is mandatory for all staff. The ICT Data Centre is accredited and conforms to ISO27001 information security standard. Investment in a cyber technology monitoring tool (IT Health Dashboard) has been made. Individual ICT risks have also been raised on the local ICT register to manage linked vulnerabilities. These are risks 3412, 3246, 3247, 3446, 3875, 3876, 3986 and 4060.	HIGH	Business case to form a dedicated cyber security team is currently being formulated which will require approval through Chief Officer Group There has been a significant increase in threats being seen in the last few months. There are now 14 high CareCERT alerts open where patching cannot be completed in the timeframe required by NHS Digital. Although monitoring and preventative applications are in place, attacks cannot be completely prevented. Essential patching cannot currently be completed in the time frame given by NHS Digital due to limited ICT resource and essential testing, and there are currently 2 outstanding alerts. There has been a notable increase of threats throughout the Coronavirus Pandemic. Cyber Essentials accreditation has not been retained for 2022 due to non-compliance's. In line with national surveillance the UK remains on alert for cyber-attacks due to the Russian invasion of Ukraine. Not all vulnerabilities can be mitigated timely or completely. Not all devices on the corporate network are managed by ICT, notably MEBS equipment. Although investment has been made in the IT health assurance dashboard, ICT do not currently have sufficient resource to respond to the quantity of alerts and vulnerabilities highlighted. The Trust has a mobile device refresh scheme, however some outstanding work remains to be completed around unsupported mobile devices. Data Security and Information Governance training is only completed annually and human factor remains the highest risk of an attack being successful. The current training requires a review and update to cover new and emerging methods of attack. Specific cyber awareness training not currently available to all staff. Newly acquired cyber monitoring technology has highlighted multiple new vulnerabilities which has increased this risk level. Spam attacks are being attempted daily and often use topical regional or government advice as a lure.	Expected to occur at least Daily	Major	20	LOW	6	30-Dec-2022	ICT Security sub-group ICT Security and Compliance Information Governance Committee Risk Committee External assurance is led by NHS Digital and Independent Third Party Cyber Security provider.	None noted	31/12/2023
3779	13-Apr-2021	14/04/2021	Lack of permanent Mortuary Fridge/Freezer Space (HTA inspection major finding)	Corporate	Operational	Mortuary	Clinical Diagnostic Services	IF the Trust does not address the shortfalls identified in the Human Tissue Authority report THEN this may lead to the HTA determining that the major shortfalls identified cumulatively in the report give rise to a critical shortfall leading to regulatory action (see attached letter). □ A critical shortfall may result in one or more of the following:□ • A notice of proposal being issued to revoke the licence□ • Some or all of the licensable activity at the establishment ceasing with immediate effect until a corrective action plan is developed, agreed by the HTA and implemented.□ • A notice of suspension of licensable activities□ • Additional conditions being proposed□ • Directions being issued requiring specific action to be taken straightaway□ □ If the Trust are unable to provide adequate freezer capacity, then patients who should go into the freezer at 28 days (preserve their condition) will remain refrigerated. This could cause reputational (family upset) damage as the patients condition deteriorates. □ □ Over recent months,	HIGH	15	Kiran Patel	Mr Ian Sturgess	Miss Katie Das	Human Tissue Authority Committee/Quality and Safety Committee	21.09.22 - COG meeting held 20.09.22 - see actions agreed attached.□ 12-09-22 - COG paper submitted - see attached. Meeting stood down for this week, Attendance to be confirmed at next meeting.□ 15-08-22 - Paper discussed at CDG where further information was requested, due to short turnaround time the paper is being deferred to a later COG.□ 30.06.22 - FD charging went live 27.06.2022. Capacity and demand paper to be completed as verification of effectiveness of FD charging. HTA major shortfall evidence submitted 21.05.2022, awaiting feedback from HTA. □ □ □ □ □	HIGH	Funeral Directors still delaying collection and using UHCW as an extended storage facility. Letters are being sent to prompt swift collection but need to take further action. Certain FDs continue to use UHCW/RSX as storage for extended periods of time despite being informed their patients are clear for collection - see attached email	Expected to occur at least Daily	Major	20	LOW	6	30-Dec-2022	Risk monitored via monthly quality report which is presente to C.Gov committee and disicipline board Progress tracked at monthly Network Mortuary Governance meeting	Escalation to the Trust with options appraisal paper - no support for the mitigation	31/12/2022

1.0 High Corporate Risks

ID	Date Identified	Date Risk logged on Datix	Title	Risk Type	Risk Subtype	Specialty	Specialty Group	Description	Risk level (initial)	Rating (initial)	Executive Lead	Person Accountable	Person Responsible	Responsible Committee/s	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	Target Date
4085	1-Apr-2022	17/05/2022	22/23 Contract Income Risk - High Costs Drugs and Devices Block	Corporate	Financial	Finance Department	Core Services	IF the Trust is unable to control the level of expenditure for high costs drugs and devices for the Coventry and Warwickshire ICB,□ □ THEN there is a risk that the Trust will exceed the block allocation value and incurring costs without any funding,□ □ RESULTING in the failure to met the financial plan position (which is not sustainable).	MOD	9	Susan Rolason	SR	Mr Antony Hobbs	Finance, Resources and Performance Committee	1) Performance monitored through the Integrated Finance Report to F&P□ 2) Performance monitored through CFO updates to COG	HIGH	No Gaps in controls.	Expected to occur at least Weekly	Catastrophic	20	LOW	6	31-Jan-2023	Integrated Finance Report CFO Private Board Report	No Gaps in assurance.	31/03/2023
4145	12-Jul-2022	12/07/2022	Failings in Theatre infrastructure	Corporate	Operational	Theatres	Clinical Support Services	If the physical infrastructure of the theatres is not life-cycled in a timely manner then it will be subject to repeated failings leading to closures of theatres whist awaiting repairs. these closures impact on patient care.□ Theatres ready for lifecycle which includes but is not exclusive of □ Lights□ Surgeons Panels□ AHUs□ Doors□ Laser doors□ Laser fittings□ Floors□ Walls□ Ceiling mounted microscopes (PFI)□ Scrub sinks and panelling□ WIFI upgrade□ Chillers□ PACS screens□ □	HIGH	15	Gabrielle Harris	Dr Claire Ingram	Lacey Bennett	Quality and Safety Committee	12-7-22 Escalate on a daily basis if there are any issues which are dealt with reactively.□ Weekly theatre lifecycle meeting to discuss and plan as the theatres will be closed for 8-9 weeks, two at a time.□ □ Paper going to COG October submitting plans for refurbishment of Theatres .□ 18/10/22 . LB	HIGH	Replacement of all items mentioned in description Replacement of all items mentioned in description	Expected to occur at least Daily	Major	20	VLOW	2	31-Dec-2022	Weekly Meeting with estates, weekly actions progressing Utilisation of closed sessions allows us to flex the theatres Four hour window mandated for attendance from VINCI	Delays while waiting for VINCI to attend cause delays to theatres resulting in end of day canx During periods of extreme heat, chillers are unable to cope and the theatres overheat. Resulting in on the day cancellations and detriment to staff well being	09/07/2024
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.□ □ 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.□ □ 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	16	Tracey Brigstock	Mr Lincoln Dawkin	Mr David Millage	Quality and Safety Committee	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) □ 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)□ 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□ 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. □ 29/05/2020 Update - The issue of excessive storage on hospital corridors still continues to be a concern. The amount of items being stored on hospital corridors represents an enforcement risk to the organisation. □ A working group had been established to address the issue and some initial improvement was made to the amount and type of equipment being stored on the corridors throughout the hospital. This group has not met for some time and as such the situation on the hospitals corridors is not improving significantly.□ The lack of suitable storage facilities, particularly within the wards and departments is the main contributing factor to the excessive amount of storage on the hospitals corridors and this needs to be addressed urgently at senior Trust Management level.□ This continuing serious issue is been brought to the attention of the Trust Management over a number of years via the annual report and at various risk committees.□ To Be added to Fire and Safety site walk list for reporting out□ 12/08/2021 Review of storage space undertaken at Rugby for beds and furniture□ 12/08/2021 Initial Review of basment storage for beds at UH undertaken□ 10/08/2021 Process floww for removal of beds from corridotrs developed□ 06/01/2022 ward 41 and 42 back corridor trial still ongoing . All storage on front corridor must be raised with the help desk□ 21/03/2022 Working group involving Vinci, Soft Services, Project Co, and health and safety now looking at this□ 22/09/2022 Back corridors are in the process of being marked up with identified storage points for beds, linen and damaged equipment.□ 22/09/2022 Teams from estates supported by clinical team are undertaking weekly inspections of back corridors to drive down the number of incorrectly stored items and drive up a positive housekeeping culture for these areas.	HIGH	None identified	Expected to occur at least Weekly	Major	16	LOW	4	19-Dec-2022	Discussed at NCRM committee and Risk Committee clear Instruction has been given to all teams that NO beds are to be stored on the front street. Regular monitoring in place and breaches addressed Working group established to oversee management of this topic Review to explore possibility of procuring TNT store room to facilitate moving short term maintenance and repair furniture and other items to that store Review to explore possibility of providing a portacabin modular unit to provide additional stroage space for bed awaiting repair/replacement GE to review and improve furniture repairs and replacement procedure NMC forum to identify a nurse manager representative for the stroage group	None identified Limited assurance that the continued storage of items along the rear corridors is controlled sufficiently to enable safe evacuation along this route if necessary Linited assurance that the trust is compliant wit relevant Health and Safety and Fire Safety legislation whilst this situation exists	19/12/2022

1.0 High Corporate Risks

ID	Date Identified	Date Risk logged on Datix	Title	Risk Type	Risk Subtype	Specialty	Specialty Group	Description	Risk level (initial)	Rating (initial)	Executive Lead	Person Accountable	Person Responsible	Responsible Committee/s	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	Target Date
1858	1-Apr-2016	16/05/2013	Capacity, statutory and reputational impact of cold/hot water pipe failure (Harm to people and loss of infrastructure)	Corporate	Health and Safety / Environment	Estates & Facilities	Core Services	1. There is a concern that the Girpi water system at UHCW may release water (hot /cold) in an uncontrolled manner.□ 2. This will cause potential harm and damage to people and infrastructure□ 3. Resulting in a, Loss of Services, b, Harm to patients, contractors, and others. In addition a catastrophic failure may result in statutory breaches.□	MOD	12	Tracey Brigstock	Mr Lincoln Dawkin	Mrs Julie Rice	Quality and Safety Committee	14/02/2020 - The Marshall Report was issued last year. Long term "under pressure" testing has been taking place and once the results of this are available the Final Report Marshall Report will be issued. Estates will chase the Project Company for this.□ System is still on test in Germany report still ongoig 08/03/2021□ System report still not recieved 30/08/2021□ System report still not recieved 10/01/2022 formal letter sent by L Dawkin to Project Co requesting immediate update□ Still experiencing major problems whenever GIRPI is worked on or cooled 05/04/2022□ GIRPI issues still in evidence accross the trust when system is worked on 05/07/2022□ □	HIGH	A number of items are identified within the specialist report that require action, the Trust has requested a detailed response from Project Co against all of these points. Rev 2 Girpi Risk Assessment_20141104.docx provides details of Gaps in Controls.	Expected to occur at least Weekly	Major	16	LOW	6	23-Jan-2023	Skanska construction to Identify all the pipes schematics (Constant Temperature and Variable Temperature systems) and ensure that the risk exposure is clearly identified to both people and infrastructure. As soon as possible. (Skanska) [Completed 2/5/13] Reduce operating temperature of the system to minimise hot water hazard. Today (26/4/13). (Project Co) [Completed 2/5/13] Ensure that all non-essential works are put on hold until independent assessment of failed pipe is obtained with immediate effect. (Project Co, Vinci) [Completed 2/5/13] Inform users to be vigilant of leaks from ceiling and to report to help desk. As soon as possible. (Trust) [Completed 2/5/13] Regular patrols across the hospital sites to be implemented to monitor any leakage or failures. (Action Vinci) [Completed 2/5/13] Clear Maintenance procedures in place and agreed with Project Co and Partners Protocol / procedure to be developed and and adhered to when carrying out any work under licence or permit system. (Trust and Project Co)	Rev 2 Girpi Risk Assessment_20141104.docx this details the gaps in assurance The risk exercise was discussed at Risk Committee and recommendation made that the risk should be escalated to BAF	25/03/2023
3816	14-May-2021	07/05/2021	Inability to keep CAMHS patients safe	Corporate	Safety - Clinical	Paediatrics	Women & Children's Services	If we are unable to provide enhanced support to complex CAMH's patients, then there is a high risk of self harming on the unit, suicide by misadventure due to patients with escalating behaviours and aggressive and violent behaviours towards staff. Which could impacts on the quality of care on other medical patients resulting in delay in care and discharges.	HIGH	20	Tracey Brigstock	TBS	Mrs Sue Ellis	Quality and Safety Committee/Safeguarding Vulnerable Adults and Children Committee	Continuing to admit varying numbers of CAHMs patients utilising escalation where required. CAHMs patients are admitted to both ward 14 and ward 16 when the volume dictates this being the safest management. □ □ Joint protocol and escalation policy is established and in place. Ability to initiate an escalation meeting when either numbers or complexity increase in order to expedite actions.□ □ ALT team recruited to full establishment and seven day service established, resulting in a more timely review and development of a management plan for CYP admitted to Ward 14. □ System risk logged and overarching local trust risk linked to Risks ID: 3530,3528, 3527 and 3526□ June 2021- Following an unprecedented surge in numbers of children in crisis a daily system wide bronze operational group meeting to ensure all of the partner agencies have oversight of activity throughout system. There is also in place a bi-weekly strategic bronze meeting that feeds into a bi-weekly silver meeting attended by Execs/senior staff. □ 14.09.2021 - Risk overall reduced. Following discussion with CNO the risk to staff and environment decreased. □ 10.11.2021 - No update□ 12/01/22 - No update - managed risk□ 12.05.2022 - Risk reviewed. Due to recent incidents where 4 staff members were injured and extensive environmental damage this risk has been upgraded. □ 13.07.22 -Risk reviewed, incidents continue involving CiC which involves CYP awaiting for social and mental health placements.□ 30/09/22 - No further update	HIGH	Potential sickness affecting 24/7 cover for CAMHS liaison team No guarantee of shifts being filled to facilitate 1:1 nursing or HCA where it is identified	Expected to occur at least Weekly	Major	16	LOW	6	30-Dec-2022	Regular clinical supervision for staff in place and debriefs following an incident	Sustained RED escalation if there are delays in transfers of patients	30/03/2023

