University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD
HELD AT 10:00 AM ON THURSDAY 6 OCTOBER 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.	Staff Story – Pathway to Excellence Guests: Lisa Dunn, Anna Steward & Michelle Hartanto	T Brigstock	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 04 August 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.	People Committee 6.1 People Committee Approved Minutes 30 June 2022 6.2 Meeting Report 26 September 2022	J Mawby-Groom	Enclosure	As	10 mins
	Quality and Safety Committee: 6.3 Approved Minutes 28 July 2022 6.4 Meeting Report 29 September 2022	C Mills			
	Finance and Performance Committee: 6.5 Approved Minutes 25 August 2022 6.6 Meeting Report 29 September 2022	J Gould			
	6.7 Board Committee Annual Reports 2021/22	A Ismail			5 mins
7.	Board Assurance Framework	D Walsh	Enclosure	N	5 mins
8.	Integrated Quality, Performance and Finance Report a. Operations b. Quality c. Finance d. Workforce	K Patel G Harris M Hussain S Rollason D Griffiths	Enclosure	N	15 mins
BREAK 11:15 – 11:20					
9.	Patient Safety Incident Response Framework	A Hardy	Enclosure	Ap	5 mins
10.	Operational Activity Update	G Harris	Enclosure	N	10 mins

	Item	Lead	Format	Action	Duration
11.	Winter Plan 2022-23	G Harris	Enclosure	Ap	10 mins
12.	Critical Care ODP Guest: Lacey Bennett	Gaby Harris	Enclosure	Ap	15 mins
13.	Patient Experience and Engagement Report 2022-23	M Hussain	Enclosure	N	10 mins
14.	Research and Development Annual Report 2022-21 Guest: Harpal Randeva	K Patel	Enclosure	N	10 mins
15.	Medical Appraisal and Revalidation Annual Board Report	K Patel	Enclosure	N	5 mins
16.	Annual Health, Safety, Fire and Security Annual Report 2021 - 2022 Guest: David Millage	T Brigstock	Enclosure	As	5 mins
17.	CQC Registration Report	M Hussain	Enclosure	Ap	5 mins
18.	Receipt of Human Tissue Authority (HTA) Licence	K Patel	Enclosure	N	10 mins
19.	Timetable of Board and Committee Meetings 2023-24	Chair	Enclosure	Ap	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.					
20.	Draft Board agendas	Chair	Enclosure	N	5 mins
21.	Meeting Reflections	Chair	Verbal	D	
22.	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 01 December 2022 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

MINUTES OF A PUBLIC MEETING OF THE TRUST BOARD OF UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST HELD ON 04 AUGUST 2022 AT 10:00AM IN ROOM 10009/10011 CLINICAL SCIENCES BUILDING, UNIVERSITY HOSPITAL, CLIFFORD BRIDGE ROAD, COVENTRY

MINUTE REFERENCE	DISCUSSION	ACTION

HTB 22/56 **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
Mo Hussain (MH), Chief Quality Officer
Jerry Gould (JG), Non-Executive Director
Jenny Mawby-Groom (JMG), Non-Executive Director
Kiran Patel (KP), Chief Medical Officer

HTB 22/57 **IN ATTENDANCE**

Daisy Benson (DB), Chief of Staff
Antony Hobbs (AHo), Director of Operational Finance *(representing SR)*
Alex Johnson (AJ), Minutes
Lynda Scott (LS), Director of Marketing and Communications
Lorna Shaw (LSh), Freedom to Speak Up Guardian *(for item HTB 22/77)*
David Walsh (DW), Director of Corporate Affairs

HTB 22/58 **PATIENT STORY**

An audio recording of the patient story was played. The patient, Rosemary, summarised her experience of the cataract surgery, which she had chosen to have at UHCW. Her story included her thoughts around pre-operative processes. She noted that there had been a lack of information and inadequate communications provided to her regarding surgery waiting times, the process for pre-operative assessment could have been undertaken via the telephone and the she gave details of some logistical challenges she had experienced during the Covid PCR testing process.

Rosemary went on to commend the communications and staffing at St Cross on the day of her surgery, where she experienced exceptional care, which was entirely patient centred, with great communications from all staff.

Rosemary conveyed that she felt there were lessons that could be learned by the Trust from her experience. For example, improved verbal and written communication to patients, use of patient feedback to enhance quality of care and provision of services and to ensure that timescales for surgery were provided to patients.

Rosemary commended the nurse at St Cross who was particularly helpful in managing collection arrangements for Rosemary after surgery.

MH summarised that Rosemary was an individual who already had good knowledge of UHCW services, as she held a Patient Partner role and was a member of PSEC (Patient Safety and Effectiveness Committee). He confirmed that the issues raised in relation to communications, telephone pre-operative assessment and waiting list/scheduling information would be explored further through the Quality Improvement meetings (QIPS). Overall, it was felt that Rosemary had provided a balanced view on her experience and gave both positive opinions and suggested areas for improvement.

SM asked about the status of the waiting list scheduling tool which had been developed at UHCW. GH confirmed that the tool was in the process of being rolled out across all groups and that ophthalmology was next in the roll out programme.

AH referred to Rosemary's points on the Covid PCR testing, where she had been asked to undertake the test in her vehicle and had queried how the process would have worked if public transport had been used to get to the UHCW site. TB advised that this matter would be reviewed as part of the pre-operative process and considerations would be given to ways in which the testing could be carried out without patients coming on to the site for one single reason. This was also linked to the Trust's net zero targets.

SM thanked Rosemary for her story and asked to be kept informed of any developments in relation to the scheduling tool and Covid testing.

The Trust Board **NOTED** the patient story.

HTB 22/59 APOLOGIES FOR ABSENCE

Afzal Ismail (AI), Non-Executive Director
Carole Mills (CM), Non-Executive Director
Gavin Perkins (GP), Non- Executive Director
Susan Rollason (SR), Chief Finance Officer

HTB 22/60 CONFIRMATION OF QUORACY

The meeting was declared quorate.

HTB 22/61 DECLARATIONS OF INTEREST

There were no declarations of interest.

HTB 22/62 MINUTES OF THE LAST PUBLIC TRUST BOARD MEETING HELD ON 9 JUNE 2022

DG referred to page 5 of the minutes (HTB 22/38 – Assurance Reports, People Committee). The minute referenced a report released by the

Department of Health and Social Care (DHSC) into management standards. DG clarified that the report discussed had related to a leadership review, rather than management standards. The minute and associated action on the action matrix should be updated to reflect this.

With the exception of the amendment above, the minutes of the Public Trust Board meeting held on 9 June 2022 were **APPROVED**.

HTB 22/63 ACTION MATRIX

The following updates were provided:

- HTB 22/50 – declarations of interest actions were in progress and further updates would be provided in due course.
- HTB 22/38 – action to be updated to reflect that the DHSC report was related to a leadership review (not management standards).
- HTB 22/03 – MH confirmed that he had discussed raising awareness around the bowel screening programme with Rachael Chapman, Public Health Consultant and Lydia Fresco, Consultant Oncologist. Both were keen to be involved and further discussions would be scheduled in order to progress this. The action could be closed on the action matrix.
- HTB 22/36 – there were now a series of actions underway in relation to deputisation arrangements for the ICB/ICS and the action could be closed on the action matrix.
- HTB 22/41 – JR confirmed that she had discussed ways in which to increase visibility of Non-Executive Directors with LS/DW and a programme of work would be put in place. The action could now be closed.

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

HTB 22/64 CHAIR'S REPORT

SM referred to the unusual and historical event of UHCW being awarded Freedom of the City and she thanked Coventry City Council for this great honour.

SM acknowledged the continued operational pressures that faced the trust and had been exacerbated by the extreme weather conditions of late. She paid tribute to staff who continued to provide care in those difficult conditions and encouraged them to ensure they took their annual leave.

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

HTB 22/65 CHIEF EXECUTIVE OFFICER REPORT

AH drew the Board's attention to the following key highlights:

- A plaque would be unveiled at UHCW and St Cross to commemorate the award of the Freedom of the City. Event details would be communicated in due course;

- AH attended an event to thank Coventry Hospitals Charity for their donation to the new robot. He noted that the Charity had raised over £11m for the Trust since the 1970s.
- UHCW hosted a visit by colleagues from Worcester in relation to improvement methodologies. UHCW would be working in partnership with the Virginia Mason Institute (VMI) to provide training to Worcester. Gary Kaplan, Chief Executive of the VMI, was scheduled to visit UHCW on 30 September and an invitation would be sent to the Board for this event.
- AH recognised the good work undertaken by GH/TB in relation to hospital only discharge.

AH referred the Board the consultant appointments for ratification and also recognised those consultants that had recently retired. He particularly noted the fabulous contribution Ramesh Patel had made to the Trust over the years.

The Board **RECEIVED ASSURANCE** from the report and **RATIFIED** the consultant appointments.

ACTION: letter to be sent to Coventry Hospitals Charity to thank them for the support they had provided to the Trust. **SM**

HTB 22/66 ASSURANCE REPORTS

Audit and Risk Assurance Committee (ARAC)

The Trust Board **RECEIVED ASSURANCE** from the approved minutes of ARAC held on 21 April 2022.

People Committee

JMG advised that the Committee was trialling the new “alert, advise, assure” reporting format and that it was working well to date. She drew the Board’s attention to one alert raised at the June People Committee in relation to an increase in use of agency staff and further information had been requested on this. JG also noted that an improvement had been seen in the rate of medical and non-medical appraisals.

The Trust Board **RECEIVED ASSURANCE** from the People Committee Meeting minutes of 28 April and meeting report of 30 June 2022.

Quality and Safety Committee (QSC)

In the absence of CM, MH summarised that QSC had received a number of assurances around the maternity safety report and Ockenden action plan. MH added that work was underway on the development of the quality strategy and this had also been discussed at QSC.

The Trust Board **RECEIVED ASSURANCE** from the QSC minutes of 26 May and meeting report of 28 July 2022.

Finance, Resources and Performance Committee (FRPC)

As outlined in the meeting report of 30 June, JG confirmed that the FRPC had discussed in detail the month 2 financial position, which included the deficit status of the Trust, year-end forecast, waste reduction position, potential risks around Elective Recovery Fund (ERF) claw back and the Trust's position against the 104% performance target. JG confirmed that the Committee had requested more information to be presented within the integrated quality, performance and finance report, so that there could be better visibility of the risks. He added that there was also particular focus on agency cost and the capital position at FRPC.

JG informed the Board that he was involved in the Trust's "dragons den" events as an observer as well as the local waste reduction board meetings.

The Trust Board **RECEIVED ASSURANCE** from the minutes of the FRPC meeting held on 26 May and the meeting report of 30 June 2022.

HTB 22/67 BOARD ASSURANCE FRAMEWORK (BAF)

DW informed the Board that the BAF had been taken to the Board Committees. QSC had made some minor changes since the report was produced and those amendments were not yet reflected in the BAF report presented today. **ACTION:** Update BAF with amendments from QSC and circulate latest version to the Trust Board **DW**

DW referred to the content of the report and noted that the new format was working well. The risks were now directly owned by the appropriate Committees. The document was now very dynamic and risks could be updated with ease.

SM was pleased to see that the risk related to emergency department overcrowding and flow was reflected within the BAF, as it was a key issue that faced the Trust.

SM asked for an update on the status of the permanent mortuary capacity. KP informed the Board that the formal Human Tissue Authority (HTA) licence had been received earlier this week. Receipt of this licence reflected that the HTA was largely satisfied with mortuary provision at UHCW, however KP added that there was further work to do on permanent freezer capacity, particularly for bariatric patients. AH explained that options were being considered for extra fridge/freezer capacity at UHCW and/or St Cross.

DG added that the format of the BAF was particularly helpful as it allowed risks and associated actions to be reviewed in real time.

The Trust Board**:**

1) **RECEIVED** the BAF entries for 'Financial Stability' and 'Operational Performance' following consideration by the Finance and Performance Committee on 30 June 2022.

2) **RECEIVED** the BAF entries for 'Staff Wellbeing and Morale' and 'Workforce Supply' following consideration by the People Committee on 30 June 2022.
3) **RECEIVED** the BAF entries for 'Quality of Care and Patient Experience' and 'Service Stability' following consideration by the Quality and Risk Committee on 28 July 2022.
4) **CONSIDERED** and triangulated any additional assurances received during the Board meeting in the context of these documents.

HTB 22/68 CORPORATE RISKS REPORT

MH summarised the content of the report and particularly drew the Board's attention to risk 3834 (children with minor injuries in adult minor injury unit). He noted that that the risk had reduced and would be further considered at an upcoming Risk Committee. He added that work was underway on risk 2911 (raising concerns).

SM referred to risk 3810 (breast screening demand and capacity) and GH provided more information. She explained that the risk was live and that there were a number of actions underway to mitigate the concerns. Discussions were underway with commissioners at NHS England to ensure that the service could get back on track.

GH further explained that the gaps in the breast screening service were due to a shortage of sufficiently skilled staff to handle the volume of patients and that there was a balance in the workforce to be met to address this issue. The workforce shortage was a national issue. KP added that the pressures being experienced now were partly due to breast screening services being stood down during the pandemic. Some Trusts had considered an increase to the period of screening intervals, in order to provide additional capacity. However, KP assured that UHCW would not be taking this route, and aimed to continue to meet the national screening programme guidelines.

It was confirmed that AH and GH were providing targeted support to the breast screening team.

DG referred to risk 2279 (registered nursing vacancies) and noted that the registered nursing vacancy rate had improved recently. Consideration would now be given to whether the vacancy rate should be split for different roles (e.g. nursing, midwifery) as the vacancy position varied for the differing roles.

TB noted the importance of ensuring that risk 3816 (keeping CAMHS patients safe) was managed, both from a patient perspective but also in relation to pressures felt amongst relevant staff groups.

JG asked for an update on the position of the Dermatology service at UHCW. JR explained that there was system process review underway, led by Laura Nelson at the ICB. UHCW was a key stakeholder in that process, which aimed to establish the specification for the dermatology model in the community and "right-size" the service for Coventry. The review process was expected to conclude in March 2023 and once the specification was known, further discussion would be required on how

to proceed and whether UHCW was the right lead provider for the service.

The Trust Board:

- **RECEIVED ASSURANCE** from the Corporate Risks Report.
- **ACKNOWLEDGED** the challenges on the breast screening service and **ENDORSED** the actions being taken to address those issues.
- **NOTED** the changing position on nursing and midwifery vacancy rates and the need for continued monitoring.

The following items taken out of order on the agenda.

HTB 22/69 STRATEGIC DELIVERY BOARD (SDB) PROGRESS UPDATE

JR summarised the content of the report which outlined the business conducted at the SDB and progress made against the strategic delivery agenda.

JR noted that the SDB had been established for 12 months now and a review had taken place, the outputs of which were included in the report. As part of that review, a revised SDB structure had been developed and the structure chart was contained within the report.

Reflections and learnings from work already completed by the SDB, including the TUPE of staff during the MSK programme and Urgent Treatment Centre.

AH added that the work on development of St Cross site was beginning to take shape. The Rugby Board was in place and the second meeting was held last week. This led to a discussion around the strategy for Rugby and how the funding for development would become available.
ACTION: Schedule Rugby Development/Strategy for a future Board Strategy Workshop (per request from SM). **DW**

SM welcomed the report and noted that the governance structure diagram was particularly useful.

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

HTB 22/70 PATIENT SAFETY REPORT

MH introduced the item. The report was presented to QSC last month and contained information on actions and learnings around serious incidents (SI), never events and national patient safety alerts (NPSA).

MH reported that there had been an increased focus on pressure ulcers and falls and that a Kaizen event had been held in relation to those areas. As an outcome of that improvement work, there would be some functionality built into the EPR system which would help ensure a more consistent approach to falls across the Trust.

MH informed the Board that there had been two never events recorded this financial year, the details of which were presented within the report, along with learnings and associated actions.

The Trust Board **REVIEWED** and **DISCUSSED** the content of the report. JMG stated that she had attended the most recent QSC and that it had been helpful to see the data presented in the new format. SM agreed that the format was useful and that it enhanced the overall governance. The issues around pressure ulcers and falls were **NOTED** and the increased focus on these areas was welcomed.

Break.

HTB 22/71 INTEGRATED QUALITY, PERFORMANCE AND FINANCE REPORT

KP introduced the item and informed the Board of the current key areas of focus. There continued to be sustained pressure in non-elective care services, with the Emergency Department particularly challenged and busy. The demand for elective care was also high and there had been increased focus in recent months to reduce the RTT (referral to treatment) waiting times, specifically the 104 and 78 week waits.

KP drew the Board's attention to the executive summary of the report, which provided information on cancer and diagnostic waits performance. He also noted the rise in the number of patients with a long length of stay and provided assurance that cross system working was underway to address this. A number of key performance indicators had been identified as having a statistically significant variation in their trends and that the details were provided under Appendix B of the report.

Operational Performance

GH provided the operational performance headlines. She explained that the long bank holiday weekend in June and increased levels of Covid had led to a particularly challenged position in urgent and emergency care. Although most Covid cases seen at the Trust in the reporting period were incidental, i.e. patients attending the Trust for other reasons and there had been a minimal impact upon critical care during the recent Covid wave, it had still led to a significant operational challenge because of the infection control implications.

GH explained that there had been a concentrated focus on ambulance handover times. There had been an improvement in the 60 minute handover target, however this area remained a priority area for the Trust. She added that the emergency 4-hour wait standard had now been replaced with a 12-hour standard, however the Trust continued to monitor the 4-hour waits, as the data helped provide insight to the overall position in urgent and emergency care. Achievement of the 4-hour target continued to be a struggle.

GH noted the operational impact of long length of stay patients and reiterated the importance of system partners working together to address the matter. She confirmed that cancer performance was high

on the Trust's agenda, with particular focus on timeliness of patient care. The Trust's cancer performance against the various standards was provided, along with the incomplete RTT position and GH noted that the Trust was now moving its emphasis from 104 week waits to that of 78 weeks and 52 weeks.

SM referred to the Trust's improvement work which was underway with the KPO team on urgent and emergency care and hospital flow. She asked if there were any early outcomes of the programme of work for the Board to be made aware of.

In response, GH confirmed that a number of Kaizen events had taken place, led by clinical and non-clinical senior management teams within the organisation. Early indications showed that there was good engagement and enthusiasm for the improvement work and a number of areas had been identified for attention. The impact of the improvement work should become more visible over the next few months.

DG added that she was involved in improvement work with the Women and Children's group to review triage processes and a Kaizen event was scheduled to take place on this. TB also noted that improvement work was underway in relation to board rounds and working more closely with care homes to ensure appropriate packages of care were in place when required.

Quality and Safety

MH drew the Board's attention to the quality and safety headlines contained within the report and specifically noted the 100% achievement for the target in turnaround of complaints letters. There was one reported RIDDOR incident in June. There was also one never event reported in June and this would undergo the usual governance process. A deep dive was underway with the Quality and Safety Committee in relation to urgent clinical letters sent within 7 days.

Finance

AHo informed the Board that that the financial landscape for the Trust remained a challenge. The financial plan had been based on zero Covid, however the operational challenges still presented by Covid were having an ongoing impact.

AHo gave the overview position as at month 3, which showed a year to date position of £6.7m deficit compared to the £1.8m deficit plan, an adverse variance of £4.9 from the plan.

The reasons for the position were related to the Trust being behind target on its waste reduction programme, increased pressure around high cost drugs and devices and the ongoing operational pressures within urgent and emergency care.

AHo explained that the reported financial position assumed no Elective Recovery Fund (ERF) claw back to month 4, however formal confirmation from the national team was yet to be received on this matter and therefore there was still a level of risk for the Board to be aware of.

The year to date agency spend was £0.9m over target, however the forecast trajectory showed a reducing run-rate and AHo expressed a level of confidence inthe Trust's ability to meet the year-end target which had now been set by the regional team at £20.8m.

In response to a query from SM regarding the waste reduction programme and the support Deloitte was providing, AHo confirmed that the programme was going well, with a high level of engagement with the clinical groups and several schemes had been identified. The next step was to progress those schemes and ascertain whether they were achievable (whether cost could be removed) and that was work in progress.

Workforce

DG summarised the key points from the workforce element of the report. She reinforced AHo's earlier comments in relation to agency utilisation for which had now begun to reduce. Much of the high agency cost earlier in the year had been driven by the need to cover short term absences due to sickness and the higher cost per shift.

In relation to the Trust's vacancy position, DG confirmed that this had increased and returned to the 2019/20 baseline.

The People Committee would explore agency utilisation in more detail and would also undertake a deep dive on nursing, midwifery, AHP (Allied Health Professional) and HCA (Health Care Assistant) vacancies.

DG provided an overview of staff absence, in which there had been an increase, largely due to Covid. The report also outlined the wellbeing and psychological services available to staff.

SM referred to the breakdown of data provided on staff leaving the Trust and asked whether the reasons for leaving were recorded. DG confirmed that although the mechanism was in place for this information to be recorded, it was not always completed by the manager and there was some work underway to address that.

In relation to nursing staff who were intending to retire, DG explained that the Trust had utilised the national retention toolkit, which provided guidance on retaining staff, perhaps in a different capacity to their existing role. TB further explained that the national retention toolkit encouraged exploration of alternative, more creative ways of working, in order that the skillset of the retiree was not lost. For example, putting mechanisms in place for senior nurses to provide support or training to more junior nurses.

In response to a query from MH, DG confirmed that there had been some challenges around completion and tracking of exit interviews and that several approaches had been tried to date. DG was unable to provide specific figures around compliance but confirmed that this area was being further explored. MH suggested that the completion of exit interviews should be encouraged and could be tied to the Trust value of openness.

Although it was not contained within the report, DG noted that the national pay award had been announced and steps were underway to prepare for any potential industrial action.

KP stated that there had been an increase in staff taking their NHS pension and it was confirmed that tracking of staff retiring and returning was in place.

The Board **REVIEWED** and **NOTED** the content of the report, and acknowledged the ongoing work to address areas of concern.

HTB 22/72 MORTALITY UPDATE

KP provided the key points from the report. He made reference to the TARN (Trauma Audit and Research Network) outlier status, as detailed under item 8.2 of the report and the mortality alert in relation to brain injury. The Trust had been subject to an external review and a report had now been received on this alert. KP confirmed positive news in that the Trust management was not at fault and the alert had now been closed.

KP informed the Board that the Trust was at risk of becoming an outlier for stroke thrombectomy, due to the level of service requirement not being met. He confirmed that an action plan was in place to address that issue.

An area that required close monitoring was in relation to the outcome of a report from the Royal College of Emergency Medicine, in which they had reported an increase in mortality rates where patients were waiting in Accident and Emergency for longer than 6 hours. Nationally, there had been 1000 excess deaths due to the lengthy waiting times.

Close monitoring of Hospital Standardised Mortality Ratio (HSMR) data was in place. The most recent value available was 115 (as at March 2022). KP advised that he had discussed the HSMR status with other medical directors, external to UHCW and a combination of acuity and complexity of cases, along with increased demand in some areas was believed to be contributing to the HSMR value.

KP informed the Board of a number of other areas of focus for the Trust which included:

- Increased medical examiner provision (over 7 days);
- Development of a policy where parents could take babies home after death, if they wished to do so;
- Actions around the mortality review process, particularly cases that were over 12 months old;

The Trust Board acknowledged the challenges faced in relation to delays in the emergency department and increased complexity of activity in the system. The Board **RECEIVED ASSURANCE** from the content of the report and the actions underway.

HTB 22/73 MEDICAL EDUCATION REPORT

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

- Financial implications of the reduced tariff from HEEWM (Health Education England - West Midlands) and the associated pressure on delivery;
- Action plan in place for improvements in Neurology;
- The work underway to ensure that all national guidelines were followed and high ratings against all standards;
- The Trust's surgical training centre hosted a visit from the Welsh Government;
- Surgical Training Centre re-accreditation from the Royal College of Surgeons;
- New projects and initiatives, particularly that related to formalisation of the partnership with the American University of Antigua (AUA) which would require a visit from members of UHCW senior leadership team to the AUA to cement the relationship and sign the contract.

In response to a query from SM, KP confirmed that the challenges within the neurology team had been related to various aspects of the training provision and that the action plan would now address those issues.

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

HTB 22/74 GUARDIAN OF SAFE WORKING HOURS REPORT

KP summarised the content of the report. He explained that the Trust was proactively working to guard against overwork of JDTs (junior doctors in training). This included work around ensuring that they were safely rostered, with any gaps in rosters filled and a focus on provision of SPA (Supporting Programmed Activity) time. KP noted that it was positive that there had been a reduction in the number of exception reports.

A discussion followed on the national status and concerns around junior doctor pay. DG explained that this group of staff was not covered by the NHS medical and dental pay review and instead was subject to an annual pay deal, through which they had recently been offered a 2% increase. The group of staff may be formally balloted for industrial action and DG assured that she was in discussions with staff side colleagues and the Medical Negotiating Committee (MNC) on this matter. DG added that there were currently approximately 386 junior (post graduate) doctors in place at UHCW, 150 of whom had already been in place at UHCW prior to the recent rotation. She assured that there were a very small number of unfilled gaps in the rotas.

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

HTB 22/75 MEDICAL REVALIDATION AND APPRAISAL ANNUAL REPORT

KP introduced the item and informed the Board that the medical appraisal rate at UHCW was 83% and that the governance for

revalidation and appraisals was now formally taken through the Responsible Officer Advisory Group.

The Trust Board **RECEIVED** and **APPROVED** the annual report. The Board **APPROVED** the Statement of Compliance confirming that the Trust, as a Designated Body was compliant with regulations, and appreciated that would be shared with the Higher Level Responsible Officer.

HTB 22/76 **SAFEGUARDING ADULTS AND CHILDREN BI-ANNUAL REPORT**

TB summarised the content of the report and drew the Board's attention to the key points.

The main reason for referrals from UHCW to Children's Social Care was for the safeguarding category of "emotional abuse". The trend for referrals for adolescents in mental health crisis continued to be a common theme at the Trust. For referrals to adult social care, there had been an increase in those categorised as "self-neglect" and there had been an increase in domestic abuse, which was a trend being seen nationally.

TB provided assurance around training compliance at UHCW which was within the 90% target, with the exception of safeguarding adults level 3 and some targeted work was underway to address that particular compliance rate.

In relation to Serious Case Reviews, TB confirmed that UHCW had contributed to two cases for investigation. For one of those cases, there were no learnings or omissions identified for UHCW. For the second case, there was some opportunity for learning that was identified in relation to patients with a learning disability and actions were underway to ensure those learnings were addressed.

TB informed the Board that the implementation of the Liberty Protection Safeguards (LPS) was in progress and that there were plans in place to proceed with the recruitment required to implement LPS at UHCW.

JR added that children's social services in Coventry had recently been through an inspection and the outcome was expected in the near future. JR also noted that there was a multi-agency approach in place to tackle the issues around increased domestic violence. UHCW was actively involved and working with partners from the police and Coventry City Council on that matter.

SM referred to the ongoing challenge of mental health amongst adolescents and she asked for further information on the status. TB confirmed that demand in this area continued to increase. The responsiveness of system partners, specifically that of Coventry and Warwickshire Partnership Trust was fairly strong and there were appropriate processes in place, however service provision and placement availability was the key challenge.

The Board **RECEIVED ASSURANCE** in relation to the safeguarding activity and management in place at UHCW.

HTB 22/77 FREEDOM TO SPEAK UP / RAISING CONCERNS BI-ANNUAL REPORT

LSh joined the meeting and summarised the content of the report. For the reporting period (January – June 2022) there were 20 concerns raised. 9 of those were formal concerns and 8 were now closed. The one remaining open concern had been open since May.

The priorities for the next 6 months included the preparations for Freedom to Speak Up Month which was scheduled to take place in October, and this would be aligned with the launch of the Speak Up App and potentially a staff survey.

DG stated that she would put LSh in touch with the appropriate members of her team who could provide the appropriate support in relation to the survey.

In response to a query from DG in relation to how the number of concerns was calculated, LSh confirmed that national guidance was to document the number of "contacts" made with the guardian. There were 20 contacts made in the most recent reporting period and from those, 17 concerns were raised.

SM referred to the reason why the Freedom to Speak Up framework was initially developed, which was to ensure there was a mechanism in place for individuals to raise concerns in relation to matters such as patient care, safety and wellbeing, potential malpractice or wrongdoing. SM asked LSh whether she felt that the kinds of issues being raised were aligned to these areas.

In response, LSh stated that she felt that the Freedom to Speak Up framework was not being used entirely for the purpose it was set up for. Management and HR related concerns were the main issues raised to LSh and she noted that there was some education required for staff to ensure they fully understood what the Freedom to Speak Up framework was set up for and the matters it aimed to address.

Nationally, it was becoming clear that Freedom to Speak Up was not being utilised to highlight concerns around patient safety and quality, staff safety or malpractice. The training that had been developed in association with Health Education England and the launch of the Freedom to Speak Up app were two tools that would help address the matter.

DG added that the Freedom to Speak Up remit and the types of issues being raised had been discussed at People committee. The discussion included education of staff and appropriate signposting, to ensure staff concerns were directed to the right place, dependent upon their specific issue. LSh and the Freedom to Speak Up Ambassadors had worked closely with the HR team in that respect and DG thanked them for their support.

SM noted that she particularly welcomed the "speak up, listen up, follow up" approach to the training and noted that there was a collective responsibility to tackle issues related to patient safety and quality of care, which could also be linked to safeguarding. DG suggested that

Freedom to Speak Up month should be utilised to promote all routes of speaking up that were available across the organisation. SM thanked LSh for her report and LSh left the meeting.

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

HTB 22/78 COMPLAINTS AND PATIENT ADVICE AND LIAISON SERVICE (PALS) ANNUAL REPORT

SM confirmed that the item had been fully discussed at a recent extraordinary Trust Board and the content was **NOTED**.

HTB 22/79 FUTURE BOARD AGENDAS

SM noted that the work undertaken on performance reporting, the BAF and the Corporate Risk Report had been beneficial and had led to the Board agendas being streamlined, and contributed to more effective governance overall.

DG suggested that item 8 (Employee Relations) on the December Trust Board agenda should be removed and taken through the People Committee instead. This was **AGREED** by the Board.

SM asked for Rugby Development to be scheduled for a future Board Strategy Workshop. She also suggested that consideration should be given to alignment of items that were scheduled for the Strategic Delivery Board that may need future discussion at Trust Board, as this would help with forward planning.

JG noted that item 6.5 (FRPC Minutes 28 July 2022) could be removed from the next Board agenda, as that FRPC meeting did not take place.

ACTION: Update Trust Board and Board Strategic Workshop agendas based on points made above. **DW**

HTB 22/80 MEETING REFLECTIONS

SM summarised that useful discussions took place on a variety of topics. It had been particularly beneficial to review the BAF and to have received information on safeguarding, Freedom to Speak Up, risks and performance. She also acknowledged the ongoing operational pressures within the organisation.

HTB 22/81 QUESTIONS FROM MEMBERS OF THE PUBLIC WHICH RELATE TO MATTERS ON THE AGENDA

There were no questions raised.

HTB 22/82 DATE AND TIME OF NEXT MEETING

The next meeting will take place on Thursday 6 October August 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
09/06/2022	Register of Interests, Gifts and Hospitality	HTB 22/50	Ensure staff defined as key decision makers, who have withdrawn consent to have their declarations published on the register, are taken through the appropriate governance processes. Register to be reproduced and resubmitted to Trust Board in due course to include declarations previously omitted due to confidentiality requests	DW	06-Oct-22	30 Sept – action closed. Where applicable, key decision makers who had previously withheld consent to publish their declarations have now provided consent to publish. The DOI register for 2021/22 has been updated to reflect this and the latest version can be found on the UHCW website.
04/08/2022	Chief Executive Officer's report	HTB 22/65	Letter to be sent to Coventry Hospitals Charity to thank them for the support they had provided to the Trust.	SM/DW	06-Oct-22	Completed in August 2022
06/10/2022	Board Assurance Framework	HTB 22/67	Relating to circulation of updated BAF	DW	06-Oct-22	Completed in August 2022
06/10/2022	Strategic Delivery Board Update	HTB 22/69	Schedule Rugby Development/Strategy for a future Board Strategy Workshop	DW	06-Oct-22	Upcoming dates filled as per item on Board programme on agenda for today's public Board meeting - to be scheduled in consultation with Chair
06/10/2022	Future Board agendas	HTB 22/79	Updates to future Board agendas (removal of Employee Relations from December Board meetings)	DW	06/10/22	Complete - see item on future Board agendas

Deadline Key:	
	Not started
	In Progress
	Overdue
	Completed

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 6 OCTOBER 2022

Subject Title	Chair's Report
Executive Sponsor	Dame Stella Manzie, Chair
Author	Dame Stella Manzie, Chair
Attachment(s)	None
Recommendation(s)	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 4 August 2022. First may I welcome to the Board Janet Williamson (Non – Executive Director) formerly of the Care Quality Commission and Douglas Howat (Associate Non-Executive Director) from Coventry University, who joined the Board on 1st September. We are delighted to welcome them. They were able to participate in an externally facilitated Board workshop session on the day they started, on Mentoring for Inclusion. This focused on a number of issues about Equalities, Diversity and Inclusion.

Clearly the major national event which has taken place since the last Board meeting has been the sad death of Her Majesty the Queen on 8th September. The initiation of the national mourning period until 22nd September with the associated protocols, and the creation of the Bank Holiday on the day of Her Majesty's funeral, created a number of operational implications for the Trust which the Chief Officer Team and many others responded to promptly and efficiently. The Chief Executive Officer and I both attended the Lord Mayor of Coventry's service of thanksgiving for the life of the Queen on Sunday 18th September. The Trust was honoured to have one of its senior nurses May Parsons take part in the funeral procession as part of the NHS delegation. I have written to May thanking her and congratulating her.