1.0 High Corporate Risks

ID	Date Identified	Date Risk logged on Datix	Title	Risk Type	Risk Subtype	Specialty	Specialty Group	Description	Risk level (initial)	Rating (initial)	Executive Lead	Person Accountable	Person Responsible	Responsible Committee/s	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	Target Date
3975	2-Dec-2021	02/12/2021	Inability to deliver a sustainable Dermatology service	Corporate	Strategy	Dermatology	Medicine	If a suitable location for the delivery of Dermatology services cannot be identified then the patients (Adults, Children and patients on a cancer pathway) who require access and treatment to this service may experience delay in their care, which could result in patient harm. □ □ In addition delays to identifying the location for a sustainable service may result in poor retention of staff, a decline in operational performance and reputational damage for the organisation, including, but not limited to, the inability to achieve our vision of integrated care for this service.□ □ The contributing factors to the current delay in the refurbishment of a suitable location include; □ 1)The requirement to undertake a 12 week consultation with the public, as per National Guidance. □ □ 2) The structure of financial support for this project is interdependent with the Emergency Department expansion timeframes, which may result in threat or loss of the allocated funding via this route. □ □ 3) The delivery timeframe	HIGH	16	Justine Richards	Mrs Justine Richards	Ms Kara Marshall	Quality and Safety Committee/Risk Committee	The current controls to mitigate this risk as far as is reasonably possible are as follows;□ □ 1)Engagement of Chief Officer Group for escalation and discussion of impacts of delays and potential solutions.□ □ 2)Project Team established with key stakeholders including engagement lead to proactively manage the public consultation.□ □ 3)Streamlining of project plan and viable options in order to support the time frames, and reduce the impact of potential delays.□ □ 4)In order to ensure patient care experiences minimal impact; the Trust has an operational response which includes; outsourcing of adult end to end pathways, use of temporary space for Paediatric clinics within the existing Children's outpatient footprint, lease of rooms at BMI Meriden for minor operations and temporary expansion of services at the Hospital of St Cross, Rugby. □ □ 5) Establishing a patient representative group to engage and influence the design of the shortlisted options.□ □ 6) Regular dialogue with NHSIE and the CCG with regard to a forward plan and alignment of the service with the service specification provided.	HIGH	- Public consultation may not support preferred clinical model - Viable options may not be financially achievable - Any of the proposed options may not support future service expansion - If any further unforseen risks/delays occur with the ED expansion project the financial allocation for dermatology could be compromised - Alternative funding source would be required if funding availability does not coincide wiht project timescales	Expected to occur at least Weekly	Major	16	LOW	6	30-Dec-2022	- Oversight of performance against project to Strategic Delivery Board - Enagement and establishment of a Patient rep group to ensure service is designed to suit needs of patients - NHSE/I support in options and solutions	Patient rep group is a small group of long term users of the service so may not be fully representative of the wider patient cohort. Wider NHS governance and structural changes may impact on identified responsibilities of e.g. CCG. This could delay clarity around consultation requirements.	30/11/2022
4086	1-Apr-2022	17/05/2022	22/23 Emergency Pressures	Corporate	Financial	Finance Department	Core Services	IF the Trust is not able to delivery the Emergency activity within the block funding allocation, □ □ THEN then the Trust may either exceed it's planned budget or redirect resources from Elective delivery, □ □ RESULTING in the failure to met the financial plan position by either overspending or a reduction in ERF income, (which is not sustainable).□	MOD	9	Susan Rollason	SR	Mr Antony Hobbs	Finance, Resources and Performance Committee	1) Performance monitored through the Integrated Finance Report to F&P□ 2) Performance monitored through CFO updates to COG	HIGH	No Gaps in controls.	Expected to occur at least Weekly	Major	16	LOW	6	31-Jan-2023	Integrated Finance Report CFO Private Board Report	No Gaps in assurance.	31/03/2023

1.0 High Corporate Risks

ID	Date Identified	Date Risk logged on Datix	Title	Risk Type	Risk Subtype	Specialty	Specialty Group	Description	Risk level (initial)	Rating (initial)	Executive Lead	Person Accountable	Person Responsible	Responsible Committee/s	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	Target Date
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 □ THEN the risk of a fire incident developing might increase. □ RESULTING IN potential patient harm and/or consequent risks to the Trust's ability to deliver effective and safe services□ □ 20/10/2021 Vinci have now identified to Project Co and the Trust that there is a further issue with compartmentation accross the UHCW building due to the current inspection and test process associated with the in line fire dampers within the HVAC system ducting□ □ IF the trust can not assure automatic fire dampers will function in the event of a fire within one of the hospital areas□ THEN Fire and smoke may be able to spread in an uncontrolled manner to other locations within the hospital, through the internal ducting□ RESULTING IN potential patient harm and/or consequent risks to the Trust's ability to deliver effective and safe services□	HIGH	15	Tracey Brigstock	Mr Lincoln Dawkin	Mr David Millage	Quality and Safety Committee	10/08/2021 – Once fire stopping has been completed then Estates will convine a Risk Assessment team to review this risk with a view to closing this down (Repeat of process that was undertaken to generate risk onto register)□ □ 05/10/2021 - At a recent meeting between Project Co, Tenos, Trust, IFC and Skanska, Skanska informed all those in attendance that the programme of fire stopping works throughout the University Hospital will be completed at the end of September 2021. □ □ 17/11/2021 Vinci have assured that there are now 15 secured damper zones within the hospital , All 3 towers are safe from adjoining structure and all floors for all 3 towers are safe from the floors above and below. work continues within these safe zones to improve damper reliability through each fire wall□ A system of checks and assurances will then take place by Tenos, the independent fire engineers, which will subsequently mean that the hospital will be confirmed as being remediated by the end of December 2021 at the very latest.□ It is not anticipated that any delays will occur to delay the work, however the process will continue to be monitored and scrutinised by the Trust.□ □ 22/12/2021 Vinci have presented to the trust and WMFS the level of risk and suggested action plan to deal with the fire dampers that are impacting on fire zone control as did the fire stopping issue.□ □ 2131 dampers accross site which need to undergo annual statutory inspection 1444 have passed 2021 inspection , 42 were in operational areas and will be inspected by 31/03/2022, 338 were inspected and require some remedial work which will be completed by 31/03/2022, leaving 307 that could not be inspected due to legacy access issues frome the date the hospital was built and commissioned.□ □ Action plan for work on the 307 will be available from 31/01/2022 when this risk will be updated□ □ West midlands Fire Officer has been briefed on this and is happy with this control strategy and agrees risk rate currently as correct□ □ 39 dampers across site are still inaccessible due to other services and infrastructure that were installed during the construction phase of the hospital.□ Access to these dampers is still under review and needs to be factored against disruption to hospital operations□ □ □	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	30-Dec-2022	West Midlands Fire Service review Board 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. Lack of solution for remedial works in the Emergency Department	30/12/2022
2658	3-Apr-2017	21/12/2016	Clinical evaluation may not be recorded in Patient Records for Plain film imaging Examinations not reported by Radiology	Corporate	Safety - Clinical	Radiology	Clinical Diagnostic Services	IF a clinical evaluation of an imaging examination is not recorded within the patients records THEN a diagnosis is will not be seen or recorded appropriately WHICH could result in delay to treatment and will be a breach of IRMER 17 legislation.	HIGH	15	Kiran Patel	Dr Beth Harrison	Ms Tracey Humpheys	Quality and Safety Committee	Radiology COP 186 Reporting A guideline for use in Radiology indicates circumstances where images are not formally reported by Radiology. COP 868 Unreported Examinations: A Summary of Practice describes Trust process for ensuring all radiographs not evaluated by trained radiology staff are clinically evaluated by other UHCW health care professionals. □ Updated: 16.08.22 Proposal from Plain Film Reporting Task and Finish Group presented to PSEC 11.08.2022 - see documents attached. Exec sponsor agreed to support drafting of BC for Radiology to recruit and train staff to report 27000 ward based plain film images currently not formally reported by Radiology. PSEC acknowledged risk will remain at current level whilst BC drafted and submitted for approval After which there will be 18 months lead in to completion of phase 1. With subsequent 2 years for phases 2 & 3. Estimated 5 years before risk for ward film plain reporting to be mitigated.	HIGH	Audit not complete for all involved specialities Sign up from Trust clinicians to undertake audit not yet confirmed COP for unreported Images has been submitted, but is not yet uploaded to e library GIRFT visit highlighted UHCW as an outlier in that not all first exams have Radiology report. This has since been partially mitigated by ensuring all first examination referrals from acute admission wards via ED are now reported by Radiology.	Expected to occur at least Daily	Moderate	15	LOW	6	30-Dec-2022	Radiology QIPS Trust CD Forum Other Specialty QIPS throughout Trust Accepted to Corporate Risk Register Clinical Evaluation Audit approved as Trust Mandatory audit - for all specialties involved to complete - supported by Trust Clinical Audit Team.		30/12/2022