It has been the season of Annual General Meetings, so we have held the AGM for the Trust on 29th September and Andy Hardy and I both attended the AGM of the Friends of the Hospital of St Cross earlier in the month where a number of volunteers received awards for their dedication and length of service.

As usual, Andy Hardy has kept myself and my fellow Non-Executive Directors fully updated on all the operational issues facing the Trust, and I have continued to join the regular regional health leaders update calls with Dale Bywater (NSHE/I Regional Director for the Midlands) where a major focus of attention has been ambulance turnaround and hospital and system "flow", subjects which are addressed on this agenda. I have also been undertaking my usual routines of update meetings with Chief Officers and with Lorna Shaw the Freedom to Speak Up Manager.

As colleagues and stakeholders will be aware our new -ish Organisational Strategy is called "More than a Hospital". It has an increasing emphasis on looking outwards and working across the system. An example of engagement with wider communities was the visit of myself and the Chief

Executive Officer to the British Organisation of People of Asian Origin, who had organised a meeting with key community and religious leaders in the Foleshill area of Coventry on the evening of 1st September. Ably supported by Director of Strategy Jamie Deas, we had very useful discussions with those attending the meeting, including being able to share with them the future creation of the Community Diagnostics Centre in the centre of Coventry which was received very warmly.

I have had the pleasure of acknowledging the hard work and commitment of members of staff who have been nominated for a World Class Colleague Award. The recipients of the award from me over the last couple of months have been a Healthcare Assistant and an MDT Facilitator for Cancer Services. I also had the pleasure of reviewing the nominations for two categories for the Outstanding Service and Care Awards (OSCAs) namely 'Leading the Way' and 'Supporting Learning' awards and am looking forward to attending the OSCAs on 7th October.

As well as my usual meetings with the Chief Executive Officer, I have also had 'catch up' meetings with various Chief Officers to keep me updated with what is happening operationally around the Trust, and I have met with Lorna Shaw, the Trust's Freedom to Speak Up Guardian.

I have chaired the Coventry and Warwickshire Pathology Services Stakeholder Board and I have met with members of the 'Hospital at Night' team to gain a better understanding of what usually happens 'out of hours'. I also undertook some mandatory training to ensure my compliance remained at 100%.

As named Board Health and Well–being Guardian I have met with Donna Griffiths (Chief People Officer) and Anna King (Health and Well-Being Lead) and attended the regional Health and Well-being Guardian Network meeting. Other meetings I have attended externally have included Chairs' meetings relating to the ICS and a planning meeting for the Coventry and Warwickshire Women's Network. I was part of an interview panel for the last Non-Executive Director recruited for the Coventry and Warwickshire ICS. The Board Vice–Chair Jerry Gould very kindly attended the Warwickshire County Council Health and Well-Being Board on my behalf when I could not do so. The ICS related Chairs meetings are for the chairs of the key health provider institutions relating to the ICS area. This is in addition to the Integrated Care Partnership meeting of which I am a member, the first meeting of which is due to take place on 13th October.

I alluded earlier in this report to the challenges of ambulance turnaround which is a symptom of the numbers of people "stranded" in the Trust and the volume of patients being brought to the Trust Once again I would like to take this opportunity to extend my gratitude to all staff members who are continuing to go 'above and beyond' for our patients and their families.

Dame Stella Manzie

PREVIOUS DISCUSSIONS HELD

Not applicable

KEY IMPLICATIONS	
Financial	Not relevant to this report
Patients 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. The World Class Colleague are a key part of recognition of our staff.
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 6 OCTOBER 2022

Subject Title	Chief Executive Officer Update
Executive Sponsor	Andrew Hardy, Chief Executive Officer
Author	Andrew Hardy, Chief Executive Officer
Attachment(s)	None
Recommendation(s)	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 August and September 2022.

Professor Andrew Hardy – Chief Executive Officer

I write this report as the country comes out of its national mourning following the sad death of Her Majesty Queen Elizabeth II. For all of us who are privileged to work in public service, the Queen represented the ultimate public servant. I hope that members of staff wishing to pay their respects to the Queen had the opportunity to light a candle and sign the books of condolence which were available at the Faith Centre at University Hospital and the Chapel of St Elizabeth at Rugby St Cross. I am also pleased that bedside TVs were made available free of charge on Monday 19th September to enable our patients to watch the funeral throughout the day. I would like to extend my sincere thanks to staff members who worked tirelessly to ensure high quality care was delivered to our patients and enabled the smooth running of services both on the day of the funeral (which was a public Bank Holiday) and beyond. This was a difficult time and I am proud of the way everyone has come together to support each other.

As usual, my internal commitments have included Board briefings (including those with our Chair and Non-Executive Directors); the Board Strategic Workshop; the Rugby Board; Medical Negotiating Committee; the monthly local VMI Trust Guiding Teams meetings; I joined the monthly Chief Officer Forum briefing sessions, my weekly discussion/update meeting in relation to Referral to Treatment Time (RTT) and Emergency Department (ED) and the Strategic Delivery Board. Other internal meetings I have attended include the elective recovery meetings; the Electronic Patient Record (EPR) Programme Board and regular update meetings; and the Quarterly Performance Review meetings with all the Groups; and I have carried out some Rounding sessions with UHCWi.

I have undertaken my regular staff Q&A sessions at both University Hospital and Rugby St Cross and have had Intro meetings with our newly appointed Non-Executive Directors (NEDs) - I would like to welcome Janet Williamson (NED) and Douglas Howat (Associate NED) who joined the Trust on 1st September. I also hosted an informal dinner with Stella Manzie (Chair) and the Non-Executive Directors and completed my mandatory training to ensure 100% compliance.

As part of my ongoing external engagement with key stakeholders I met with Harry Hayer (the Non-Executive Director allocated to the Integrated Care Board for Coventry). I also joined the Research and Development Stakeholder Committee. I also met with Simon Weldon (the Chief executive Officer at Kettering and Northampton NHS Trust) and took part in a valuable Executive to Executive meeting with Chief Officers from Worcestershire Acute Hospitals NHS Trust.

Turning to internal commitments I joined the Breast Screening and surgery follow-up meeting; attended the Innovation Update meeting and joined other Chief Officers for the COG Residential event. Other internal commitments have included regular EPR Updates from Mo Hussain (Chief Quality Officer); EPR Building and 'signage' Walkabouts; completion of the remaining appraisals for the Chief Officers; Rounding sessions with Neil Griffin (KPO Lead); I joined a meeting in relation to the CQC Inspection report for the BMI Meriden Hospital and joined an interview for the Ockenden review. Alongside Su Rollason (Chief Finance Officer) and Andy Smith (Head of PMO) I met with all the groups for the Star Chamber meetings to ensure financial spend is reviewed and kept within target as part of our strong focus on waste reduction.

Looking outward to community, myself and Stella Manzie (Chair) accepted an invitation to deliver a presentation on the Organisational Strategy to the British Organisation for People of Asian Origin in Coventry. This was a great opportunity to engage on our future plans and gain valuable feedback from our community members. Last month was also the Trust's Annual General Meeting, to which, our stakeholder partners were invited and I also attended the Friends of St Cross AGM.

As part of our commitment to being an international leader in healthcare the Trust had the pleasure of hosting a visit and speech by Dr Gary Kaplan (Senior Vice President of CommonSpirit Health and former Chief Executive of the Virginia Mason Institute) creator of Virginia Mason Production System. On the same theme, 'better never stops' I had the pleasure of meeting the latest cohort of staff undertaking the UHCW Leader course and nominating the recipients of the CEO 'Individual' and 'Team' OSCA awards.

Turning to media appearances I was interviewed by Bob Griffiths on his 'Feel Good Wednesday' programme on Coventry Hospital Radio; undertook a radio interview for CWR in relation to the newly opened Minor Injuries Unit and I was interviewed by Sky News about Cancer services.

I have been involved in wide range of other engagements which included meeting with colleagues from Healthwatch; meeting with Ruth Freeman from Myton Hospice; a speaker slot / presentation with Bernard Crumb at the EFMD event being hosted by University of Warwick along with the EiP Awards Dinner; recording a Podcast for Warwick Business School; I met with colleagues from University of Warwick at the Joint Academic Strategy Group; attended the Warwick Business School Global Advisory Board meeting and Dinner in London; the Coventry Health and Well-being Board; the Chairs and Chief Executives Network meeting in London and I also delivered a speech in London on "How will ICSs capture the benefits of data for their populations and patients?" I joined various on-line events including a System Leaders' Webinar on 'Winter Resilience Planning'; the NHS Approach to Improvement (Development Session); the UKHSA/NHS Providers Member Engagement Roundtable and the UEC Strategy System Reference Group which focussed on Emergency Care.

Working closely with partners makes up a significant amount of my time and as part of this I have had my regular 'catch up' / 1:1 meetings with Phil Johns, Glen Burley and Mel Coombes; the Coventry and Warwickshire Integrated Care Board meetings and the monthly Partnership Executive Group meetings. I also joined the Development Session for the Coventry and Warwickshire Integrated Care Board; the West Midlands Care Collaborative Commissioning Board and the System meeting with Phil Johns, Angela Brady and Consultants.

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) and I virtually joined the 'NHS Approach to Improvement' sessions.

My external commitments recently included the Extracare Development Committee.

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	
Victoria Jane Bower	Substantive Consultant Anaesthetist
Joy Chang	Substantive Consultant Oncologist in Breast
Jennifer Katherine Warren	Locum Consultant Intensivist

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

University Hospitals Coventry and Warwickshire NHS Trust

MINUTES OF THE MEETING OF THE PEOPLE COMMITTEE HELD AT 09:30 ON THURSDAY 30 JUNE 2022 AT UHCW CSB

MINUTE REFERENCE	DISCUSSION	ACTION

22/016 PRESENT

Jenny Mawby-Groom (JMG), Non-Executive Director - Chair
Donna Griffiths (DG), Chief People Officer
Carole Mills (CM), Non-Executive Director
Justine Richards (JR), Chief Strategy Officer

22/017 IN ATTENDANCE

Wendy Bowes (WB), Director of Workforce
Michelle Brookhouse (MB), Director of Organisational Development
Dan Pearce (DP), Head of People Development
David Walsh (DW), Director of Corporate Affairs
Jessica Mabbott (JM) Committee Officer – note taking

22/018 APOLOGIES FOR ABSENCE

Apologies were received from Afzal Ismail and Sudhesh Kumar (Non-Executive Directors)

22/019 CONFIRMATION OF QUORACY

The meeting was declared quorate.

22/020 DECLARATIONS OF INTEREST

No declarations of interest were made.

22/021 MINUTES OF THE PREVIOUS MEETING

MB confirmed she was not in attendance at the previous People Committee and asked if this could be removed from the minutes of the previous meeting. JMG agreed for this to be amended. The committee agreed that the minutes were an accurate record of the previous meeting.

22/022 ACTION MATRIX

DG explained that the action 'Integrated Quality, Performance and Finance Report / Workforce Performance Report' had been included

MINUTE REFERENCE	DISCUSSION	ACTION

within the Workforce element of IPQFR which was presented at the previous People Committee meeting on the 28 April 2022. JMG agreed the action had been completed and could be removed from the action matrix.

22/023 MATTERS ARISING

No matters arising.

22/024 WORKFORCE PERFORMANCE REPORT

The committee received a report from WB providing an update in relation to performance reporting within the Workforce area. It was highlighted that sickness absence had reduced from 6.31% in April to 5.31% in May. WB confirmed that this had been driven by a 1% decrease in covid infections. However, WB told the committee that this was to be treated with caution due to several significant events happening recently such as the jubilee celebrations and the removal of mandatory mask wearing in non-clinical areas which could lead to an increase in covid infection.

WB highlighted that if there were covid outbreaks in particular areas, masks would be reintroduced locally in those areas for a short period of time. DG explained that the sickness absence report was dated from the month of May and DG expects there to be an increase in covid related absence in future reports. DG confirmed that staff would had access to wellbeing programmes, fast track services etc to support staff wellbeing.

WB emphasised to the committee that business partners for each area were aware of their sickness absence rates and individual sickness cases were being closely tracked. DG also stated that there was to be expected changes to national guidance around covid sick pay.

WB provided an update on vacancy rates, confirming that vacancies had fallen from 6.19% to 5.98% during the same period. JMG agreed that the recruitment pipeline for some areas was looking particularly good. DG highlighted that for Band 5 registered Nurses she anticipated a 14% vacancy rate in this area by the end of November which was a significant shift compared to 18 months ago. DG also explained that within Midwifery a 12% vacancy rate was expected by the end of October which DG acknowledged as significant progress.

WB confirmed that there had been a slight decrease in mandatory training compliance from 93.27% to 93.09%, with this being monitored through Group Accountability Reviews and Quarterly Performance Reviews. Meanwhile, WB reported that there were improvements relating to appraisals, with 81.74% completed in non-medical roles while 88.83% of medical appraisals had been completed. WB clarified to the committee that this was being monitored through the trust performance framework.

JR queried if there was an update on the trust wide schemes regarding agency utilisation. DG confirmed a report at FPC usually

MINUTE REFERENCE	DISCUSSION	ACTION
	discusses this. JMG questioned whether a deeper dive may be needed for this especially regarding the people element of it. DG agreed she was happy for a deeper dive into agency utilisation to take place.	DG
	Committee received **ASSURANCE** from the report.	
22/025	**FREEDOM TO SPEAK UP / RAISING CONCERNS Bi-ANNUAL REPORT**	
	The committee received a report from LS providing an update regarding continuing to raise the profile of Freedom to Speak Up (FTSU), training and Raising Concerns Activity. The report also provided a summary analysis of trends from themes raised and priorities for the next six months.	
	LS highlighted that the freedom to speak up ambassadors did not get a lot of activity and it was important to keep the ambassadors motivated and interested in the role. Currently ambassadors, once trained, provided support to staff during disciplinary hearings. LS would be creating posters for the trust which would clarify the role of an ambassador and the role of a Guardian. It was expected that this would generate interest and activity.	
	LS elaborated on the fact that staff come to her with HR related queries and staff needed support with accessing materials such as policies and encouragement to had conversations with their managers.	
	LS also provided an update on the deployment of the UHCW speak up app. It was confirmed that the app would be a one-step download process which would provide easier access for contactors and ISS, which would enable a wider reach. JMG queried how this would ensure only workers had access to the app.	
	LS confirmed that Communications may not advertise the app on the website, ensuring that only staff were aware of the app. DG noted that there was not a process to stop the public using the app, however this would be monitored to ensure the app was used appropriately. DG questioned when the app would be launched, in which LS indicated to the committee that the app would be launched on the last week of July. However, this was still to be confirmed.	
	LS ended her report by confirming that when she next presents the data within the report, she would also be providing context including historical comparisons to make the data more meaningful.	
	The committee received **ASSURANCE** from the report.	
22/026	**CORPORATE RISKS REPORT**	
	The committee received a report from LC. It was reported that there were two open corporate risks for which the People Committee was the assigned responsible committee. Both risks were currently	

MINUTE REFERENCE	DISCUSSION	ACTION

graded as moderate and were within their next review date. Details of these risks were included in the report. There were two new corporate risks awaiting approval at the next Risk Committee in August 2022:

- Risk ID 4055: Parking revoked at Paybody / COCHC
- Risk ID 4090: 22/23 Agency Expenditure

The risk management policy was under review (moving to a risk management strategy) and as such the new strategy would support a review of the current risk register content. People Committee was asked to review all open risks under the portfolio with focus on any 'HIGH' risks (scored 15 or above) identified.

LC confirmed that there was a significant reduction in high risks. DG commented that the Registered Nurse and Registered Midwife Vacancies risk should be split into two separate risks due to how these were measured. It was considered that Tracey Brigstock would be supportive of this. **LC**

The committee received **ASSURANCE** from the report.

22/027 **APPRENTICESHIP LEVY REPORT**

MB provided an update on spend against the Apprenticeship Levy. The key points to note were that UHCW's Levy balance was currently £3,799,990 and the Levy spend had increased.

The Levy spend for the current financial year (April –June) stood at £261,819. Meanwhile, a total of £1.689.805 of Levy funds had been allocated to apprenticeships commencing in 2022/23. New apprenticeships which were due to commence include the Operating Department apprenticeship with allocated funds of £62k for the duration of the 3-year programme.

DG explained that the Trust would be removed from the register of supporting provider as the terms and conditions state that the supported provider must directly deliver apprenticeship training within 6 months of being listed on the register. However, Coventry University had changed its sub-contracting arrangement which meant the Trust was unable to claim funds for support given.

MB advised that work experience opportunities were stood down during the period of COVID, however this was looking to be reinstated in September 2022. MB elaborated that she would like to see a communication piece on this to provide guidance and support to staff.

DG confirmed that the report would be changed to focus on an update around employability.

Committee received **ASSURANCE** from the report.

MINUTE REFERENCE	DISCUSSION	ACTION

22/028 ALERT, ADVISE, ASSURE GROUP REPORTING

The committee was provided with a report from DG. As part of the restructuring of the committees reporting into Trust Board, agreed on 31 March 2022, the People Committee was established and the reporting groups below it were reviewed and reset. This was reported to the committee at its meeting on 28 April 2022, when the terms of reference for the three reporting groups (People Support Group, Workforce Supply and Transformation Group and People Development Group) were also approved.

It was also reported that a new mechanism of upward reporting would be trialled. The process used an 'Alert, Advise, Assure' template to enable groups to share with the committee items which they may be concerned about or which they believed the committee should be alerted to, as well as items that were being advised for information sharing purposes, and those where particular assurance had been received warranting reporting.

Effective mechanisms for the flow of information between committees and their reporting groups were a sign of good governance that would be considered as part of any Well-Led Assessment of the Trust's arrangements.

The groups reporting into People Committee had commenced using the new system since the committee's previous meeting, and these reports were provided as attachments. It should also be noted that the next stage of the development of this system had already commenced, with some of the subgroups which report into the three groups described above now also using this system for upward reporting.

It was hoped that following successful trial and any necessary refinement of this process it could be rolled out more widely across all committees. DG suggested that the reports were taken as read with no questions asked. The committee agreed with this.

10.1 – PEOPLE SUPPORT GROUP
Report was taken as read with no questions.

10.2 – WORKFORCE SUPPLY AND TRANSFORMATION GROUP
Report was taken as read with no questions. WB asked if the title could be changed to 'People Workforce Supply and Transformation Group'. This was agreed by the committee.

10.3 – PEOPLE DEVELOPMENT GROUP
Report was taken as read with no questions.

Committee received **ASSURANCE** from the report.

MINUTE REFERENCE	DISCUSSION	ACTION
22/029	**MANDATORY TRAINING**	

People Committee received a report from DG. The paper set out a detailed analysis of the Trust's position in relation to mandatory training across all staff groups, clinical groups, and core services. The data used for this analysis was taken from May 2022.

The report cross referenced this performance against each element of mandatory training requirements and set out the actions already taken and those that were planned to reach the required target and to maintain that position moving forward. DP outlined that there were certain topics which naturally had a disproportionate effect on the overall compliance figures due to the staff groups that were targeted and the number of staff in those areas.

These areas were typically specialist or high-level training areas such as advanced training. Learning and development started some useful conversations around those areas, and this had had a positive impact.

DP added that certain staff groups collectively had an impact on the overall figures and warrant additional attention. For May 2022 Medical and Dental was the only staff group below 90% compliance. Changes were being investigated and implemented.

DP pointed out that it was possible to be more proactive in identifying gaps which would allow areas to fall into noncompliance and doing something to action this more promptly. DG noted the difficulties with face-to-face training but highlighted that a significant portion of training was done online such as e-learning. It was agreed that this needed to be as easy as possible for staff to access.

MB mentioned the 'Get Green, Stay Green' campaign designed by the Learning and Development team which used posters, graphics, and social media to highlight the importance of mandatory training compliance to staff across the Trust. MB went on the confirm that the campaign would be used to motivate all staff to consider their own accountability to mandatory training.

Committee received **ASSURANCE** from report.

22/030 BOARD ASSURANCE FRAMEWORK

The committee received a report from DW. In 2021, the Board agreed to make changes to the way in which it used a Board Assurance Framework (BAF) to measure levels of assurance. There was an appetite among some Board members to incorporate the concept of critical risks (i.e. areas of specific concern) into the BAF, and this was developed during risk workshops undertaken in the final quarter of 2021/22.

At its Board Development session in March, Board agreed principles of how the new BAF would operate, and this was finessed at meetings of the Risk Committee and Audit and Risk Assurance

MINUTE REFERENCE	DISCUSSION	ACTION

Committee in March and April before being reported back to a Board Strategic Workshop in May 2022.

This was the first formal presentation of the new BAF relating to the People Committee, which reflected items within the remit of the committee and within the identified areas of critical risk. Other critical risk areas would be covered in the BAF papers presented to the other Board committees. The new BAF operated 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 would 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 did not attend.

The first draft had been developed based on previous reporting to the committee and other committees.

It was anticipated that as the committee took ownership of the BAF by using it as committees, the entries that appeared on it would become increasingly reflective of the levels of assurance the committee considers it had received.

DW highlighted that in the 'Associated Corporate risks section' Agency Expenditure was a mistake and would be removed from the report. DW went on to suggest recategorising the Apprenticeship Levy as Amber and the IPQFR – Turnover as red. DG, WB and JMG disagreed with the latter and agreed it should be categorised as amber as assurances had been provided in relation to activity. WB queried if IPQFR – Non-medical Appraisals should be categorised as red, in which DG agreed that this should be downgraded to amber.

The committee received **ASSURANCE** from the report.

22/031 DRAFT AGENDA FOR NEXT MEETING

DG requested deep dive into agency to be added to the next agenda and assurances around Nursing and Midwifery health care support workers.

No other changes were made.

22/032 ANY OTHER BUSINESS

CM highlighted the issues on social media around Junior Doctors rotation. DG reassured that there were always last-minute changes, however there were standard procedures in place to support this.

MINUTE REFERENCE	DISCUSSION	ACTION
22/033	**CHAIR'S REPORT TO TRUST BOARD**	
	DG was assured by the Freedom to Speak up guardian's report and to note the progress of the app. Also received assurance on the Deep Dive Mandatory Training report and the actions taken. JMG was assured and found useful the Alert, Advise, Assure Group Reporting.	
22/034	**MEETING REFLECTIONS**	
	There was a consensus that it had been a good meeting with a balanced agenda, and that the focus on the area was demonstrating the benefits of the committee having been developed.	
22/035	**MEETING END TIME – 12:30**	

MINUTES OF THE MEETING OF THE QUALITY AND SAFETY COMMITTEE HELD AT 09:00 ON THURSDAY 28 JULY 2022 VIA MICROSOFT TEAMS

MINUTE REFERENCE	DISCUSSION	ACTION
QSC/22/065	**PRESENT** Carole Mills (CM) – Non-Executive Director Jenny Mawby-Groom (JMG) – Non-Executive Director Tracey Brigstock (TB) – Chief Nursing Officer Mo Hussain (MH) – Chief Quality Officer	
QSC/22/066	**IN ATTENDANCE** David Walsh (DW) – Director of Corporate Affairs Lisa Cummins (LC) – Director of Quality Duncan Watson (DWa) – Deputy Chief Medical Officer Katie Jones (KJ) – Clinical Scientist [for QSC/22/076] Louisa Talbot (LT) – Women's and Children's Risk Manager [from QSC/22/081 to QSC/22/082] Sailesh Sankar (SS) – Consultant - Endocrinology [for QSC/22/083] Dan Pearce (DP) – Head of People Development [for QSC/22/086] Paula Seery (PS) – Associate Director of Nursing Workforce [for QSC/22/087]	
QSC/22/067	**APOLOGIES FOR ABSENCE** Apologies were given for Kiran Patel – Deputy CEO & Chief Medical Officer and Jeremy Gould – Non-Executive Director	
QSC/22/068	**CONFIRMATION OF QUORACY** The meeting was confirmed quorate.	
QSC/22/069	**DECLARATIONS OF INTEREST** No Declarations of interest were made.	
QSC/22/070	**MINUTES OF THE PREVIOUS MEETING** The minutes of the previous meeting held on the 26th May 2022 were confirmed as an accurate record of the meeting.	
QSC/22/071	**ACTION MATRIX** The committee **NOTED** the actions and agreed the completed actions were to be closed.	
QSC/22/072	**MATTERS ARISING** No matters arising.	

MINUTE REFERENCE	DISCUSSION	ACTION

QSC/22/073 CHIEF OFFICERS' EXCEPTIONS/UPDATE

TB updated the committee that the Pathway to Excellence Survey had been completed. TB added that this was the second stage for the pathway to accreditation with the ANCC. TB confirmed that the survey had a 67% response rate and that results of the survey should be received in the next 6-8 weeks. CM queried if the report would be received by the committee, in which TB confirmed the report would be received by the committee. JMG questioned if the learning would be shared from the survey. TB agreed that the learning would be shared.

TB also added that the trust had been awarded an ISO 45001 which was an accredited system for Health and Safety. The award was valid for a year. TB ended her update by congratulating two nurses who had been successfully accepted on to Digital Fellowships.

MH updated the committee next. MH informed the committee that the trust would be receiving a visit from the regional team around assurance from Ockenden, which was scheduled for the 11th August. MH added that a visit from the QSC was scheduled for the 5th September. MH stated that there had been a recent visit from the Joint Advisory Group on GI Endoscopy, which provided accreditation to endoscopy services. MH confirmed that the Trust was awaiting an outcome from this.

MH went on to add that the Meriden was rated as inadequate in the safe domain for surgery. MH had asked for additional assurances and these assurances had been received and a paper was being prepared to be presented at COG. MH added that several SOPs had been put in place. MH stated that an assurance visit had taken place together with the CCG and assurance had been received. JMG asked if the trust would be using the Meriden in the future. MH confirmed that the trust intended to use the Meriden in the future, but there was ongoing dialogue to ensure the necessary assurances were provided.

QSC/22/074 PATIENT SAFETY AND RISK LEARNING REPORT

LC presented the report to the committee. LC confirmed that a new style Patient Safety Learning report was being submitted which presents data relating to Serious Incident (SI) and Never Event performance, key themes and trends identified from SIs and updates on current National Patient Safety Alerts. LC added that the report would be further matured as part of an overall review of Quality data reporting.

LC stated that for June 2022 there were two key performance indicators that demonstrated reduced performance over the last three months: (1) the number of breached Serious Incident (SI) investigations and (2) the number of overdue SI actions. LC informed the committee that at present the national timeframe for completing SI investigations remains suspended by the Clinical Commissioning group (CCG) due to the covid-19 pandemic but internally the KPI remains. LC added that on review, the reason behind these breaches

mostly relates to delays in assigning a lead investigator and issues with lead investigator capacity.

LC mentioned that the number of overdue SI actions increased in the month of April 2022; however, this had reduced in May 2022. LC assured the committee that action owners continue to be contacted regularly to offer support in completing the action and escalations are completed monthly via Quality Improvement and Patient Safety (QIPS) meetings and via the Quality Partners for each clinical group. Future work would focus on reviewing and improving the current process for making recommendations related to learning from SI investigations and an options paper would be planned for discussion at SIG Governance.

LC confirmed that, on review of the number of SIs reported over the previous two financial years, the identified themes include unstageable and category 3 and 4 pressure ulcers along with inpatient falls. There was ongoing improvement work around inpatient falls, which was being included in a Kaizen event focused on reviewing themes from previous investigations and current falls prevention measures. The outcomes of this event would be fed back to the Patient Safety and Effectiveness Committee (PSEC).

LC stated that there had been two Never Events registered this financial year. One Never Event registered in April 2022 relates to a wrong site block. This incident was identified in retrospect after first being reported on Datix as no harm in February 2022. LC confirmed an SI investigation had been completed and shared with QSC for assurance of learning.

LC mentioned that there was a further Never Event registered in May 2022 relating to an unintended retained foreign object within Maternity Services. An SI investigation had commenced, and the specialty are reviewing previous similar incidents to ensure all actions remain in place.

LC updated the committee that from April 2019 to May 2022, there had been 103 incidents reported relating to hospital acquired pressure ulcers that had attracted a severity of harm score of moderate harm or above. This relates to category 3, category 4 pressure ulcers (PU) and unstageable pressure ulcers.

Category 3 and unstageable pressure ulcers are subject to a root cause analysis (RCA) investigation by the local team, which was presented to the pressure ulcer forum. A new template for these local investigations were being trialled and the first reports using this template were presented at the PU forum in May 2022.

Category 4 pressure ulcers constitute severe harm to the patient and are reviewed via the SI process. The investigations for three of the incidents relating to category 4 pressure ulcers had been completed. Key themes of learning from these investigations included Communication, Documentation and Weight. LC assured the committee that the top 3 clinical areas with the highest number of hospital acquired pressure ulcers had been set key objectives to

MINUTE REFERENCE	DISCUSSION	ACTION

assist in reducing this and improving pressure ulcer prevention.

LC reported that from April 2019 to May 2022, there had been 59 SIs reported in relation to inpatient falls where moderate harm or above had been caused to the patient. LC stated that there was a significant decrease in the number of inpatient falls reported from January 2020 to June 2020, which coincides with the reduction of inpatient activity in the Trust due to the Covid-19 pandemic.

From December 2021 onwards, there had been an increase in the total number of inpatient falls. The highest number of inpatient falls was reported in January 2022 (212). Of these 212 incidents, 134 related to unwitnessed falls which continues to be a common theme. LC added that on previous review of this theme, it was identified that there was a higher number of patients requiring care in a side room, due to infection control guidelines, who would not usually had been cared for in a side room environment; this was mitigated by encouraging areas to use additional falls prevention measures. LC confirmed that the number of falls meeting the SI criteria had not increased and remains below pre-pandemic reporting levels.

MH advised that a deeper dive into these areas would be beneficial. LC agreed and added that a timeline could potentially be created. LC

LC lastly stated that one National Patient Safety Alert (NPSA) had been received in April 2022; Inadvertent oral administration of potassium permanganate. This was ongoing with regular updates on progress reported to Medicines Safety Committee.

Report was **NOTED** by the committee.

QSC/22/075 SAFEGUARDING ADULTS AND CHILDREN BI-ANNUAL RPEORT

TB updated the committee on the report. TB stated that the report provided information on the following areas in relation to the Safeguarding of Adults and Children:

Safeguarding Referrals
TB reported that the category of ‘emotional abuse’ was the predominant reason for referrals to Children’s Social Care from UHCW. The majority of these referrals stem from adolescents who were in a mental health crisis and parents or carers who present with mental health concerns or substance misuse, including alcohol intoxication.
TB added that in relation to referrals to Adult Social Care, ‘self-neglect’ and neglect were the main reasons for referral. There had been an increase in the number of referrals made under the category of domestic abuse during this period.

Training compliance
TB informed the committee that compliance with safeguarding training throughout the Trust was mostly achieving the Integrated Care Board (ICB) target of 90% except for safeguarding adult’s level 3 which was 88.5% compliant. TB assured the committee that there

MINUTE REFERENCE	DISCUSSION	ACTION
	was a plan to offer bespoke training sessions to the clinical group to help improve this compliance. JMG commented that she did not understand the colouring of the table, in particular the safeguarding children section. TB agreed. JMG queried whether training was to be split up into smaller time periods to allow easy access for staff. TB noted that they were looking at more creative ways to deliver the training using different mechanisms. JMG questioned if there was a timescale for this, which TB confirmed this was being monitored to an agreed timescale.	
	Serious Case Reviews TB reported that UHCW NHS Trust were contributing to 2 of the agreed cases across Coventry and Warwickshire that had met the threshold for a full Serious Adult Review. On review of the care there were no omissions or learning identified in one case and some learning in relation to reasonable adjustments in the other. TB mentioned that in response to the initial learning, actions had been taken such as the Safeguarding Team supporting Learning Disability Awareness Week in June 2022.	
	Liberty Protection Safeguards TB updated the committee on The Mental Capacity Amendment Bill (2019), in which the current Deprivation of Liberty Safeguards (DoLS) system was to be replaced by a new system, known as Liberty Protection Safeguards (LPS). A business case articulating the resource required to implement LPS was approved in June 2022. TB stated that the recruitment process would commence in quarter 4 of 2022/23 with the aim of the new recruits commencing in April 2023.	
	Learning Disabilities TB informed the committee that UHCW were working collaboratively with Coventry and Warwickshire Partnership Trust Learning Disability Acute Liaison Team. The Associate Director of Nursing for Quality and Patient Safety met with the Acute Liaison Team on a monthly basis to identify areas for improvement. The Trust were currently working on an action plan produced following the results of the 2021 NHS England & NHS Improvement Learning Disabilities Improvement Standards.	
	CM questioned where the Safeguarding Practice reviews goes to in relation to UHCW. TB confirmed that this was received through the Safeguarding Committee in which the members of the committee distribute the learning to relevant groups. CM queried if this would be seen at an executive level. TB stated that this was shared at COF and COG if any issues were highlighted. MH added that there was flexibility in the governance structure as to when reports could be seen. CM asked if an update could be provided in future reports on Safeguarding Adults and how this was being given the same attention as Safeguarding children. TB agreed with this being added to future reports.	TB
	Committee received **ASSURANCE** from the report.	
QSC/22/076	**INFECTION PREVENTION AND CONTROL UPDATE**	

MINUTE REFERENCE	DISCUSSION	ACTION

KJ presented the report to the committee. The provision of a robust Infection Prevention and Control (IPC) strategy was an essential requirement in continuing the trusts focus on reducing healthcare associated infection (HCAI) and in ensuring compliance to Care Quality Commission (CQC) outcome 8 (regulation 12) Cleanliness and Infection Control.

KJ explained that surveillance of infections was monitored and reported through the monthly Infection Prevention Control Committee and reflects trust submissions to Public Health England. KJ added that a ceiling threshold level for a maximum number of cases per annum had been set for acute trust providers to target reductions in Healthcare Associated Infection.

The following organisms were subject to mandatory reporting:

KJ stated that the Trust had reported 14 cases of Clostridiodes difficile against a quarterly ceiling threshold of 15 cases and that reviews of 10 cases had been completed together with colleagues from the CCG to consider any lapses in care. KJ added that there had been no cases of Methicillin-resistant Staphylococcus aureus bacteraemia (MRSA) reported.

KJ stated that there were 12 Methicillin-sensitive Staphylococcus aureus bacteraemia (MSSA) cases reported in quarter 1 of 2022/23, against a ceiling threshold of 15.

KJ highlighted that the trust had reported 28 cases of E.coli against a threshold of 34. KJ explained that the key themes from the review align to national findings of increased age, links to indwelling items and those who were immunocompromised.
The trust had reported 5 Klebsiella against a trajectory of 15, and 4 pseudomonas against ceiling threshold of 9.

KJ provided an update on COVID-19. The IPC team reviewed all cases of COVID-19 admitted to the hospital to support the prevention of nosocomial acquisition. KJ added that root cause analysis was undertaken on nosocomial cases and reported through the established DATIX process.

KJ highlighted that the IPC team had performed a confidence in care survey that demonstrates high levels of confidence from patients in IPC related practices at UHCW.
CM queried whether the threshold levels were set by UHCW. KJ confirmed that the threshold levels were set nationally, but UHCW had set internal threshold levels as well.

The committee received **ASSURANCE** from the report.

QSC/22/077 CORPORATE RISKS REPORT

LC reported that there were 16 open corporate risks for which the Quality & Safety Committee (QSC) was the assigned responsible committee. LC elaborated that there were five high risks (rated between 15-16) with currently no risks rated between 20 and 25.

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LC highlighted that the five highest rated risks (15-16) were:

- 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
- Risk ID 3816: Inability to keep CAMHS patients safe.
- Risk ID 3975: Inability to deliver a sustainable Dermatology service.
- Risk ID 2658: Auto reported examinations.

LC explained that the full risk register details of the above “high” and the remaining 11 risks (moderate and below) were included in the report.

LC added that since the last meeting there had been four risks listed for closure which were under the QSC portfolio.
LC noted that the closure of the below risk had been approved by Risk Committee:

- Risk ID 2237: Severe shortage of permanent storage capacity in mortuary at UHCW.

LC stated that a new risk had been reported following the HTA inspection and awaited approval at risk committee.

LC went on to confirm that the closure of the remaining three risks requires approval at Risk Committee:

Risk ID 2067: Overcrowding in the Emergency Department (ED).
LC stated that the risk had been reduced from its initial risk grading of ‘HIGH’ to its target risk rating of ‘LOW’ following a revision of the ED overcapacity operating procedure to increase safety rounding and an additional doctor out of hours to focus on overcapacity patients.
LC added that a newly reported risk which reflects changes to this situation was awaiting approval by the Risk Committee.

Risk ID 2656: Drug Security.
LC reported that the risk had been reduced from its initial risk grading of ‘HIGH’ to its target risk rating of ‘MODERATE’ as there was a comprehensive medicines policy. Medicines were stored within automated cabinets with biometric access across 70+ areas of the Trust. Medicines security risk assessments were completed and reviewed annually by ward and departmental managers.

Risk ID 3834: Children with minor injuries in adult minor injury unit.
LC highlighted that the risk rating had been reduced from moderate to the target rating of low (6). The risk had been discussed at the ED group board meeting and agreed for closure as the risk had been mitigated and target achieved.

MH commented on risk 2472 Lack of Hybrid Operating Theatre. MH advised that the target date should be reviewed at the next Risk Committee. LC stated that all risks were reviewed on a monthly basis so the data may change when they reach the target date. CM questioned how assurance could be received from the report if the LC

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target dates were subject to change. LC agreed with this and would look into this.

The committee received **ASSURANCE** from the report.

QSC/22/078 QUALITY STRATEGY UPDATE

MH provided an update on Quality Strategy. MH stated that effective quality systems must serve three main aims for the ICB, local authorities and partners. Firstly, a timely insight and intelligence sharing into opportunities for learning and improvement, and issues that need to be addressed and escalated. Secondly, a positive assurance that statutory duties were being met, concerns and risks were addressed, and improvement plans were having the desired effect. Thirdly, a confidence in the ongoing improvement of care quality, drawing on timely diagnosis, insight, and learning. This includes confidence that inequalities and unwarranted variation were being addressed.

MH assured the committee that to date a consultation exercise to support the development of the system wide Quality Strategy had been undertaken, (to which UHCW contributed), and this would further shape our strategic approach to quality. MH highlighted that by Adopting the definition for quality put forward by the National Quality Board, the ambitions for improvements to Quality were framed at a system and organisational level under 5 areas: Safe, effective, caring and responsive, well-led and sustainable.

MH added that the associated delivery plan would be socialised and developed with the aim to finalise the Quality Strategy by December 2022.

JMG queried about timelines and reporting on learning from this. MH explained that a schedule may be developed with the help of LC to highlight key milestones. MH clarified to the committee that this should be completed in January 2023. CM queried what the trust was doing to help with prevention for example: smoking and unhealthy diets. MH responded that the organisation had services which patients could sign up for to help with prevention.

The Committee **NOTED** the report.

QSC/22/079 MORTALITY (SHMI AND HSMR) UPDATE

DWa presented the report to the committee, highlighting that the purpose of this report was to provide an overview of UHCW NHS Trust mortality data and ongoing HSMR Alerts covering a rolling 12-month data period.

DWa explained that there were 17 Primary Mortality reviews over 12 months old and there had been 1032 Primary Mortality reviews requested for Covid-19 related deaths. DWa added that there were

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currently 67 Primary Mortality reviews pending, of which 55 was over 30 days and there had been 11 inpatient deaths of a person with a learning disability within the last 12 months.

DWa highlighted that the report details 11 LeDeR deaths which had a completed mortality review. DWa assured the committee that these reviews had been shared directly with the LeDeR Deputy and Programme Coordinator at the CCG.

JMG referred to point 4.6 in the report and questioned where the organisation reported this data. DWa stated that it was reported through the Quality Standards Committee. JMG stated that this should be reported through FPC to provide greater clarity. The committee agreed with this.

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

QSC/22/080 **INTEGRATED QUALITY, PERFORMANCE AND FINANCE REPORT**

DWa presented the report to the committee, explaining that the report details performance for June 2022 relating to Quality and Safety KPIs. The latest reported HSMR figure was 115.99 for March 2022 and was within Dr Foster's calculated relative risk range. DWa stated that 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 3,865 for May, an increase of 198 from April. This compares to a national average of 1,876.

DWa advised that additional benchmarking information had been included in this report and that the average number of long length stay patients had risen to 184 – an increase of 22. DWa pointed out that a Never Event had been reported for June and that details were included in the report. It was Highlighted by DWa that the Trust reported three 12-hour trolley waits within the Emergency Department and additional information on Day Case activity had been included in the report as previously requested. DWa stated that this compares activity levels with that of 2019 (pre-pandemic) and shows how Day Cases contribute to the Referral to Treatment Open Pathways. DWa acknowledged that some national submissions had been suspended due to the pandemic. Where possible the KPI remains reported within scorecards.

JMG highlighted that far more detail was provided in FPC regarding waiting lists and it was being monitored. CM queried whether the use of day care surgery was being optimised to tackle waiting lists. DWa said that day care was being used to tackle waiting lists, however DWa did not have additional information on this and agreed to provide a more detailed update on this at the next QSC meeting. DWa/KP

The committee received **ASSURANCE** from the report.

MINUTE REFERENCE	DISCUSSION	ACTION
QSC/22/081	**OCKENDEN ACTION PLAN**	
	LT joined the meeting to present the report. LT explained that the report detailed progress against the first and the final Ockenden Report 2022. LT outlined the key points from the report, firstly confirming that there were 2 sub-actions from the first Ockenden Report response that were outstanding. Firstly, resource to allow for daily reviews across all maternity services points with the business case in progress. Secondly, the identification of a Bereavement room with separate entrance and exits. LT advised that both actions were currently mitigated. CM queried the location of the current bereavement room and facilities, adding that it was not appropriate and firm proposals had not been decided on this. TB agreed with the frustration around this, and plans had been put forward to make this a priority piece. TB agreed to share a timeline for this with the group.	TB
	LT went on to confirm that there were 15 new IEAs with 88 specific components. A bi-weekly meeting attended by the Group triumvirate, key clinical colleagues together with CMO/CNO and Director of Quality takes place to monitor progress of the “gap analysis” and evidence for compliance to date. LT added that currently 58 of the components were complete with 45 of these having full level of assurance regarding data and examples gathered and recorded evidence. 21 Components were in progress and 9 were not applicable due to awaiting national guidance to be received. TB assured the committee that this had been reported to LMNS and the schedule was in development.	
	LT advised that wider learning had been disseminated and shared at Chief Officer Forum, with all groups developing 3 priorities for action that resonated with their group. LT confirmed that this would be monitored through QIPPS and accountability meetings. LT also provided an update on Maternity Continuity of Care, in which there were plans in place to introduce this once staffing levels permit this. LT emphasised that NHSEI would undertake an on-site visit or review of Ockenden on the 11th August 2022.	
	The committee **NOTED** and received **ASSURANCE** from the report.	
QSC/22/082	**MATERNITY SAFETY REPORT AND PLAN**	
	LT presented the report to the committee. LT confirmed that the report aims to share maternity updates for quarter one of 2022/23. LT advised that current activities including births, deliveries and bookings had seen a statistically insignificant decrease of 1.1%. LT advised however, that the department were on track with all nationally agreed timescales for multi-disciplinary reviews, including patient involvement in investigation and review processes.	
	LT stated that the Continuity of Care implementation was on hold until staffing levels had been restored, adding that the current midwifery vacancy was 39.38 WTE and the department was on track to achieve the projected vacancy of 13.12 WTE by October 2022 for	

MINUTE REFERENCE	DISCUSSION	ACTION
	new starters. LT highlighted that the midwife to birth ratio was maintained between 1:30-1:32 and for the period reported, one to one care in labour was achieved on all but two occasions and supernumerary status of the coordinator was achieved. LT reported that there were red flags relating to delays in women starting Syntocinon/ARM of more than 20 minutes, however it had been regionally agreed that the timescale should be changed to 48 hours as part of the regional OPEL escalation review. LT clarified that there was no harm reported because of these red flags. LT elaborated that a local assurance review on the governance processes and reporting of stillbirths was completed and would be shared at PSEC in August. LT raised an issue regarding a high-risk item on the risk register for maternity in relation to midwifery staffing, adding that actions had been put in place to mitigate against this to maintain safe staffing on a daily basis and to improve the vacancy rate. JMG queried if the staff leavers were based on an estimation of previous staff leavers or was there known notice periods that staff were currently working. TB and LT confirmed the staff leavers was based on a previous estimation and newly qualified midwives were supported. CM questioned if the trust was accommodating flexible working for staff members. TB advised the trust was preparing leaders to be more flexible; however, this was a work in progress. MH added if this could be picked up through people committee through agile working. JMG agreed. MH questioned if data could be shared on mortality rates which include brain damage and level 2/3 complex pregnancies for example. LT said this had been approached to acquire this data, however there had been a push back due to maternity being in the limelight at the moment. The committee agreed this data should be included in future reports.	TB/LT
	The committee received **ASSURANCE** from the report.	
QSC/22/083	**MEDICAL EDUCATION REPORT** SS joined the meeting to present the report to the committee. SS explained that 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. SS outlined that the report would cover recent progress and challenges faced by each of the departments/services, our Training Leads, and the groups we serve. SS stated that the NETs survey identified some training issues for Neurology trainees and a meeting between the Neurology team and representatives from HEEWM had discussed a proposed action plan to address the shortfall. The recently published GMC survey reflected the same concerns. SS said it had been agreed that the service would implement the planned changes and the training programme would be reviewed formally again by the HEEWM team when the next NETs survey was undertaken in the autumn.	

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SS reported that a positive area was Surgery, adding that the centre had achieved reaccreditation by the Royal College of Surgeons and the internal auditors had reported satisfaction with the progress that had been made to enhance the centres management governance. SS also highlighted that the undergraduate general feedback for UHCW was very positive. SS advised that most teaching had returned to face to face teaching and the needs of the cohorts adversely affected by the pandemic had been recognised and efforts were being made to help these groups make up the ground they had lost. SS brought to the attention of the Committee that the NSS survey report had received a decrease satisfaction result from the previous year. SS suggesting the Covid-19 pandemic may had contributed to this.

SS declared that the Trust was awarded a national award, elaborating that the Trust had been recognised by Health Education England for sustainable and innovative postgraduate medical education and training recovery interventions. SS highlighted that there had been an
Appointment of SAS Lead and Locally employed Lead and funding for Medical Support Workers had been extended.

MH mentioned the NSS survey and questioned what impact this had on students wanting to work at UHCW. SS acknowledged that the survey results were disappointing and suggested it was due to the Covid-19 pandemic. SS added that nationally there had been a decline in student satisfaction and there should not be a significant impact on student retention.

The committee received **ASSURANCE** from the report.

QSC/22/084 WARD ACCREDITATION

TB presented the report to the committee. TB explained that the Accreditation Framework was a tool containing 15 standards which was used to measure the quality of care delivered in a clinical area. Accreditation brings together key measures of nursing and clinical care into one overarching framework to enable a comprehensive assessment of the quality of care being delivered. TB added that when used effectively, it could drive continuous improvement in patient outcomes, increase patient satisfaction and staff experience at ward and unit level.

TB stated that the Accreditation Framework was aligned with UHCW's Pathway to Excellence journey and was a key component of the quality standard providing recognition of high standards of care delivered in clinical areas and a focus for where improvements were needed. TB confirmed that the threshold of each standard was 95%.

In conclusion, TB stated that the assessments conducted in February-May 2022 demonstrate an improvement in the number of standards being met across the majority of wards and had provided focussed areas for improvement.

MINUTE REFERENCE	DISCUSSION	ACTION

The committee received **ASSURANCE** on the report.

QSC/22/085 HEALTH AND SAFETY UPDATE

TB presented the Health and Safety Update to the committee. TB confirmed that HSC meetings had now been pushed back to pre-Covid duration of 2 hours to allow for full review of all agenda items. TB added that there was a total of 10 policies sanctioned by the committee, of which 8 were in date and 1 was out of date due to further clinical review. TB noted that 1 policy was awaiting approval at the July HSC meeting.

TB reported that accident numbers had reduced by 17% against 2021 year to date and RIDDOR reportable accidents for 2022 to date had reduced by 56% since 2021. TB advised the committee that there were no pending prosecutions or enforcement interventions on Health and Safety.

TB drew attention to fire stopping and stated that there was outstanding work to be completed with 93% completed currently. Fire dampers being identified as inaccessible had extended the fire compartmentation risk. TB assured the committee that Fire, and Security standards had been well maintained over 2022 with policy and training all up to date and H&S auditing and inspection schedules had been successfully delivered during 2021 with bench line scores in place for several departments.

TB ended the report by stating that PFI partners had submitted a joint report to the meeting which would improve consistency of information received and that the committee was working well within its terms of reference and was compliant with H&S legislation that drives meeting protocol.

The committee received **ASSURANCE** from the report.

QSC/22/086 MANDATORY TRAINING COMPLIANCE

DP joined the meeting to present the Mandatory Training Compliance Report to the committee. TB advised that the paper sets out a detailed analysis of the Trusts position in relation to mandatory training across all staff groups, clinical groups, and core services. DP confirmed that the data used for analysis was taken from June 2022.

DP highlighted that the compliance target was 95% with mandatory training compliance currently sitting at 93.59% for June 2022. DP added that this was an increase of 0.50% on May 2022. DP went on to confirm that all 8 staff groups were over 90% compliance with 5 staff groups meeting the 95% target. DP stated that new starters were not included in the figures, however long-term sickness was included in the figures.

DP highlighted several improvement opportunities that could be made to booking and confirmation processes, availability of courses

MINUTE REFERENCE	DISCUSSION	ACTION
	and opportunities in relation to proactive and intentional completion of courses ahead of compliance elapsing. DP advised that some of the typical challenges that staff face when attempting to maintain compliance were staff not knowing how to access the system, not knowing when compliance was due to elapse and who to engage with to find solutions. DP added that the review established some variations in data accuracy and reporting which could impact overall figures, however supportive measures were in place to eliminate those variations. DP assured the committee that the team would monitor performance on a monthly basis and would expect to see improvement by October 2022. MH queried what the mandatory training figures were for bank staff and if it was broken down in the same format. DP confirmed the data for bank staff was broken down in the same way and that a summary of the whole data for mandatory training was included in the report rather than a separate breakdown of bank staff compliance. DP added that a breakdown of just bank staff data could be provided. MH agreed this would be helpful. MH queried if the data for agency staff would be different. DP stated that agency staff were not employed by the trust and therefore, assurance was sought in a different way and this data was not included in the report. MH questioned how the committee would be assured that agency staff were appropriately trained. DP said that this data was managed by a different team. DP would provide a response to this at a later date. DP agreed to circulate information outside of the meeting regarding requirement for agency and bank staff to book shifts, regarding mandatory training compliance.	DP
	The committee received **ASSURANCE** from the report.	
QSC/22/087	**NURSING AND MATERNITY EDUCATION AND TRAINING** PS joined the meeting to present the report to the committee. PS stated that the purpose of the report was to provide assurance that nursing and midwifery staff had the appropriate skills and knowledge to carry out their roles, had access to training and development opportunities and training compliance was monitored and maintained. This aligned with the key obligations under National Quality Board expectations and Royal College of Nursing workforce recommendations. PS confirmed to the committee that bank only staff training requirements reflect those of substantive staff and there was a review underway of how this was monitored going forward. Processes for monitoring the standard and compliance of agency staff training was also currently under review. PS advised that the utilisation and booking of agency staff was monitored and controlled by the senior nursing team.	

MINUTE REFERENCE	DISCUSSION	ACTION

There were processes in place to ensure the appropriate induction of temporary nursing staff and a clear procedure of how to escalate concerns regarding performance.

The committee received **ASSURANCE** from the report.

QSC/22/088 APPG REPORT ON SICKLE CELL DISEASE

DW presented the report to the committee. DW provided context to the report by highlighting that on the 5 May 2022 the Chief Medical Officer received a letter from the NHS Specialised Commissioning – Midlands highlighting recommendations on an APPG Report on Sickle Cell Disease, titled 'No One's Listening'. A copy of the letter was provided to the committee as an attachment. DW added that NHS acute providers were requested to consider the recommendations and provide an action plan detailing how they would respond to the local Haemoglobinopathy Coordinating Centre (HCC) by 31 July 2022.

DW assured the committee that a working group was developed involving clinical colleagues from a range of specialties including Haematology and Emergency Medicine, and alongside colleagues from within Clinical Effectiveness and Assurance an action plan had been developed to respond to the recommendations. DW advised that the working group was due to meet on 28 July 2022 to finalise the action plan ready for submission, but a summary of the actions that had been agreed and progress made was set out in the supporting report.

DW explained that An All Party Parliamentary Group (APPG) on Sickle Cell and Thalassaemia was formed in 2008. It finalised its report in November 2021, highlighting avoidable deaths and failures incare provided for sickle patients in secondary care.

The committee received **ASSURANCE** from the report.

QSC/22/089 BOARD ASSURANCE FRAMEWORK

DW presented the Board Assurance Framework to the committee. DW stated that the BAF developed for the last meeting of the committee, built broadly following a desktop exercise reflecting on assurances received previously, had been further developed following the input of the committee, as it considered the assurances it received.

DW commented that a number of the areas on the BAF, which was attached to this cover report, feature on the agenda for this committee meeting. This had been updated during the meeting and any suggested changes in assurance levels were proposed verbally during presentation of the item.

DW suggested the Pathway to Excellence accreditation could be changes to green as it was on track. DW added that the mortality update should be moved from amber to green because it was amber

MINUTE REFERENCE	DISCUSSION	ACTION

on the basis of questions around coding and the report received detailed the work being done to action this.

The Sickle cell report actions and Ward accreditation also remained green as suggested by DW. DW commented that the Mandatory Training report should remain amber on the basis of the bank and agency staff and the BMI Meriden should remain with the rating of amber.

DW stated that the Ockenden Action plan should be given the rating of green, however it was noted that there was concern over timeframes regarding bereavement rooms. The committee agreed the Ockenden Action plan should be given a rating of amber. DW advised that the IQPFR should be given a rating of amber. DW confirmed that he would circulate the BAF outside of the meeting to the committee members.

MH questioned whether the Medical Education report should be given the rating of amber. The committee agreed with this, and the amendment was made.

The committee received **ASSURANCE** from the report.

QSC/22/090 DRAFT AGENDA FOR NEXT MEETING

CM confirmed the draft agenda of the next meeting could be taken as read. No further comments were made.

QSC/22/091 ANY OTHER BUSINESS

TB queried whether a Nursing, Midwifery and AHP education report would be useful to be presented to the committee. The committee agreed with this. TB

QSC/22/092 CHAIR'S REPORT TO TRUST BOARD

CM commented on Safeguarding Adults and the need for assurance around this being given an equal profile to Safeguarding Children. CM advised that the Quality Strategy should ensure it reflects our role and what could be done in prevention strategy.

CM stated that the Ockenden and Maternity safety report should be clarified regarding timescales and actions put in place. CM added that the Flexibility of shift patterns to optimise the workforce should have had a raised profile.

MH commented that the mandatory training around medical and dental to be clarified in October 2022. CM agreed.

QSC/22/093 MEETING REFLECTIONS

JMG reflected that the committee was useful and interesting. TB thought the format was useful and complemented the BAF for

MINUTE REFERENCE	DISCUSSION	ACTION
	providing conclusions. CM agreed that this was a dynamic approach. JMG stated that the AAA approach used in People Committee was useful and could be added to other committees.	
	MEETING END TIME- 12:30	

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD HELD ON 6 OCTOBER 2022

Report of the Quality and Safety Committee (Q&SC) following its meeting held on 29 September 2022

Committee Chair:	Carole Mills
Quoracy:	Yes.
Purpose:	This report seeks to provide assurance that Q&SC 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
8. Maternity Services: Findings of Regional and System Insight Visit	We received an update following the 11 August visit by the NHSE Regional Chief Midwife and members of the Local Maternity and Neonatal System. Their report provided overall assurance against delivery of the seven immediate essential actions arising from the initial Ockenden report. Areas for consideration were identified, including potential risks relating to the new EPR system replacing the current one in maternity, and the progress on the proposed bereavement suite. Updates in relation to these issues and others identified were requested in future reports to the committee.
10. Hospital Transfusion Committee Annual Report 11. Research and Development Annual Report	These two annual reports were discussed and provided assurance in relation to the activity in these areas during 2021/22.
13. Patient Experience and Engagement Report	This focussed on various aspects of patient experience and engagement. Complaint responsiveness was 98% responded to within 25 days v a target of 90%. Communication remained a key complaint theme. PALS achieved 78% v its 90% target for responding to enquiries within five days in Q1. Actions arising from the 2021 maternity survey were described, including a review of the birth options leaflet, ongoing audit of Ockenden Report actions, and antenatal training sessions around infant feeding being regularised. We noted the high proportion of compliments and thanks from within gynaecology (72 of 286 recorded in Q1) and discussed the possible factors contributing to this.
15. Nursing, Midwifery and AHPs (NMAHP) Education	We received a presentation detailing the many avenues for education for nurses, midwives and allied health professional. The report and presentation gave reassurance overall but we asked that future reports provide more information on benchmarks and comparative data to ensure full assurance.

Item or issue for escalation	Purpose for escalation	Escalated to
None	N/A	N/A

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 9 Corporate Risks Item 16 Board Assurance Framework
Approval of the quality strategy	Item 12 Quality Strategy Update
Review the Quality Account	Item 14 Quality Account Priorities Progress Update
Receive assurance on the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and recommend modifications	Item 16 NMAHP Education
Receive reports from 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	Item 12 Quality Strategy Update Item 14 Quality Account Priorities Progress Update
Review performance against quality indicators and seek assurance about the effectiveness of remedial actions and identify good practice.	Item 7 Integrated Quality, Performance and Finance Report Item 14 Quality Account Priorities Progress Update
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 8 Maternity Services: Findings of Insight Visit Item 13 Patient Experience and Engagement
Review the terms of reference for the Committee and recommend approval to the Trust Board	
Other	Item 10 Hospital Transfusion Committee Annual Report Item 11 Research and Development Annual Report

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			
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	✓	✓	×			
Chief Quality Officer		Member	✓	✓	✓			

*Where the CMO, CNO or CQO are not present, a deputy was present.

University Hospitals Coventry and Warwickshire NHS Trust

MINUTES OF THE MEETING OF THE

FINANCE AND PERFORMANCE COMMITTEE

HELD AT 13.30 ON THURSDAY THE 25 AUGUST 2022 VIA TEAMS

ITEM	DISCUSSION	ACTION
FPC/22/118	**PRESENT**	
	Jerry Gould (JG), Non-Executive Director – Chair Jenny Mawby-Groom (JMG), Non-Executive Director	
FPC/22/119	**IN ATTENDANCE** Lisa Cummins (LC), Director of Quality for item **FPC/22/134** Lincoln Dawkin (LD), Director of Estates & Facilities for item **FPC/22/133** Daniel Gilks (DG), Associate Director of Finance Costings for item **FPC/22/128 & 129** Jo Lydon (JL), Deputy Chief Operating Officer For Item **FPC/22/130, 131 & 132** Su Rollason (SR), Chief Finance Officer David Walsh (DW), Director of Corporate Affairs	
FPC/22/120	**APOLOGIES FOR ABSENCE** Apologies were received from Gaby Harris (GH), Chief Operating Officer	
FPC/22/121	**CONFIRMATION OF QUORACY** The Chair confirmed the quoracy of the meeting and declared the meeting open in accordance with Standing Orders.	
FPC/22/122	**DECLARATIONS OF INTEREST** There were no declarations of interest made.	
FPC/22/123	**MINUTES OF THE MEETING 30 JUNE 2022** The minutes of the Finance and Performance Committee held on 30 June 2022 were **APPROVED** as a true and accurate record.	
FPC/22/124	**ACTION MATRIX** It was reported that the actions relating to minutes FRPC/22/44 & 45 could come off the matrix and that FPC/22/109 could be removed subject to an agenda item further in the meeting.	

ITEM	DISCUSSION	ACTION
FPC/22/125	**MATTERS ARISING** **FPC/22/111** A question was raised as to the intended transfer of services from Roche to Siemens. DW stated that he was unable to confirm this but as at 12 August 2022 the risk relating to this remained on the Corporate Risk Register. It was agreed to request the officers involved update the committee on this outside of the meeting.	**DW**
FPC/22/126	**INTEGRATED FINANCE REPORT** SR introduced the report and highlighted the following points. Financial Plan • The Trust had submitted a revised plan on the 20th June 2022 following the national announcement of further funding to address the inflationary pressures facing the NHS. The revised plan was £14.8m deficit and underpins this report. • The Month 4 year to date position shows a £9.5m deficit compared to the NHSI deficit plan of £3.6m. The forecast position shows a £20.4m deficit compared to the NHSI deficit plan of £14.8m. • WRP performance was £4.9m year to date which was an improvement of £2.0m from month 03 with a forecast of £28.7m which was a shortfall of £10.1m • Capital expenditure was £7.7m at Month 4 compared to a £8.0m plan. • Agency expenditure was £8.0m at Month 4, which was £1.1m above the year-to-date agency ceiling of £6.9m. Forecast expenditure was £21.3m at Month 4, which was £0.5m above the agency ceiling of £20.8m. • Predicted elective recovery performance for Month 4 YTD, after allowing for the usual improvement in data quality and completeness between first cut activity data and final cut, was 92.76%. This includes a reduction of the baseline of 1.5% due to counting and charging changes between 2019/20 and 2022/23. The report had not been incorporated into group reports as it had yet to be formally agreed. • NHSE had not yet published final baselines or official in-year monitoring, however the draft monitoring which had been circulated indicated that UHCW performance was in-line with, or actually, slightly better than other Midlands providers. Given this, and indications that the ERF rules were likely to be revised, The Trust was not factoring any loss of income into the financial position at this stage. However, had this not been the case, delivery of 92.76% would have equated to a £6.2m reduction in income year to date. (£18.7m full year). • The forecast income position was based on delivering plan for the rest of the year for emergencies, critical care and others.	

ITEM	DISCUSSION	ACTION
	• The forecast for elective was based on 104% delivery from October. SR continued the report noting that ERF performance was now better than shown and the Trust was now one of the highest performing Trusts. The Trust had pushed the priority of the WRP and this was now showing significant financial benefits. There was still an issue over confirmation of digital funding for EPR and the funding for the CDC's was now threatened by the government decision to use the capital allocated to fund the NHS pay rise. Whilst YTD agency spending was slightly over target the Trust was confident of bringing that back to a balanced budget position by year-end. The "Downside/Upside" position was noted, it was stated that there would not be an ERF clawback for the first half of the year. Recognition is that the Trust would not achieve 104% and awaiting further guidance on this matter. NHSEI undertaking reviews covering efficiencies, growth in paylines and price rises, Covid costs and the removal of swabbing etc. Recovery plans. Responses had been made which leads into the sustainability reviews and internal audit. JG asked for clarity around who was conducting the assessments mentioned in the report, particularly as the word "system" was being used. SR responded that this would be the Trust's Internal Auditors. It was noted that the Trust's biggest pressures were concerning High Cost drugs and the WRP. The Committee **RECEIVED ASSURANCE** from the report.	
FPC/22/127	**WASTE REDUCTION PROGRAMME UPDATE** SR presented the report noting the following highlights. **Month 4 Reporting** • As at month 4, YTD delivery was £4.86m which was 59% of YTD target • Forecast delivery had been externally reported as £28.67m **Progress Update** • As of 10th August, £6.9m of waste opportunities had been identified across clinical groups and • corporate departments according to PM3 (25% of target of £27.32m) • £3.17m was recurrent (46%) and £3.73m non recurrent (54%) • There had been good progress since the start of July in identifying and developing Waste opportunities: • A series of Idea Generation sessions had been held in July with the clinical groups to support rapid	

	identification and development of new waste schemes, with 93 new ideas identified • An additional £3.03m added to PM3 across the operational and corporate Groups since 15th July • Engagement with groups had improved, with an increased focus on Waste across all clinical groups. • Support and input from chief officers and corporate directors had helped to unblock challenges and increase scrutiny on waste reduction. **Plans to Drive Delivery** To maintain momentum, the Trust would be focusing on developing & delivering project plans to realise the benefits for the schemes already identified and improve delivery, whilst also maintaining a relentless push on identifying schemes to close the gap and mitigate potential shortfalls. As part of this, the Trust would focus in the following areas: • **Clinical Groups** – continue to work with groups to capture and develop the ideas from the generation sessions, support the identification of benefits and support implementation planning and delivery. • **Trustwide programmes** – finalise the Trustwide programmes, including confirmation and sign off of group level targets for productivity and temporary staffing, and move into implementation. • **Strategic programmes** – focus over last month had been on working with groups and supporting the development of the Trustwide programmes. Over the next month, the Trust would look at capturing the benefits for the Trust's strategic programmes where possible waste reduction opportunities had been identified. • Further training and support had been provided to groups to ensure they record schemes correctly in PM3 to be included in monthly reporting. • The Productivity Dashboard would be developed further. • Weekly delivery update emails sent to chief officers, group triumvirates and corporate directors to maintain awareness of performance SR continued the report noting that there were very fast moving changes occurring and that she had recently consulted with Deloitte about providing furth support. Proposed savings from the identified schemes were now in excess of the year's target, so the focus now is to significantly increase delivery of the programme. SR agreed to take JMG through the more technical figures for a greater understanding. JG asked whether the £10.1m year-end forecast shortfall figure was realistic. SR confirmed that this would reduce. JG and JMG questioned the virement of budgets to mitigate the inflationary effects on them. PM3 would have a complete set of figures for the proposed WRP schemes. JG requested that a list of the schemes be provided to next committee to enable it to gain assurance though he didn't require this to be provided as part of every	

ITEM	DISCUSSION	ACTION
	WRP report. SR would ensure that this is included as an appendix at the next meeting at which a WRP report is due. The Committee **RECEIVED ASSURANCE** from the report. The group were congratulated for the work they had done.	
FPC/22/128	**NATIONAL COST COLLECTION** DG joined the meeting to present this and the subsequent agenda item. He stated that this report had already been submitted and approved by the Trust Board and highlighted a number of points This first report is one of three and was for the Finance and Performance Committee to confirm that it was satisfied with the Trust's costing processes and systems and that the Trust would submit its return within the deadline. Production of costing information was a statutory requirement of NHS Providers, and the data collected via the NCC was published and used for a variety of purposes such as Model Health System, GIRFT and Care Quality Commission Use of Resources assessments. Therefore, the Board assurance process had been updated to reflect the importance of cost submissions and raise the profile of costing across the organisation. The purpose of this report was to provide a summary of the key items, that when considered together, would provide members of FPC with the necessary assurance that the Trust would adhere to the following specific terms: • The national cost collection would be prepared in accordance with the principles and standards set out in NHSE's *"Approved Costing Guidance";* • an appropriate costing system was in operation; • the costing team was appropriately resourced to complete the NCC return accurately within the prescribed timescale'; • procedures were in place to ensure that the self-assessment quality checklist was completed at the time of the national cost collection return. He further noted an error had been found concerning outpatient attendances and an application to vary the figures had been made. JG asked whether the Trust would betaking up the optional system module to enable direct integration with the Financial Control Platform. DG said he would go back to the costing team to find out. SR stated that the Trust was not in a position to answer as the Trust was going through a full review of the financial strategy. JG also asked whether testing of the costing plan was to be added to the internal audit programme, as a test of accuracy. SR stated that this should be added in the future. This to be added to the Action Matrix.	**SR**

ITEM	DISCUSSION	ACTION
	JMG asked a question concerning staffing levels and allocation of staff to departments, with implications to Staff Plans. DG said that job plans and moving staff to cover emergencies had not settled down yet JMG also asked about project governance and what was being done to improve the costing methodology, in particular coding of actions as the Trust recovers from the pandemic. SR gave the same response as DG had just replied. A gap statement was requested to be presented to the next meeting. The Committee **ENDORSED** the Trust's approach and **NOTED** the report.	**DG**
FPC/22/129	**NCC PUBLICATION (COST INDEX)** Following publication of the National Cost Collection Indices by NHSEI on 27th July 2022, this report provided members with a description of how UHCW NHS Trust's NCCI had changed from 2019/20 to 2020/21. The Trust's NCCI showed an improvement from 102 to 101, but conclusions drawn from the data or comparisons with peers were difficult, due to the impact of the pandemic response on the indices. The report covered an overview of the costing process to inform the 2020/21 reference cost submission and the main drivers of the change to the Trust's cost base between 2019/20 and 2020/21. The Trust also received the results of the National Costing Assessment Tool, which was a self-assessment of the underlying cost data. This showed an improvement from 84% to 92% overall, despite the difficulties highlighted with data capture during the pandemic. DG then highlighted some of the figures presented to the Committee in particular the comparison table with other Trusts in the region and SWFT which had a very large community arm. SR stated that it was hard to draw conclusions from the figures presented. There were other influences shown within the figures and every provider includes or excludes figures. JMG asked whether there were any figures that stood out for investigation. DG stated that all categories were being constantly looked at and nothing was warranting further investigation. DG then left the meeting. The Committee **RECEIVED** the update and **NOTED** the difficulties in drawing comparisons with other Trusts using the data given the impact of the pandemic.	