1.0 High Corporate Risks

ID	Date Identified	Date Risk logged on Datix	Title	Risk Type	Risk Subtype	Specialty	Specialty Group	Description	Risk level (initial)	Rating (initial)	Executive Lead	Person Accountable	Person Responsible	Responsible Committee/s	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	Target Date
3030	16-Apr-2018	19/04/2018	Violence and Aggression against staff	Corporate	Health and Safety / Environment	Estates & Facilities	Core Services	IF staff are not well equipped to deal with violence and aggression by patients and visitors THEN an occurrence of such violence and aggression could RESULT in harm to either party or other patients.	HIGH	15	Tracey Brigstock	Sr Sarah Hartley	Mr Barry Newell	Health & Safety Committee Quality and Safety Committee	A working group to review this risk and formulate an action plan has been established and led by an ADN.□ A de-escalation policy is being written to support staff managing these situations. Staff can access conflict resolution training and further training is being sourced in relation to de-escalation.□ □ 10/02/2020 meeting held with Barry Newell, David Powell, Lincoln dawkin, Sarah Hartley, 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.□ □ .What happens out of hours and when LSMS is on leave / and expectation of Managers (in / out of hours:□ .There needs to be a link to staff well-being and a robust de-brief process described (where involved) and include in Managers Duties and Responsibilities outlined on Page 17 □ □ •Monitoring compliance needs to include staff feedback (as this is the Non Execs concern) and 6 monthly audit to include this discussion was held on the correct route for any amendments and it was agreed that following discussion with LSMS, the policy should go to the Staff Side for approval and then brought back to the next meeting.□ □ 22/05/2020 Physical intervention policy has been reviewed by authors Barry Newell and Clare Baker and is ready for submission to appropriate committee.□ □ Audits on Ward compliance with violence and aggression policy need undertaking by matrons for area and fed back to trust LSMS and Sarah Hartley – realistically will not happen until Covid 19 crisis calms down□ □ 28/08/20 - a report of all incidents by Group has been pulled.□ □ 05/02/21. Meetings for Violenee and Aggression reconvened 20/08/20. Currently meet every 2 weeks. Current focuses include a policy relaunch to increase awareness- Reduction of Acknowledgement of Responsibilty Agreements(ARA's)- is it a result of lack of awareness. Datix report for incidents related to Violence and Aggression (Ooctober 2019 to October 2020) by group continues to show Emergency Medicine (ED) to have highest incidence. Targeted work/gap analysis therefore curently ongoing with ED. □ 10/05/21 Work has continued with ED. As a result of this the Department now has a Violence and Aggression meeting, a Violence and Aggression Nurse (not an additional post but existing member of staff now has this within their remit and further to a paper submitted to Risk Committee Body Cams are due to be trialled. The Violence and Aggreision Policy is due to be updated in June and a Comms to raise awareness will coincide. Work on going with re hate crime with Head of Diversity.□ 06/01/2022V&A policy has been updated to cover Hate Crime and is now with LSMS to action □ □ 07/03/22 - The Violence and Aggression Group meet on a monthly basis. Targeted work within the Emergency Department continues. the Pilot of Body Cams was successful with positive feedback from staff. Increased awareness of staff has resulted in an increase in reporting of incidents - from 40 (in the 6 months prior to the Body Cams pilot) to 103 (in 6 months following). THe Emergency Department are also testing a new way of communicationg with patients after incidents occur - each incident reported is reviewed in the ED Violence and Aggression Reduction Group along with any additional evidence and then look to provide support to affected staff, as well as try and reduce future incidents. The group can put an alert onto a patients records warning staff that the patient has been involved in a violent or abusive incident, and the group may determine that contacting the patient to advise them that the behaviour displayed on site was unacceptable.□ No Excuse for Abuse Campaign was launched throughout the Trust in September 2021 □ Investment in training for staff to handle and de-escalate challenging situations is required and ECT Lead now involved in group and mapping out the requiremnts for high incident areas.□ Kaizen event facilaitatd by the KPO Team being planned to improve the support in place for staff post incidents. SH 07/03/22 □ Kaizen Event held on 27/0/22 with representation from Trauma & Neuro services and other stakeholders from the Trust(ISS, ECT, ED, Paedeatrics, Clinical Site Management Team. This resulted in a pilot launch of a staff safety Repsonse Team to repond to an incident of violence, aggression or abuse occurs and staff feel at immediate risk of harm and unable to safely de-escalate the situation. The Staff Safety Response Teamcomprises of Clinical Sita Manager , Enhanced Care Team Bleep Holder, Security, Staff support (Leaders in the Organisation.Pilot commenced on Wards 42, 43,	HIGH	Violence and aggression is not consistently managed and data not always visible across the Trust Investment in training for staff to handle and de-escalate challenging situations is required and ECT Lead now involved in group and mapping out the requirements for high incident areas. RMN's availability and cover ECT's demand versus capacity	Expected to occur at least Daily	Moderate	15	MOD	9	28-Feb-2023	Regular reports presented at Health and Safety Committee	During pandemic Health and Safety Committee may be stood down	30/11/2023
3810	1-May-2021	06/05/2021	Inability to meet the demand for Breast Imaging/screening services within the capacity	Corporate	Operational	Breast Screening	Clinical Diagnostic Services	IF the Trust is unable to meet the demand within its capacity for Breast Imaging services, THEN patients treatment pathways may be delayed which could RESULT IN harm to patients and impact on operational performance. □ Risk factors impacting the services capability to meet demand relate to resourcing and recruitment to establishment and provision of equipment and are managed within the following specific risks:□ □ 1. RISK ID 3607:Insufficient accommodation within the Breast Screening Unit□ 2. Risk 4061: Shortage of qualified mammographers to support the Breast Screening Service□ 3. Risk 4075: Essential mammography equipment replacement resulting in 50% loss in service capacity□ 4. Risk 3159: Shortage of Symptomatic Breast Imaging Staff - Delays to Diagnosis and Treatment□	HIGH	15	Gabrielle Harris	Dr Vandana Gaur	Mrs Claire Pittam	Quality and Safety Committee	25/10/2022 - All contributory risks have been updated in Radiology Risk Oversight Meeting 25/10/2022. Full report attached in documents.	HIGH	No funded establishment for symptomatic service No funded establishment for symptomatic service 9.6.22 2 WTE radiographer posts offered following interviews. 1.8 WTE radiographer posts outstanding - Shortage of breast imaging screening staff - Reduction in qualified mammographers to support breast screening service - Insufficient accommodation to meet current demand in the breast screening unit - Additional resources to support training - National shortage of staff - Business case awaiting approval - Department seeking to secure funding for additional X ray machine - 16/07/2021: For the detail please refer to the individual risks.	Expected to occur at least Daily	Moderate	15	MOD	12	30-Dec-2022	Radiology and Diagnostic Board Screening Programme Committee 16/07/2021: For the detail please refer to the individual risks.	16/07/2021: For the detail please refer to the individual risks.	30/12/2022

1.0 High Corporate Risks

ID	Date Identified	Date Risk logged on Datix	Title	Risk Type	Risk Subtype	Specialty	Specialty Group	Description	Risk level (initial)	Rating (initial)	Executive Lead	Person Accountable	Person Responsible	Responsible Committee/s	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	Target Date
4151	20-Jul-2022	20/07/2022	Registered Midwife Vacancies	Corporate	Workforce (HR)	Obstetrics	Women & Children's Services	If there are high levels of Registered Midwife vacancies THEN this could lead to insufficient numbers of skilled and experienced midwives to care for our patients which may RESULT in a risk to safe and effective patient care.□	HIGH	15	Tracey Brigstock	Ms Gaynor Armstrong	Ms Suzanne Wilson	Peoples Committee/Quality and Safety Committee/Risk Committee	20.7.22 Current band 5/6 Midwifery vacancy is 38.52 (21%) against the 2021/022 baseline. Additional funding has been received from NHSE Ockenden money for 17.4 WTE midwives to be added to the baseline establishment. □ International recruitment commenced in February 2022 as part of a collaborative bid with 5 Midwives having now completed training, and a further 8 undertaking training. □ Student Midwife numbers increased from 23 to 45 (2021/22). 2 Return to Practice Midwives employed in May and 3 further places offered to commence later this year.□ A SLA has been developed with Birmingham City University for the Midwifery shortened course and we are advertising for 5 places to start in January 2023.□ A bi-weekly meeting with Recruitment and Workforce is in place to discuss challenges and updates relating to pipeline starters and leavers. This works well to ensure that there is timely response to all aspects of recruitment.□ There is a Golden Hello in place for band 5/6 Midwives.□ We continue to advertise various roles to attract Band 5/6 midwives including community only posts and have planned recruitment events.□ An enhanced bank rate in place since July 2021 supports further shift cover.□ We are participating in a national pilot for Retention Self-Assessment using the newly developed Toolkit. We are also funded to have a Retention Midwife in post who is showing good results with supporting staff to remain in post.□ We have a strong Clinical Preceptorship Support Midwifery team in place to support newly qualified midwives including one specifically for community.□ All specialist Midwives and ward managers are rostered clinical shifts each week and are used clinically at other times as part of escalation. □ Community Midwifery caseloads are being reviewed and re-aligned with further work to streamline the workload in community such as centralised booking clinics.□ Agency nursing shifts are used for Labour ward and ward 25, and although these cannot be included within the midwife to birth ratio, this model has been shared regionally as good practice for enhanced safety whilst midwifery staffing remains a national challenge.□ The introduction of a Matron of the Day has also supported safe staffing and escalation within the department with senior oversight and attendance at the trustwide safe staffing meetings.□ A workforce plan is in place to monitor vacancies and pipeline starters and leavers.	HIGH		Expected to occur at least Daily	Moderate	15	LOW	6	30-Dec-2022	Carter Nursing and Midwifery metrics and performance management Vacancy monitored at COG, NMHAP, NMC and Quarterly Performance Reviews Bi-annual review of risk assessment at Nursing and Midwifery Committee Twice yearly Maternity safety report which includes staffing to Trust Board and NMC HCSW programme of recruitment commenced with NHSE/I target 0%-1% vacancy level IR 14 midwives recruited, 12 completed training 2 in the pipeline Carter Nursing and Midwifery metrics and performance management Vacancy monitored at COG, NMHAP, NMC and Quarterly Performance Reviews Bi-annual review of risk assessment at Nursing and Midwifery Committee Twice yearly Maternity safety report which includes staffing to Trust Board and NMC HCSW programme of recruitment commenced with NHSE/I target 0%-1% vacancy level IR 14 midwives recruited, 12 completed training 2 in the pipeline	retention of staff may increase if we fail to recruit due to increase demands of work We may fail to recruit HEI nurse/midwifery graduates in the numbers identified as they seek jobs closer to home Staff sickness and absence remains a challenge particularly COVID related sickness	30/12/2022

2. Moderate Corporate Risks

ID	Date Identified	Date Risk logged on Datix	Title	Risk Type	Risk Subtype	Specialty	Specialty Group	Description	Risk level (initial)	Rating (initial)	Executive Lead	Person Accountable	Person Responsible	Responsible Committees	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	Target Date
2279	1-Apr-2016	04/03/2015	Registered Nurse Vacancies	Corporate	Workforce (HR)		Core Services	IF there are high levels of Registered Nurse vacancies, THEN this could lead to insufficient numbers of skilled and experienced nurses to care for our patients which may RESULT IN a risk to high quality, safe and effective patient care.□ □ □	HIGH	15	Tracey Brigstock	Sr Vicky Williams	Mrs Paula Seery	Nursing and Midwifery CommitteePeoples CommitteeQuality and Safety Committee	29.9.2022 Current Band 5 registered nurse vacancy is 150.10 wte (10%) □ increase in month of budgeted establishments□ □ International recruitment for nurses (commenced in July 2020) □ Successful IR as at May 2022 has lead to 281 registered nurses recruited and in band 5 posts Further funding has been made available from NHSE/I successful bid - for 159 wte RN's to be recruited by 31st December 2022□ □ Monthly Update provided to NMHAP workforce group □ Monthly IR stakeholder group meeting □ weekly reports and monitoring of current position ESR data analysis□ Carter - monthly meetings with groups□ Safe Staffing twice daily meetings and governance remains in place□ □ Controls include;□ Retention Work streams - involvement in regional retention pilots & projects □ A comprehensive programme of recruitment events and review of on boarding processes□ Excellent and well-invested relationship with HEE to maximize nurse graduate recruits.□ Conditional job offers ahead of NMC registration. □ Strong preceptorship and career development opportunities. □ Focus on staff well-being and support. □ Acquisition of further funding for additional student placements to current numbers (national workforce planning initiative) future-proofing. □ Bank bonus schemes to further encourage bank shift fill rate approval for periods of escalation □ return to practice placement offers □ HCA to RN adaptation programme for IEN internal and external approved and commenced □ SNA placements and adoption of role across specialties - programmes supported with Cov uni	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 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. Lack of robust national nursing workforce planning. Highly competitive market. Increasing complexity and demand on staff - human factors and work life balance. Junior workforce - leadership experience gap. Professional bodies slow to publish regulatory frameworks for new roles and skill mix. Local quality and timeliness of ESR / vacancy data - to ensure reponsive plan. Vacancy data is challenged by workforce leaders as inaccurate. ESR review underway Lack of agreed process to agree N&M budgets/Reoster annually.	Expected to occur at least Weekly	Moderate	12	LOW	6	31-Jan-2023	Nursing shift Fill CHPPD data available on insite by ward level Recruitment plan in place for N&M workforce to aim to 10% vacancy by Dec 2021 Carter Nursing Workforce metrics and performance management since 2017 reviewed Oct 2021. Turnover for RN= 6%,HCA = 8%, below Trust target of 10% Reduced external agencies to all framework , better quality assurance. Enhanced Care Team commenced Oct 2015. Substantive team in place with line manager - clinical Monitored at COG,NMHAP, NMC and quarterly Performance Reviews Bi annual review of risk assessment at Nursing and Midwifery Committee Twice yearly Safer Staffing report to Trust Board and to NMC HCSW programme of recruitment commenced Dec 2020 with NHSE/I target 0% - 1% vacancy level New programme for 100 wte RN`s IR successful bid 2021/2022 programme IR programme of 281 nurses January 31 2021 with NHSE/I funding completed	RN vacancy reduced to 9.78% November 2021 Agency spend reduced from £16M spend 2016/17 to <£9M 2017/18, but over cap shifts remain 45-60% Nurse agency spend above trajectory More staff may leave if we fail to recruit due to demands of work We may fail to recruit HEI nurse / midwifery graduates in the numbers identified as they seek jobs closer to home. Plan assumes bank availability and no additional workforce growth ie Business Cases Staff sickness and absence remains a challenge particularly covid related Mandatory covid vaccination risk of staff who decline vaccine	31/03/2023
2416	4-May-2016	02/10/2015	Breaches of Confidentiality	Corporate	Information Governance		Core Services	IF documents containing highly sensitive and confidential information are not disposed of securely / correctly, THEN breaches of confidentiality will occur RESULTING in reportable breaches to the ICO leading to reputational damage and possible regulatory action and/or a monetary fine. The affected individual could also litigate against the Trust.□	HIGH	20	Mo Hussain	DW6	Mrs Harjit Marharu	Audit and Risk Assurance CommitteeInformation Governance Committee	1) There are policies and procedures in place that deal with the safe disposal of printed person identifiable information.□ □ 2) There are confidential waste bins providing coverage across the Trust.□ □ 3) There is signage around the organisation reminding staff to stop and check to ensure that they are not taking any printed patient information with them and must dispose of it in confidential waste bins before they leave their work area.□ □ 4) There is signage in meeting rooms instructing staff to also stop and check to ensure that they have not left behind any paperwork.	MOD	Due to operational considerations, at present it is not possible to prevent or cease the printing of documents containing patient information.	Expected to occur at least Weekly	Moderate	12	LOW	4	30-Dec-2022	The IG Committee review incidents rountinely to assess the adequacy of current controls.	There continue to be incidents of abandoned patient lists being found within the Trust.	30/06/2023
2537	1-Apr-2016	19/05/2016	Inadequate specialist IT resource available to support new and emerging technologies.	Corporate	Information Technology	Information & Communications technology	Core Services	Due to the limited number of specialist IT resource within ICT the delivery of Trust digital requirements is being affected, as with the current resource, the increasing requirements for IT support cannot always be provided and delivered in the time scale required. This could result in a delay in realisation of benefits, increased security vulnerabilities, loss of reputation, potential loss or interruption to service and ultimately, a potential impact to patient safety.□ □	HIGH	16	Mo Hussain	Mr James Matthews	Mrs Hazel Tippins	Finance, Resources and Performance CommitteeInformation Governance CommitteeRisk Committee	A revised digital strategy has been drafted and is awaiting approval by Trust Board. □ □ ICT provides a Digital Request process which, if follows ensures appropriate review and planning can be completed in line with ICT resource and availability. □ □ Monitored at Digital Board and Design Authority. □ □ A Digital Programme Management Office within ICT has been formed to support managing these projects and an ICT Programme Governance meeting is being established to manage priorities.□ □ Where required, the use specialist staff through Agency partners is to be utilised.□	MOD	Increasing demands for services and resources is outstripping current allocations. Clinical and service developments needing unplanned ICT resources sometimes bypass assurance mechanisms, e.g. the Digital Request process Challenge of recruitment and retention of scarce ICT resources. Emergence of new requirements, particularly Artificial Intelligence have not been resourced within current establishment. Some vacancies cannot be filled as applicants are not meeting the minimum person specifications Funding for 2022 and beyond has not been agreed.	Expected to occur at least Monthly	Major	12	MOD	9	31-Dec-2022	Digital Development and Project Group (to be established), to prioritise and manage new and existing projects within ICT ICT Security and Compliance Group ICT is a Capital Budget Holder at EPRG.	None noted.	31/03/2023