ITEM	DISCUSSION	ACTION
FPC/22/130	**INTEGRATED QUALITY, PERFORMANCE AND FINANCE SUPPORT** JL joined the meeting to present the report, giving detail of the following. This report detailed performance for July 2022 relating to operational KPIs. The Trust delivered performance of 70.6% for July for the four hour standard, below the national standard of 95%. UHCW performance improved by 0.7% from last month. UHCW remained below the benchmarked position for England and the Midlands. The RTT incomplete position remained below the 92% national target and stands at 55.1% for June. The average weeks wait was 20. 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 4,225 for June, an increase of 360 from May. This compared to a national average of 2,018. Diagnostic waiters performance was 10.07% in July, a deterioration in performance of 0.58% on the previous month. Four national cancer standards were achieved in June. The Cancer 31 Day Diagnosis to Treatment (99.61%), Subsequent Surgery (95.83%) and Subsequent Drug (100%) and the 28 Day Faster Diagnosis Breast Symptomatic (96.81%) standards were achieved. The Two Week Wait suspected cancer standard was reported as 70.93% for June, 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 69.26% for June, due to the delays in first outpatient appointment, overall theatre capacity, reduced staffing due to COVID and delays to diagnostic investigation in some specialties. The Trust failed to achieve the 62 Day National Screening Programme standard in June at 69.77% due to diagnostic delay and treatments. The overall 28 Day Faster Diagnosis Standard reported 73.6% against the 75% target. 18 breaches (23 patients) were treated after the 104+ day target. The average number of long length of stay patients for July was 182 a reduction of two from June. Reason to reside data collection compliance for eligible areas was 83%.	

ITEM	DISCUSSION	ACTION
	The Trust had delivered 93,360 Covid-19 vaccinations (as at 15/8/2022). Some national submissions had been suspended due to the pandemic. Where possible the KPI remains reported within scorecards. The Committee **RECEIVED ASSURANCE** from the report.	
FPC/22/131	**EMERGENCY CARE UPDATE** JL presented the report which described the Emergency care position for the Trust for June 2022, also providing reference to the operational challenges in July 2022. June 2022 commenced with the additional challenges of the four day Jubilee weekend. The Trust experienced a high demand for services during this time. There was also noted a further surge in COVID cases in the population, that whilst didn't manifest in primary hospital admissions, the impact was felt through an increase in incidental patient numbers of COVID and staff absence. The Trust had started to see a reduction in the number of COVID cases in August 2022 but there remained 88 patients with COVID which generates additional operational pressures as these patients require isolation. The Red alert heat wave at the end of July had also created a challenging environment for patients and staff with efforts taken to protect both patients and staff but also the physical infrastructure of the Trust from the impact of excessive heat. The lessons learnt from this excessive heatwave were being captured and would form part of the new Annual Summer Plan that the Trust was developing as it was likely events like this would continue through subsequent summers. **Ambulance Handovers:** This remained a focus for the Trust, and whilst performance was above average for the WestMidlands despite UHCW being the second largest single site for ambulance conveyancing. However, the impact on individual patients could be profound and the Trust continued to work closely with WMAS to put actions in place to improve handover times. The key action points were outlines in the report. At times of extremis when the Trust had struggled to maintain timely handover performance, support had been given by neighbouring George Elliott and SWFT which was recognised. There was assurance that any patient who had had a prolonged period waiting in an ambulance greater than 3 hours had a patient harm review completed. To date there had been no incidents of direct harm caused due to delays in handover. The report acknowledged that the risk in the community due to slow handovers had not been quantified.	

ITEM	DISCUSSION	ACTION
	Flow and Discharge: There was an understanding that pressures at the front door were created by high levels of demand and an inability to flow patients through the hospital and onwards into the community. There were multiple workstreams focused on discharge. The Trust had improved in key metrics which had allowed the Trust to be stepped down from the National Hospital only discharge programme although there remained improvement work to continue and we were voluntarily continuing to use their support. The NHS had launched its 100 day challenge across health and social care that was being led by ICS teams locally and the Trust had completed all the actions relevant to the acute providers. To respond to the challenges within the Trust, using UHCWi methodology there was a focus on flow with 5 kaizen events planned for September led by the Clinical Directors and Chief Officers to turn the dial and reduce length of stay. The ED expansion continued and was due to enter the third phase of development in the autumn. The new Minor Injuries Unit was opened at the beginning of June with a corresponding increase in performance in the time pathways in Minors. **Partnership Working:** The success of the Urgent and Emergency Care pathways was intrinsically linked with the success of system-wide initiatives to manage patients. The key workstreams that the Trust was collaborating on were: • Urgent Community Response with CWPT • Improving Lives for Older People with Coventry Care Collaborative • Improvements in Mental Health pathways with CWPT • 100 day discharge challenge with all system partners **Direct Streaming with WMAS** JMG asked a question concerning repatriations and moving patients into the community. JL reported that there were local improvements in the figures. JG questioned the partnership arrangements and how well they were performing. This would be answered through the milestone work JL would produce. JG then followed with a question on operational priorities and the Collaboratory work being undertaken with CWPT. Milestones would be added to the next report and would be shared at the next meeting.	**JL**

ITEM	DISCUSSION	ACTION
	The Committee **NOTED** the contents of the report and **RECEIVED ASSURANCE** in the measures in place to support improvement in Urgent and Emergency Care. .	
FPC/22/132	**ELECTIVE AND CANCER CARE UPDATE** JL reported that since January 2022 there had been a continuous wave of COVID with 3 spikes within the wave. As a consequence Elective and Cancer care performance had been the challenged by the high level of COVID infection in the community manifesting itself in higher than normal staff absences. The Trust was aware of the impact that this can have on specialist teams and mitigations were in place to try to minimise the impact of short notice staff absence on patients accessing cancer care. **Elective Care:** The Trust had maintained its zero 104-week waiters and was now working towards zero 78-week waiters by the end of August 2022 excluding those patients choosing to wait. The next phase of elective recovery had begun and there were key workstreams being implemented to address the challenges that delivering 52-week target presented. The key components of this would be a focus on outpatient utilisation to drive down the wait for first appointment to 26 weeks. This was in combination with a whole waiting list validation exercise. The Health Inequalities Scheduling Tool had been rolled out to all groups with a range of impacts being expected dependent on the overall waiting time for that specialty. The admin teams across the Trust were aware of the changes to the waiting lists and would see the patients continue to be prioritised by clinical need, exceptionally long waits and then other factors impacting their health. This was an exciting development for scheduling and the impact on performance would be closely monitored. **Cancer Care:** The Trust continued to focus on Cancer Care performance and recover its pre-pandemic position. Improvements had been made in 31-day performance and whilst further attention was required for radiotherapy waiting times, the overall performance had improved. There was a slight improvement in the 28-day FDS to 73.6% in June 2022 with the impact of screening being felt in the overall performance. The next step would be for a greater understanding of the number of cancer positive patients in the 75% and 25% cohorts in addition to close monitoring of the longest waiting patients without a definitive diagnosis. Specific improvements plans were in place for key tumour sites and there was an expectation that the Trust would move back to best practice pathways as a result. A key quality component of this is the	

	next step principle of ensuring that all patients on the pathways had a date for their next step. JG asked a question concerning mitigations for staff absence, JL reported that staff were moved where possible and all groups flexed. JG further asked what the cancer 75%/25% cohorts was related to. JL responded that this related to the 75% target of patients being contacted and initial treatment started . He also asked whether Covid testing was still nationally mandated or whether its continued use was a local infection control decision. JL said that unvaccinated patients would be tested but otherwise not. Urgent/emergency admissions were still being tested. The Committee **NOTED** the contents of the report and **RECEIVED ASSURANCE** in the measures in place to support improvement in Elective Care. At this point JL left the meeting.	
FPC/22/133	**SUSTAINABLE DEVELOPMENT UPDATE** LD was welcomed to the meeting and presented this item giving highlights from the report. The purpose of the report was to ensure the Committee was sighted on current issues and progress in relation to sustainable development. • Governance – progress continues 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. • Energy – Increased electrical load allows full usage of CHP generated electricity. • Hospital of St Cross Decarbonisation – Trust receives £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. LD reported that the new Net Zero Delivery Group had now commenced operations so would be the better Committee to report to FPC. The CHP was now able to supply virtually all the electricity requirement for the site. Rugby Council took more interest in the St Cross Decarbonisation scheme resulting in delays and having to undertake additional work.	

ITEM	DISCUSSION	ACTION
	JG asked whether the CO2 savings show for gas were net of the gas used to operate the CHP gas engine. LD confirmed that the table showed a net figure. LD also explained that as gas is not a carbon neutral fuel there would never be a complete saving of CO2. The Committee **NOTED** and were **ASSURED** of the report. At this point LD left the meeting.	
FPC/22/134	**CORPORATE RISKS REPORT** At this point LC joined the Committee and presented the report highlighting the following detail. **Total No. of Open Risks:** There were twelve open and approved corporate risks for which the Finance, Performance Committee (FPC) was the assigned Responsible Committee. Ten of these risks were approved at the Risk Committee in August 2022 and so were newly added to the FPC portfolio. Of the twelve risks, three were graded as 'HIGH' and full risk register details for these risks could be found in the report. The remaining nine risks were graded as 'MODERATE' and summarised details of these risks could also be found in the report. 4071 Reduction in Research Capacity 4092 22/23 Capital Programme - Funding 4091 22/23 Capital Programme - Delivery 4090 22/23 Agency Expenditure 4089 22/23 Waste Reduction Delivery 4088 22/23 Inflation Pressure 4087 22/23 COVID Costs 4086 22/23 Emergency Pressures 4085 22/23 Contract Income Risk - High Costs Drugs and Devices Block 4084 22/23 Contract Income - ERF (Elective Recovery Fund) JG noted the high-risk areas and suggested that the mitigations used to reduce the risks should be listed as without them being listed, ether was no visibility for the committee to understand how any difference between the initial and current risks score had been determined. LC then left the meeting. The Committee **RECEIVED ASSURANCE** from the report.	
FPC/22/135	**BOARD ASSURANCE FRAMEWORK** 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 updated BAF operated 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 would 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. JG mentioned that the version he could see differed to the version presented. DW replied that this was a very dynamic document and also reflected inputs from other Committees. 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.	
FPC/22/136	**DRAFT AGENDA FOR NEXT MEETING** The draft agenda was accepted.	
FPC/22/137	**ANY OTHER BUSINESS** JG reported a discussion with SR concerning a revised Financial Strategy which was to dovetail with the new Trust strategy. The existing Financial Strategy ended in 2020/21 and a briefing would be produced for work into the final quarter of this year. DW reported that ARAC had made a decision to develop a BAF entry around cyber-risks and that it had been agreed this risk would be monitored by that committee. To that end, it was proposed the FPC terms of reference be reviewed to see if any interim changes were required as digital currently sat under FPC's areas of responsibility. This was agreed.	
FPC/22/138	**MEETING REFLECTIONS** The Chair thanked the members for their attendance and participation. The Chair declared the meeting CLOSED at 15.50	

REPORT TO PUBLIC TRUST BOARD
HELD ON 6 OCTOBER 2022

Report of the Finance and Performance Committee following its meeting held on 29 September 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. Integrated Finance Report (including financial performance and waste reduction programme)	The month 5 deficit position was £11.5m compared to £9.5m at M4. This was £6.1m worse than the YTD plan. The year-end forecast remained as M4 at £5.6m deficit worse than plan. Key challenges driving the position were the WRP and high-cost drugs. The cash position remained better than plan. Capital was £600k behind plan but the committee's greatest concern was the investment risks related to EPR / digital funding due to this year's capital funding remaining unclear. Schemes to achieve the full amount required to achieve our waste reduction plan year-end target had been identified. However, these needed to be delivered in the context of delivery capacity challenges given all the other pressures on the organisation. Also, far too large a proportion (79%) of the currently identified schemes were non-recurrent. Agency costs were above plan by £1.4m and it was anticipated that they would exceed the plan year-end figure by £800k. Performance against the 104% activity target remained a challenge. The officially calculated figure for M4 was expected to be around 99%. NHSE has indicated no clawback for the first 6 months. Currently, we are still expecting to achieve 104% for the rest of the year and therefore no clawback is assumed in the forecast position. However, NHSE's position on ERF for the rest of the year was not confirmed.
8. Emergency Care Update	Pressures remained across the trust and in particular at the front-door in terms of 4 hour waits and ambulance handover, etc. and discharge remained a challenge with LLOS over 21 days at a high of 199. The committee was concerned to hear that the Adastra system used at the Urgent Treatment Centre had been subject to a malware attack which had resulted in an inability to capture data for the UTC since 4th August.
9. Winter Plan	Included on Board agenda. The report detailed actions to be taken to address the expected winter operational challenges and the national priorities. This included a self-assessment against a set of "good practice basics" which identified that we are in a strong position in most respects but with action still needed in some areas.

	However, the allocation of finance to cover the Winter Plan costs across the ICS remained subject to agreement.

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

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 12 Board Assurance Framework Item 11 Corporate Risks Report
Review the financial strategy	Item 6 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 8 Emergency Care Update Item 9 Winter Plan
Receive reports from the Chief Officers relating to organisational performance within the remit of the Committee	Item 7 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 6 Integrated Finance Report
Review the capital programme	
Receive assurance about the effectiveness of arrangements for; • Financial management • Operational performance • Recruitment, employment, training and workforce management • PFI arrangements • Organisational development • Emergency preparedness • Insurance and risk pooling schemes (LPST/CNST/RPST) • Cash management • Waste reduction and environmental sustainability	Item 6 Integrated Finance Report Item 7 Integrated Quality, Performance and Finance Report Item 9 Winter Plan
Receive reports from the Chief Finance Officer on actual and forecast financial performance against budget and operational plan	Item 6 Integrated Finance Report

TERMS OF REFERENCE: Did the meeting agenda achieve the delegated duties? Yes	
Item from terms of reference	State which agenda item achieved this
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 BOARD
HELD ON 6 OCTOBER 2022

Subject Title	Review of the Board Committee Annual Reports 2021/22
Sponsor	Afzal Ismail, Chair - Audit and Risk Assurance Committee
Author	David Walsh, Director of Corporate Affairs
Attachments	• Audit and Risk Assurance Committee (ARAC) Annual Report 2021/22 • Finance, Resources and Performance Committee (FRPC) Annual Report 2021/22 • Quality and Safety Committee (QSC) Annual Report 2021/22
Recommendations	The Committee is asked to **RECEIVE ASSURANCE** from the 2021/22 annual reports of ARAC, FRPC and QSC.

EXECUTIVE SUMMARY

The Annual Reports of the Quality and Safety Committee and Finance, Resources and Performance Committee for 2021/22 were considered by the Audit and Risk Assurance Committee on 17 August 2022. ARAC was assured that the reports demonstrated the committees had operated effectively during the year and met their terms of reference. In the same meeting, ARAC approved its own annual report.

All the reports are now presented to Board for assurance.

The reports describe the activities undertaken during the year in each of the committees, the attendance of members during that period and details of matters considered in the context of the committees' terms of reference.

PREVIOUS DISCUSSIONS HELD

Approval of the QSC Annual Report by the committee – 26 May 2022

Approval of the FRPC Annual Report by the committee – 30 June 2022

Approval of the ARAC Annual Report by the committee – 17 August 2022

KEY IMPLICATIONS

Financial	None in this report
Patients Safety or Quality	None in this report
Workforce	None in this report
Operational	None in this report

AUDIT AND RISK ASSURANCE COMMITTEE ANNUAL REPORT 2020/21

Introduction

This Annual Report summarises the activities of the Audit and Risk Assurance Committee (ARAC), which is a formal Committee of the Trust Board and describes how it has met its terms of reference and complied with the duties delegated to it by the Trust Board in the financial year 2021/22.

Terms of Reference

The terms of reference in place for the 2021/22 year were approved by Trust Board on 28 May 2020 following a comprehensive review and replaced the Audit Committee. They describe the purpose and duties of the Committee and are used to develop the work programme. The Terms of Reference have since been reviewed and the current arrangements for 2022/23 were approved on 31 March 2022.

Purpose of the Committee

The Committee is a statutory committee established by the Trust board to review the following areas;

- Internal control systems
- Financial and resource control
- Integrated governance
- Risk management

Meetings and Quoracy

Following changes put in place during the Covid-19 pandemic, the committee returned to the standard practice of four ordinary meetings as well as one extraordinary meeting specifically to deal with year-end matters such as the Annual Report, Annual Accounts and receipt of the Head of Internal Audit Opinion and External Audit Report.

The meeting quorum has been two non-executive directors. The meetings were quorate throughout 2021/22.

Membership and Attendance

The terms of reference provides for four non-executive directors (NEDs) and the members (following the approval of terms of reference) were:

- Afzal Ismail, Non-Executive Director
- Guy Daly, Non-Executive Director
- Jerry Gould, Non-Executive Director
- Sudhesh Kumar, Non-Executive Director

A schedule of attendance is set out in the following table:

ATTENDANCE LOG						
		Apr 21	**Jun 21**	**Jul 21**	**Oct 21**	**Jan 22**
Was the meeting quorate?		Yes	Yes	Yes	Yes	Yes
Non-Executive Director (Afzal Ismail)	Chair	✓	✓	✓	✓	✓
Non-Executive Director (Guy Daly)	Member	✓	✓	×	✓	✓
Non-Executive Director (Jerry Gould)	Member	×	✓	✓	✓	✓
Non-Executive Director (Sudhesh Kumar)	Member	×	✓	✓	×	✓

[1] Extraordinary meeting

Audit and Risk Assurance Committee Annual Work Programme

The Committee approved the revised annual work programme in April 2021 to provide a rationalised and balanced plan for the work of the year, taking into account the revised terms of reference.

The Committee considered all matters that are properly under its jurisdiction within the year. The Committee work programme drove the agenda for each meeting and ad hoc reports were requested where appropriate and necessary in response to emerging issues.

Agendas were reviewed and adjusted to take account of the pressures of the pandemic but covered all key areas of the work programme.

Business Conducted

The Committee had a number of items which it reviewed regularly, including.

- Board assurance framework
- Risk management including corporate risks
- Counter-fraud progress
- Debt write-offs
- External audit progress
- Internal audit progress and recommendations update
- Losses and special payments
- Waivers of standing orders and standing financial instructions

Internal Audit Reports Received

- Annual Internal Audit Report and Head of Internal Audit Opinion
- Counter Fraud Annual Report 20/21 and Plan 21/22
- Internal Audit Performance Outcome Measures and KPIs
- NFI Summary Report

The following internal audits provided:

- Board assurance framework
- E-procurement
- Charitable Funds
- West Midlands Surgical Training Centre – Governance Review

- Innovate UK Grant – Project PathLAKE Plus
- Recovery of Salary Overpayments
- Financial Governance – Adherence to National Planning Guidance
- Financial Systems
- Payroll
- Salary Overpayments Follow-up
- Restoration and Recovery – Wellbeing
- Innovate Grant; expenditure claims Q1, Q2 (revised) and Q3

External Audit Reports Received

- Value For Money Risk Assessment
- External Audit 260 Report including Directors' Report and S30 Referral and Audit

Other Reports

In addition to these regular items, the following items were also taken throughout the year;

- Governance arrangements during Covid-19
- Fraud, Bribery and Corruption Policy
- Annual governance statement
- Update on Clinical Audit Activity
- Information Governance Report – IG Incidents
- Annual report and accounts (including external audit reports
- Data Security Protection Toolkit Compliance Report
- Innovate UK Grant reports and updates
- TIAN Performance Reporting Survey
- External Audit Re-Tender Process
- Salary Overpayments
- Cyber Security Risks and Mitigations
- Policies, Procedures and Strategies Update
- Code of Business Conduct Policy
- Review of the Annual Reports of Board Committees and ARAC Annual Report
- Review of the Registers of Interests, Gifts and Hospitality
- Accounting Policies and Technical Account Update
- Annual Report and Accounts

Reporting Requirements

The approved minutes of the Committee are submitted to the public Trust Board. For the meeting immediately before the Trust Board, a short summary report is prepared on behalf of the Committee Chair within which key issues are highlighted.

Annual reports from the other Board committees are prepared and presented alongside this report to determine the effectiveness of the committees over 2021/22.

Conclusion

The Committee is of the view that it has taken appropriate steps to perform its duties as delegated by the Board and that it had no cause to raise any issues of significant concern arising out of its work during 2021/22.

Afzal Ismail

Chair, Audit and Risk Assurance Committee

August 2022

FINANCE, RESOURCES AND PERFORMANCE COMMITTEE ANNUAL REPORT 2021/22

Introduction

This Annual Report summarises the activities of the Finance, Resources and Performance Committee (FRPC), as a formal Committee of the Trust Board and describes how it met its terms of reference and complied with the duties delegated to it by the Trust Board in the financial year 2020/21.

Terms of Reference

The terms of reference were approved by Trust Board on 28 May 2020 following a comprehensive review and replaced the previous Finance and Performance Committee. They describe the purpose and duties of the Committee and are used to develop the work programme.

Following the development of a People Committee, the terms of reference were reviewed again at the final meeting of the year, on 31 March 2022, and changes were agreed. These will be used moving forward, with the committee again reverting to its previous title of Finance and Performance Committee for 2022/23.

Purpose of the Committee

The Committee was established by the Trust Board to review the following areas during 2021/22:

- Financial management and performance
- Operational performance
- Workforce
- Estates and facilities
- Information and communications technology

The workforce elements have been removed from the terms of reference for 2022/23 as part of the changes detailed in the previous section.

Meetings and Quoracy

Normally the Committee meets monthly, but following variations that took place during the pandemic, a practice of 10 meetings per year was adopted during 2021/22 and has been planned for 2022/23 as well. All meetings were held virtually through Microsoft Teams, though there is intention to move to a blend of remote and face-to-face meetings during 2022/23.

The meeting quorum has been two non-executive directors and one chief officer, with substitute attendees not counting towards the quorum. The FRPC meetings were quorate throughout 2021/22. Changes were agreed to the terms of reference of all committees by Board on 31 March, to allow for substitute attendees to count towards the quorum in such extreme circumstances and only with the express consent of the Chair.

Membership and Attendance

The terms of reference provides for four non-executive directors (NEDs) and three chief officers. The committee carried a non-executive vacancy after June 2021. The members of the Committee were:

- Jerry Gould, Chair
- Jenny Mawby-Groom, Non-Executive Director
- Carole Mills, Non-Executive Director

- Brenda Sheils, Non-Executive Director (for meetings held up to and including 23 June 2021)
- Donna Griffiths, Chief People Officer
- Laura Nelson, Chief Operating Officer (for meetings held up to and including 22 July 2021)
- Su Rollason, Chief Finance Officer
- Gaby Harris, Chief Operating Officer (for meetings held from and including 23 September 2021)

A schedule of attendance is set out in the following table:

ATTENDANCE LOG											
		Apr	**May**	**Jun**	**Jul**	**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	✓	×	✓	✓	✓	×	✓	✓	✓	✓
Chief Finance Officer	Member	✓	✓	✓	✓	✓	✓	✓	✓	×	✓
Chief Operating Officer	Member	✓	✓	×	✓	✓	✓	×	✓	✓	✓
Chief People Officer	Member	✓	×	✓	✓	✓	✓	✓	✓	×	✓
Non-Executive Director (Carole Mills)	Member	×	✓	✓	✓	×	✓	×	✓	✓	✓
Non-Executive Director (Brenda Sheils)	Member (until 30 June 2021)	✓	✓	✓							

Finance and Performance Committee Annual Work Programme

The Committee approved the revised annual work programme in February 2021 that provided a rationalised and balanced plan for the work in 2021/22.

The Committee considered all matters that are properly under its jurisdiction within the year. The Committee work programme drove the agenda for each meeting and ad hoc reports were requested where appropriate and necessary in response to emerging issues.

Agendas were reviewed and adjusted to take account of the pressures of the pandemic but covered all key areas of the work programme.

Business Conducted

The Committee had a number of items which it reviewed regularly, including.

- Corporate Risks, including the Board Assurance Framework
- Capital Programme
- Elective care updates (including restoration)
- Emergency care updates
- EPR Updates

- Estates brief
- Integrated Finance Report
- Integrated Quality, Performance and Finance Report
- Procurement updates
- Sustainable Development
- Waste Reduction Programme
- Workforce Information

Other Reports

In addition to these regular items, the following items were also taken throughout the year;

- Costing and Benchmarking
- E-Referral System
- Business Cases and Investments including the Emergency Department Expansion
- Apprenticeship Levy
- Performance Benchmarking
- Research and Development income and expenditure
- Costing Development Strategy 2021-23
- Emergency Department Expansion project updates
- Gender Pay Gap
- Equality, Diversity and Inclusion
- Integrated Pharmacy Medicines Optimisation
- Staff Transportation Policy
- Procurement Strategy
- Chargeable Overseas Visitors

Reporting Requirements

The approved minutes of the Committee are submitted to the public Trust Board. For the meeting immediately before the Trust Board, a short summary report is prepared on behalf of the Committee Chair within which key issues are highlighted.

Assurance is given to the Audit and Risk Assurance Committee that the Committee is operating effectively and within its terms of reference through this report.

Conclusion

The Committee is of the view that it has taken appropriate steps to perform its duties as delegated by the Board and that it had no cause to raise any issues of significant concern with the Audit and Risk Assurance Committee arising out of its work during 2021/22.

Jerry Gould
Chair, Finance, Resources and Performance Committee

June 2022

QUALITY AND SAFETY COMMITTEE ANNUAL REPORT 2021/22

Introduction

This Annual Report summarises the activities of the Quality and Safety Committee (QSC), which is a formal Committee of the Trust Board and describes how it has met its terms of reference and complied with the duties delegated to it by the Trust Board in the financial year 2021/22.

Terms of Reference

The terms of reference in place for most of 2021/22 were approved by Trust Board on 28 May 2020 following a comprehensive review and replaced the Quality Governance Committee. They describe the purpose and duties of the Committee and are used to develop the work programme.

A new terms of reference has since been developed following changes to the working of committees reporting into Board, including the development of a People Committee. That terms of reference was approved by the committee, and Board, on 31 March 2022. It will reflect the expectations of the committee in 2022/23 onwards but also reflects some in-year changes that were agreed by the committee during 2021/22, such as the frequency of meetings.

Purpose of the Committee

The Committee was established by the Trust Board to review the following areas;

- Patient safety and quality
- Patient experience
- Clinical effectiveness
- Health and safety

Meetings and Quoracy

Historically the QSC and its predecessor meetings have met monthly, with a minimum of 10 meetings per year. This was reduced to nine meetings during the COVID-19 pandemic due to operational pressures that arose, and a decision was taken during 2021-22 to trial meeting in alternate months, as agreed at the meeting in October. This resulted in a total of eight meetings taking place during the year, and the revised terms of reference now reflect this new approach.

The meeting quorum has been two non-executive directors and one chief officer, with substitute attendees not counting towards the quorum. The QSC meetings were quorate on seven out of eight occasions during 2021/22, with the final meeting of the year being inquorate due to two chief officers becoming unexpectedly available, due to a combination of illness and extraordinary travel issues. Changes were agreed to the terms of reference of all committees by Board on 31 March, to allow for substitute attendees to count towards the quorum in such extreme circumstances and only with the express consent of the Chair.

Membership and Attendance

The terms of reference provides for four non-executive directors (NEDs) and three chief officers. The members of the Committee (following the approval of terms of reference) were initially:

- Sudhesh Kumar, Chair
- Guy Daly, Non-Executive Director
- Mo Hussain, Chief Quality Officer
- Nina Morgan, Chief Nursing Officer
- Carole Mills, Non-Executive Director

- Kiran Patel, Chief Medical Officer
- Brenda Sheils, Non-Executive Director

Following the end of Brenda Sheils' terms of office as a Non-Executive Director, the committee operated with a vacancy, save for one meeting in November when Jenny-Mawby Groom was temporarily appointed to the committee in anticipation of some expected absences.

The Chief Nursing Officer member role was occupied by Nina Morgan until her departure from the organisation on a secondment, after which it was occupied by her successor Tracey Brigstock.

*Changes were made to the Non-Executive Director membership in advance of the final meeting of the year, resulting in Carole Mills replacing Sudhesh Kumar as Chair of the QSC.

A record of attendance is set out below:

Attendance		**Apr**	**May**	**Jun**	**Aug**	**Oct**	**Nov**	**Jan**	**Mar**
Was the meeting quorate?		Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Non-Executive Director Carole Mills	Chair*	×	✓	✓	✓	✓	✓	✓	✓
Non-Executive Director Sudhesh Kumar	Chair*	✓	×	✓	×	✓	✓	✓	×
Chief Medical Officer	Member	✓	✓	✓	✓	×	✓	✓	×
Chief Nursing Officer	Member	×	✓	×	✓	✓	✓	×	×
Chef Quality Officer	Member	✓	✓	✓	✓	✓	✓	✓	×
Non-Executive Director Guy Daly	Member	✓	✓	✓	✓	✓	×	✓	✓
Non-Executive Director Brenda Sheils	Member	✓	✓	✓					
Non-Executive Director Jenny Mawby-Groom	Member						✓		

Quality and Safety Committee Annual Work Programme

The Committee approved the annual work programme for 2021/22 in February 2021 that provided a rationalised and balanced plan for the work of the year.

The Committee considered all matters that are properly under its jurisdiction within the year. The Committee work programme drove the agenda for each meeting and ad hoc reports were requested where appropriate and necessary in response to emerging issues.

Agendas were reviewed and adjusted to take account of the pressures of the pandemic but covered all key areas of the work programme.

Business Conducted

The Committee had a number of items which it reviewed regularly, including.

- Corporate Risks, including the Board Assurance Framework
- Integrated Quality, Performance and Finance Report
- Maternity Update (including Ockenden briefing)

- We Care report
- Serious Incident and Never Event reports / Patient Safety Risk and Learning reports
- Mortality (SHMI and HSMR) updates
- Medical Education Reports
- Infection Prevention Control Updates

Other Reports

In addition to these regular items, the following items were also taken throughout the year (some on more than one occasion):

- World Class Ward/Department Accreditation Framework
- Closure of Actions from CQC / other CQC-related matters
- Board Walkarounds
- Quality Account 2020-21 review
- Quality Account Priorities 2021-22 progress reports
- Quality Strategy Updates
- Quality Strategy
- Clinical Prioritisation and Clinical Harm
- Quality Impact Assessments
- Clinical Status Reviews
- Health and Safety Updates
- Audit Findings
- Safeguarding Adults and Children
- National Patient Safety Strategy Briefing
- NNAP Outlier Letter
- Hospital transfusion committee annual report
- End of Life Care Reports
- UHCW Continuity of Care Implementation Plan
- Staffing Assurance Framework for Winter Preparedness
- Safe Staffing reports
- National Survey Programme action plans

Reporting Requirements

The approved minutes of the Committee are submitted to the public Trust Board. For the meeting immediately before the Trust Board, a short summary report is prepared on behalf of the Committee Chair within which key issues are highlighted.

Assurance is given to the Audit and Risk Assurance Committee that the Committee is operating effectively and within its terms of reference through this report.

Conclusion

The Committee is of the view that it has taken appropriate steps to perform its duties as delegated by the Board and that it had no cause to raise any issues of significant concern with the Audit and Risk Assurance Committee arising out of its work during 2021/22.

Carole Mills
Chair, Quality and Safety Committee
May 2022

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 6 OCTOBER 2022

Subject Title	Board Assurance Framework (BAF)
Executive Sponsor	David Walsh, Director of Corporate Affairs
Author	David Walsh, Director of Corporate Affairs
Attachment(s)	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(s)	The Committee is asked to: 1. **RECEIVE** the BAF entries for 'Financial Stability' and 'Operational Performance' following consideration by the Finance and Performance Committee on 29 September 2022 2. **RECEIVE** the BAF entries for 'Staff Wellbeing and Morale' and 'Workforce Supply' following consideration by the People Committee on 26 September 3. **RECEIVE** 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. **CONSIDER** and triangulate any additional assurances received during the Board meeting in the context of the documents described above. 5. **NOTE** the update in relation to the development of a Cyber Security critical risk for BAF monitoring through the Audit and Risk Assurance Committee.