2. Moderate Corporate Risks

ID	Date Identified	Date Risk logged on Datix	Title	Risk Type	Risk Subtype	Specialty	Specialty Group	Description	Risk level (initial)	Rating (initial)	Executive Lead	Person Accountable	Person Responsible	Responsible Committees	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	Target Date
2769	24-May-2017	24/05/2017	Delays to assessment/transfer to a Mental Health Unit for patients with serious mental health problems	Corporate	Safety - Clinical		Emergency Medicine	IF mental health assessment or admission is delayed for patients who need it, THEN their length of stay in the Emergency Medicine footprint will be increased. Emergency Medicine cannot provide an equivalent therapeutic environment to a mental health unit, RESULTING in patients experiencing delays in diagnosis or care for serious mental health problems. □ □ 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)	HIGH	15	Tracey Bigstock	Dr Edward Hartley	St Marie Fogarty	Patient Safety CommitteeQuality and Safety Committee	ED now have a working group in partnership with CWPT, RCA process is complete and ready to share with CWPT and the trust. AMHAT now have an office base within the emergency department post COVID. Mental health steering group meeting continues. □ □ Monthly audit of MH activity. Review of impact of Covid completed Aug 2020 and reported to EMG and to Chief Officers□ Matron post approved and in place for MH □ RMNs used as required and Enhanced care team will support level 4 pt requiring 121. We request additional staff and undertake a full risk assessment of the patients needs. □ Security accompany all patients detained under an MCA or MHA.□ Organisational decision no to admit patients with a pur mental health problem. □ Commenced Mental Health training review and Ligature training for Clinical Staff across group. □ MH activity shared with STP Aug 19 onwards□ Daily escalation calls with CWPT via ED team reinstated July 2020. □ Compassionatre Community MH Volunters recruited and trained Aug 19 and now reinstated post covid Aug 2020 □ □ 20.6.21 □ Mental Health group with clinical lead consultant from ED and nurse clinical lead, daily meetings with CWPT, escalations of all delays to executive team, mental health dashboards, discussions at Board level.□ □ 04/10/21□ Group continue to experieince delays to accessing IP MH beds - manifesting in operational impact within ED and AMU, and financial impact through increaseed use of RMN staff. This has been escalated to Chief officers through quarterly review□ □ 22/12/21□ Report prepared for chief officers indicates recent waits in ED of up to 7 days for IP mental health beds. EM now represented at UEC place board, where MH will be prioritised.□ □ 3/3/22□ MH performance monitored through twice daily bronze and weekly silver meetings. MH report due to UEC board March 22. □ □ 28/04/22 - Risk ratification held - to be updated within the next month.□ □ 23/05/2022 - updating from risk ratification forum - risk ID: 3551 is to be closed and amalgamated into this risk to include issues around AMHAT. To be reviewed as normal next month.□ □ 28/06/2022 - risks amalgamated 3551 is now closed. □ □ 22/08/2022- discussed at risk committee with chief officers. this risk is being escalated to system board.	MOD	If funding is withdrawn this will impact the ED service in winter CWPT have been unable to make use of accommodation provided at UHCW CWPT escalation paper approved by UHCW - not yet approved as the paper is pending AMHATsign off. Office space approved and available in the Emergency Department however has not yet been utilised by AMHAT, meetings not routinely represented by AMHAT to resolve or escalate utilisation of the office space. Funding secured for five full time Registered Mental Health Nurses, however in the recruitment process so not yet recruited.	Expected to occur at least Weekly	Moderate	12	LOW	6	31-Dec-2022	CWPT have been unable to make use of accommodation provided at UHCW Monthly discussion at group board Plan for MAPA training for HCA's within the Emergency Department, external agency confirmtion pending. Funding approved for five whole time RMN nurses, with a plan for contracts to cover the busy twilight shift. Currently in the recruiting process. Roles not yet filled.	Increased attendance may result in KPI not being achieved RMN roles not yet filled and attempts made to cover with Agency. HCA MAPA training requested - pending the external training agencies confirmation to complete	31/12/2023
3878	30-Jun-2021	09/07/2021	Lack of access to ECGs taken throughout the Trust on CRRS	Corporate	Safety - Clinical	Cardiology	Medicine	If an ECG is performed outside of Cardiology then there is no mechanism for these clinical results to be viewed on CRRS. This can lead to progressive changes in ECGs not being identified and Cardiologists relying on non-specialist interpretation of ECGs taken in other areas in the Trust. This could lead to an incorrect clinical diagnosis.	MOD	12	Kiran Patel	Mr Kiran Patel	Dr Shamil Yusuf	Quality and Safety CommitteeRisk Committee	No contols currently in place. Paper copies of ECGs should be added to patient notes.□ Prior to COVID starting, DCI used to assist with ECG recordings in A&E using our own department machine which downloaded and stored the ECG's into the Cardiology reporting system (McKesson). These ECG's could then be viewed via CRRS.□ □ Following the re-organisation of the A&E pathways at the beginning of Covid and A&E becoming a Red and Amber route this service was stopped by A&E and re-directed to the Cardiology Admission Unit, and A&E continued to perform their own ECG's on the machines that they have up there.□ This service has not resumed as previously, as we currently have a vacancy but also because the ECG workload in clinic 7 has significantly increased. We have also established that the service that we provided in A&E previously was not 'purchased' by them as they said. □ □ 14/07/2021. Discussed with CMO Prof Kiran patel. This should be raised to corporate risk as affects multiple slecialities and wards across Trust. Aim now to set up task force to address this issue. □ □ 28/07/2021 Meeting arranged with KP and NB for 18th August 2021 to discuss.□ □ 18/08/2021 - risk discussed in Medicine B Board meeting - meeting with K Patel happened today. N Buckley to liaise on what support will be given to the team following the meeting as this risk is 'corporate'.□ □ 25/08/2021 Have had input from IT on how to take this further. We have further information on the ECG machines across the trust. Next task is to set up a Task force to take this forward.□ □ 15/09/2021 - discussed in Medicine B Board meeting - N Buckley stated that focus group has been started to mitigate this risk and work on this has begun.□ □ 14/01/2022 - Discussed at Cardiology QIPS - This is a corporate risk. All ECGs are compatible with Internet Networking and it has been established across Trust. Waiting for IT to come back to decide where all ECGs will be stored across the Trust once they are uploaded.□ □ 11/02/2022 - discussed in QIPS - Meetings have been held regarding the risk. Critical thing at the moment is where to store the ECGs. Huge database is required and funding for this is required. □ □ 11/03/22 - risk discussed in Cardiology QIPS - ECGs are not put onto CRRS and the team are stuck. IT do not have any storage to put ECGs. Next step is to speak to raise it even higher and Dr Yusuf will arrange a meeting.□ □ 04th may 2022. We have had a meeting about this issue at board level. Present were the individuals who are looking to implement the new EPR. They will incorporate this task into their workings with EPR.□ □ 25.08.2022 - The last time we discussed this was with the EPR team. They are aware of the issue and are working on solutions to enable ECG's undertaken throughout the hospital to be uploaded onto the new EPR / CRRS platform so that they can be accessed. This is a corporate risk and from our perspective there is little more to add. Risk review updated to 3 months time. □ □ 12/09/2022 - discussed in QIPS - Whilst this is a corporate risk, Dr Yusuf has been to imaging to discuss and they have said when EPR comes on progress will be made. Every patient on CCU should be uploaded. Lisa Fereday will look into whether the ward clerk can upload these for CCU. □ □ 02/11/2022: Risk being managed with EPR setup or as part of that. Waiting for updates.	MOD		Expected to occur at least Monthly	Major	12	LOW	4	30-Jun-2023			30/06/2023

2. Moderate Corporate Risks

ID	Date Identified	Date Risk logged on Datix	Title	Risk Type	Risk Subtype	Specialty	Specialty Group	Description	Risk level (initial)	Rating (initial)	Executive Lead	Person Accountable	Person Responsible	Responsible Committees	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	Target Date
4071	3-May-2022	03/05/2022	Reduction in Research Capacity	Corporate	Operational	Research & Development team	Core Services	If clinical service pressures affect capacity in research supporting departments (ICT, pharmacy, radiology), then new research projects will be turned away, resulting in a loss of research income and reputational damage.	MOD	12	Kiran Patel	Mrs Ceri Jones	Mrs Ceri Jones	Finance, Resource and Performance CommitteeTraining, Education & Learning Committee	All research portfolios are being reviewed to ensure that they can be safely delivered.□ New research is being rejected if it cannot be set-up and delivered in the timeline expected by the study sponsor.□ Ongoing dialogue with departments, escalated to CD for Radiology, and Directors for Pharmacy and ICT.	MOD	No Gaps in Controls	Expected to occur at least Weekly	Moderate	12	LOW	4	4-Jan-2023	Considers all Research risks. Recruitment reports each quarter R&D report at each meeting. Annual Report of R&D Income Implemented weekly Delivery & Capacity Reviews	There is no integrated dashboard for research	03/05/2024
4088	1-Apr-2022	17/05/2022	22/23 Inflation Pressure	Corporate	Financial	Finance Department	Core Services	IF the Trust is not able to manage inflationary increases within the national 2.7% inflation funding, □ □ THEN the Trust may not be able to operate within its agreed budget, □ □ RESULTING in the Failure to meet the financial plan position (which is not sustainable)	HIGH	16	Susan Rollason	SR	Mr Antony Hobbs	Finance, Resources and Performance Committee	1) Costs monitored through the Integrated Finance Report to F&P□ 2) Costs monitored through CFO updates to COG	MOD	No Gaps in controls.	Expected to occur at least Monthly	Major	12	LOW	4	31-Mar-2023	Integrated Finance Report	No Gaps in assurance.	31/03/2023
4097	23-May-2022	23/05/2022	Emergency medicine overcrowding and patient flow	Corporate	Safety - Clinical		Emergency Medicine	IF hospital occupancy remains over 90% and patients are unable to move out of the ED and MDU to base wards THEN there will be delays in assessment of new patients, ambulance holding and overcrowding in ED RESULTING in morbidity, mortality, infection control concerns, failure to comply with standards and reputational impacts.	MOD	12	Gabrielle Harris	GH5	Dr Edward Hartley	Quality and Safety CommitteeRisk Committee	23/05/2022 - discussed at group risk ratification forum on 28.04.2022 - this risk amalgamates risk ID: 3631/2067/3656/3721/3722 to cover the risk across the whole Emergency Medicine group as opposed to individual areas.□ □ 24/05/2022 - reviewed/discussed group board - group happy. Move to review in June. Ambulance holding and performance risks (4004 & 3674) amalgamated into this overall risk. Changed to corporate risk to replace 2067 corporate risk of overcrowding in ED. □ □ 29/07/2022 - d/c with MF - transfer of patients off ambulances and release of ambulance back to community remains a daily operational focus. We continue to perform higher than the rest of the west midlands in 0-60 minute turnover (87.3%) and over 1 hour. Surge remains in place and used to support ambulance offloads, this was recently extended to 12 beds as part of heatwave planning. CD is leading on a value stream to improve admission avoidance. Kaizen events are being organised for early August with support of KPO team. RPIW week engaged by group regarding AMU1 patient flow, recently presented back at stand up. □ □ 31/08/2022- CD value streams are progressing- 4 identified for front door ambulatory pathways that have dates for kaizen events. winter funds have been offered to trust to support with patient flow- group have put together options and awaiting approval.	MOD	Lack of 7 day working Unplanned staff sickness impacting on service delivery Impact of expansion	Expected to occur at least Weekly	Moderate	12	MOD	9	30-Dec-2022	HCA reviews waiting room every 30 minutes, review of incidents, FFTs and complaints, receptionist and triage nurse in reception 24/7 Discussed at group board every month Hourly monitoring Process & o/c indicators Mortality KPIs - FREED metrics	Complex patient pathways with large numbers of patients affected Capacity is reliant upon external partnerships, and community pathways being updated limited capacity forces short term plans to deal with constraints	31/12/2023
2472	25-Jan-2016	25/01/2016	Lack of Hybrid Operating Theatre	Corporate	Strategy	Vascular Surgery	Surgical Services	IF the Trust does not have a hybrid operating theatre THEN it may impact upon the Trusts ability to provide an adult Major Trauma service RESULTING IN patients from Coventry and Warwickshire and surrounding areas having to relocate to another major trauma provider for treatment.□	HIGH	15	Justine Richards	Mrs Justine Richards	Mr Nicholas Malhanu	Quality and Safety Committee	* Business case is currently being drafted and will require both Trust Board and ICS approval. □ *Access to interventional radiology on an adhoc basis. □ □ □ □ □ □ □	MOD	Drafting business case estimation completion December 2023 Use of interventional radiology is sub-optimal, with no access to surgery. Interventional radiology is on a different floor to theatres Repurposing of a current theatre is technically not possible based on advice from private sector partners In addition, staff are being exposed to higher levels of radiation than would occur if we had a fixed system for imaging.	Expected to occur at least Annually	Catastrophic	10	LOW	6	31-Dec-2022	Monitored through incident reporting & Mortality review Business case progress monitored by strategic COG and Strategy Team	Business case will need approval through Integrated care system	31/12/2023