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 'red' area of assurance in relation to specific areas reported at the last Board meeting remains, namely:

- Quality and Safety Committee recorded 'red' assurance against the Learning from Deaths internal audit, which has been reported to Audit and Risk Assurance Committee to date. This will be presented in due course.

A second 'red' area reported at the last Board meeting, relating to non-medical appraisals was upgraded to 'amber' at the most recent People Committee. While attainment remains below target, the trajectory is positive and the committee were assured that the necessary actions were being taken to remedy the issue.

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. One 'red' area remains, in relation to 'Associated Corporate Risks' within the Financial Sustainability BAF.

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

In developing the BAF, Board identified seven critical risk areas, six of which are captured above. The seventh (Cyber Security) was not captured and has remained an area for consideration by Audit and Risk Committee in overseeing the BAF. At the last ARAC meeting, it was agreed that a new BAF risk in this area will be developed and monitored by ARAC for future reporting.

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: **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

First line of assurance

Assurances received

Issue/report	Last review	Rating
IPQFR - sickness absence	26/9/22	
IPQFR - vacancies	26/9/22	
IPQFR - mandatory training	26/9/22	
IPQFR - Turnover	26/9/22	
IPQFR - Medical appraisals	26/9/22	
IPQFR - Non-medical appraisals	26/9/22	
IPQFR – Agency spend	26/9/22	
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	

Gaps

- Sickness absence reduced to 4.95% against target of 4%
- Mandatory training at 93.48% (95% target), Non-medical appraisals at 82.41% (90% target), Turnover at 10.96% (10% target)
- Overspending on agency (£3m+) (Sept 22)
- Forecast expired apprenticeship levy of £675k in 22/23
- FTSU app not yet rolled out, some gaps in lessons learned

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 revisied following implementation of NHSE/I requirements

Actions

- Deep dive on recruitment and retention of Band 5 nurses, midwives, HCSWs and AHPs in August
- Three-month improvement trajectories set relating to non-medical appraisals in accountability meetings.

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	7/10/21 (Board)	
Workforce Disability Equality Standard	7/10/21 (Board)	
Internal Audit – Medical Appraisals	> 2022/23	
Internal Audit – Payroll and Overpayments	> 2022/23	

Gaps

- 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

Mitigations

- Actions arising from Overpayment internal audit (moderate assurance) all now completed and reported to ARAC.

Actions

- Programme of work being monitored through People Support Group relating to WRES/WDES actions, and will be reported to People Committee

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	

Actions

- 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

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
UHCW Theatre infrastructure failings*	20	15	2
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

*Also included on QSC BAF

First line of assurance

Assurances received

Issue/report	Last review	Rating
IQPFR	29/9/22	
Emergency Care	29/9/22	
Cancer Care	25/8/22	
Performance benchmarking	28/4/22	
Elective Care – 104 week waiters	25/8/22	
Elective Care – update	25/8/22	
Sustainable Development	25/8/22	
Winter Plan	29/9/22	

Gaps

- IQPFR – caution around waiting list profile in July and August (May 22) – to be reported in IQPFR Sep and Oct
- Cancer – two-week wait (72.25%), 28-day (73.6%) and 62-day standards (62.13%) off track (July data, reported Sept 22)
- RTT incomplete at 53.5% vs 92% national target
- Long length of stay: 199 patients at 21 days or over (July reported Sep)

Mitigations

- Waiting list being managed ahead of anticipated increased numbers in July and August (May 22)
- 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)

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

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	

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
UHCW Theatre infrastructure failings*	20	15	2
Potential of major fire risk	15	15	8
Inability to meet demand for breast imaging/screening	15	15	12
Storage on hospital corridors	16	12	4
Delays to assessment/transfer for MH patients	15	12	6
Registered Nurse vacancies	15	12	6
Lack of hybrid operating theatre	15	10	6
Stroke centralisation – system funding risk*	10	10	6
Maintaining up-to-date clinical guidelines	16	9	6

*Also included in the FFC BAF

First line of assurance

Assurances received

Issue/report	Last review	Rating
IQPFR	29/9/22	
Patient Safety, Risk, Learning, Nev. Ev.	28/7/22	
Patient Exp. & Engagement	29/9/22	
Complaints Annual Report	26/5/22	
Maternity Safety/Ockenden delivery	29/9/22	
N&M Safe Staffing	26/5/22	
Safeguarding Adults & Children	28/7/22	
Health and Safety update	28/7/22	
IPC Update	28/7/22	
BMI Meriden rating	28/7/22	
Training – mandatory and role-specific	28/7/22	
Quality Account	29/9/22	
Medical Education	28/7/22	
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	29/9/22	

Gaps

- Recording gaps around H&S near misses identified (Jan 22)
- Learning from Meriden visit not yet demonstrable (Jul 22)
- Remaining questions over training standards expected for substantive staff vs bank vs agency (Jul 22)
- IPQFR – continued flow issues including impact of night transfers (Sep 22)

Mitigations

- Actions in place to improve reporting of near misses (Jan 22)
- Visit undertaken at Meriden with CQC and Deputy CMO - action plan close to sign-off (Jul 22)
- Bristol model being explored relating to flow (Sep 22)

Actions

- Reinforcing use of Datix to capture H&S near misses – assurance required for next report to committee (Jan 23)
- Further assurance on training bank/agency (Sep 22)
- Development of plan to introduce PSIRF (verbal Sep 22)
- Data on night transfers to future meeting (Sep 22)
- Assurance around benchmarking for NMAHP Education (Sep 22)

Second line of assurance

Assurances received

Issue/report	Last review	Rating
National survey action plans	31/3/22	
Mortality Update	28/7/22	
Dermatology review	29/9/22	
Learning from Deaths – internal audit report	Scheduled for Nov 2022	
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)
- Identification of recommendations arising from completion of dermatology review (Sep 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 outcomes and Urgent & Emergency Care Survey 2020
- Dermatology update being presented to Board

Actions

- Progress on action plan in response to Learning from Deaths internal audit to be presented

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	Nov 22	
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	

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: **Finance and Performance Committee**
Critical risk areas: **Financial stability**

Associated risks

Managed risk	Initial	Current	Target
2022/23 Contract income – ERF	20	20	8
2022/23 Waste reduction delivery	20	20	4
2022/23 Inflation pressure	16	16	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	9	6
2022/23 Emergency Pressures	9	9	6
2022/23 Covid costs	9	9	6
2022/23 Capital programme delivery	9	9	4

*Also included on People Committee BAF

First line of assurance

Assurances received

Issue/report	Last review	Rating
IQPFR	29/9/22	
Waste Reduction programme	25/8/22	
Integrated Finance Report	29/9/22	
Procurement Update	26/5/22	
Research and Development Income, Expenditure and Compliance	29/9/22	
National Cost Collection 2021/22 – process and arrangements	25/8/22	

Gaps

- IQPFR – see Operational Performance BAF entry
- Performance of 92% against ERF 104% target (Jun 22)
- M5 £11.5m deficit vs £5.4m plan, capital spend of £10.1m vs £10.7m plan (Sep 22)
- CDC funding changes at national level – detail awaited
- Uncertainty flagged on UHCW costing allocations (Aug 22)
- Agency expenditure (Sep 22)

Mitigations

- Deloitte delivering focused 15-week programme to support waste delivery, embedded with PMO to support
- 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

Actions

- Procurement: NHSE/I framework issue being reviewed – feedback from regional committee awaited
- Star chambers planned with groups to improve traction on achieving waste targets (Sep 22 onwards)
- Detail of waste reduction schemes requested for next meeting (Sep 22)
- Recommend to ARAC addition of costing to internal audit plan, and assurance on current arrangements in next report

Second line of assurance

Assurances received

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	
Mandated review of HFMA Best Practice Assessment internal audit	Update provided 25/8/22	

Gaps

- 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)

Mitigations

- Actions arising from all gaps identified above completed by 31/3/22
- HFMA – in addition to mandated actions rated 5, UHCW will undertake actions by local choice for those rated 4

Actions

- Scope of financial sustainability internal audit received and now progressing – replaced financial assessment that has previously been undertaken by CW Audit but is wider
- HFMA outcome to be presented via FPC, ARAC and Board

Third line of assurance

Assurances received

Issue/report	Last review	Rating
VFM Audit Plan (ARAC)	21/4/22	
National Cost Collection 20/21 outputs	25/8/22	

Gaps

- 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

Actions

- 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

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 6 OCTOBER 2022

Subject Title	Integrated Quality, Performance & Finance Report – Month 5 – 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: August 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 August 2022.

The Trust has achieved 10 of the 35 indicators reported within the Trust's performance scorecard. The Trust scorecard aligns Trust level indicators with the objectives outlined in the Trusts 2018-2021 Organisational Strategy.

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

The Trust delivered performance of 64.4% for August for the four hour standard, below the national standard of 95%. Performance deteriorated by 6.2% from last month and is reduced with no activity included for the Coventry Urgent Treatment Centre. UHCW remains below the benchmarked position for England and the Midlands.

The RTT incomplete position remains below the 92% national target and stands at 53.5% for July. The average weeks wait was 20.5.

The Trust has 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 compares to a national average of 2,147.
RTT 78 week waits are reducing with 127 reported for July, a decrease of 19 on June.
The Trust reported no 104 week waits for July.

Diagnostic Waits performance was 89.72% seen within 6 weeks in August, a deterioration in performance of 0.21% on the previous month.

Cancer performance for July 2022 was:

- Cancer TWW: 75.25% (target 93%)
- Cancer 31 day diagnosis to treatment: 93.56% (target 96%)
- Cancer 62 day referral to treatment: 62.13% (target 85%)
- Cancer 104+ days wait: 19.5 breaches, 26 patients (target 0)

- Cancer 62 day screening: 86.49% (target 90%)
- Cancer 28 days Faster Diagnosis Overall: 71.95% (target 75%)

The average number of long length of stay patients has risen to 199 – an increase of 17.

Reason to reside data collection compliance for eligible areas is 82%.

The latest reported HSMR figure is 122.81 for May 2022 and is outside Dr Foster's calculated relative risk range.

A Category 4 Pressure Ulcer has been reported for June. Further details are included in this report.

Complaints Turnaround time <= 25 days was 98%.

The Trust has delivered 93,360 Covid-19 vaccinations (as at 14/09/22).

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
- Sickness Rate
- Medical Appraisal Rate
- 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: August 2022

NHS
University Hospitals Coventry and Warwickshire NHS Trust

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 demonstrate the challenge of restoring elective care services, whilst delivering non elective services at a scale we had not planned for, in the context of striving to achieve financial balance. I am proud that we continue to have no patients waiting in excess of 104 weeks for elective care at the trust. We are working hard to ensure we treat all patients waiting over 78 weeks and then ultimately all those waiting over 52 weeks. In parallel, our teams are working hard to deliver excellent cancer services in terms of quality and waiting times, despite increasing demand and staffing sickness. On emergency care, we continue to monitor our performance against the 4 hour standard, despite it no longer being used nationally in the same way, and we are constantly looking for improvements, which we aim to see develop as measures pertaining to COVID-19 restrictions continue to be slowly lifted. Footfall to ED remains in line with the national picture of increased demand and we continue to safely manage that. Operationally, our teams are working to deliver on all these fronts despite an increasing level of staff sickness absence and an increase in Covid-19 cases (both among staff and patients). We continue to have a significant focus on well-being and efforts to engage and listen to staff at a level beyond our conventional approach. As part of our staff engagement we strive to return to more business as usual, demonstrated by our increasing rates of medical and non-medical appraisal as well as a return to high levels of mandatory training. In addition to the services we deliver, we also have focus on what we plan to deliver.

Professor Andrew Hardy, Chief Executive Officer

10 KPIs achieved the target in August

	Indicators achieved	Indicators in exception	Indicators in watching status	Total indicators
Safest care and excellent experience	3	5	1	9
Leader in operational performance	2	11	1	14
Model employer	2	0	3	5
Achieve financial sustainability	0	2	0	2
Frontrunner in research innovation and education	3	2	0	5
All domains	**10**	**20**	**5**	**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	4	0
Achieve financial sustainability	0	0	0
Frontrunner in research innovation and education	0	0	0
All domains	**2**	**13**	**1**

* 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	64.4%
Cancer 62 Day Standard plus 31 Day Rare Cancers (1 month in arrears)	85%	F	62.13%
18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears)	92%	F	53.5%
A&E 12hr Total Wait Time	2%	F	8.5%

Special Cause Improvement

Measure	Annual Target	Target Assurance	Latest Position
Diagnostic Waiters - 6 Weeks and Over (National Target)	95%	F	89.72%

Common Cause Variation

Measure	Annual Target	Target Assurance	Latest Position
Breaches of the 28 Day Readmission Guarantee	0	F	13

Non Mandatory (Local or Regional Targets)

Special Cause Concern

Measure	Annual Target	Target Assurance	Latest Position
Mandatory Training Compliance	95%	F	93.68%
Sickness Rate	4%	F	4.95%
Appraisal - Medical	90%	F	91.93%
Cancer 104+ days wait (treated) - (1 month in arrears)	0	F	19.5
Average Number of Long Length of Stay Patients	109	F	199
Friends & Family Test - Recommender Targets Achieved	7	F	1

Special Cause Improvement

Measure	Annual Target	Target Assurance	Latest Position

Common Cause Variation

Measure	Annual Target	Target Assurance	Latest Position
Appraisal - Non-Medical	90%	F	82.41%

Quality and Safety | Headlines August 2022

University Hospitals Coventry and Warwickshire NHS Trust

INFECTION CONTROL

This month 0 MRSA and 10 CDiff cases were reported.

Infection Rates
Cumulative

33 CDiff
YTD target 27
Annual Target 65

0 MRSA
0 YTD target
Annual Target 0

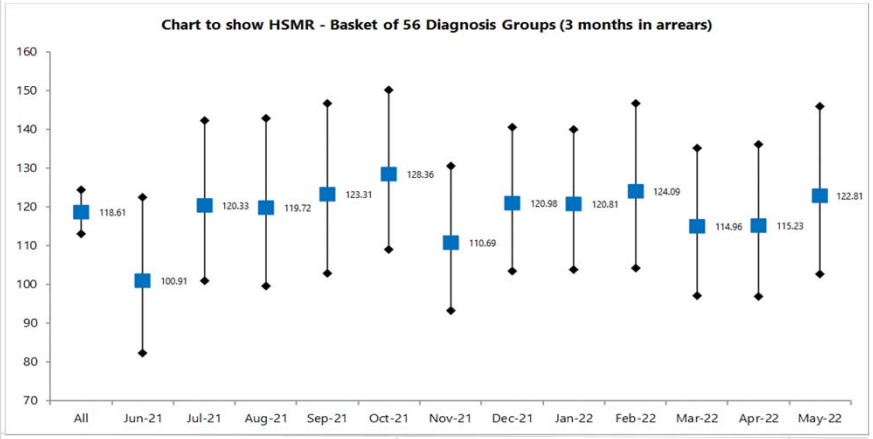
- **CDiff 9 RCAs** carried out and reviewed. 1 deemed avoidable. No further RCAs held.
- **MRSA** High Risk Elective Inpatient Screening: **97.8%**
- **MRSA** High Risk Emergency Screening: **93.0%**

MEDICINE RELATED SERIOUS INCIDENTS

No medication errors causing serious harm have been reported.

HSMR

The latest HSMR score reported from Dr Foster is 122.81



Summary

RIDDOR – There were four reported incidents in August.

The average number of patients with a length of stay of 21 days is 199, an increase of 17 against the Trusts target of 109.

One Category 4 Pressure Ulcer was reported in July, details are included in this months report.

The latest HSMR score reported is 122.81 for May and is outside Dr Foster's calculated relative risk range

Four 12 hour trolley waits

RIDDOR

4 Incidents reported for August

No urgent operations have been cancelled for a second time

Never Events 0

2 YTD performance against target of 0

4hr Achievement Overview - as at 14/9/2022

Stream	Last Month	Current Month	Last Year	This Year
Type 1 Majors	28.27%	29.68%	38.78%	28.35%
Type 1 Resus	27.06%	24.86%	36.40%	26.70%
Type 1 Paediatrics	71.33%	64.42%	69.32%	62.60%
Local Health Economy	64.38%	61.71%	73.87%	68.20%

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

Urgent Clinic Letters sent in 7 calendar days

79.3%

Last month: 70.1%
Target 100%

LLOS

Average number of patients with a length of stay 21 days and over
199

Reason to Reside
Data Collection compliance for eligible areas: 82%

Incomplete RTT pathways

52 Weeks

4,811 (July)

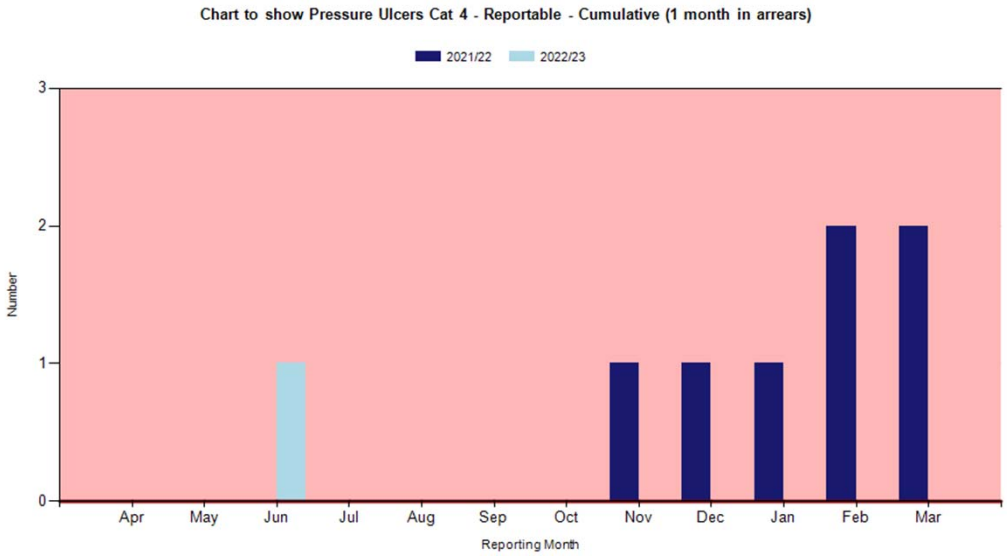
Previous month 4,225
Target 0

Integrated Quality, Performance and Finance Reporting Framework

Quality and Safety Summary

Area of underperformance – Pressure Ulcer Category 4

A Category 4 Pressure Ulcer has been reported in June.



Category 4 Pressure Ulcer.

Patient admitted on the 29th May 2022 following a fall at home. Care continued and on the 21st June 2022, a category 2 pressure ulcer was identified on the patient's clamped hand between their fingers. Tissue Viability reviewed the patient on the 1st July 2022 as the damage was reported to have deteriorated.
A category 4 pressure ulcer was confirmed and it was noted that the patient had a contracted hand causing the fourth finger to press into the inner surface of the third finger.

The below immediate learning was identified on review of the incident by the Patient Safety Response team:

- There should be documentation to record pressure ulcer prevention measures that are in place for patients.
- All areas of the body should be checked when completing skin assessments

A Serious Incident Investigation is underway to identify learning and actions for improvement. The Root Cause Analysis is in progress and is due for completion by October 2022.

Operational Performance | Headlines August 2022

NHS University Hospitals Coventry and Warwickshire NHS Trust

Operational Summary

Emergency 4 hour wait:

August 2022 - **64.4%**

Latest benchmarked month:

England – August 71.4%

Midlands – August 73.1%

4hr Achievement Overview - as at 14/9/2022

Stream	Last Month	Current Month	Last Year	This Year
Type 1 Majors	28.27%	29.68%	38.78%	28.35%
Type 1 Resus	27.06%	24.86%	36.40%	26.70%
Type 1 Paediatrics	71.33%	64.42%	69.32%	62.60%
Local Health Economy	64.38%	61.71%	73.87%	68.20%

Diagnostic Waiters 6 Weeks and Over

10.28% : 1,594 breaches across all areas

Ambulance Handover

Within 30 minutes : **60.6%**

Within 60 minutes : **83.8%**

Summary

Emergency 4 hour wait was 64.4% for August, a deterioration of 6.2% from last month. Performance is reduced as no activity for the Coventry Urgent Treatment Centre is included for August. UHCW remains below the benchmarked position for England and the Midlands.

Cancer 31 day subsequent drug (100%) and radiotherapy (95.03%) standards and the Faster Diagnosis Breast Symptomatic (94.55%) standard were met. Two week wait (75.25%), 31 day diagnosis to treatment (93.56% and 62 day (62.13%) standards were not achieved in July.

Covid-19 Vaccinations

93,360 as at 14/09/2022

Urgent Clinic Letters sent in 7 calendar days

79.3%

Last month: 70.1%

Target 100%

Incomplete RTT pathways

Submitted Position	Inc %	Backlog (Over 18 Weeks)	Latest Benchmarked Month	UHCW	NHS England
Jul 2022	53.5%	29,794	01/07/2022	53.5%	60.6%
Jul 2021	57.7%	21,731	01/07/2021	57.7%	67.7%
YTD UHCW Change	-4.2%	8,063	Benchmark Change	-4.2%	-7.1%

4,811 (July)

Previous month 4,225

Target 0

LLOS

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

199

Four 12 hour trolley waits

Reason to Reside

Data Collection compliance for eligible areas: 82%

Cancer standards - July

	Mth
TWW:	75.25%
31 day:	93.56%
62 day:	62.13%
FD Overall:	71.95%
TWW Breast Symp	74.77%
31 Day Sub Surg	92.59%
62 day Screening	86.49%

19.5 breaches (26 patients) treated over 104 days

Last minute Non-Clinical Operations – Elective

0.8%

of elective admissions – 56 Patients

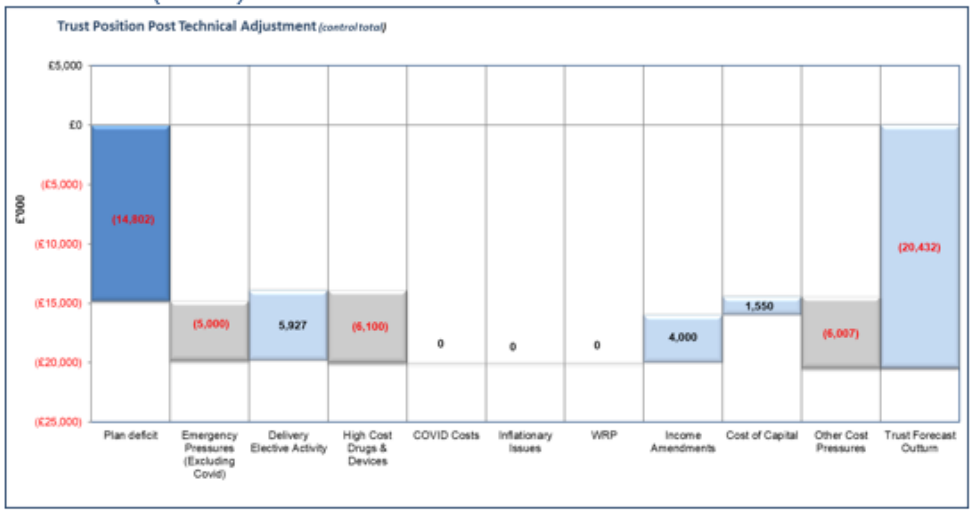
Last month – 56 Patients

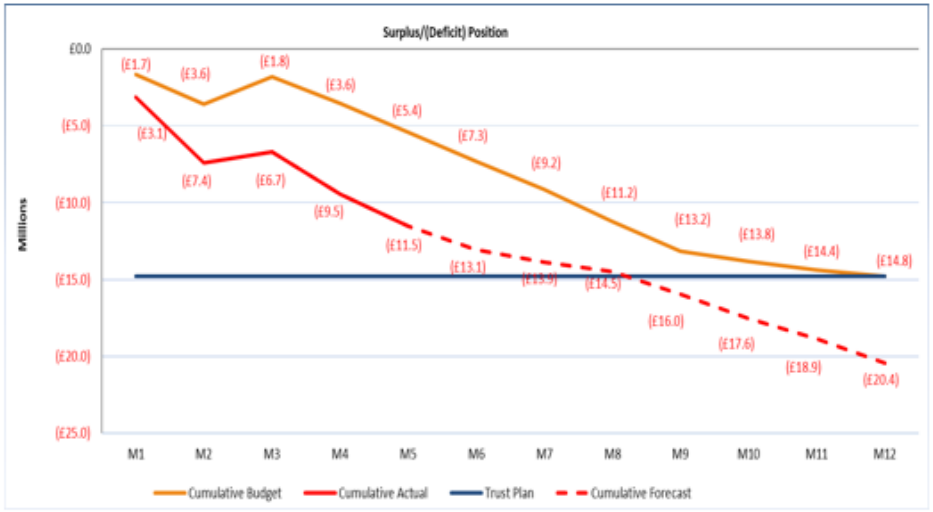
Integrated Finance Report | Finance Headlines

NHS University Hospitals Coventry and Warwickshire NHS Trust

Reporting Month: August 2022

The month 5 year to date position shows a (£11.5m) deficit compared to (£5.4m) deficit plan, an unfavourable variance of (£6.1m). This is a deterioration of (£2.0m) from Month 4. The forecast position at Month 5 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 Income changes £4.0m, Managing Emergency pressures (£5.0m), Delivery of elective activity £5.9m, High-cost drugs & devices (£6.1m), Cost of Capital £1.6m and other cost pressures (£6.0m).

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

ERF Income Assumption:

- Internal monitoring to month 04 indicated delivery of 92.3%, 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 October with no loss of income at this stage.

CONTRACT & ACTIVITY INCOME

£1.0m surplus

The Trust reported £1.0m surplus compared to plan at Month 5.
The forecast position is £1.8m surplus compared to plan at Month 5.

Waste Reduction Programme

£5.6m has been delivered against a YTD £10.4m target

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

Capital

Capital Plan £46.1m

Capital Expenditure of £10.1m at Month 5.

YTD £10.1m Agency Spend

Agency expenditure at Month 5 is £10.1m compared to an indicative target of £8.7m

Finance Summary

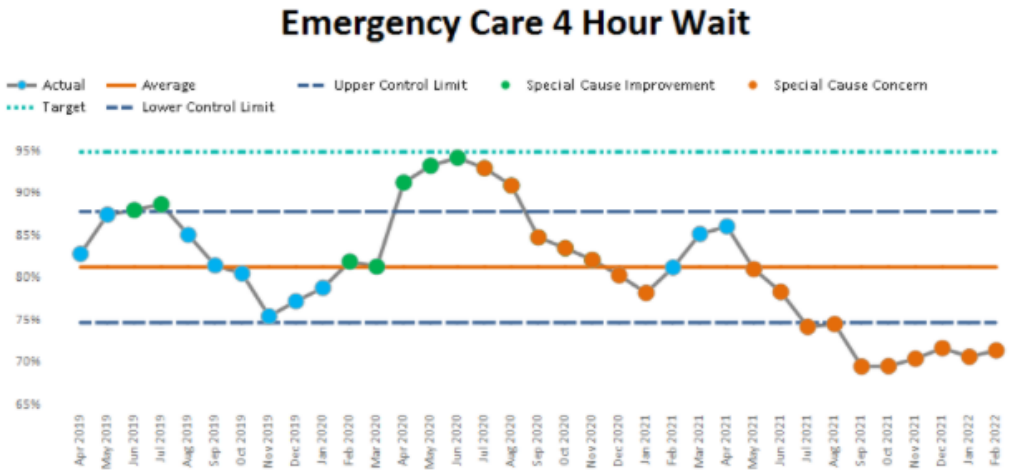
NHS
University Hospitals Coventry and Warwickshire NHS Trust

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

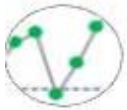
Variation (Performance Trend)	Trigger
Special Cause Improvement	60% of the last 13 data points showed a statistical improvement
Special Cause Concern	60% of the last 13 data points showed a statistical decline
Common Cause Variation	No pattern of decline or improvement in the last 13 data points
Assurance (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



How to understand the SPC Chart colours

No Special Cause detected - changes shown are due to natural variation, (such as seasonality) and are within the Upper and Lower limits

Special Cause - Concern detected - these changes are statistically due to factors outside of the normal variation, and need to be investigated. For example there may have been a reduction in services or an external influence.



Special Cause - Improvement detected - these changes are statistically due to factors outside of the normal variation, and have resulted in an improvement. For example the Area may have put in additional work to improve performance

Trust Scorecard

Reporting Month : August 2022

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

NHS University Hospitals Coventry and Warwickshire NHS Trust

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	23	33	↓	27	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	2.0	→	0	0	CMO	N/A	N/A
	Serious Incidents - Number	449	15	16	↓	15	15	CQO		P
	HSMR - Basket of 56 Diagnosis Groups (3 months in arrears)	264	115.23	122.81	↓	RR	RR	CMO	N/A	N/A
	SHMI - Monthly (6 months in arrears)	267	109.76	109.82	↓	RR	RR	CMO	N/A	N/A
	Average Number of Long Length of Stay Patients	1336	182	199	↓	109	109	CNO		F
	Patient Experience									
	Friends & Family Test - Recommender Targets Achieved	1487	1	1	→	7	7	CQO		F
	Complaints Turnaround <= 25 Days (1 month in arrears)	1064	98%	98%	↑	90%	90%	CQO		P
Leader in operational performance										
	Patient Flow									
	Emergency Care 4 Hour Wait	45	70.6%	64.4%	↓	95%	95%	COO		F
	A&E 12hr Total Wait Time	1511	6.9%	8.5%	↓	2%	2%	COO		F
	Bed Occupancy Rate - KH03 (3 months in arrears)	1065	96.6%	96.6%	→	93%	93%	COO	N/A	N/A
	Breaches of the 28 Day Readmission Guarantee	16	8	13	↓	0	0	COO		F
	Diagnostic Waiters - 6 Weeks and Over (National Target)	1507	89.93%	89.72%	↓	95%	95%	COO		F

Appendix B – Trust Scorecard

Trust Scorecard

Reporting Month : August 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	4225	4811	↓	4060	4060	COO	N/A	N/A
	RTT 78 Weeks Wait Incomplete (1 month in arrears) (National Target)	1509	146	127	↑	284	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	55.1%	53.5%	↓	92%	92%	COO		F
	Last Minute Non-clinical Cancelled Operations - Elective	14	0.9%	0.8%	↑	0.8%	0.8%	COO		?
			Cancer							
	Cancer 62 Day Standard plus 31 Day Rare Cancers (1 month in arrears)	73	69.26%	62.13%	↓	85%	85%	COO		F
	Cancer 104+ days wait (treated) - (1 month in arrears)	860	18.0	19.5	↓	0	0	COO		F
	Cancer 28 Day Faster Diagnosis Overall	1409	73.60%	71.95%	↓	75%	75%	COO	N/A	N/A
	National Cancer Standards Achieved (1 month in arrears)	1290	4	3	↓	12	12	COO	N/A	N/A
Model employer										
	Mandatory Training Compliance	384	93.84%	93.68%	↓	95%	95%	CPO		F
	Appraisal - Non-Medical	641	81.38%	82.41%	↑	90%	90%	CPO		F
	Appraisal - Medical	642	87.55%	91.93%	↑	90%	90%	CMO		F
	Sickness Rate	385	6.35%	4.95%	↑	4%	4%	CPO		F
	Vacancy Rate Compared to Funded Establishment	650	6.79%	6.61%	↑	10%	10%	CPO	N/A	N/A

Appendix B – Trust Scorecard

Trust Scorecard

Reporting Month : August 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	£4.860m	£5.642m	↑	10448	38788	CFO	N/A	N/A
Frontrunner in research innovation and education										
	Patients Recruited into NIHR Portfolio-Cumulative (2 months in arrears)	297	964	1455	↑	1289	5213	CMO	N/A	N/A
	Commercial Income Invoiced - Cumulative (1 month in arrears)	684	£138k	£188k	↑	300	900	CFO	N/A	N/A
	NIHR Research Capability Funding (3 months in arrears)	1332	£302k	£302k	→	250	1000	CMO	N/A	N/A
	Trial Recruitment Income (3 months in arrears)	1344	£506k	£506k	→	513.25	2125	CMO	N/A	N/A
	All Grant Income (3 months in arrears)	1345	£1.730m	£1.730m	→	500	2000	CMO	N/A	N/A
Enhanced Performance										
	Diagnostic Waiters - 6 Weeks and Over (Local Target)	33	10.07%	10.28%	↓	1%	1%	COO		F
	RTT 52 Week Waits Incomplete (1 month in arrears) (Local Target)	416	4225	4811	↓	0	0	COO	N/A	N/A
	RTT 78 Weeks Wait Incomplete (1 month in arrears) (Local Target)	1503	146	127	↑	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