2. Moderate Corporate Risks

ID	Date Identified	Date Risk logged on Datix	Title	Risk Type	Risk Subtype	Specialty	Specialty Group	Description	Risk level (initial)	Rating (initial)	Executive Lead	Person Accountable	Person Responsible	Responsible Committees	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	Target Date
4092	1-Apr-2022	17/05/2022	22/23 Capital programme - Funding	Corporate	Financial	Finance Department	Core Services	*IF there is insufficient capital financing □ □ THEN the Trust will not be able to invest in strategic and operational developments □ □ RESULTING IN reduction in the Trust's ability to achieve its strategic objectives.□ □	MOD	12	Susan Rollason	SR	Mr Antony Hobbs	Finance, Resources and Performance Committee	1) Capital Finance Update to COG bi monthly.□ 2) Additional controls/rigour continues in 21/22 to support the regional capital allocation process.□ 3) NHSI/E aware of capital constrains□ 4) CPRG - on going review of capital priorities.□ 5) Long term solution being pursued with NHSI/E to support the overall capital system allocation.	MOD	No Gaps in Controls	Expected to occur at least Annually	Catastrophic	10	VLOW	3	31-Mar-2023	Integrated Finance Report CFO Private Board Report	No Gaps in assurance.	31/03/2023
4170	1-Jul-2022	10/08/2022	Stroke Centralisation - Recruitment Funding Risk	Corporate	Safety - Clinical	Stroke Services	Trauma & Neuro Services	If there is lack of funding for Orthoptists and Radiologists this will result in the inability to provide an effective stroke service to our patients.	MOD	10	Gabrielle Harris	Mrs Juliet Starkey	Mr Talha Khalifa	Finance, Resources and Performance Committee	10.08.2022 - System level request for approval for multiple vacancies to be recruited to, including acknowledgement of risk of funding. □ Risk Target set with consideration for national shortages.□ □ 26/10/2022: Funding requests to be discussed in November ICB meeting.	MOD		Expected to occur at least Daily	Minor	10	LOW	6	30-Dec-2022			30/12/2022
1864	1-Apr-2014	23/08/2013	Unauthorised access of Trust systems - mis-use of access by Trust staff	Corporate	Information Governance		Core Services	IF data security arrangements are inadequate or ineffectively managed□ THEN inappropriate access to information could occur and lead to breaches of the Data Protection Act, Computer Misuse Act, and Human Rights Act□ RESULTING in enforcement action being taken by the ICO□	MOD	9	Mo Hussain	DWB	Ms Harjit Malharu	Audit and Risk Assurance Committee/Information Governance Committee	1) Strong passwords are enforced when logging on to the Trust network, making it difficult for passwords to be guessed or gleaned.□ □ 2) Staff must sign to agree to the terms and conditions of use of the ICT Security Policy before access to the Trust network and systems is granted after training. The policy explicitly states staff responsibilities for acceptable use of Trust system, such as only accessing information on a strict need to know basis, and to not share passwords or smartcard access with other staff.	MOD	CRRS appears to be preferred system for staff that committ unauthorised access - this is based on the numbers of incidents reported in Datix since 2016/17. Once access is granted to staff, the whole of the system can be accessed. There is no granularity of access. In the absence of intelligent software for auditing to spot patterns of access, a programme of local audit should be implemented. For example, top ten records accessed each week, top ten frequent users per week.	Expected to occur at least Monthly	Moderate	9	LOW	6	30-Dec-2022	Staff are granted access to Trust systems based on their job role in the organisation. All incidents reported in Datix and categorised as 'Information Governance' are notified to the IG team who contact the handler of the incident to provide support in the containment of the incident and appropriate actions. The IG team triage all incidents for which they recieve notifications, and report on the Data Security and Protection Toolkit as per guidance from NHS Digital. All IG incidents reported in Datix are reviewed at the IG Commitee. Workforce provide a regular report to the IG Committee that details cases of inappropriate access and disciplinary outcomes for staff known to have breached Trust policy.	The Trust does not have the software required to undertake intelligent auditing, so the extent of unauthorised access is not known, only those incidents that are reported in Datix.	30/06/2023

2. Moderate Corporate Risks

ID	Date Identified	Date Risk logged on Datix	Title	Risk Type	Risk Subtype	Specialty	Specialty Group	Description	Risk level (initial)	Rating (initial)	Executive Lead	Person Accountable	Person Responsible	Responsible Committees	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	Target Date
2792	22-Jun-2017	22/06/2017	Lack of effective system for management of medical equipment training	Corporate	Safety - Clinical	Medical Equipment & Bio-engineering Services (MEBS)	Clinical Support Services	If the Trust does not train its staff to use medical equipment correctly, then patients may come to harm which may also lead to financial and reputational loss for the Trust.□ □ 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.	MOD	12	Tracey Bigstock	Mr Christopher Koller	Dr Claire Ingram	Health & Safety CommitteeMedical Devices Safety CommitteePatient Safety CommitteeQuality and Safety Committee	Training in use of Resus equipment is currently managed within ESR.□ A limited set of training data of specific items of other medical equipment items is retained within ESR.□ Local training records may be retained in locally maintained spreadsheets or in paper records.□ 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.□ □ The role of Lead Medical Devices Safety Officer has been revised to include responsibility for Medical Device Training and now incorporates the following elements:□ □ 1.Chair and oversee the work of the Medical Devices Training Group.□ 2.Provide the MEBS lead on Medical Equipment Training. □ 3.Identify and manage the Trust's training needs for the use of medical equipment.□ 4.Identify and develop lesson plans and competency checklists as appropriate in conjunction with the appropriate clinical trainers.□ 5.Co-ordinate training undertaken by external trainers in conjunction with departmental clinical trainers and ensure such training is effectively delivered and captured.□ 6.Ensure that the status of Trust trainers is maintained.□ 7.Ensure production of appropriate training reports.□ □ Dec 2020: Awaiting appointment of Lead MDSO, delayed due to COVID-19.□ Update 29/3/21: Still awaiting appointment of LEAD MDSO. This is currently being progressed with Workforce.□ □ List of local training leads has been obtained by the MEBS training co-ordinator who has the responsibility of contacting them each quarter to request updates to staff trained.□ Work has continued on production of a list of equipment to be trained on..□ It is proposed to introduce a simplified system whereby key ward equipment is covered in the first instance. Specialist equipment will then be added as required for specific areas. Update 17/6/21. With the retirement of the Head of MEBS this risk is being transferred to the Director of Clinical Physics.□ JC - to continue working up options into paper to be presented. 30/06/21□ JC - MEBS compiling paper to go to group to identify case for resource to make this happen following review with Emma Fish/Joan Goodbody. Draft policy written for MD Training. □ □ Update TMA 28/09/2021: Lead MDSO has been appointed and due to start in November. Medical Device training will be part of their role. □ □ update 29th Nov 2021: lead MDSO in post and meeting with CSS, MDSO adn ADN for quality and safety to look at current state of training, to review medical equipment training policy and options appraisal, undertake a training needs analysis of some key areas to determine equipment that is core, and what training is undertaken, required and how this is logged□ □ Jan 28th 2022 - Scoping for options appraisal as part of a business case and currently testing a gap analysis approach, collecting information from a small number of areas related to equipment they have as core equipment and equipment that is considered needed specialist training. The business case will consider how we will ensure there are competencies, type of training needed, frequency. This review/case will also look at how training is recorded and where training records are held(Jan 2022). This work is being lead by Head of MEBS and Lead MDSO to be presented once completed.□ □ 9/3/22□ business case completed and sent to Martin Robinson and Nick Sturgess- Alex for review and comment. Policy re-drafted but awaits business case to finalise □ Met with Andy Philips in June to discuss. awaiting meeting with Finance.□ □ 11/10/22 Training needs analysis in progress for wards.	MOD	There is not a Trust Medical Equipment Training Policy, only a draft version. There 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).	Expected to occur at least Monthly	Moderate	9	LOW	6	31-Jan-2023	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 Information on training compliance rates	There is no Trust wide strategy for co-ordination of medical device training. Current reporting system not fit for purpose The Trust Medical Device Training Committee has not met for some considerable time and no meetings are in the calendar for 2021	31/10/2023
2911	28-Nov-2017	28/11/2017	Raising concerns	Corporate	Workforce (HR)		Core Services	IF there are not sufficient confidence levels in staff to speak up and raise concerns THEN patient safety or staff issues may not be identified RESULTING IN potential poor patient care or experience, or staff dissatisfacton and/or increased turnover	MOD	9	Andy Hardy	MH01	Ms Lorna Shaw	Audit and Risk Assurance CommitteePeoples Committee	Posters promoting policy under the value of 'openness'□ Regular contacts with chaplain, staff side and E D & I team.□ FTSUG meets with Chair, Lead NED and CPO independently□ UHCW uses a Raising concerns app developed for both iPhone and android which can be downloaded using organisation email address, followed by a UHCW unique passcode. The UHCW Speak Up app enables our employees options to raise concerns Openly, Anonymously and in Confidence. The app became live on October 19 2022.	MOD	Greater publicity for FTSUG and Raising Concerns	Expected to occur at least Monthly	Moderate	9	LOW	6	30-Dec-2022	Positive outcomes from national staff survey 6 monthly report to Board		30/12/2022

2. Moderate Corporate Risks

ID	Date Identified	Date Risk logged on Datix	Title	Risk Type	Risk Subtype	Specialty	Specialty Group	Description	Risk level (initial)	Rating (initial)	Executive Lead	Person Accountable	Person Responsible	Responsible Committees	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	Target Date
3394	1-Apr-2019	25/07/2019	Maintaining up to date clinical guidelines on e-library	Corporate	Quality	Quality Department	Core Services	IF the Trust cannot ensure up to date evidence based clinical guidelines are made available to staff via e library in a timely and robust process, THEN staff cannot have access to current guidelines and procedures RESULTING in possible negative impacts to the delivery of safe and effective patient care. □ □ The Trust Quality Strategy target for up to date guidance on elibrary is 96%.	HIGH	16	Mo Hussain	MH01	Mrs Sharron Salt	Quality and Safety Committee	Generic mailbox to receive all clinical guideline support requests, managed by the clinical effectiveness team. □ Prioritising the uploading of high risk guidelines or high risk areas e.g. Intrathecal register□ Restructure of the clinical effectiveness team after filling of vacancies to build resilience into the process and allow cross working□ Use of a production board and huddle process to monitor progress and identify challenges□ collaborative working with quality officers and admin within groups to collate necessary evidence for upload to elibrary□ Definition of clinical guidelines within CE team and those still within group to identify where focus is needed.□ QA check to ensure accurate upload of clinical guidelines to elibrary□ Tracker to identify progress of guidelines through process.□ Planning of trajectory for guidelines under review that will expire at month end.□ May 2020- Improvement work in progress with the Medicines Management Committee(MMC) to streamline the process for the management of clinical guidance containing medicines. This will inform the Trust Policy of the management of local clinical guidance.□ Review period of guidance on elibrary extended from 3 months to 6 months to flag guidance due to expire earlier.□ KPI metrics identified to forecast guidance due to expire each month□ Quality partner discussion with groups at group board to escalate expired guidance.□ KAIZEN event output. □ Template change to 1 template□ Separate process for PGD to meet national guidance□ Standard work for communication with CE team□ Forecasting of guidelines expiry dates 12 months ahead with clinical leads□ 26/4/2021□ Appointment of guidelines and PGD pharmacist to increase support for guidelines with medicines□ Clinical effectiveness attendance at MMC□ Process review to increase adoption of national guidance□ Prioritisation of workstream to focus on expired clinical guidelines.□ 08/10/2021 Elibrary mapping is taking place to align documents on elibrary with responsible specialities to improve data quality.□ The insite reporting has been modified to include comments and tracking status to increase visibility and accuracy of information for specialties.□ Radiology to take ownership of Non medical referer protocols in terms of elibrary access and governance.□ Weekly meetings with Medicine regarding expired guidelines□ Guidelines and PGD pharmacist has commenced in post to support pharmacy governance process.□ 20/12/2021 □ tracking status used on elibrary with direct feed to insite for progress updates □ 26/1/2021 Non medical referrer protocols removed from guideline section into their own to clarify reporting and create governance process in Radiology.□ Tracking status for Pharmacy Governance steps identified.□ Application form created to identify medicines at the start of process□ Definitions of Clinical guideline and Clinical Operating Procedure refreshed.□ Clinical guideline facilitator appointed to focus on guidelines.□ Working policy document in progress□ 4/4/22 Tracking status to elibrary updated to reflect all steps in process. All guidelines on elibrary mapped to NICE guidance.□ Template revised to have one type of local guideline document□ SOPPs to be transformed into guidelines and competency packages removed and locally held. Pilot of new process in Urology and Endocrinology. QIPS approval criteria being drafted based on AGREE 2 framework. MMC escalation defined and approved at MMC.□ 31/5/2022 Pilot of new process in progress. Template approved. QIPS approval criteria complete and in use in pilot. Implementation plan for roll out devised and to commence from June.□ 15/8/2022- Changes to process rolled out across organisation 25 July.□ New templates available on elibrary□ Comms plan to share infomration new process□ Presentation at CSLF and Grand round to share new process□ attendance at QIPS meeting and meetings with quality officers in group.□	MOD	Evidence summaries not provided routinely for all guidance. CEBIS team resource not set up to accommodate. ACTION: determine all types of guidance requiring evidence to identify how CEBIS can support automatic evidence summaries. Not all specialties have a quality officer to support the local management of clinical guidelines in group Not all specialties have a specialist Pharmacist to support review of clinical guidelines. Pharmacy department are supporting by sharing work load within pharmacy as a temporary measure to groups investing in specialty pharmacists.	Expected to occur at least Monthly	Moderate	9	LOW	6	30-Dec-2022	Weekly Focus board huddle Guidelines focus at weekly QD focus board huddle Weekly reporting to ADQ of guidelines expired numbers Monthly group level reporting on guidelines progress and expired numbers Guideline discussion with quality partners and monthly group board for all groups weekly meetings with Pharmacy to disucss guidelines for pharmacy review and progress of AAA process MMC agenda sent in advance to CE team to identify potential uploads Reporting of performance and escalations quarterly Weekly project meeting to progress priority actions for guideline process changes	Quality assurance of the clinical guideline content and medicines content to prior to approval at MMC or QIPS	30/12/2022
3791	28-Apr-2021	28/04/2021	Risk of patients self harming	Corporate	Safeguarding		Core Services	If a patient intends to harm themselves (self harm) whilst receiving care at UHCW and preventative measures are not in place or are not effective, then the patient may actually self harm, leading to serious injury or death, which would also impact trust reputation, coronial sanctions and concern with the CQC.	MOD	9	Tracey Brigstock	Sr Emma Fish	Ms Elaine Clarke	Quality and Safety CommitteeSafeguarding Vulnerable Adults and Children Committee	*Risk Tool to be embedded to support staff to assess the environment and select appropriate interventions for patients □ □ *Training for recognising behaviour cues in patients for staff in high risk areas (AMU/ward 1/ECT Team) to begin April 2021. Additonal training framework has been created to include e-learning on managing challenging behaviour, face to face mental health training and mental health first aid course hosted by Coventry University (from April 2022. Training being deleivered trustwide from March 2022 by Enhanced care team lead following development of safe and supportive observations guidelines including self harm.□ □ *Ligature Cutter Training for staff in high risk areas - (cascade trainers trained in June) for trust wide roll out. □ □ *Guidance on how to manage patients with capacity but demonstrate an intent to self harm. This has been added into the reviewed guidance for safe and supportive observation levels for clarity of supervision levels for patients. This is being rolled out around the Trust from the beginning of March 2022□ □ *Guidance on how to manage patients with capacity but demonstrate an intent to self-harm. □ □ *Guidance and support being provided by AMHAT across the trust, in adherence to national standard. □ □ *RMN currently being recruited into the EM group. □ □ *ED are reviewing their self harm triage and risk tools. □ □ Update August 2022□ *Mental health steering group has been commenced. This is a Trust wide group, meets every other month with a focus on pathways, review of incidents, care of patients that are on a section or who have a mental health crisis in hospital □ □ *Investment case written to have CPI intervention training provided in house for de-escalation □ □ Training is being offered on the different sections delivered by CWPT	MOD	The roll out of training is dependant staffing availability and accessibility	Expected to occur at least Monthly	Moderate	9	LOW	4	30-Dec-2022	Monitoring of self harm incidents reviewed, where moderate harm or above supported by PSR, working with external stakeholder (CWPT)	Nil H&SC and NMC updated	30/12/2022

2. Moderate Corporate Risks

ID	Date Identified	Date Risk logged on Datix	Title	Risk Type	Risk Subtype	Specialty	Specialty Group	Description	Risk level (initial)	Rating (initial)	Executive Lead	Person Accountable	Person Responsible	Responsible Committees	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	Target Date
4087	1-Apr-2022	17/05/2022	22/23 COVID Costs	Corporate	Financial	Finance Department	Core Services	IF the Trust is not able to contain the level of COVID costs within the set funding, □ □ THEN the Trust will exceed it's agreed budget, □ □ RESULTING in the failure to meet the financial plan position, (which is not sustainable)□	MOD	9	Susan Rollason	SR	Mr Antony Hobbs	Finance, Resources and Performance Committee	1) Performance monitored through the Integrated Finance Report to F&P□ 2) Performance monitored through CFO updates to COG	MOD	No Gaps in controls.	Expected to occur at least Monthly	Moderate	9	LOW	6	31-Mar-2023	Integrated Finance Report CFO Private Board Report	No Gaps in assurance.	31/03/2023
4090	1-Apr-2022	17/05/2022	22/23 Agency Expenditure	Corporate	Financial	Finance Department	Core Services	IF there is a failure to control/reduce agency staffing expenditure,□ □ THEN there is a risk that the Trust will exceed its expected Agency Target of £20.830m□ □ RESULTING in the failure to meet an NHSE/I key control	MOD	12	Susan Rollason	SR	Mr Antony Hobbs	Finance, Resource and Performance Committee/Peoples Committee	BAU Controls:□ 1) Budgetary control processes.□ 2) Monthly operational delivery meetings.□ 3) WRP focus on agency controls.□ 4) Group Targets will be issued for 22/23, once the external target are released.	MOD	No Gaps in controls.	Expected to occur at least Monthly	Moderate	9	LOW	4	31-Mar-2023	Integrated Finance Report Integrated Finance Report	No Gaps in assurance.	31/03/2023
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	Performance & Informatics	Core 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).□ □ 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.□ □ 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.□ □ 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.□ □ UPDATE by MdJ 29.03.22 - Staff will be re-trained in the current process of scheduling follow up appointments. ICT is now working on EPR and the CRRS outcomes tool will not be completed. EPR system has provision for follow up patients and will mitigate this risk.□ □ UPDATE by MdJ	MOD	10	Gabrielle Harris	DH5	Mrs Merlisa De Jesus	Elective Care BoardQuality and Safety Committee	12.10.22 - The patient access team continue to work with the clinical Groups weekly to validate and track these patients until we migrate to EPR. Groups are prompted continuously to ensure their teams are following process to reduce this risk.□ □ 04.08.22 - The Patient Access continue to chase Clinical Groups within weekly Senior Access meeting to validate and track follow up patients and also to send any new starters to the RTT team for training around the process of follow ups.□ □ 29.03.22 - Staff will be re-trained on the current process until we move to EPR. Follow up report is looked and chased on a weekly basis at Senior Access.□ □ 21.12.2021 - There is now a follow up process in place for follow up patients. Patients requiring a follow up are added to the CRRS follow up worklist. This worklist now has a report on Insight to track patients waiting for follow up appointments. These follow up patients are tracked weekly at the Senior Access Huddles with the Patient Access Team (RTT Team). The Outpatient Programme is currently trialing the Patient-initiated-Follow-Ups which will allow patients to initiate a follow up appointment should they require one. Once this trial has been completed, it will be rolled out to the Specialties. Until we move to EPR, there is no more to do around these follow up patients other than govern the current process in place.□ □ 04.10.2021 - Outpatients Programme Board established emcompassing 9 strategic elements designed to improve outpatient services and experience, one such project is centered on PIFU and another looks at virtual appointments which shall include the development of a cashing up SOP to reduce the risk of patients lost to follow up. As previously agreed, this risk needs to be migrated to P&I's Access Team.□ □ □ 02.06.2021 - discussions taking place with P&I who manage Access/RTT at a corporate-level to assume responsibility for this risk.□ □ - New focus on PIFU as part of the Outpatients Accelerator project whereby groups are required to indicate any specialities which could utilise PIFU.□ □ In place:□ □ Follow up project group established with 4 clear initial work streams:□ - Reporting□ - Ophthalmology □ - Validation□ - Future State□ □ 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.□ □ 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.□ □ The volume of suspended outcomes as at 21st March 2019 is has reduced to 3738.□ □ Black Status Patients - 7231□ Red Status Patients - 11987□ □ (No filters applied)□ □ 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.□ □ 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	ICT does not have capacity to complete the CRRS outcomes tool to mitigate risk Trust moving to new system EPR and will not know risk around follow ups until we move to EPR	Expected to occur at least Weekly	Minor	8	LOW	6	31-Aug-2023		AGM/RTT Lead meeting not yet held No update documented since 03-2019 Post-RPIW anticipated CRRS build delays, not scheduled until c02-2020	31/08/2023
4084	1-Apr-2022	17/05/2022	22/23 Contract Income - ERF (Elective Recovery Fund)	Corporate	Financial	Finance Department	Core Services	IF the Trust does not deliver the Operating Framework requirement to deliver 104% of 2019/20 elective activity levels,□ □ THEN the Trust will be at risk of loosing the ERF Funding of up to £22.6m□ □ RESULTING in failure to meet the Trusts financial plan position (which is not sustainable)□	HIGH	20	Susan Rollason	SR	Mr Antony Hobbs	Finance, Resources and Performance Committee	1) Annual Planning Process sets the the delivery plan for 22/23□ 2) In month delivery reported to F&P through IFR□	MOD	None	Expected to occur at least Annually	Major	8	LOW	4	31-Mar-2023	Elective Performance reported to Finance and Performance committee - IFR	No Gaps in assurance.	31/03/2023

3.0 Low / Very Low Corporate Risks

ID	Date Identified	Date Risk logged on Datix	Title	Risk Type	Risk Subtype	Specialty	Specialty Group	Description	Risk level (initial)	Rating (initial)	Executive Lead	Person Accountable	Person Responsible	Responsible Committee/s	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	Target Date
4091	1-Apr-2022	17/05/2022	22/23 Capital Programme - Delivery	Corporate	Financial	Finance Department	Core Services	IF the Trust is not able to spend it's capital allocation in year, □ □ THEN it will result in underspend against the external CDEL limit;□ □ RESULTING result in the reduced capital allocations in future years.□ □ A combination of the global supply chain challenges, uncertainty over the 22/23 capital allocations and the likelihood of additional capital allocation later in the year contribute to this risk	MOD	9	Susan Rollason	SR	Mr Antony Hobbs	Finance, Resources and Performance Committee	1) Capital Finance Update to COG bi monthly.□ 2) Additional controls/rigour continues in 22/23 to support the regional capital allocation process.□ 3) NHSI/E aware of capital constrains□ 4) CPRG - on going review of capital priorities.□ 5) Long term solution being pursued with NHSI/E to support the overall capital system allocation.□	LOW	No Gaps in controls.	Expected to occur at least Annually	Moderate	6	LOW	4	31-Mar-2023	Integrated Finance Report CFO Private Board Report	No Gaps in assurance.	31/03/2023
4089	1-Apr-2022	17/05/2022	22/23 Waste Reduction Delivery	Corporate	Financial	Finance Department	Core Services	IF the Trust is not able to fully identify and deliver the 2022/23 Waste Reduction Programme, □ □ THEN it will not meet its external waste reduction target, which will,□ □ RESULT in the failure to meet the financial plan position (which is not sustainable).	HIGH	20	Susan Rollason	SR	Mr Antony Hobbs	Finance, Resources and Performance Committee	BAU controls include□ 1) Waste Reduction financial targets allocated as part of budget setting process.□ 2) Waste Reduction PM3 system used to record/monitor progress.□ 3) Waste reduction Board established to oversee the Waste reduction. Programme.□ 4) Waste performance reported to Finance and Performance committee	VLOW		Not expected to occur for Years	Negligible	1	LOW	4	31-Mar-2023	Integrated Finance Report Corporate Finance Risks Waste Reduction Updates	None	31/03/2023

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 1 DECEMBER 2022

Subject Title	Board Assurance Framework (BAF)
Executive Sponsor	David Walsh, Director of Corporate Affairs
Author	David Walsh, Director of Corporate Affairs
Attachments	BAF for critical risk areas: • Financial stability • Operational performance • Quality of Care and Patient Experience *and* Service Stability • Staff Wellbeing and Morale *and* Workforce Supply
Recommendation	The Board is asked to: 1. **RECEIVE** the BAF entries for 'Financial Stability' and 'Operational Performance' following consideration by the Finance and Performance Committee on 24 November 2022 2. **RECEIVE** the BAF entries for 'Quality of Care and Patient Experience' and 'Service Stability' following consideration by the Quality and Risk Committee on 24 November 2022 3. **RECEIVE** the BAF entries for 'Staff Wellbeing and Morale' and 'Workforce Supply' following consideration by the People Committee meeting on 27 October 2022 4. **CONSIDER** and triangulate any additional assurances received during the Board meeting in the context of the documents described above.