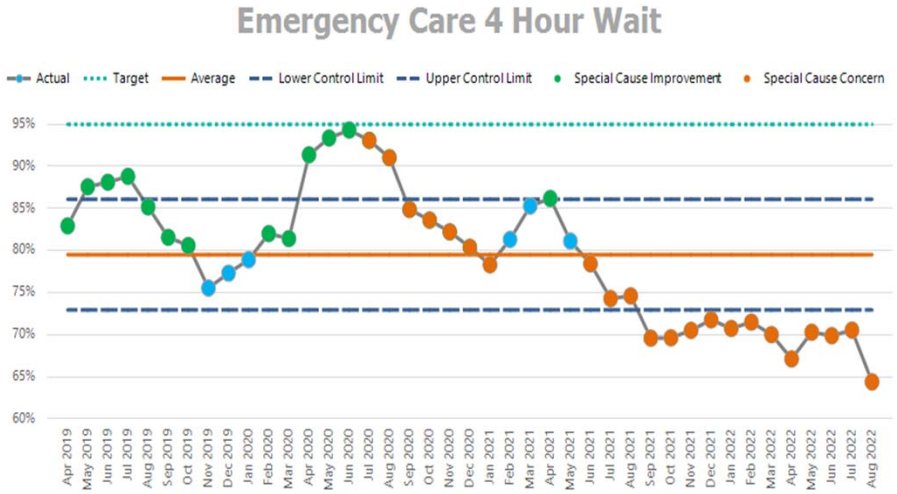
Measure	Emergency Medicine	Medicine	Trauma and Neuro Services	Surgical Services	Women and Children's Services	Clinical Diagnostics Services	Clinical Support Services	Trust	Trust Target
Reporting Period:								**August 2022**	
Group Level Indicators									
Safest care and excellent experience									
Healthcare associated incidents of Clostridioides difficile - Cumulative	3	11	2	4	0		0	33	27
MRSA Bacteremia - Trust Acquired - Cumulative	0	0	0	0	0		0	0	0
Never Events - Cumulative	0.0	0.0	0.0	0.0	1.0		1.0	2.0	0
Serious Incidents - Number	2	4	2	0	5	0	3	16	15
HSMR - Basket of 56 Diagnosis Groups (3 months in arrears)	139.59	117.36	100.20	139.95	47.76			122.81	100
Average Number of Long Length of Stay Patients	0	102	70	15	0	0	12	199	109
Friends & Family Test - Recommender Targets Achieved	0	0	0	0	1		1	1	7
Complaints Turnaround <= 25 Days (1 month in arrears)	100%	100%	100%	100%	80%	100%	100%	98%	90%
Leader in operational performance									
Emergency Care 4 Hour Wait	61.1%			99.6%	82.1%			64.4%	95%
Breaches of the 28 Day Readmission Guarantee			4	9	N/A		0	13	0
Diagnostic Waiters - 6 Weeks and Over (Local Target)		30.10%	19.55%	17.30%		7.75%		10.28%	1%
18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears)		55.1%	57.0%	50.5%	52.3%	67.0%	55.7%	53.5%	92%
RTT 52 Week Waits Incomplete (1 month in arrears) (Local Target)		1548.0	590.0	2094.0	565.0	5.0	9.0	4811.0	0
Last Minute Non-clinical Cancelled Operations - Elective	0.0%	0.0%	2.4%	2.3%	0.0%	0.0%	0.5%	0.8%	0.8%
Cancer 62 Day Standard plus 31 Day Rare Cancers (1 month in arrears)		77.17%	N/A	53.33%	37.50%			62.13%	85%
Cancer 104+ days wait (treated) - (1 month in arrears)		2.5	0.0	15.5	1.5			19.5	0
Cancer Faster Diagnosis Overall - Group		84.03%	91.67%	72.44%	44.41%			72.13%	75%
National Cancer Standards Achieved (1 month in arrears)		4	5	2	4			3	12
Model employer									
Mandatory Training Compliance	91.35%	92.26%	92.37%	94.24%	91.29%	94.94%	95.98%	93.68%	95%
Appraisal - Non-Medical	86.47%	77.00%	84.45%	88.74%	84.68%	82.67%	86.44%	82.41%	90%
Appraisal - Medical	92.59%	95.54%	92.06%	87.61%	93.62%	97.01%	94.25%	91.93%	90%
Sickness Rate	5.45%	4.32%	5.70%	4.41%	6.35%	4.56%	5.55%	4.95%	4%
Achieve financial sustainability									
WRP Delivery	£366k	£886k	£396k	£280k	£357k	£479k	£552k	£5.642m	10448
Frontrunner in research innovation and education									
Patients Recruited into NIHR Portfolio-Cumulative (2 months in arrears)	7	631	75	169	480	0	93	1455	1289

Trust SPC - Areas of Concern - Mandatory

NHS University Hospitals Coventry and Warwickshire NHS Trust

Appendix B – Trust Trends

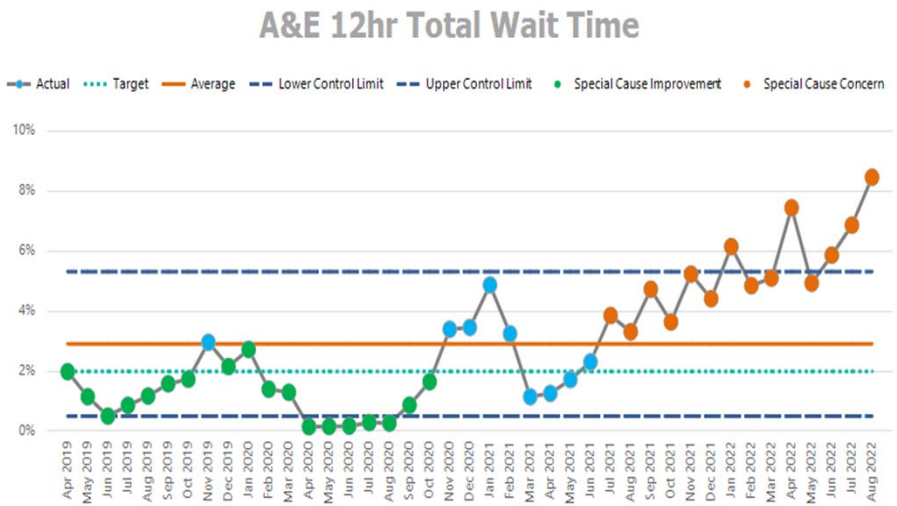
Special Cause Concern



The statutory 95% target has not been achieved this financial year, remaining the case in August 22. The Trust saw a maintenance of the performance for this metric in July 22 but have noted a significant deterioration in August 22. This deterioration in performance has been driven by a number of factors, the most significant of all is the overall occupancy of the department resulting from a delayed flow out to the medical bed base. The number of patients in the bed base waiting over 21 days has grown over August and has remained exceptionally high at over 200 patients. There is a direct correlation between LLOS and ED performance. In addition the cyber attack and resulting downtime of Adastra has impacted the recording of performance for the UTCs which has contributed.

In majors, actions include the use of an appropriately staffed ED surge area, where patients continue to receive treatment, but allows the release of ED cubicles. There are further actions to improve patient safety particularly around the time to triage and safety walk abouts in the waiting area. There has also been a focus on reducing the LOS for patients in September to recover the position.

Commentary Provided by Chief Operating Officer

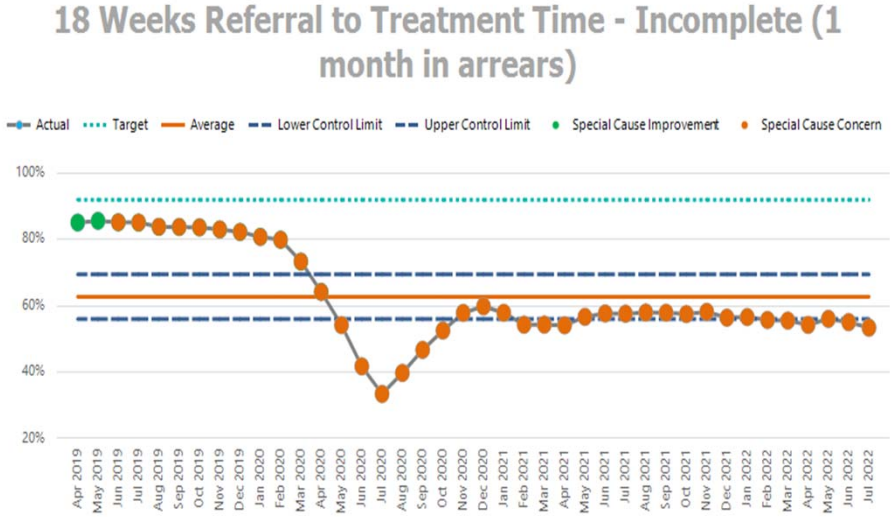


This performance metric is directly linked to the challenges described for the performance in the 4 hour wait – in particular the challenges experienced in the majors stream which is impacted by increased occupancy and LOS in the medical bed base.

Commentary Provided by Chief Operating Officer

Trust SPC - Areas of Concern - Mandatory

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, by eliminating 104wks 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 which will have a significant impact on this metric over the course of the autumn months.

Commentary Provided by Chief Operating Officer

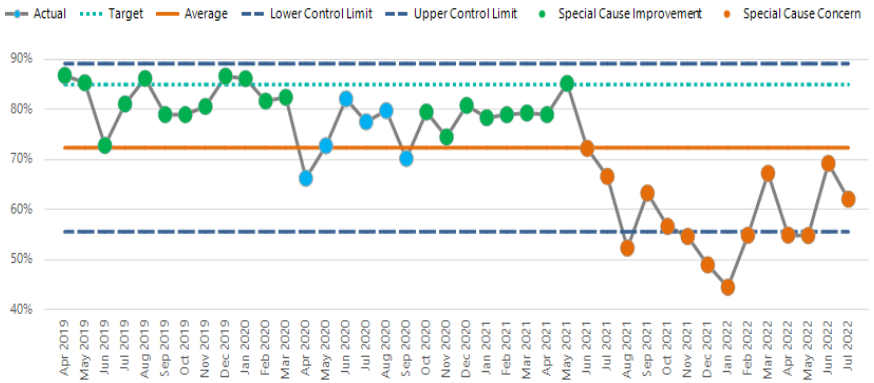
Trust SPC - Areas of Concern – Mandatory/Non Mandatory

NHS University Hospitals Coventry and Warwickshire NHS Trust

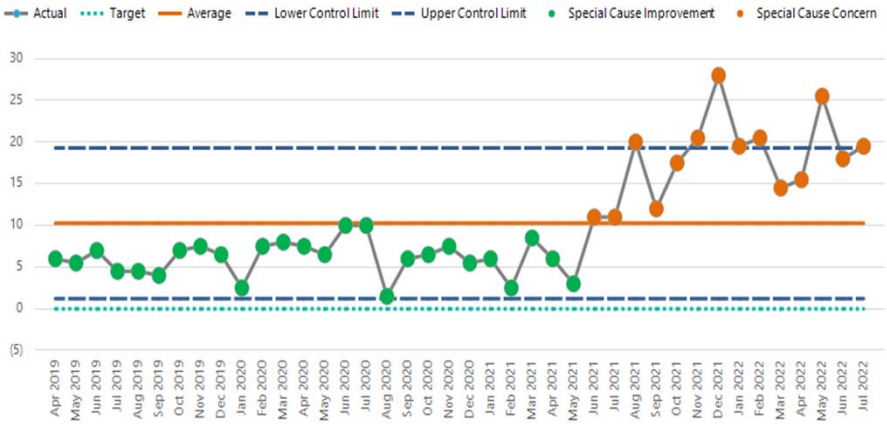
Appendix B – Trust Trends

Special Cause Concern

Cancer 62 Day Standard plus 31 Day Rare Cancers (1 month in arrears)



Cancer 104+ days wait (treated) - (1 month in arrears)



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 COO led confirm and challenge for patients at 104+ days and patients due to tip over to support backlog reduction
- 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.

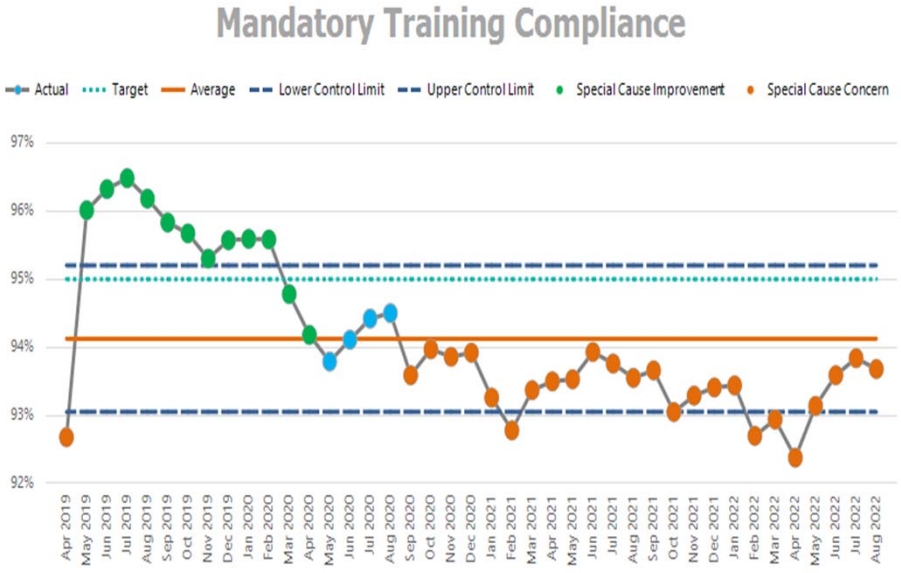
Commentary Provided by Chief Operating Officer

Trust SPC - Areas of Concern – Non Mandatory

University Hospitals Coventry and Warwickshire NHS Trust

Appendix B – Trust Trends

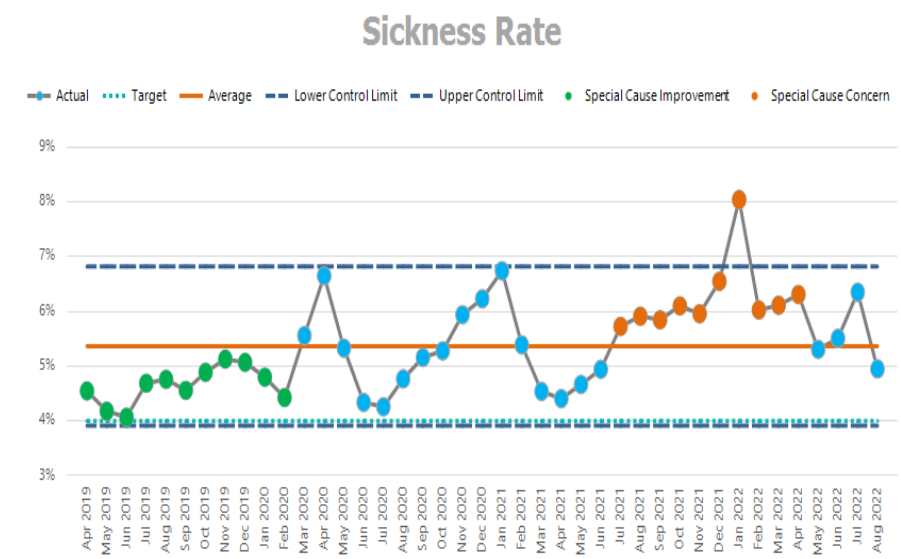
Special Cause Concern



Overall Mandatory Training compliance for substantive staff remains in a stable position. There was a slight decrease of 0.16% in August 2022. Staff compliance rates continue to be affected by unforeseen and sporadic Covid-19 related absences and the operational pressures of the Trust along with the seasonal fluctuations seen in the past two years. All Clinical Groups are achieving over 90% compliance.

The Trust-wide awareness campaign entitled 'Get Green, Stay Green' 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



The overall Trust sickness absence rate has decreased by **1.40%** from July **6.35%** to August **4.95%.** Our Covid-19 absence level has fallen from 1.82% in July to 0.72% in August, reflecting the national picture of reduced infection.

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. We continue to explore new opportunities to support the health and wellbeing of our staff including a remote GP service being launched in September and a new programme of psychological first aid training.

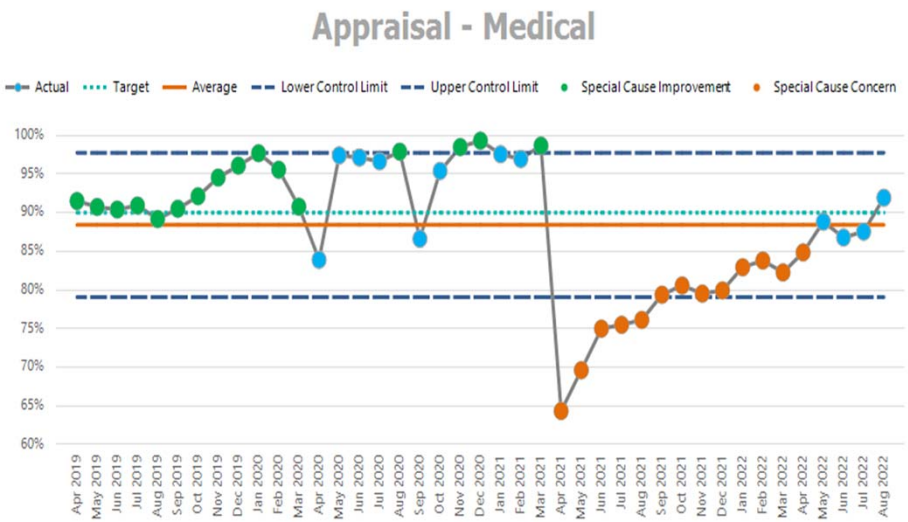
In addition, we launch the annual Flu and Covid-19 booster programme for staff in September 2022.

Commentary Approved by the Chief People Officer

Trust SPC - Areas of Concern – Non Mandatory

NHS
University Hospitals
Coventry and Warwickshire
NHS Trust

Special Cause Concern



Executive Comment provided by the Chief Medical Officer/ DCMO

Medical appraisal was stood down during the pandemic but reintroduced in Dec 2021. We have therefore set an objective that all appraisals should be undertaken or have an approved postponement in line with GMC regulations.

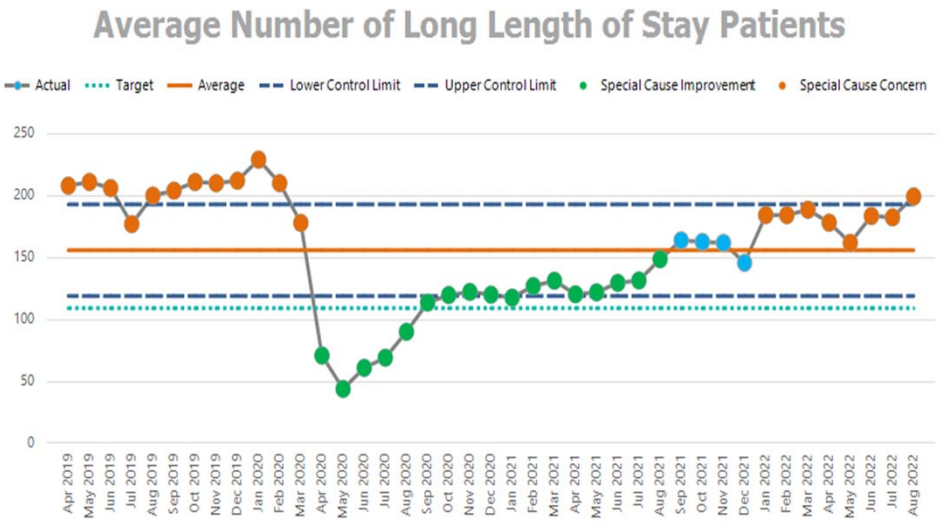
We are seeing a steady increase in appraisal rates and I am assured that our process of escalation will improve rates. Ultimately, non engagement culminates in the issue of a REV6 form i.e. GMC non engagement referral and we will inform board when that occurs via the annual organisational audit

Trust SPC - Areas of Concern – Non Mandatory

NHS
University Hospitals
Coventry and Warwickshire
NHS Trust

Appendix B – Trust Trends

Special Cause Concern



The complexity of patient care needs on discharge has been steadily increasing, while there has been a reduction in the availability of packages of care to meet these needs.
In addition, complex patients are being turned down, multiple times, when assessed for care home placements, causing further delay.
Strategic Programmes & (Improving Lives for Older People) and PLACE based partnerships will offer more medium to long term solutions.
Internally, there is daily focus through site function, Matrons and Managers of the Day for each Group.
There is a weekly 'Confirm and Challenge' meeting with each specialty and 'long length of stay' oversight by CEO/CNO.
A discharge improvement workstream is focussed on improvement primarily across the general medical wards and includes implementation of professional standards and Criteria Led Discharge (CLD).

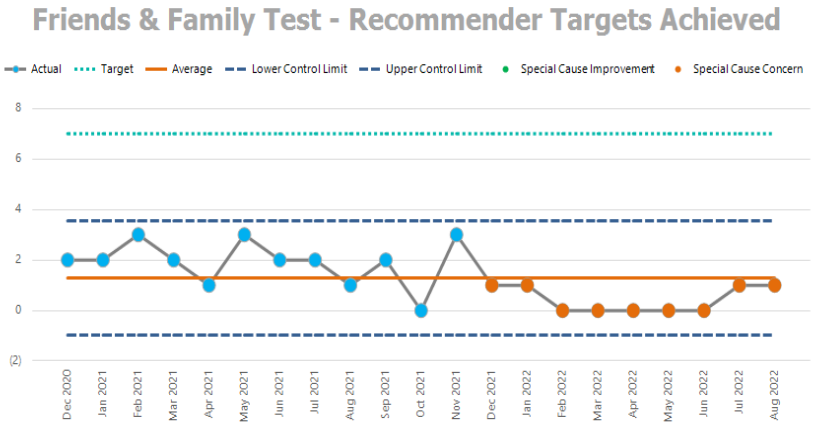
Commentary Provided by the Chief Nursing Officer

Trust SPC - Areas of Concern – Non Mandatory

NHS 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 consistent 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 services they used to their friends and family, has reduced over the past nine months based on feedback.

For the past two months the recommender rate improved and for August 2022 the maternity touchpoints one and two met the recommender rate targets, with other touchpoints not far off reaching the targets set.

Through monitoring FFT performance in the Patient Experience and Engagement Committee it has been identified that there are data discrepancies between the data the Trust sends and receives from Healthcare Communications who manages this process of text messaging patients on behalf of the Trust for FFT. The Performance and Informatics Team along with Healthcare Communications, with oversight by the Patient Insight and Involvement Team are investigating the issue. If the FFT response data is incorrect, this will lead to incorrect FFT recommender data. Updates regarding this 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:

- Investing in a three month text message trial to increase the number of patients who are contacted to complete the FFT.
- Commenced FFT text messaging within maternity services.
- Introduced the statutory Post Covid FFT survey.
- Re-introduced the Volunteer Rota to promote FFT completion in Outpatients and on the Wards.
- The FFT QR code and link will be displayed on all patient information leaflets.
- iPad's utilised in the Children's Emergency Department to increase FFT completion.

Commentary Provided by the Chief Quality Officer

Trust Scorecard – Quality and Safety Committee

Reporting Month : August 2022

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

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	23	33	↓	27	65	CNO	N/A	N/A
	E. Coli - Trust Acquired - Cumulative	162	39	53	↓	58	137	CNO	N/A	N/A
	Pseudomonas - Trust Acquired - Cumulative	1497	7	12	↓	16	40	CNO	N/A	N/A
	Klebsiella - Trust Acquired - Cumulative	1499	9	12	↓	26	63	CNO	N/A	N/A
	MRSA High Risk Elective Inpatient Screening	1280	96.9%	97.8%	↑	95%	95%	CNO		P
	MRSA High Risk Emergency Screening	1281	92.7%	93.0%	↑	90%	90%	CNO		P
	Serious Incidents - Number	449	15	16	↓	15	15	CQO		P
	Serious Incidents - Overdue	475	9	16	↓	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	35.8%	34.8%	↑	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	2	4	↓	2	10	CMO	N/A	N/A
	Never Events - Cumulative	848	2.0	2.0	→	0	0	CMO	N/A	N/A

Appendix C – QSC Scorecard

Trust Scorecard – Quality and Safety Committee

Reporting Month : August 2022

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

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	115.23	122.81	↓	RR	RR	CMO	N/A	N/A
	SHMI - Monthly (6 months in arrears)	267	109.76	109.82	↓	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	3	3	→	24	24	CNO	N/A	N/A
	Falls with Moderate Harm or Above per 1000 Occupied Bed Days	1063	0.21	0.08	↑	0.08	0.08	CNO		?
	Eligible Patients Having VTE Risk Assessment (1 month in arrears)	1373	96.5%	95.9%	↓	95%	95%	CNO		P
	Average Number of Long Length of Stay Patients	1336	182	199	↓	109	109	CNO		F
	Reason to Reside	1490	83%	82%	↓	95%	95%	CNO		F
	Transfer of Patients at Night (UH to Rugby)	1343	18	9	↑	0	0	COO		F
	Friends & Family Test Inpatient Recommenders (Inc. Day Cases)	1482	85.7%	85.4%	↓	95%	95%	CQO		F
	Friends & Family Test Inpatient Coverage (Inc. Day Cases)	1014	21.5%	22.2%	↑	26%	26%	CQO		F

Appendix C – QSC Scorecard

Trust Scorecard – Quality and Safety Committee

Reporting Month : August 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

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	71.9%	75.9%	↑	87%	87%	CQO		F
	Friends & Family Test A&E Coverage	398	8.9%	15.7%	↑	15%	15%	CQO		F
	Friends & Family Test Outpatient Coverage	1178	6.52%	6.36%	↓	8%	8%	CQO		F
	Maternity FFT Recommenders - 36 weeks	1483	95.70%	92.37%	↓	97%	97%	CQO		F
	Maternity FFT Recommenders - Labour / Birth	1484	94.55%	97.25%	↑	97%	97%	CQO		?
	Maternity FFT Recommenders - Postnatal Hospital	1485	95.51%	90.72%	↓	97%	97%	CQO		F
	Maternity FFT Recommenders - Postnatal Community	1486	98.21%	86.89%	↓	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	42	43	↓	33	34	CQO		?
	Complaints per 1000 Occupied Bed Days (1 month in arrears)	1068	1.35	1.79	↓	0.99	0.99	CQO		?
	Complaints Turnaround <= 25 Days (1 month in arrears)	1064	98%	98%	↑	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%	99.8%	→	99%	99%	COO		P

Trust Scorecard – Quality and Safety Committee

Reporting Month : August 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

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	98.3%	98.3%	→	95%	95%	COO		P
	12 Hour Trolley Waits in Emergency Care	646	1	4	↓	0	0	COO	N/A	N/A
	Ambulance Handover within 15 minutes	129	17.5%	15.1%	↓	65%	65%			F
	Ambulance Handover within 30 Minutes	131	63.6%	60.6%	↓	95%	95%	COO		F
	Ambulance Handover within 60 Minutes	405	87.7%	83.8%	↓	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	4225	4811	↓	0	0	COO	N/A	N/A
Leading research based health care organisation										
	Patients Recruited into NIHR Portfolio-Cumulative (2 months in arrears)	297	964	1455	↑	1289	5213	CMO	N/A	N/A
	Performance in Initiating Trials - Quarterly	421	7.0%	7.0%	→	80%	80%	CMO	N/A	N/A
	Performance in Delivery of Trials - Quarterly	422	85.7%	85.7%	→	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	63	117	↑	93	246	CMO	N/A	N/A

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	60.6%
Ambulance Handover within 60 Minutes	100%	F	83.8%

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	15.1%

Non Mandatory (Local or Regional Targets)

Special Cause Concern

Measure	Annual Target	Target Assurance	Latest Position
Friends & Family Test A&E Coverage	15%	F	15.7%
Maternity FFT No of Touchpoints Achieving a 15% Response Rate	4	F	3
Serious Incidents - Overdue	0	F	16
Reported Harmful Patient Safety Incidents (1 month in arrears)	24.94%	F	34.8%
Friends & Family Test Outpatient Coverage	8%	F	6.36%
Average Number of Long Length of Stay Patients	109	F	199

Special Cause Improvement

Measure	Annual Target	Target Assurance	Latest Position
Maternity FFT Recommenders - 36 weeks	97%	F	92.37%
Reason to Reside	95%	F	82%

Common Cause Variation

Measure	Annual Target	Target Assurance	Latest Position
Friends & Family Test Inpatient Coverage (Inc. Day Cases)	26%	F	22.2%
Transfer of Patients at Night (UH to Rugby)	0	F	9
Friends & Family Test A&E Recommenders	87%	F	75.9%
Friends & Family Test Inpatient Recommenders (Inc. Day Cases)	95%	F	85.4%
Maternity FFT Recommenders - Postnatal Hospital	97%	F	90.72%

Trust Scorecard – Finance & Workforce Committee

NHS University Hospitals Coventry and Warwickshire NHS Trust

Reporting Month : August 2022

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

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	70.6%	64.4%	↓	95%	95%	COO		F
	12 Hour Trolley Waits in Emergency Care	646	1	4	↓	0	0	COO	N/A	N/A
	A&E 12hr Total Wait Time	1511	6.9%	8.5%	↓	2%	2%	COO		F
	Ambulance Handover within 15 minutes	129	17.5%	15.1%	↓	65%	65%	COO		F
	Ambulance Handover within 30 Minutes	131	63.6%	60.6%	↓	95%	95%	COO		F
	Ambulance Handover within 60 Minutes	405	87.7%	83.8%	↓	100%	100%	COO		F
	30 Day Emergency Readmissions (1 month in arrears)	447	7.6%	7.7%	↓	8.2%	8.2%	COO		?
	Number of Medical Outliers - Average per Day	950	65.0	45.9	↑	50	50	COO		?
	Length of Stay Acute - Average	951	7.1	7.0	↑	6.9	6.9	COO		F
	Non emergency care									
	Last Minute Non-clinical Cancelled Operations - Elective	14	0.9%	0.8%	↑	0.8%	0.8%	COO		?
	Breaches of the 28 Day Readmission Guarantee	16	8	13	↓	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	55.1%	53.5%	↓	92%	92%	COO		F

Appendix C – FPC Scorecard

Trust Scorecard – Finance & Workforce Committee

NHS University Hospitals Coventry and Warwickshire NHS Trust

Reporting Month : August 2022

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

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	4225	4811	↓	0	0	COO	N/A	N/A
	RTT 78 Weeks Wait Incomplete (1 month in arrears) (Local Target)	1503	146	127	↑	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	2.2%	3.0%	↓	4%	4%	COO		?
	Diagnostic Waiters - 6 Weeks and Over (Local Target)	33	10.07%	10.28%	↓	1%	1%	COO		F
	Bed Occupancy Rate - KH03 (3 months in arrears)	1065	96.6%	96.6%	→	93%	93%	COO	N/A	N/A
	Cancer									
	Cancer 2 Week Wait GP Referral to OP Appointment (1 month in arrears)	59	70.93%	75.25%	↑	93%	93%	COO		F
	Cancer 2 Week Wait Breast Symptom (1 month in arrears)	61	76.04%	74.77%	↓	93%	93%	COO		?
	Cancer 31 Day Diagnosis to Treatment (1 month in arrears)	63	99.61%	93.56%	↓	96%	96%	COO		?
	Cancer 31 Day Subsequent Surgery Standard (1 month in arrears)	67	95.83%	92.59%	↓	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	88.68%	95.03%	↑	94%	94%	COO		?
	Cancer 62 Day Standard plus 31 Day Rare Cancers (1 month in arrears)	73	69.26%	62.13%	↓	85%	85%	COO		F
	Cancer 62 Day Screening Standard (1 month in arrears)	75	69.77%	86.49%	↑	90%	90%	COO		F
	Cancer 62 Day Consultant Upgrades (1 month in arrears)	77	80.0%	68.5%	↓	85%	85%	COO		F

Appendix C – FPC Scorecard

Trust Scorecard – Finance & Workforce Committee

NHS University Hospitals Coventry and Warwickshire NHS Trust

Reporting Month : August 2022

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

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	18.0	19.5	↓	0	0	COO		F
	Cancer 28 Day Faster Diagnosis Two Week Referral	1406	74.89%	73.23%	↓	75%	75%	COO	N/A	N/A
	Cancer 28 Day Faster Diagnosis Breast Symptomatic Referral	1407	96.81%	94.55%	↓	75%	75%	COO	N/A	N/A
	Cancer 28 Day Faster Diagnosis Screening	1408	51.61%	50.21%	↓	75%	75%	COO	N/A	N/A
	Cancer 28 Day Faster Diagnosis Overall	1409	73.60%	71.95%	↓	75%	75%	COO	N/A	N/A
Excellence in patient care and experience										
	Theatre Productivity									
	Theatre Efficiency - Main	423	58.5%	62.3%	↑	85%	85%	COO		F
	Theatre Efficiency - Rugby	424	64.4%	70.2%	↑	85%	85%	COO		F
	Theatre Efficiency - Day Surgery	425	56.3%	53.7%	↓	85%	85%	COO		F
	Theatre Utilisation - Main	369	78.4%	79.1%	↑	85%	85%	COO		F
	Theatre Utilisation - Rugby	370	78.0%	86.3%	↑	85%	85%	COO		F
	Theatre Utilisation - Day Surgery	371	74.3%	73.8%	↓	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%	30.0%	↑	75%	75%	COO		F

Appendix C – FPC Scorecard

Trust Scorecard – Finance & Workforce Committee

University Hospitals Coventry and Warwickshire NHS Trust

Reporting Month : August 2022

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

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	£4.860m	£5.642m	↑	10448	38788	CFO	N/A	N/A
	YTD Income & Expenditure Trust	986	£-9461k	£-11525k	↓	-5425	-14802	CFO	N/A	N/A
	Agency Expenditure	1315	£1.954m	£2.082m	↓			CPO		?
Leading research based health care organisation										
	Submitted Research Grant Applications - Quarterly - Cumulative	683	40	40	→	38	152	CMO	N/A	N/A
	Commercial Income Invoiced - Cumulative (1 month in arrears)	684	£138k	£188k	↑	300	900	CFO	N/A	N/A
	NIHR Research Capability Funding (3 months in arrears)	1332	£302k	£302k	→	250	1000	CMO	N/A	N/A
	Trial Recruitment Income (3 months in arrears)	1344	£506k	£506k	→	513.25	2125	CMO	N/A	N/A
	All Grant Income (3 months in arrears)	1345	£1.730m	£1.730m	→	500	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	64.4%
Cancer 62 Day Standard plus 31 Day Rare Cancers (1 month in arrears)	85%	F	62.13%
Ambulance Handover within 30 Minutes	95%	F	60.6%
Ambulance Handover within 60 Minutes	100%	F	83.8%
18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears)	92%	F	53.5%
A&E 12hr Total Wait Time	2%	F	8.5%

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	13
Cancer 62 Day Screening Standard (1 month in arrears)	90%	F	86.49%
Cancer 62 Day Consultant Upgrades (1 month in arrears)	85%	F	68.5%
Ambulance Handover within 15 minutes	65%	F	15.1%

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	75.25%
Cancer 104+ days wait (treated) - (1 month in arrears)	0	F	19.5
Length of Stay Acute - Average	6.9	F	7.0

Special Cause Improvement

Measure	Annual Target	Target Assurance	Latest Position
Theatre Utilisation - Rugby	85%	F	86.3%
Theatre Utilisation - Day Surgery	85%	F	73.8%

Common Cause Variation

Measure	Annual Target	Target Assurance	Latest Position
Theatre Utilisation - Main	85%	F	79.1%
Theatre Efficiency - Main	85%	F	62.3%
Theatre Efficiency - Rugby	85%	F	70.2%
Theatre Efficiency - Day Surgery	85%	F	53.7%
Theatre Lists Started within 15 mins of Start Time	75%	F	30.0%

Integrated Finance Report | Trust Financial Position

NHS University Hospitals Coventry and Warwickshire NHS Trust

Reporting Month: August 2022

05 Months Ended 31st August 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	320,774	321,781	1,007	772,288	774,554	2,266
Adjusted Top Up Income	1,670	1,617	(53)	1,995	3,559	1,564
Total Other Operating Income	19,221	24,820	5,599	49,752	60,341	10,589
Total Operating Income	341,665	348,218	6,553	824,035	838,454	14,419
Total Medical and Dental - Substantive	(56,708)	(58,457)	(1,749)	(134,798)	(141,262)	(6,464)
Total Agenda for Change - Substantive	(117,701)	(126,788)	(9,087)	(277,940)	(297,475)	(19,535)
Total Medical and Dental - Bank	(5,610)	(4,628)	982	(13,434)	(11,297)	2,137
Total Agenda for Change - Bank	(13,180)	(10,016)	3,164	(32,081)	(25,189)	6,892
Total Medical and Dental - Agency	(4,067)	(5,088)	(1,021)	(9,084)	(10,315)	(1,231)
Total Agenda for Change - Agency	(5,478)	(5,017)	461	(12,409)	(11,321)	1,088
Other gross staff costs	(742)	(515)	227	(1,782)	(1,386)	396
Total Employee Expenses	(203,486)	(210,509)	(7,023)	(481,528)	(498,245)	(16,717)
Total Operating Expenditure excluding Employee Expenditure	(113,582)	(117,878)	(4,296)	(281,189)	(286,021)	(4,832)
Total Operating Expenditure	(317,068)	(328,387)	(11,319)	(762,717)	(784,266)	(21,549)
Operating Surplus/Deficit	24,597	19,831	(4,766)	61,318	54,188	(7,130)
Total Finance Expense	(27,352)	(27,113)	239	(65,677)	(64,127)	1,550
PDC dividend expense	(2,840)	(2,839)	1	(6,814)	(6,814)	0
Movements in Investments & Liabilities	0	0	0	0	0	0
Net Finance Costs	(30,192)	(29,952)	240	(72,491)	(70,941)	1,550
Surplus/Deficit For The Period	(5,595)	(10,121)	(4,526)	(11,173)	(16,753)	(5,580)
Control Total adjustments						
Donated assets (income)	0	(1,573)	(1,573)	(4,035)	(4,085)	(50)
Donated assets (depn)	170	169	(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	(5,425)	(11,525)	(6,100)	(14,798)	(20,432)	(5,632)

Year to date Financial Performance:

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

- Overseas Patients £0.3m
- Contract income additional to block contract £0.7m

Other Operating Income: £5.6m favourable:

- Donated Asset Income £1.5m
- Education & Research Income £2.6m
- Targeted Lung £0.9m
- Recharges £0.6m;

Expenditure: (£11.3m) adverse

- Unidentified WRP (£4.8m)
- Pass-through drugs (£3.2m)
- Education & Research (£2.3m)
- Targeted Lung Health Check (£0.9m)
- Other cost pressures (£0.1m)

Forecast Financial Performance:

Income from Patient Care Activities (including Adjusted Top Up £3.8m favourable:

- Overseas Patients £0.3m
- Contract income additional to block contract

Other Operating Income: £10.6m favourable:

- Education, Training & Research £7.1m
- Targeted Lung Health £2.2m
- Recharges £1.0m; Charitable Funds £0.3m

Expenditure: (£21.5m)

- Targeted Lung Health (£2.2m)
- Pass-through drugs & Devices (£8.4m)
- Education, Training & Research (£5.9m)
- Managing Emergency Pressures (£5.0m)

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: August 2022

Statement of Financial Position 5 months ended 31 August 2022	Full Year			Year To Date		
	Plan (£'000)	Forecast Outturn (£'000)	Variance (£'000)	Plan (£'000)	Actual (£'000)	Variance (£'000)
Non-current assets						
Property, plant and equipment	472,661	476,485	3,824	447,813	449,071	1,258
Intangible assets	16,592	13,643	(2,949)	13,936	12,966	(970)
Investment Property	12,080	12,080	0	12,080	12,080	0
Trade and other receivables	35,060	37,251	2,191	31,353	33,543	2,190
Total non-current assets	**536,393**	**539,459**	**3,066**	**505,182**	**507,660**	**2,478**
Current assets						
Inventories	17,183	17,289	106	16,707	16,792	85
Trade and other receivables	50,232	59,687	9,455	64,523	59,116	(5,407)
Cash and cash equivalents	19,291	19,291	0	26,090	51,702	25,612
	86,706	**96,267**	**9,561**	**107,320**	**127,610**	**20,290**
Non-current assets held for sale	0	0	0	0	0	0
Total current assets	**86,706**	**96,267**	**9,561**	**107,320**	**127,610**	**20,290**
Total assets	**623,099**	**635,726**	**12,627**	**612,502**	**635,270**	**22,768**
Current liabilities						
Trade and other payables	(78,322)	(94,853)	(16,531)	(91,836)	(117,629)	(25,793)
Borrowings PFI obligations	(2,904)	(2,904)	0	(3,942)	(4,465)	(523)
Borrowings leases	(5,914)	(4,450)	1,464	(5,914)	(4,450)	1,464
DH Capital loan	(899)	(898)	1	(898)	(899)	(1)
Provisions	(2,548)	(3,364)	(816)	(2,722)	(2,914)	(192)
Total current liabilities	**(90,587)**	**(106,469)**	**(15,882)**	**(105,312)**	**(130,357)**	**(25,045)**
Net current assets/(liabilities)	**(3,881)**	**(10,202)**	**(6,321)**	**2,008**	**(2,747)**	**(4,755)**
Total assets less current liabilities	**532,512**	**529,257**	**(3,255)**	**507,190**	**504,913**	**(2,277)**
Non-current liabilities:						
Trade and other payables	0	0	0	0	0	0
Borrowings PFI obligations	(222,526)	(222,526)	0	(223,978)	(223,448)	530
Borrowings leases	(32,898)	(35,223)	(2,325)	(32,498)	(35,278)	(2,780)
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**	**266,589**	**(5,580)**	**245,350**	**240,823**	**(4,527)**
Financed by taxpayers' equity:						
Public dividend capital	249,876	249,877	1	229,479	229,479	0
Retained earnings	(77,644)	(83,225)	(5,581)	(72,066)	(76,593)	(4,527)
Revaluation reserve	99,937	99,937	0	87,937	87,937	0
Total Taxpayers' Equity	**272,169**	**266,589**	**(5,580)**	**245,350**	**240,823**	**(4,527)**

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

- Receivables balances are lower than Plan due to due to reduced income accruals following cash payments from commissioners in August;
- Payables balances are significantly higher than Plan due to high levels of accrued expenditure;
- Retained earnings reflect the year-to-date increased deficit position;
- The above variances in turn are the main contributing factors to the increased cash balance as at month 05.

Full Year variances

- 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;
- Retained earnings reflect the revised forecast outturn, which is currently showing an overspend against the planned deficit position.

Workforce Information | Headlines for August 2022

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

Agency Spend
£ 2,082,153

Headcount
10009 Headcount
8840.02 WTE
(Inclusive ISS/ROE)
Bank not included

Training
93.48%
(Substantive Employees only)

Target ≥ 95%

Vacancy Rate
6.61%
607.19 WTE

Target ≤ 10%

Medical
91.93%

Non-Medical
82.41%

Target ≥ 90%

Turnover
10.96%
(12 months rolling average this data)

Target ≤ 10%

Sickness
4.95%

Target ≤ 4%

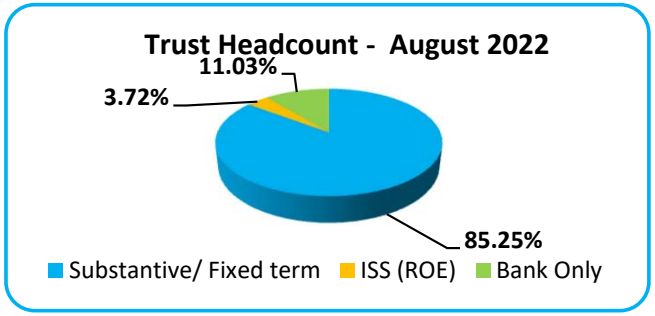
Workforce Information | Headlines for August 2022

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.

Assignment Category	Jun-22 Headcount	Jul-22 Headcount	Aug-22 Headcount
Substantive/ Fixed Term	9605	9562	9591
ISS (ROE)	420	418	418
Trust Total	**10025**	**9980**	**10009**
Bank Only	1252	1251	1241



Assignment Category	Jun-22 WTE	Jul-22 WTE	Aug-22 WTE
Substantive/Fixed Term	8522.94	8485.20	8522.62
ISS (ROE)	318.90	317.40	317.40
Trust Total	**8841.84**	**8802.60**	**8840.02**

Staff in Post by Staff Group | Monthly Variation

Staff Group	Jul-22 (WTE)	Aug-22 (WTE)	Starters Aug-22 (WTE)	Leavers Aug-22 (WTE)
Add Professional	289.22	291.93	2.36	2.00
Add Clinical Services	1944.55	1925.93	32.20	29.36
Admin & Clerical	1523.22	1534.99	19.36	15.48
Allied Health Professional	509.77	519.65	7.91	4.08
Estates & Ancillary	1.00	1.00	0.00	0.00
Healthcare Scientists	367.90	371.53	6.00	6.57
Medical & Dental	1163.29	1208.44	193.02	169.02
Nursing & Midwifery	2719.69	2723.68	15.00	13.25
Students	0.00	0.00	0.00	0.00
Total	**8518.64**	**8577.16**	**275.85**	**239.76**

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 **275.85 WTE** (**286** headcount) new starters of which **68%** (195 headcount) were primarily rotational **Medical staff** with **82** Specialty Registrars,**57** Foundation Year 1 and **30** Foundation Year 2. We also had **23** Trust grade doctors and **3** consultants join the Trust.
Additional Clinical staff had **36** new staff with **13** Healthcare Assistants, **5** Support Workers, **5** Healthcare Science Assistants, **4** Phlebotomists, **4** Other Assistants, **1** Technician and **4** Trainee pharmacists.
Nursing and Midwifery had **15** WTE (**16** Headcount) new starters including **10** Band 5 Nurses, **2** Band 6 nurse, and **1** Midwife.

Leavers (excluding bank staff)

There were **239.76 WTE** (**254** headcount) leavers in August. **Medical Staff** had **169.02 WTE** (**171** Headcount) of which **4** were Consultants and the remainder primarily rotational doctors.

Additional Clinical staff had **29.36 WTE** (**34** Headcount).

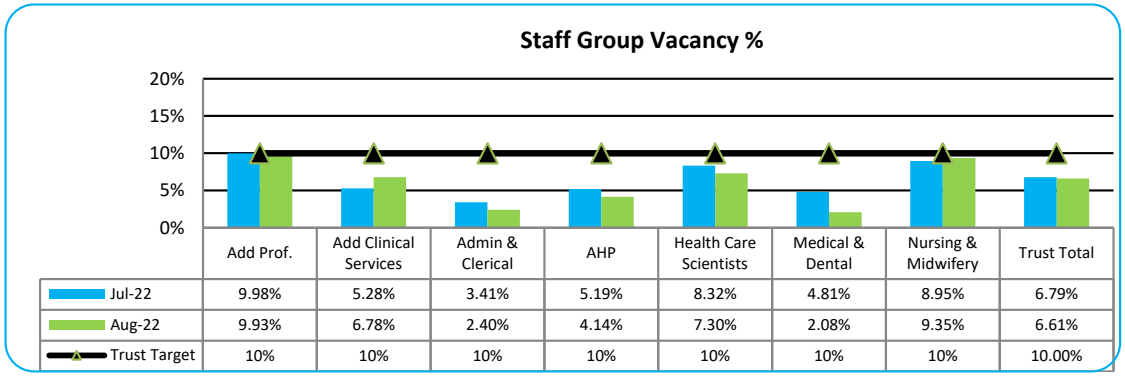
Leaving Reasons

61.02% (**155**) were end of fixed term contracts due to rotational medical staff, **11.81%** (**30** Headcount) of staff voluntary resigned with no reason recorded,
9.06% (**23** Headcount) undertaking further education, **7.09%** (**18** Headcount) relocated, and **3.94%** (**10** Headcount) retired.

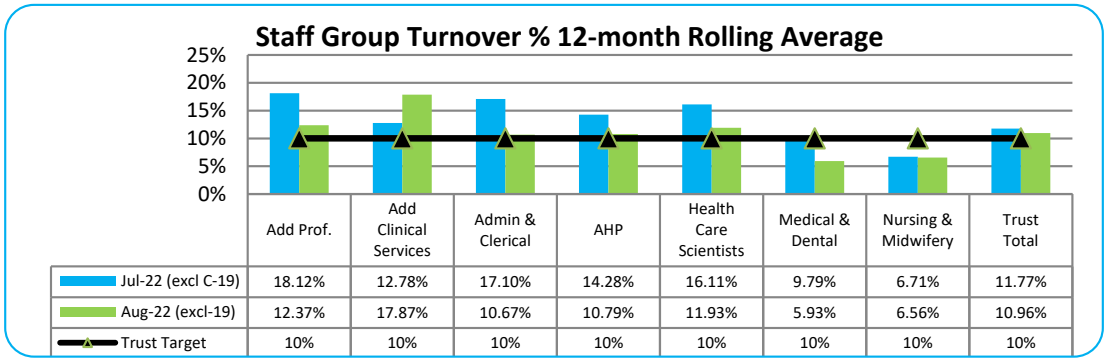
Workforce Information | Headlines for August 2022

University Hospitals Coventry and Warwickshire NHS Trust

Vacancy | by Staff Group



Staff Group	Jul-22 Funded (WTE)	Jul-22 Staff In Post (WTE)	Jul-22 Funded Vacancies (WTE)	Aug-22 Funded (WTE)	Aug-22 Staff In Post (WTE)	Aug-22 Funded Vacancies (WTE)
Add Prof Scientific and Technic	321.27	289.22	32.05	324.11	291.93	32.18
Additional Clinical Services	2053.01	1944.55	108.46	2065.90	1925.93	139.97
Administrative and Clerical	1576.95	1523.22	53.73	1572.70	1534.99	37.71
Allied Health Professionals	537.68	509.77	27.91	542.11	519.65	22.46
Healthcare Scientists	401.30	367.90	33.40	400.80	371.53	29.27
Medical and Dental	1222.09	1163.29	58.80	1234.08	1208.44	25.64
Nursing and Midwifery Registered	2986.90	2719.69	267.21	3004.49	2723.68	280.81
Estates and Ancillary	38.20	0.00	0.96	1.96	1.00	0.96
Students	1.96	1.00	38.20	38.20	0.00	38.20
Grand Total	**9139.36**	**8518.64**	**620.72**	**9,184.35**	**8,577.16**	**607.19**



Vacancy | by Staff Group

The Trust's overall vacancy rate has decreased by **0.18%** from **6.79%** in July to **6.61%** in August.

Our key recruitment campaigns are for the following staff groups:

Band 5 nurses – 150.10 WTE/10% vacancy rate
In addition to our local recruitment campaigns, the second programme of international recruitment has a target of 139 nurses by Dec 2022. In July, 84 nurses have arrived with a further 31 appointed but not yet in the country, leaving an additional 24 WTE to be recruited. By the end of 2022, the Trust will have recruited 420 International nurses. The forecast vacancy, given the current pipeline figure, is circa 4% by end of November 2022

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Midwives–47.59 WTE/26.69% vacancy rate.
The international campaign has now ended and 13 WTE overseas midwives have commenced. We have a recruitment pipeline of 13.93 WTE in pre-employment checks with the majority being newly qualified midwives. We have confirmed start dates for 5 WTE for September 2022 and 7.07 WTE for October 2022.
The current vacancy trajectory is 12.05% by October 2022.

HCSW – 68.39 WTE/7.25% vacancy rate
We have a recruitment pipeline of 39.45 WTE in pre-employment checks. We have confirmed start dates for 21.74 WTE for September and 4.4 WTE for October. Our recruitment pipeline remains strong as work to achieve our 1% vacancy rate target.

A&C – 37.71 WTE/2.40% vacancy rate
A&C vacancies remain a challenge but there are 36.54 WTE within the pre-employment stage of the recruitment pipeline. Further focus and activity is also required to address A&C turnover rates which compound the issue. We are working with our system partners to hold a system wide A&C recruitment event in late October.

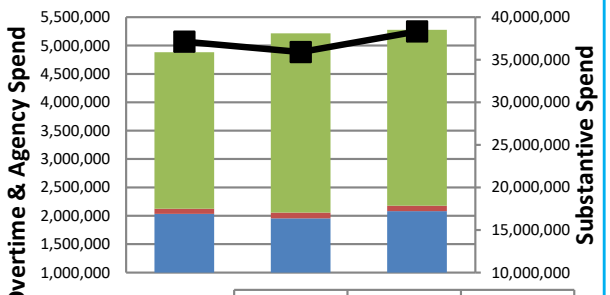
Turnover | by Staff Group

This month's turnover has decreased slightly to 10.96%**.** The planned focus of staff retention during 2022/23 should see this start to reduce from September 2022 onwards. 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.

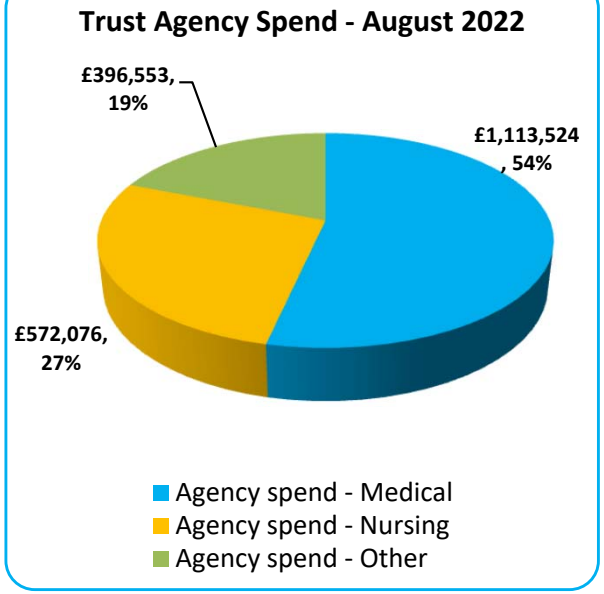
Workforce Information | Headlines for August 2022

University Hospitals Coventry and Warwickshire NHS Trust

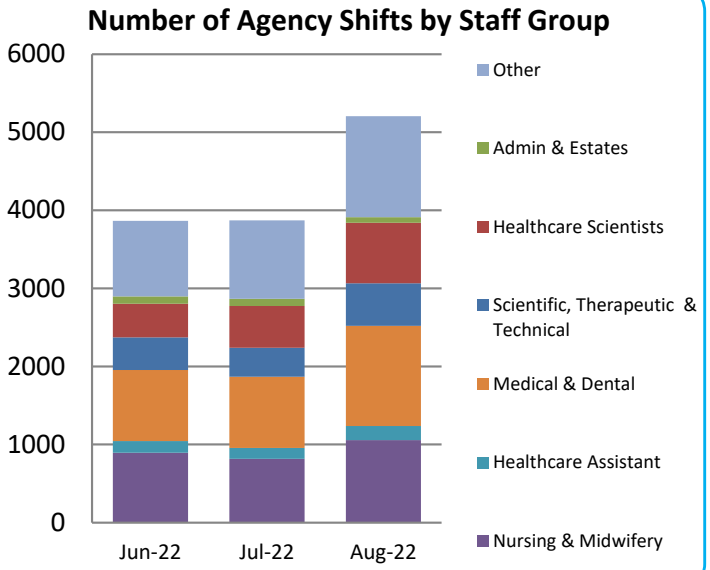
Pay Costs| Provided by Finance



	Jun-22	Jul-22	Aug-22
Bank Spend	2,758,053	3,158,261	3,099,896
Overtime Spend	89,697	102,846	96,495
Total Agency Spend	2,033,817	1,954,525	2,082,153
Substantive Spend	37,123,809	35,904,319	38,341,661



Agency | Number of Shifts Booked



Agency Shifts Booked | Reasons for Shifts Booked

There has been a significant increase in the number of shifts booked during August (5,205) in comparison with June and July where there were approximately 3,864 shifts booked.

All staff groups had an increase in the number of shifts booked apart from admin and estates.

Bank and overtime spend in this period fell which will be partly due to a largely proportion of staff and bank workers taking time off during this seasonal period. This in turn decreases the internal fill rate of shifts and leads to an increase in agency usage.

Staff Group	Jun-22	Jul-22	Aug-22
Nursing & Midwifery	895	817	1056
Healthcare Assistant	149	139	181
Medical & Dental	910	911	1283
Scientific, Therapeutic & Technical	419	371	545
Healthcare Scientists	430	535	775
Admin & Estates	93	94	72
Other	968	1,003	1293
Total Shifts Booked	**3864**	**3870**	**5205**

Workforce Information | Headlines for August 2022

NHS 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	0.74%	3.82%
218 Clinical Support Services	0.90%	4.65%
218 Core Services	0.45%	3.53%
218 Emergency Medicine	0.43%	5.02%
218 Medicine	0.70%	3.62%
218 Surgical Services	0.92%	3.49%
218 Trauma and Neuro Services	0.77%	4.93%
218 Women and Children	0.76%	5.59%
Grand Total	**0.72%**	**4.23%**

ABSENCE

The overall Trust sickness absence rate has decreased by **1.40%** from July **6.35%** to August **4.95%.** Our Covid-19 absence level has fallen as compared to July 2022 and it reflects the national picture of reduced infection. The other top reason or absence continues to be mental health.

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. Our extensive current provision includes rest facilities, virtual reality headsets and a comprehensive range of webinars and signposting to support mental and financial wellbeing. We continue to explore new opportunities to support the health and wellbeing of our staff including a remote GP service being launched in September and a new programme of psychological first aid training.

In addition, we launch the annual Flu and Covid-19 booster programme for staff in September 2022.

Group Rolling Sickness Absence Rate % (including Covid 19 sickness)	Jun-22	Jul-22	Aug-22
218 Clinical Diagnostics	5.17%	6.49%	4.56%
218 Clinical Support Services	5.91%	7.41%	5.55%
218 Core Services	4.83%	4.81%	3.98%
218 Emergency Medicine	6.64%	6.08%	5.45%
218 Medicine	4.84%	6.12%	4.32%
218 Surgical Services	5.82%	6.43%	4.41%
218 Trauma and Neuro Services	5.16%	5.88%	5.70%
218 Women and Children	6.60%	7.33%	6.35%
Trust Total %	**5.50%**	**6.35%**	**4.95%**

Absence | Reasons

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

Absence Reasons Top five August	Total WTE Days Lost	WTE Absence %
Mental Health Issues	3306.29	25.88%
Infectious diseases	1864.85	14.59%
Musculoskeletal problems	1797.67	14.07%
Gastrointestinal problems	904.77	7.08%
Pregnancy related disorders	818.90	6.41%
Overall All Absence Trust Totals	**12777.42**	**4.95%**

Workforce Information | Headlines for August 2022

NHS University Hospitals Coventry and Warwickshire NHS Trust

Mandatory Training | by Group

Group Mandatory Training %	Jun-22	Jul-22	Aug-22
Clinical Diagnostics	95.89%	95.43%	94.94%
Clinical Support Services	96.52%	95.84%	95.98%
Core Services	95.79%	93.97%	93.45%
Emergency Medicine	92.41%	91.69%	91.35%
Medicine	93.55%	92.44%	92.26%
Surgical Services	95.24%	94.44%	94.24%
Trauma and Neuro Services	93.71%	92.66%	92.37%
Women & Children	92.62%	91.86%	91.29%
Trust Total (Substantive Staff Only)	93.66%	93.73%	93.48%

Mandatory Training

Overall Mandatory Training compliance for substantive staff remains in a stable position. There was a slight decrease of 0.16% in August 2022. Staff compliance rates continue to be affected by unforeseen and sporadic Covid-19 related absences and the operational pressures of the Trust along with the seasonal fluctuations seen in the past two years. All Clinical Groups are achieving over 90% compliance.

The Trust-wide awareness campaign entitled 'Get Green, Stay Green' 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.

Appraisals | by Group

Appraisal % by Group	Non-Medical Appraisals			Medical Appraisals		
	Jun-22	Jul-22	Aug-22	Jun-22	Jul-22	Aug-22
Clinical Diagnostics	81.58%	85.44%	82.67%	97.06%	98.57%	97.01%
Clinical Support Services	83.83%	86.60%	86.44%	92.13%	91.40%	94.25%
Core Services	67.84%	70.28%	74.41%	100.00%	100.00%	100.00%
Emergency Medicine	84.07%	85.93%	86.47%	84.71%	84.71%	92.59%
Medicine	69.25%	72.46%	77.00%	89.57%	91.88%	95.54%
Surgical Services	89.17%	89.25%	88.74%	82.91%	81.67%	87.61%
Trauma and Neuro Services	81.55%	80.41%	84.45%	83.97%	87.14%	92.06%
Women & Children	86.99%	90.00%	84.68%	85.42%	82.61%	93.62%
Trust Total	79.00%	81.38%	82.41%	86.79%	87.55%	91.93%

Non Medical Appraisals

There has been a 1.03% increase in compliance of non-medical appraisals across the Trust. Completion of appraisals whilst balancing operational pressures remains a challenge.

The trust's annual cycle is May – September and all Groups are focussed on improvement trajectories and ensuring action plans are in place to support appraisals being undertaken in timely manner. Compliance is monitored through the Trust's Performance Framework.

Medical Appraisals

There has been an increase of 4.38% compliance this month and only one clinical group is below target.

We continue to communicate the importance of medical appraisals and highlight its requirement for the GMC's revalidation process. We also monitor progress of this KPI through the Trust's Performance Framework.

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 6 OCTOBER 2022

Subject Title	Patient Safety Incident Response Framework
Executive Sponsor	Andrew Hardy, Chief Executive Officer
Author	David Walsh, Director of Corporate Affairs
Attachment(s)	None
Recommendation(s)	To **APPROVE** the Chief Quality Officers, Mo Hussain, as Executive Lead in relation to delivery of the Patient Safety Incident Response Framework (PSIRF).

EXECUTIVE SUMMARY

In August, NHS England published the Patient Safety Incident Response Framework (PSIRF), which will replace the Serious Incident Framework (SIF) that has been in place since 2015. PSIRF is intended to improve the way in which NHS organisations are able to undertake patient safety investigations, introducing a range of tools and templates to support learning and improvement. It also involves ICBs in consider the overall response of providers within their areas.

The transition from SIF to PSIRF is expected to take around 12 months so updates will be provided to the Board as this work develops. NHSE has asked all Trusts to nominate a lead executive to oversee this work, and to that end this report recommends that our Chief Quality Officer, Mo Hussain, be confirmed to undertake that leadership role.

KEY IMPLICATIONS	
Financial	None arising from this report
Patients Safety or Quality	Confirmation of a nominated executive lead for delivery of PSIRF will ensure Board-level leadership for local adoption of this important change to the national approach
Workforce	None arising from this report
Operational	None arising from this report

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 6 OCTOBER 2022

Subject Title	Operational Activity Update
Executive Sponsor	Andy Hardy, Chief Executive Officer
Author	Gaby Harris, Chief Operating Officer
Attachment(s)	Nil
Recommendation(s)	The Board is asked to **NOTE** the Operational activity for July - September 2022

EXECUTIVE SUMMARY

This paper describes the key events during July, August and September 2022 that have impacted the Trust's operating environment. The purpose of this paper is to provide context for the Trust's Board of the challenges faced by areas of the Trust which have had impact on operational activity.

July 2022:
The Met Office issued a level 4 heatwave alert in July 2022 with temperatures reaching 40oC towards the end of the month. The impact of this was twofold, firstly the Trust saw an increase in attendances with heat related conditions mostly impacting the frail elderly. In addition to this the extreme heat had a detrimental impact on key parts of the Trust's infrastructure including Theatres, MRI scanners and the Radiotherapy equipment. There was difficulty in maintaining optimal temperatures for drug storage and blood analysers as well as keeping the temperatures in clinical areas down. The Trust implemented an internal level 4 response in line with the Emergency Planning Heatwave policy.
The Trust's endoscopy services were visited by the JAG accreditation team on 13 July 2022. Formal feedback will be taken through the appropriate sub committee for assurance.

August 2022:
The Commonwealth Games were held in the West Midlands during August 2022. The Trust had put in place appropriate responses through the emergency planning structures.
The National ambition to eliminate patients waiting in excess of 104weeks for elective care meant that requests for mutual aid were received from neighbouring providers in the West and East Midlands. The Trust was able to support a small number of cases whilst continuing to reduce elective waiting times.
Due to factors external to the NHS, there were notable shortages in key materials including Iodine Contrast, Bowel prep and HistoWax. The Trust mitigated the impact of these shortages by engaging clinical teams to identify alternative products as well as working with NHSE procurement teams to ensure that supply was maintained.

September 2022:
Due to routine maintenance work on the Trust's boiler system on 9 September an extensive hot water leak occurred throughout most of the University Hospital site. The Trust declared an internal incident to manage the impact. The most significant impact was seen in Theatres where 50% of the Theatre suite was closed for 24hours as the issue was rectified.
The death of Her Majesty Queen Elizabeth led to a period of National Mourning and a bank holiday being put in place. The Trust responded in line with the National Mourning requirements and reduced planned activity levels for 19 September to bank holiday services.

Summary:
The Operational impact of these challenges have been mitigated by the Trust and the impact on performance reflected in the performance reports for the periods discussed.

PREVIOUS DISCUSSIONS HELD
Nil.

KEY IMPLICATIONS	
Financial	Financial implications from the Operational challenges encountered in the period described are reported in the Trust' financial reports.
Patients Safety or Quality	Impact on patients' safety and quality from the activity described has been mitigated.
Workforce	Nil.
Operational	The impact of Operational activity for the period described in this paper is reflected in the Trust's performance reports that are discussed in detail in other agenda items.

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 6 OCTOBER 2022

Subject Title	Winter Plan 2022-23
Executive Sponsor	Gaby Harris, Chief Operating Officer
Author	Jo Lydon, Deputy Chief Operating Officer
Attachment(s)	Winter Plan 2022-23 NHSE Self Assessment
Recommendation(s)	The Board is asked to **RECEIVE ASSURANCE** and **APPROVE** the contents of this report

EXECUTIVE SUMMARY

This paper described the high level Winter plan for 2022/23. It is important to note that the Winter plan is linked to the Trust's Operational Delivery Plan. There are detailed action plans formulated by the Groups developed from the NHSE Winter self assessment.

1. The NHS enters winter 2022/23 after a period of significant challenge.

2. At University Hospitals Coventry and Warwickshire (UHCW) the winter period has the potential to place significant pressure on elective, cancer and urgent & emergency care pathways.

3. 8 National priorities for winter, focusing on urgent and emergency care, have been defined.

4. The UHCW Winter Plan focuses on delivery of these priorities together with maintaining and further restoring elective and cancer pathways.

5. The plan focuses on both improving efficiency and use of the capacity available and further opportunities that could be achieved with financial investment.

6. Behind this document is a detailed operational plan, informed by each of the Clinical Groups.

It is proposed that governance of operational delivery is via Operational Clinical Group and Chief Officers Group for assurance.

PREVIOUS DISCUSSIONS HELD

Operational Clinical Group – 23 September 2022

Chief Officers Group – 20 September 2022

Finance and Performance Committee – 29 September 2022

KEY IMPLICATIONS	
Financial	The schemes identified requiring additional funding have been submitted to the ICB as part of the bids for the Winter funding allocation. This allocation to the system is circa £9m. UHCW has bid for schemes totalling £5m. It is expected that all other schemes in the Winter plan are within the Group's funding resource.
Patients Safety or Quality	To promote patient safety, across all pathways, both in hospital and the community. The Winter plan aims to minimise patient safety risks and improve quality for all patients during the Winter.
Workforce	Clarity of expectations, plans and support.
Operational	NHSE has described key Winter priorities. Each of these priorities has been identified to minimise attendance numbers and minimise length stay in acute beds. A successful winter plan will support improved performance of both the emergency and elective pathways.

University Hospitals Coventry and Warwickshire NHS Trust

Winter Plan 2022/23

We Care. We Achieve. We Innovate.

1.0 Introduction

The NHS enters winter 2022/23 after a period of significant challenge due to the COVID-19 pandemic but also a period of significant delivery in terms of restoration of services. University Hospitals Coventry and Warwickshire (UHCW) is no exception to this. Our response to these challenges has been strong, but the winter period has the potential to place significant pressure on elective, cancer and urgent & emergency care pathways.