EXECUTIVE SUMMARY

The complete BAF is presented following consideration at the various monitoring committees to ensure Board members are equally sighted on activity and levels of assurance in all areas.

Background

The BAF operates on the principles of bringing together the various sources of assurance provided to Board and its committees, reflecting on a RAG-rated assessment of assurance arising from each, and bringing together an overall level of assurance. The BAF papers considered by each of the committees will come together at Board level to represent an overall picture of assurance, and to support Executive and Non-Executive Board members in maintaining oversight across all committees, including those they do not attend.

Committees consider the BAF as the final business item in meetings, providing the members opportunity to reflect on and triangulate the assurances received, and agree changes to assurance ratings and document content within the meeting, ensuring the BAF remains dynamic.

Highlights since previous Board consideration

Detailed first, second and third lines of assurance are set out in the attachments.

Red RAG ratings of individual sources of assurance

One previous 'red' area of assurance in relation to specific areas reported at the last Board meeting has now been uprated to 'amber'. The Quality and Safety Committee previously recorded 'red' agains the Learning from Deaths internal audit report, which returned limited assurance. However, having considered progress against the internal audit action plan, this was changed to 'amber' with a view to reconsidering the action plan in May 2023 in anticipation that it will be possible to move to 'green' assurance at this stage.

However, one area of assurance previously 'green' has been downrated to 'red'. This relates to the mortality update and issues relating to the Trust's HSMR status. The committee received assurance that this was being managed through a weekly mortality review group, but determined to maintain a 'red' status until consideration of the HSMR action plan, which it agreed to receive at its meeting in January.

Changes to RAG ratings of individual lines of assurance

RAG ratings are also applied to the associated corporate risks (overall) and the three lines of assurance for each of the BAF documents. The one 'red' area has been eliminated, in relation to 'Associated Corporate Risks' within the Financial Sustainability BAF. Although risks remain in this area, assurance was provided at the October meeting of Finance and Performance Committee in relation to the management of these risks with significant shift shown between initial and current risk scores.

There has been change elsewhere on individual lines of assurance. In relation to Operational Performance, the overall first line of assurance rating moved upward from 'amber' to 'green' in October, given the quantity of 'green'-rated assurance sources, while the third line of assurance moved downward from 'green' to 'amber'. This was due to the UHCW being placed in Tier 2 by NHSE/I for cancer standards, and it is anticipated assurance will be given at the next meeting in January to move this back to 'green'.

There has been a positive change to the RAG rating of the lines of assurance, with the third line of assurance (external reviews etc) under Quality of Care and Patient Experience and Service Stability moving from 'Amber' to 'Green'.

Changes to the overall BAF RAG ratings

There have been no changes, with all four BAF documents showing an overall level of 'Amber' assurance.

Snapshot

Committee	Risk area	Associated Corporate Risks	First line of assurance	Second line of assurance	Third line of assurance	Overall level of assurance
FPC	Financial Sustainability					
FPC	Operational Performance					
QSC	Quality of Care and Patient Experience *and* Service Stability					
PC	Staff wellbeing and morale *and* Workforce Supply					

Cyber Security Risk

This remains in development and, following consideration of the issue at the Audit and Risk Committee in October, will be presented to the committee at its January meeting ready for inclusion in the BAF report to Board in February.

PREVIOUS DISCUSSIONS HELD

As described in the Executive Summary.

KEY IMPLICATIONS

Financial	None directly arising
Patients Safety or Quality	None directly arising
Workforce	None directly arising
Operational	None directly arising

Committee: **Finance and Performance Committee**
Critical risk areas: **Financial stability**

Associated risks

Managed risk	Initial	Current	Target
2022/23 Contract income – ERF	20	12	8
2022/23 Recurrent waste reduction delivery	15	15	4
2022/23 Inflation pressure	16	12	4
2022/23 Agency expenditure *	12	12	4
2022/23 Capital Funding	12	12	3
2022/23 Contract Income – High Cost Drugs and Devices	9	20	6
2022/23 Emergency Pressures	9	16	6
2022/23 Covid costs	9	9	6
2022/23 Capital programme delivery	9	9	4

*Also included on People Committee BAF

Assurances received

First line of assurance

Issue/report	Last review	Rating
IQPFR	24/11/22	
Waste Reduction programme	24/11/22	
Integrated Finance Report	24/11/22	
Procurement Update	27/10/22	
Research and Development Income, Expenditure and Compliance	29/9/22	
National Cost Collection 2021/22	24/11/22	
Financial Sustainability (mandated review) self-assessment	27/10/22	
Charging of Overseas Patients	24/11/22	
Virtual wards – approach/funding	24/11/22	

Second line of assurance

Issue/report	Last review	Rating
Financial Governance (planning guidance) internal audit report	14/10/21	
Accounts Payable internal audit report	13/1/22	
Accounts Receivable internal audit report	13/1/22	
Financial ledger internal audit report	13/1/22	
Financial Sustainability (mandated review) – internal audit	27/10/22	Due for submissi-on by 31 Jan 23

Third line of assurance

Issue/report	Last review	Rating
VFM Audit Plan (ARAC)	21/4/22	
National Cost Collection 20/21 outputs	25/8/22	

Gaps

- IQPFR – see Operational Performance BAF entry
- M7 £14.48m deficit vs £9.2m plan, capital spend of £18.2m vs £16.7m plan (Nov 22)
- CDC funding changes at national level – detail awaited
- Agency expenditure at £13.6m v YTD ceiling of £12.1m (Nov 22)
- YTD £10.3m WRP delivery vs £15m target (Nov 22), reliance on 112% non-recurrent delivery (Oct 22)
- Uncertainty relating to virtual wards alongside national requirement to proceed – staffing cost/financial risks

- Improvements identified in financial systems reports around duplicate payments, fraud/misappropriation, delayed income receipt and financial loss, budgetary impact, misreporting, impact on delivery of financial and strategic objectives (Significant assurance overall)

- Due to the current levels of underlying deficit at both the Trust and system level, KPMG identified there was a risk that the Trust did not have adequate arrangements to achieve financial stability over the medium term

Mitigations

- Group level waste delivery sessions with senior leadership engaged (COG and corporate directors)
- Trust wide waste delivery projects re-established
- Agency adjustment required re UTC
- Any staff for virtual wards could be reallocated if required

- Actions arising from all gaps identified above completed by 31/3/22

Actions

- Procurement: NHSE/I framework issue being reviewed – feedback from regional committee awaited
- Star chambers ongoing with groups to improve traction on achieving waste targets, pipeline schemes being quantified (Oct 22)
- Recommend to ARAC addition of costing to internal audit plan (Aug 22)
- WRP presentation on theatre productivity in Nov (complete) and cost control in Jan (Oct 22)

- Scope of financial sustainability internal audit received and now progressing – replaced financial assessment that has previously been undertaken by CW Audit but is wider (Sep 22)
- HFMA outcome to be presented to regional team following review by ARAC on 31 January 2023 (Oct 22)

- KPMG to revisit later in the year and the full outcome to be reported back

Overall level of assurance: **Amber**

Key: Strong assurance of actions to manage risks and issues | Risks being managed but gaps requiring further assurance | No or limited assurance on management of risks

Committee: **Finance and Performance Committee**
Critical risk areas: **Operational Performance**

Associated risks

Managed risk	Initial	Current	Target
Lack of permanent mortuary capacity	20	20	6
Inadequate support from Roche Managed Service	15	12	6
Emergency medicine overcrowding and patient flow	16	12	9
Stroke centralisation recruitment (system funding request)*	10	10	6
Non-standardisation of follow-up processes affecting RTT	10	8	6

First line of assurance

Assurances received

Issue/report	Last review	Rating
IQPFR	27/10/22	
Emergency Care	24/11/22	
Cancer Care	27/10/22	
Performance benchmarking	28/4/22	
Elective Care – 104-week waiters	27/10/22	
Elective Care – 78-week waiters	27/10/22	
Elective Care – update	27/10/22	
Sustainable Development	27/10/22	
Winter Plan	29/9/22	
Estates and Facilities	27/10/22	
Theatre Productivity	24/11/22	
Performance Benchmarking	24/11/22	

Gaps

- Cancer – two-week wait improved (78.6%), 28-day (73.38%) and 62-day standards (57.1%) off track (Nov 22)
- RTT incomplete at 52.7% vs 92% national target
- Long length of stay: 189 patients at 21 days or over (Nov 22)
- Four hour standard – 61.8% in Sept vs 95% national standard (Nov 22)
- Performance issues relating to UH estate (Oct 22)
- Theatres: Closed session % and average late starts off track (Nov 22)

Mitigations

- Cancer: funding secured for staffing in Lung, Colorectal, Gynae, RTP in head and neck commenced May 2022, rapid access pathway for patients with prostate cancer risk being commenced (May 22)
- Any patient waiting 3hrs+ has patient harm review completed - no harm caused due to delays in handover (Aug 22)
- Support from SWFT and GE functioning effectively in times of handover challenge (Aug 22)
- Targeted focus on late starts within theatre productivity programme – evidence of progress in Neuro example shared with FPC (Nov 22)

Actions

- Organisational push to commence UHCWi value streams focussed on Emergency Care at pace by November – five Kaizen events to reduce length of stay planned in September (Aug 22)
- Breakdown of mutual aid elective patients and impact on UHCW data to be included
- Report out on ED improvement focus due in Dec 22 (Oct 22)
- Commenced focus on 26-week outpatient target (Oct 22)

Second line of assurance

Issue/report	Last review	Rating
Data Quality Review – 28 Day Faster Diagnosis Standard	21/4/22 (ARAC)	
CT/MRI Scan capacity discharge planning	TBC	

Gaps

- The data quality internal audit returned moderate assurance, with improvements identified around the newly introduced standard

Mitigations

- An action plan responding to the internal audit was developed and presented to ARAC on 21/4/22

Actions

- Report to be presented to future FPC confirming compliance with actions required

Third line of assurance

Issue/report	Last review	Rating
National Hospital Only Discharge Programme – reviews/support from NHSE/I and ECIST – now exited following improvements	25/8/22	
UHCW placed in Tier 2 by NHSE/I for cancer standards	24/11/22	

Gaps

- Featuring at Tier 2 by NHSE/I for cancer standards indicating a gap

Mitigations

- Trust able to comply with NHSE/I self-declaration requirements as confirmed by letter from Chair/CEO in November 2022
- Now anticipated to be removed from Tier 2

Actions

- Update to be brought to next meeting in relation to prioritisation of actions arising from Tier 2 status – **COMPLETE**
- Self certification to be presented to Trust Board in December 2022

Overall level of assurance: **Amber**

Key: Strong assurance of actions to manage risks and issues | Risks being managed but gaps requiring further assurance | No or limited assurance on management of risks

Committee: **Quality and Safety Committee**
Critical risk areas: **Quality of care and patient experience** and **Service stability**

Associated corporate risks

Managed risk	Initial	Current	Target
Inability to keep CAMHS patients safe	20	16	6
Inability to deliver a sustainable Dermatology Service	16	16	6
Recording of clinical evaluations in patient records	15	15	6
Potential of major fire risk	15	15	8
Violence and aggression against staff	15	15	9
Inability to meet demand for breast imaging/screening	15	15	12
Registered Midwife vacancies	15	15	6

First line of assurance

Assurances received

Issue/report	Last review	Rating
IQPFR	24/11/22	
Patient Safety, Risk, Learning, Nev. Ev.	24/11/22	
Patient Exp. & Engagement	24/11/22	
Complaints Annual Report	26/5/22	
Maternity Safety/Ockenden delivery	24/11/22	
N&M Safe Staffing	24/11/22	
Safeguarding Adults & Children	28/7/22	
Health and Safety update	28/7/22	
IPC Update	24/11/22	
BMI Meriden rating	28/7/22	
Training – mandatory and role-specific	28/7/22	
Quality Account	29/9/22	
Medical Education	24/11/22	
Quality Strategy	29/9/22	
Ockenden Action Plan	28/7/22	
Ward accreditation	28/7/22	
Hospital Transfusion Annual Report	29/9/22	
Research and Development Annual Report	29/9/22	
Nursing, Midwives, AHPs Education	24/11/22	

Gaps

- Recording gaps around H&S near misses identified (Jan 22)
- Remaining questions over training standards expected for substantive staff vs bank vs agency (Jul 22)
- IPQFR – continued flow issues (Sep 22) and concern over numbers of day cases (Nov 22)
- Neonatal mortality requiring focus (Nov 22)

Mitigations

- Actions in place to improve reporting of near misses (Jan 22)
- Bristol model being explored - learning from flow improvement focus to be reviewed by senior leaders in Dec (Nov 22)
- Non-prioritisation of P3 & P4 affecting day cases (Nov 22)

Actions

- Further assurance on training bank/agency (Sep 22)
- Introduction of PSIRF in January 2023 (verbal Sep 22)
- Data on night transfers to future meeting (Sep 22)
- Assurance around benchmarking for NMAHP Education (Sep 22)
- Complaints data on upheld/not upheld and themes on compliments requested for future Patient Exp. & Eng. Report (Nov 22)
- IG to explore anonymised data being accessed (Nov 22)
- Future focus on neonatal mortality (Nov 22)

Second line of assurance

Assurances received

Issue/report	Last review	Rating
National survey action plans	31/3/22	
Mortality Update	24/11/22	
Dermatology review	24/11/22	
Learning from Deaths – internal audit report	24/11/22	
Response to NHS Spec Comm on Sickle Cell report actions	28/7/22	

Gaps

- Some areas UHCW scored in bottom 25% of Picker survey relating to Maternity (Mar 22)
- Completion of actions arising from Royal College Review of Dermatology (Nov 22)
- Limited assurance outcome of Learning from Deaths audit (May 22 – ARAC)

Mitigations

- Work related to ongoing compliance against Maternity Incentive Scheme standards and PMRT/ATAIN action plans
- Action plans developed relating to Maternity Survey 2021
- Weekly mortality review group – incl. co-morbidity issue, work with coding ongoing, reintroduction of paper records
- Learning from deaths action plan presented Nov 22 – amber overall

Actions

- Follow-up on progress on action plan in response to Learning from Deaths internal audit to be presented in May 23 (Nov 22)
- Ongoing review of HSMR and work of weekly mortality review group to be reported back in Jan, along with mortality action plan, explaining learning (Nov 22)
- HSMR action plan to be proactively discussed with CQC (Nov 22)
- Dermatology action plan to be reported to Jan QSC (Nov 22)

Third line of assurance

Assurances received

Issue/report	Date	Rating
Inspection of mortuary services by HTA	18/1/22	
CQC full inspection	11/2/20	
JAG inspection of endoscopy	TBC	
Pathway to Excellence accreditation – formal notification received on 15/8/22	29/9/22	
Visit from regional team on Ockenden assurance 11/8/22	29/9/22	
CQC surgery visit 5/9/22 – awaiting feedback	29/9/22	
ISO45001 – H&S accreditation	6/10/22 (Board)	
Maternity CQC inspection – Nov 2022	TBC	

Gaps

- HTA identified major shortfalls relating to six standards and minor shortfalls relating to four standards
- Areas for focus highlighted in Ockenden visit (Aug 22), including risk relating to EPR replacing maternity system, and delays on delivery of bereavement suite

Mitigations

- Risks added and managed through risk registers, action plan developed to address shortfalls
- CQC provider engagement meetings every eight weeks, and service-focused dynamic monitoring approach (DMA) meetings periodically
- UHCW liaising with Cerner relating to risks around maternity system

Actions

- Detailed outcome awaited on JAG inspection – to be reported back to QSC
- Outstanding issues in Ockenden visit to be addressed in next report, including Bereavement Suite

Overall level of assurance: **Amber**

Key: Strong assurance of actions to manage risks and issues | Risks being managed but gaps requiring further assurance | No or limited assurance on management of risks

Committee: **People Committee**
Critical risk areas: **Staff Wellbeing and Morale** *and* **Workforce Supply**

Associated corporate risks

Managed risk	Initial	Current	Target
Registered midwife vacancies including Community	15	15	6
2022/23 Agency Expenditure*	12	12	4
Registered Nurse Vacancies	15	12	6
Raising Concerns	9	9	6
Violence and aggression against staff	6	6	3

*Also recorded in the FPC BAF

Assurances received

First line of assurance

Issue/report	Last review	Rating
IPQFR - sickness absence	27/10/22	
IPQFR - vacancies	27/10/22	
IPQFR - mandatory training	27/10/22	
IPQFR - Turnover	27/10/22	
IPQFR - Medical appraisals	27/10/22	
IPQFR - Non-medical appraisals	27/10/22	
IPQFR – Agency spend	27/10/22	
People Strategy Development	26/9/22	
Equality, Diversity, Inclusion	28/4/22	
Freedom to Speak Up	30/6/22	
Apprenticeship Levy	30/6/22	
Gender Pay Gap	> Dec 22	

Second line of assurance

Issue/report	Last review	Rating
Staff Survey 2021	7/4/22 (Board)	
Payroll internal audit 2021/22	21/4/22 (ARAC)	
Overpayments internal audit 2021/22	21/4/22 (ARAC)	
Workforce Race Equality Standard	27/10/22	
Workforce Disability Equality Standard	27/10/22	
Internal Audit – Medical Appraisals	> 2022/23	
Internal Audit – Payroll and Overpayments	> 2022/23	

Third line of assurance

Issue/report	Last review	Rating
Disability Confident (Employer Status) - reaccredited until 2025	Aug 22	
Defence Employers Recognition Scheme – Silver	June 22	
Employer With Heart Charter	Jan 22	
Miscarriage Association: Pregnancy Loss Pledges	Jan 22	
Rainbow Badge Phase 2 (LGBTQ+)	TBC	
Pathways to Excellence accreditation	Aug 22	

Gaps

- Sickness absence increased to 5.13% against target of 4%
- Mandatory training at 94.3% (95% target), Non-medical appraisals at 82.31% (90% target), Turnover at 10.89% (10% target)
- Overspending on agency (£3m+ by year end) (Sept 22)
- Forecast expired apprenticeship levy of £675k in 22/23
- FTSU app not yet rolled out, some gaps in lessons learned

- WRES identified affected staff report lower levels of confidence in provision of equal opportunities within the Trust, and higher levels of having experienced discrimination in the workplace
- WDES identified affected staff reported higher likelihood of being discriminated against
- WRES indicator suggested reduced likelihood of being appointed following shortlisting for BME staff

Mitigations

- Non-medical appraisals currently in review period and extended to September to reflect period
- Activity to address training detailed in deep dive (June 22)
- Planned focus on retention to address turnover in 22/23
- Levy spend up from £614k in 20/21 to £1.1m in 21/22
- Agency: Cost Control Group and agency control processes in place, Agency & Bank Card rate reviews underway, engaged in West Mids Medical Agency Project, agency forecast positions being revisited following implementation of NHSE/I requirements

- Actions arising from Overpayment internal audit (moderate assurance) all now completed and reported to ARAC
- Caution on indicator re appointment of shortlisted staff as does not account for international recruitment of nurses and midwives

Actions

- Deep dive on recruitment and retention of Band 5 nurses, midwives, HCSWs and AHPs to be brought back to December meeting
- Recruitment event planned for Oct 2022 to attract admin staff
- Three-month improvement trajectories for non-medical appraisals, though some deterioration shown in September (reported Oct 2022)
- Mandatory training – focus described in AAA report from People Development Group (Oct 2022)

- Programme of work being monitored through People Support Group relating to WRES/WDES actions, and will be reported to People Committee
- Further review of recruitment and selection process to identify potentially discriminatory practices – to be reported back to committee in context of changes already made
- Launch of inclusive mentoring pilot

- Applying for Disability Confident (Leader Status) – Dec 22

Overall level of assurance: **Amber**

Key: Strong assurance of actions to manage risks and issues | Risks being managed but gaps requiring further assurance | No or limited assurance on management of risks

DRAFT
PUBLIC TRUST BOARD AGENDA

02 FEBURARY 2023

MEETING	MEETING DATE	ITEM NO.	ITEM	GUEST	LEAD	AUTHOR	FORMAT	ACTION	TIME	DUR.
PUBLIC	2 Feb 2023	0					Verbal		10:00	00:00
PUBLIC	2 Feb 2023	1	Patient Story		Mo Hussain	Lisa Cummins	Enclosure	Note	10:00	00:10
PUBLIC	2 Feb 2023	2.1	Apologies for Absence		Chair		Verbal	Assurance	10:10	00:00
PUBLIC	2 Feb 2023	2.2	Confirmation of Quoracy		Chair		Verbal	Assurance	10:10	00:00
PUBLIC	2 Feb 2023	2.3	Declarations of Interest		Chair		Verbal	Assurance	10:10	00:00
PUBLIC	2 Feb 2023	3.1	Minutes of previous meeting 01 December 2022		Chair		Enclosure	Approve	10:10	00:00
PUBLIC	2 Feb 2023	3.2	Action Matrix		Chair		Enclosure	Assurance	10:10	00:00
PUBLIC	2 Feb 2023	3.3	Matters Arising		Chair		Verbal	Assurance	10:10	00:10
PUBLIC	2 Feb 2023	4	Chair's Report		Chair		Enclosure	Assurance	10:20	00:10
PUBLIC	2 Feb 2023	5	Chief Executive Officer Update		Andy Hardy		Enclosure	Assurance	10:30	00:15
PUBLIC	2 Feb 2023	6.1	Audit and Risk Assurance Commiteee Approved Minutes 20 October 2022		Afzal Ismail	David Walsh	Enclosure	Assurance	10:45	00:00
PUBLIC	2 Feb 2023	6.2	Audit and Risk Assurance Commiteee Approved Meeting Report 19 January 2023		Afzal Ismail	David Walsh	Enclosure	Assurance	10:45	00:00
PUBLIC	2 Feb 2023	6.3	People Committee Approved Minutes 26 September 2022		Jenny Mawby-Groom	David Walsh	Enclosure	Assurance	10:45	00:00
PUBLIC	2 Feb 2023	6.4	People Committee Approved Minutes 27 October 2022		Jenny Mawby-Groom	David Walsh	Enclosure	Assurance	10:45	00:00
PUBLIC	2 Feb 2023	6.5	People Committee Meeting Report 22 December 2022		Jenny Mawby-Groom	David Walsh	Enclosure	Assurance	10:45	00:00
PUBLIC	2 Feb 2023	6.6	Quality and Safety Committee Appproved Minutes 24 November 2022		Carole Mills	David Walsh	Enclosure	Assurance	10:45	00:00
PUBLIC	2 Feb 2023	6.7	Quality and Safety Committee Meeting Report 26 January 2023		Carole Mills	David Walsh	Enclosure	Assurance	10:45	00:00
PUBLIC	2 Feb 2023	6.8	Finance and Performance Committee Approved Minutes 24 November 2022		Jerry Gould	David Walsh	Enclosure	Assurance	10:45	00:05
PUBLIC	2 Feb 2023	6.9	Finance and Performance Committee Meeting Report 26 January 2023		Jerry Gould	David Walsh	Enclosure	Assurance	10:50	00:00
PUBLIC	2 Feb 2023	7	Patient Experience and Engagement Report		Mo Hussain	Hayley Best	Enclosure	Assurance	10:50	00:10
PUBLIC	2 Feb 2023	7.5	BREAK - if meeting is longer than 2 hours				Verbal		11:00	00:10
PUBLIC	2 Feb 2023	8	Integrated Quality, Performance and Finance Report • Operations (Gaby Harris) • Quality (Mo Hussain) • Finance (Susan Rollason) • Workforce (Donna Griffiths)		Kiran Patel	Daniel Hayes/Julie Molloy / Christopher Clark	Enclosure	Assurance	11:10	00:15
PUBLIC	2 Feb 2023	9	Theatres ODP	Lacey Bennett	Gaby Harris	Lacey Bennett	Enclosure	Approve	11:25	00:15
PUBLIC	2 Feb 2023	10	Safeguarding Adults & Children Bi-Annual Report		Tracey Brigstock	Lisa Pratley	Enclosure	Assurance	11:40	00:10
PUBLIC	2 Feb 2023	11	Freedom to Speak Up Guardian		Mo Hussain	Lorna Shaw	Enclosure	Assurance	11:50	00:10
PUBLIC	2 Feb 2023	12	Patient Led Assessments of the Care Environment (PLACE) Annual Report		Mo Hussain	Hayley Best	Enclosure	Assurance	12:00	00:10
PUBLIC	2 Feb 2023	13	Update on Digital Strategy	James Matthews	Mo Hussain	James Matthews	Enclosure	Assurance	12:10	00:05
PUBLIC	2 Feb 2023	14	Guardian of Safe Working Hours Report		Kiran Patel	Andreas Ruhnke	Enclosure	Assurance	12:15	00:10
PUBLIC	2 Feb 2023	15	Medicines Optimisation Committee Annual Report 2022-23		Kiran Patel	Mark Easter	Enclosure	Assurance	12:25	00:10
PUBLIC	2 Feb 2023	16	Draft Board agendas		Chair	Corporate Affairs	Enclosure	Note	12:35	00:00
PUBLIC	2 Feb 2023	17	Meeting Reflections		Char		Verbal	Discuss	12:35	00:05
PUBLIC	2 Feb 2023	18	Questions from the public		Chair		Enclosure	Note	12:40	00:05
PUBLIC	2 Feb 2023	18.5	LUNCH BREAK				Verbal		12:45	00:30