2.0 Priorities for Winter 2022/2023

In August 2022 NHS England wrote to Integrated Care Boards and NHS Trusts to detail their next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter. Within this there are 8 core objectives and actions: -

1. **Prepare for variants of COVID-19 and respiratory challenges,** including an integrated COVID-19 and flu vaccination programme.
2. **Increase capacity outside acute trusts,** including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the winter.
3. **Increase resilience in NHS 111 and 999 services,** through increasing the number of call handlers to 4.8k in 111 and 2.5k in 999.
4. **Target Category 2 response times and ambulance handover delays,** including improved utilisation of urgent community response and rapid response services, the new digital intelligent routing platform, and direct support to the most challenged trusts.
5. **Reduce crowding in A&E departments and target the longest waits in ED,** through improving use of the NHS directory of services, and increasing provision of same day emergency care and acute frailty services.
6. **Reduce hospital occupancy,** through increasing capacity by the equivalent of at least 7,000 general and acute beds, through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway.
7. **Ensure timely discharge,** across acute, mental health, and community settings, by working with social care partners and implementing the 10 beds practice interventions through the '100 day challenge'.
8. **Provide better support for people at home,** including the scaling up of virtual wards and additional support for High Intensity Users with complex needs.

3.0 UHCW Actions

It is noted that the above national priorities are solely focused on resilience of urgent and emergency care. However, effective delivery of this is intricately linked to elective care. Considering the significant progress made to date at UHCW to restore elective care pathways, and whilst noting the ongoing progress still required (in both cancer and elective pathways), the local winter plan includes consideration of how pathways can innovate and flex to minimise risk to all patient cohorts, including those on cancer pathways.

The Winter plan is linked to the Trust's Operational Delivery Plan (ODP) with Groups focused on delivering their agreed emergency and elective activity within the agreed resources. The ODP described a 60 bed deficit in the medical pathways, this is currently being mitigated by medical patients being cared for in alternative bed bases and the use of extra capacity.

3.1 *New variants of COVID-19 and respiratory challenges*

Focus to ensure appropriate triggers, early identification and expected responses to increased presentations, including paediatric spikes in RSV.

- COVID presentations will be monitored and decisions on management made at a local level.
- 7 day IPC service provision
- Monitoring of symptomatic presentations – triggers for escalation of increased hierarchies of control
- Increased testing provision to respond to increased presentations – automatic process for full respiratory screen for symptomatic patients. Review of reintroducing 4-plex testing at front door
- Reinstatement of daily huddles and allocation support for appropriate patient placements to reduce risk of nosocomial spread and optimise flow/capacity
- Early predictions anticipate high levels of RSV within paediatrics with 2 spikes, as would normally be anticipated over a winter period. However, these spikes may be higher and last longer.
- Plans are closely aligned to the Emergency medicine winter plan for Childrens ED. This includes:-

a) communication and education to both GP's and the wider community
b) an RSV vaccination program which has been started for those identified as at risk
c) a surge plan which demonstrates the paediatric ability to increase their inpatients beds including going outside of the identified paediatric footprint
d) a bid has been put forwards to look at uplifting medical and nurse staffing over this period.

3.2 Demand and capacity

Focus to ensure appropriate use of available capacity and identify planned surge areas

- Use of escalation capacity and surge areas
- Increased use of virtual wards
- Flexible planning of elective procedures during 'peak' winter period to release bed capacity
- Promote timely repatriation of patients to local Hospitals
- Remove non-value-added IP bed days

3.3 Discharge

Focus to ensure appropriate use of available capacity with patient care delivered in the most appropriate environment

- Confirm and challenge of long length of stay & medically fit for discharge numbers with clear actions for timely escalation of delays
- Criteria led discharge
- Improved pathway for complex discharges to ensure reduced delays once medically fit for discharge
- Improved use of discharge lounge, including earlier in the day
- Multi Agency Discharge events to take place at targets times for example 2nd week January 23 / Feb half term 23

3.4 Ambulance service performance

Focus to ensure patient handover into ED is timely, with delays reduced as much as possible

- Increased use of predicted ambulance numbers to pre-empt capacity challenges and implement earlier plans
- Increased use of surge areas in ED at times of extremis Criteria
- Enhanced response & full capacity actions for a groups and lead roles

3.5 Preventing avoidable admissions

Focus to ensure that patients are treated in the right place at the right time, maximising acute capacity for those in greatest need

- Increased use of Same Day Emergency Care (SDEC)
- Improved acute frailty services – NHSE pilot site
- Speciality in-reach to ED – Speciality senior review earlier in patient's pathway
- Increased redirection to assessment areas
- Improved use of out of hospital home-based pathways
- Collaborative working with Coventry and Warwickshire Partnership Trust (CWPT) to improve mental health pathways

3.6 Maintaining elective recovery

Focus to ensure elective recovery is not compromised and reduce risk to patients of delayed treatment

- Amend case mix to maximise activity but reduce impact on beds during 'peak' winter. For example, increase in day case activity through reduction in elective IP in weeks of known increased emergency activity e.g. January
- Utilising available medical teams to increase OP activity when not in theatre
- Ringfencing of elective beds for Cancer activity
- Utilising 642 methodology to plan 6 weeks ahead for peaks in emergency activity to maintain and maximise elective activity.

3.7 Ensuring the safety of our patients

Focus to ensure risk is mitigated and reduced

- Increased senior presence to support decision making and integrity of sites
- Clearly defined and communicated enhanced response actions with agreed triggers
- Risk assess impact of failed discharge or extended periods on ambulance

3.8 Ensuring the wellbeing of our staff

Focus to ensure team resilience and wellbeing is supported at times of extremis and avoid absence

- Staff Flu / COVID vaccination
- Flexible working to provide senior support at key times balanced with appropriate rest
- The full well being offer for Winter is reported through the People Committee

4.0 Winter Assurance

External

Assurance on the Winter plan is sought by both NHSE and the ICB. There have been multiple assurance templates for submission, including a self assessment for the Trust to complete to enhance winter planning. UHCW has adapted the internal plan to ensure that areas where the Trust is assessed as not fully compliant, are incorporated into financial bids or internal group action plans.

The Trust has sought clarity on the assurance process through winter with the ICB and is waiting for a response. At Coventry Place, the Winter plan will be discussed on a bi monthly basis at the Coventry and Rugby Urgent and Care Board. This Board is chaired by the UHCW Chief Operating Officer and has attendance from CWPT and Coventry Local Authority.

Internal

Each of the clinical groups have developed a detailed action plan which includes the schemes that are dependent on additional winter funding as well as improvement schemes that drive efficiency in the pathway whilst remaining within the funding resource available.

The Deputy Chief Operating Officer for Urgent and Emergency Care is responsible for the Winter plan and will govern the development and delivery of the detailed action plans at group level through the internal UEC board which reports to the Operational Clinical Group and through to Chief Officer Group.

5.0 Financial implications

The potential financial implications of the above schemes will be minimised with focus on the efficient use of capacity available and promotion of safe and timely clinical pathways. In addition to this Groups have submitted a number of bids to the Integrated Care Board which would offer further opportunity to maximise capacity, reduce demand and promote effective pathways and admission avoidance. These schemes are in the process of review, with a decision on allocation of funds pending.

6.0 Conclusion

The winter plan aligns to the requirement from NHSE to increase capacity and operational resilience in urgent and emergency care this winter. The plan focuses on both improving efficiency and use of the capacity available and further opportunities that could be achieved with financial investment.

Behind this document is a detailed operational plan, informed by each of the Clinical Groups. This will be used for operational delivery, reporting into Operational Clinical Group and Chief Officers Group for assurance.

	UHCW		*If it is N or Partial - ICB may want to formulate an action plan.*			Sep-22								
#	Good Practice Basics	Y	N	Partial	#	Good Practice Basics	Y	N	Partial	#	Good Practice Basics	Y	N	Partial
	Out of Hospital					**Emergency Department**					**Inpatient Management**			
1	Directory of services reviewed monthly by ICB executives and with clinical service leads				16	Streaming of all patients who could be apprpriately managed by a co-located urgent/primary care service in place at times matching the demand.		X		30	Minimum of twice Daily Consultant Led MDT Board Rounds in every ward	X		
2	Co-located urgent treatment centre operating as the front door to the hospital (or streaming) (or equivalent primary and urgent care service)				17	Minimum Consultant management > 16 hours a day (or as required by other specialist centres)	X			31	Acute Medical Unit should be in place for maximum 72 hours length of stay. All other specialty patients should be bedded in alternative appropriate areas.	X		
3	111 clinical contact > 50%				18	Speciality and acute call down within 1 hour of referral. For tertiary units, acute physician presence in ED > 16 hours a day	X			32	Daily senior medical review (by a person able to make management and discharge decisions) seven days a week			X
4	Abandoned 111 call rate				19	ED are granted one way referral rights with no patient being given back to ED at any time	X			33	Red to Green Process or equivalent in place and audited weekly			X
5	Ambulance conveyance to ED <49%				20	Mental health 24/7 liaison service	X			34	All patients reviewed by a senior decision maker 7 days a week			X
6	Virtual wards in place that support admission avoidance and length of stay reduction				21	SDEC > 12 hours a day/ 7 days a week at least but ideally open at times of demand. Open access criteria to be in place for all system partners. These units should never be bedded. Capacity cap	X			35	Trust IPS clearly communicated, adhered to, escalated and audited.			X
7	Ensuring primary care have extended hours for evenings and weekends				22	Acute frailty service > 70 hours over 7 days At least but ideally open at time of demand			X	36	IPC protocol in place that adheres to the latest national guidance and balances IPC risk with flow and delays related harm risks	X		
8	Urgent community response within 2 hours				23	Dedicated, separate to adults, Paediatric ED / secure area in place	X				**Discharge**			
	Site/Operational Discipline				24	All Minor illness streamed to GPs		X		37	Expected Date of Discharge set within first 24 hours of admission. Patients should clearly have an acute reason to reside within the acute provider.	X		
9	Focused site/bed management 24/7 with minimum 3 times per day site meeting following a structured FOCUS model (or equivalent) with appropriate accountable actions	X			25	All Minor injuries streamed to an emergency nurse practitioner (ENP)	X			38	Discharge is profiled against admission demand with a focus on early in the day discharge and weekend discharges.	X		
10	Site management support & presence within ED to deliver timely flow and support to ED team	Z				**Emergency Department Environment**				39	Identify patients in ED or at admission who are likely to need complex discharge support and highlight for early intervention	X		
11	Daily Executive Director oversight responsible for all escalation and delivery of mitigations	X			26	Required capacity (numbers of cubicles and Fit to sit) in place to meet demand		X		40	Where in place, protect discharge lounge capacity from being bedded	X		
12	Bed/site management function should ideally be clinical or as a minimum has access to clinical colleagues 24x7. Site function should have annualised competency/training.	X			27	CDU adjacent or equivalent short stay Emergency patient area	X			41	7-day Transfer of Care Hub in place		X	
13	Senior Clinical and Management Directorate staff 24/7 rota to support min twice daily meetings	X			28	GIRFT data should be used to effectively plan against demand and capacity			X		**System and Trust Oversight**			
14	Full capacity protocol in place – infection, prevention and control (IPC) compliant Along with BCPs for every acute service so that no service functions stops or defaults to ED	X				**Emergency Department IT**				42	Trust and ICB executive review weekly as a minimum (taking into account variance by provider in an ICB)		X	
15	Exec signed off internal professional standards in place appropriately managed with escalation for non-compliance	X			29	ED system in place to enable patient flow against national standards	x			43	ED Performance: Over 4 hours in department + 12 hour DTAs + Over 12 hours in department	X		
										44	Ambulance Performance: Response times + Hospital Handover delays + Longest handover + Any identified patient harm including SUI	X		
										45	Potential patient harm: Overview of all patient related incidents and serious incidents with regards to ambulance delays	X		
										46	Overview of all incidents and serious incidents for patients in ED over extended periods	X		
										47	Right to reside/delayed discharges			X
										48	In and out of hours clear bronze, silver and gold escalation with recorded actions and outcomes with appropriate training & support programme. Reflective practice should be used	X		
										49	Monthly review of agreed data sets and this checklist at trust and ICB boards	X		

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 6 OCTOBER 2022

Subject Title	Critical Care Operational Delivery Plan (ODP)
Executive Sponsor	Gaby Harris, Chief Operating Officer
Author	Lacey Bennett, Operational Head of Services - Perioperative and Critical Care Services
Attachment(s)	Critical Care Operational Delivery Plan 2022/23
Recommendation(s)	The Board is asked to **APPROVE** the recommended bed model moving forward and the financial request of £1.9M to resource the additional beds

EXECUTIVE SUMMARY

The paper outlines:

1. The Operational Delivery Plan to meet 104% activity levels for Critical care
2. A proposal to close OIR in theatres
3. A proposal to close the beds Previously allocated to EPOC in Surgery and to repatriate all patients requiring Higher Dependency beds, to Critical Care.

The bed model proposed is:

1. 34 level 3 beds Friday Evening – Monday Evening, and 36 level 3 beds Tuesday Evening – Friday Evening.

This will sustain current demand (to Critical Care, EPOC and OIR) and to ensure that capacity is in place to deliver an additional 4% compared to 2021/22 levels of activity.

The shift pattern assumes that the flexing down of beds will happen after 7:30pm. This will allow for delayed discharges to be transferred with the correct nursing establishment assigned.

PREVIOUS DISCUSSIONS HELD

Approved at Operational Delivery Group in July 2022

Approved at Chief Officers' Group in August 2022

KEY IMPLICATIONS

Financial	£1.9M
Patients Safety or Quality	Improvement in Quality of patient care and experience
Workforce	Increase in workforce requirements
Operational	Increase of 4% activity levels estimated and sustained

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

REPORT TO PUBLIC TRUST BOARD

CRITICAL CARE OPERATIONAL DELIVERY PLAN 2022/23

1. INTRODUCTION

1.1 The following paper outlines the current demand for Critical Care, EPOC and OIR bed Capacity and recommends the number of beds required in each area for financial year 2022/23 effective from 1st July 2022.

1.2 The annual planning guidance is to deliver 104% of activity when compared to 2019/20 so we need to consider any additional demand or capacity required in order to meet our 2022/23 Operational Delivery Plan (ODP).

1.3 CONTEXT

1.4 Prior to April 2020, the organisation funded and maintained 32 Level 3 Critical Care beds across 2 units, General Critical Care and Cardiothoracic Critical Care, with a total footprint of 52 beds, which allowed flexibility between Level 2 and Level 3 patients.

1.5 In order to continue to deliver both emergency and elective care through the COVID pandemic from April 2020 and the restoration of surgical services in 2021, the Critical Care units merged, to provide 1 Critical Care bed base and flexed between 40 and 36 Level 3 beds. Deployment of staffing from other areas, Bank, Agencies and additional recruitment took place in order to sustain this flexibility over a 2 year period.

1.6 In addition to Critical Care beds, the Theatres Department operates a 2 bedded area of Overnight Intensive Recovery (OIR) 4 days per week (Monday – Thursday) for patients who require 1 to 1 care post-operatively and active monitoring. Only a certain criteria of patients can utilise these beds and the bed base in OIR has reduced from the overall recovery area in Theatres, staffed overnight by the Theatres Department. Use of the 2 beds at the same time requires patients to be of the same sex and overall admissions are limited.

1.7 Whilst Critical Care had expanded its bed base, the volumes of emergency and COVID admissions remained high over the first 12 months. The patient's lengths of stay also extended from an average of 3 days to an average of 14 days, resulting in lack of admission beds. This resulted in high amounts of elective patients having their surgeries cancelled on the day for lack of Critical Care bed capacity and surgical specialties were 'capped' in terms of the number of TCI's they could book per day.

1.8 From February 2022, Critical Care was temporarily funded (from the Accelerator and COVID expansion bid) to 36 Level 3 beds 24/7.

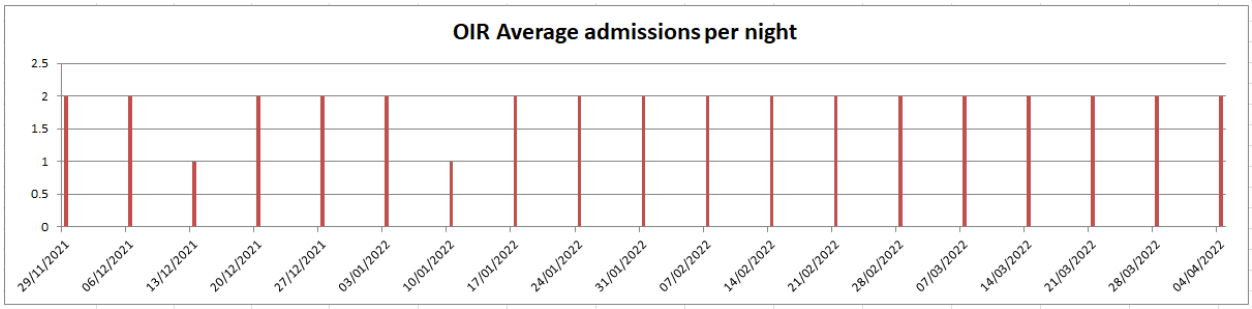
1.9 In addition to the expansion in Critical Care capacity and in order to sustain elective capacity, a number of patient pathways (previously TCI'd to Critical Care) were reviewed and it was recommended that certain pathways, whilst requiring a level of enhanced care post-operatively, did not require Critical Care and could avoid admission to that area post-operatively. This would reduce the amount of cancelled operations due to lack of Critical Care bed whilst demand for Critical Care beds remained high. The Surgical Clinical Group therefore developed an Enhanced Post-Operative Care (EPOC) 6 bedded unit on Ward 10. This was funded via the Accelerator payment. The initial implementation started in July 2021, but all 10 pathways and regular use of the beds did not happen until November 2021.

2. UTILISATION OF OIR

2.1 OIR is a 2 bedded area, staffed within the Theatres recovery footprint, from 08.00 on Monday until 08.00 Friday morning. The beds are well utilised as shown in the below table, but only for a certain criteria of patients and at a loss of recovery beds and staff during the day for general areas.

2.2 Since the COVID pandemic, OIR has strictly been a "managed Risk" area with no ability/physical space to house "Green" Patient pathways. In the peak of the pandemic, this resulted in a number of patients being either cancelled on the day because of no Critical Care bed and No Green OIR bed, or would cause patients to fall off the "Green" pathway and be housed within an amber area. The question is whether it would be better to increase Critical Care capacity (where side rooms are available) with a more flexible approach to patient pathways and accepted criteria, rather than to maintain this 2 bedded area 4 days per week.

2.3 Graph 1 – Utilisation of OIR



The above table shows that on average, 2 beds are utilised per night, Monday – Thursday in OIR

3. 2021/22 UTILISATION OF CRITICAL CARE

3.1 The annual planning guidance for 2022/23 is to achieve 104% of 2019/20 activity levels. As patients admitted to Critical Care require at least 1 overnight stay and have a national average length of stay of 3 days, the opportunity to review efficiencies and patient turnover rates does not present itself in this paper. Therefore, in order to plan to achieve 104%, we need to ensure that we have the number of beds required to meet 19/20 demand and then an additional 4% of beds on top of that.

3.2 Table 1 – Average L3 Dependency by month 2019/20

Month	Level 3 Average	Level 2 Average	Overall L3 Dependency Average
April 2019	**26**	**14**	**34**
May 2019	**21**	**19**	**30.5**
June 2019	**20**	**18**	**29**
July 2019	**20**	**17**	**28.5**
August 2019	**18**	**18**	**27**
September 2019	**22**	**18**	**31**
October 2019	**24**	**16**	**32**
November 2019	**20**	**19**	**29.5**
December 2019	**26**	**12**	**32**
January 2020	**23**	**18**	**32**

February 2020	**22**	**18**	**31**
March 2020	**23**	**14**	**30**
Year Average	**22**	**17**	**31**

3.3 The above table shows that on average, Critical Care utilised 31 level 3 beds on a daily basis to deliver 2019/20 activity levels. This data was collated over 7 day weeks and included activity at weekends, which we know to be lower in activity. The unit itself used to staff to 33 level 3 beds in week and then flex down to 31 beds at weekends.

3.4 **PLEASE NOTE:** This is not the level of beds required to deliver the demand in 2019/20. There were a number of cancelled operations in 2019/20 due to lack of Critical Care bed, it is simply outlining the capacity used to deliver the actual levels of activity we are trying to reach in 2022/23.

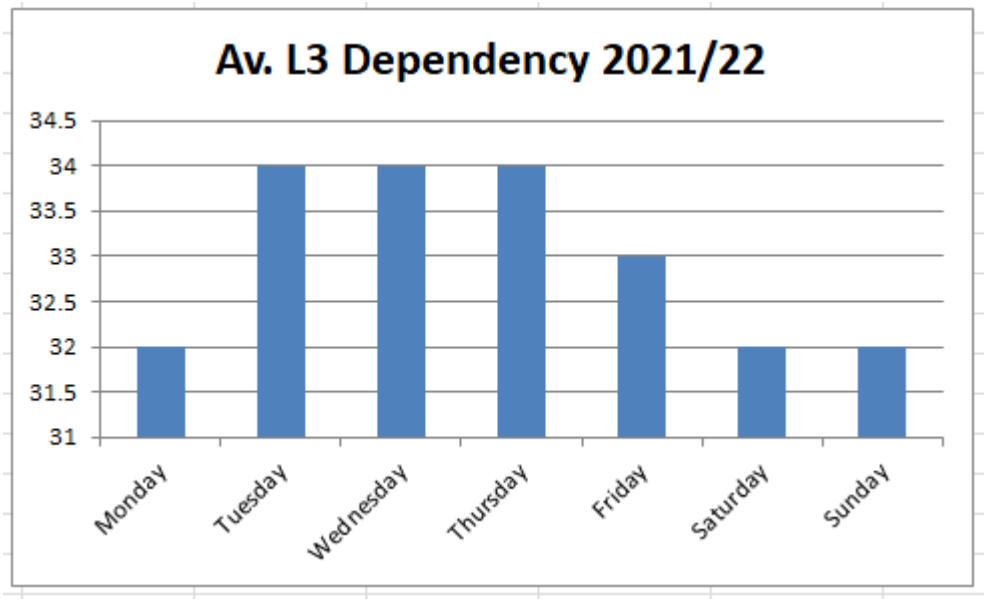
4. 2021/22 UTILISATION CRITICAL CARE

4.1 Table 2 – Average Level 3 Dependency by Month 2021/22

Month	Level 3 Average	Level 2 Average	Overall L3 Dependency Average
December 2021	**26**	**13**	**32.5**
January 2022	**23**	**17**	**31.5**
February 2022	**23**	**18**	**32**
March 2022	**23**	**17**	**31.5**
April 2022	**25**	**18**	**34**
Part Year Average	**24**	**16**	**32**

4.2 Graph 2 – Daily Average Utilisation of Critical Care 2021/22

Whilst we determined that the monthly average of utilisation is 32 level 3 beds, we wanted to look at specific days of the week where levels of admission may fluctuate:



The Graph above shows that demand for beds and actual utilisation is higher mid-week than at the weekends and on Mondays. This data includes both emergency and elective admissions.

5. EPOC

5.1 From July 2021, EPOC was implemented as a 6 bedded area on Ward 10. The area has incrementally built from taking in 1 EVAR patient per week, to 10 clinical pathways/patient criteria accepted, with further opportunity for a total of 12 patient pathways to be signed off this year.

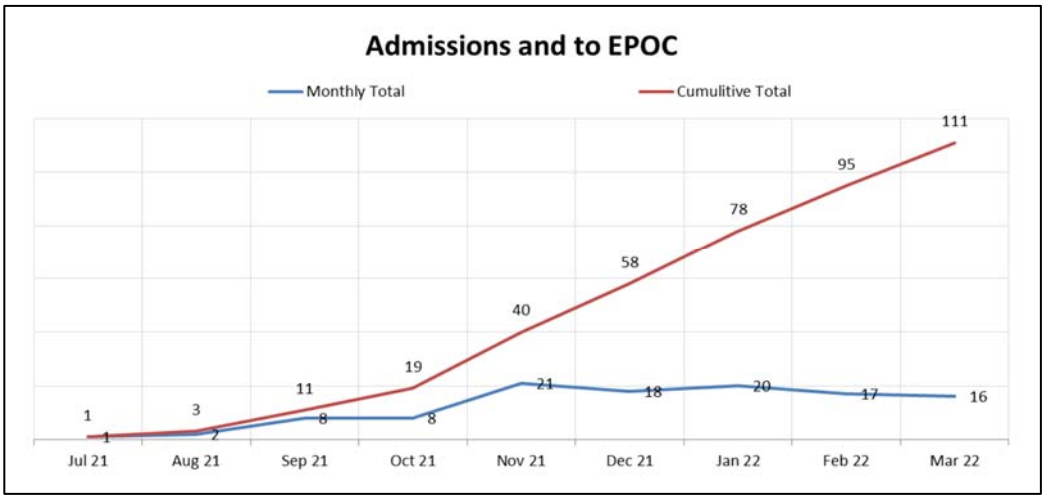
5.2 EPOC was originally funded as additional capacity to support the Critical Care expansion and restoration of elective activity. The funding allocated was from the NHSE Accelerator bid. The funding for this has now ceased from 1st April 2022 and a decision needs to be taken on whether maintain this area, or to close it.

5.3 It is fair to say that EPOC Utilisation was not realised until November 2021. The graph below will demonstrate that this area avoided admissions to Critical Care from November 2021 and also avoided a number of cancellations on the day by providing an additional space for patients to recover.

5.4 Whilst the area avoided admissions to Critical Care, Anaesthetic/Intensivist input was required post operatively for each patient on EPOC, requiring additional resource from Anaesthetics and Critical Care consultants. Originally it was planned for 1 x 4 hour ward round per week day, but more recently this has moved to a 1 hour ward round for the number of admissions realised.

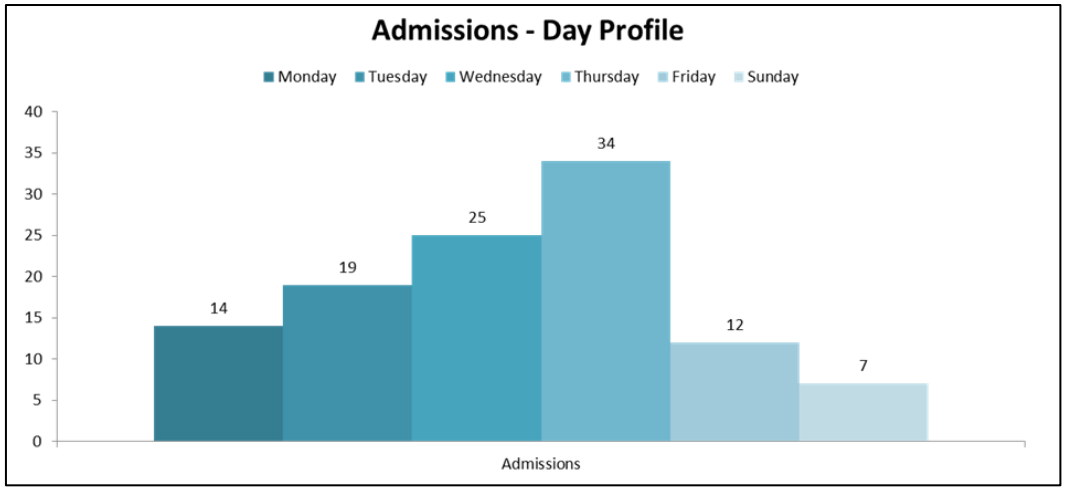
The Critical Care data above does not account for this activity. Should EPOC have not existed, Critical Care would be requiring the equivalent of 1 additional Level 3 bed per weekday to avoid further patient cancellations on the day

5.5 Graph 3 – Monthly admissions to EPOC (Week days only)



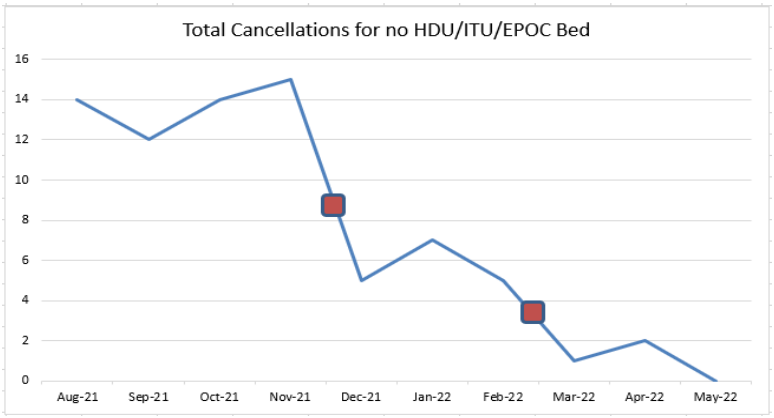
5.6 The above Graph shows that on average, EPOC is 18 patients per month, which equates to 1 patient per week day. This is an avoided admission to Critical Care and an avoided cancelled operation for no Critical Care bed.

5.7 Graph 4 – Daily Profile of Admissions to EPOC



The above graph demonstrates that the beds are mostly utilised on a Wednesday and Thursday, in line with peaks of demand in Critical Care.

5.8 Graph 5 - Cancelled Operations on the Day for No Higher Dependency Bed



5.9 The above graph shows that over the last 10 months, cancelled operations on the day have dramatically decreased. This correlates to when the capacity in EPOC was fully realised in November 2021 and when the L3 Bed Model was increased to 36 level 3 beds from February 2022 – as outlined on the above graph in red. Prior to November 2021, the average monthly cancellation rate was 13 patients per month. Over the last 6 months this has reduced to an average of 3 per month.

6. ODP FOR CRITICAL CARE 2022/23

6.1 It seems reasonable and more cost effective to match the staffing levels and the bed capacity in critical care to the days of the week where capacity is more likely to be utilised, rather than to apply a blanket approach to 7 days of the week.

6.2 In order to improve patient experience and quality of care, it seems more reasonable to move capacity from OIR, to Critical Care. This will mean that bed spaces are more flexibly available regardless of COVID status or gender and that patients receive more appropriate care within a high dependency area, than within a 2 bedded area in the Theatres Department. Moving this capacity equates to 1 Level 3 bed Monday – Thursday each week.

6.3 Clinical Support Services and Surgical Clinical Groups absolutely agree that there is potential to do more activity through EPOC, once additional clinical pathways are signed off and the demand warrants a 4 hour ward round of an Anaesthetist. This will make the operational delivery and financial viability easier. However, we are not in that position right now and so the proposal is to move the

activity back to Critical Care from July 2022, until a business case for an EPOC unit is approved and fully funded as such.

6.4 The annual plan for 2022/23 requires an additional 4% of capacity (to that of 2021/22) to be available, to sustain an increase in demand from both an elective and non elective perspective and to reach 104% activity levels of 2019/20. This too needs to be aligned to certain days of the week in a more flexible and cost effective approach.

6.5 Table 3 - Proposed Level 3 Critical Care bed model for 2022/23:

Day	Current av. demand	L3 Capacity Moved from OIR *(Based on 2 beds per night on Average required)*	Additional 4% to current demand	L3 Capacity Moved from EPOC *(Based on Average required by day)*	Total level 3 beds required 2022/23	Proposed Total L3 Beds in Critical Care 2022/23
Monday	32	1	1	0	34	34
Tuesday	34	1	1	1	36	36
Wednesday	34	1	1	1	37	36
Thursday	34	1	1	1	37	36
Friday	33		1	0	34	36
Saturday	32		1	0	33	34
Sunday	32		1	0	33	34

6.6 The above table proposes that Friday – Monday, Critical Care is equipped and staffed to support an equivalent of 34 level 3 beds and that Tuesday – Thursday, Critical Care is staffed and equipped to support an equivalent of 36 level 3 beds. The recommendation is to keep to 2 types of shift per week, rather than the shift changing 4 times per week, as it is very difficult to line manage and to keep track of how many beds per day. The shift change/flex times will need to be from 19:30 evening, in order to account for delays in discharges throughout the day.

6.7 Whilst the level of beds required on a Saturday & Sunday is 33 level 3 beds, we have proposed that we aim to staff 34 level 3 beds. This is proactively planning for additional capacity at weekends without having to surge or move away from GPICS nursing staffing levels. This will allow the unit to maintain additional emergency admissions at weekends, additional length of stay of COVID patients, additional cardiothoracic theatre sessions on Sundays too. We also see a higher amount of sickness calls on the weekends and feel that the plan to staff 34 beds at the weekends, will accommodate short notice absences without cancellation of admissions or relying on theatre recovery areas over the weekends. It also makes the management of off duty more viable, managing a 4/3 off duty rota than 3 different shift types.

6.8 The above model would allow for OIR to close within theatres and for the Theatres recovery staff to move back from nights, into the mid-week day shifts, allowing for improved resources in Theatres Recovery. This would improve patient care and experience in both areas of Critical Care and Theatres as explained above.

6.9 It is important to note that the proposed bed numbers are based on *average* capacity and that surgical cancellations are still a risk when bed pressures are above average. The recommended bed numbers are in order to deliver the ODP for 2022/23 and should not account for any further surge in activity such as COVID-19. Business continuity plans and capacity surge plans will be utilised to manage such a demand, including the use of additional bank and agency staff in these circumstances.

7. SUMMARY FOR RECOMMENDATIONS OF APPROVAL

7.1. The proposal is as follows:

- **Close OIR capacity in Theatres and to move the bed capacity to Critical Care**

  This will improve patient experience and quality of care by way of providing more flexible beds, in an appropriate setting, with the appropriate levels of support. The Recovery staff on the night shifts will move back into theatre recovery vacancies in the day and reduce the burden on general recovery areas within theatres.

Table 4 below table assumes that the funding from OIR within the Theatres budget will move across to the Critical Care budget, to offset the costs associated with the provision of beds. For clarity, the cost of OIR is currently assumed within the ODP for Theatres also, to ensure that the service is appropriately budget set, regardless of where it sits in terms of management.

- **Fund Critical Care for 34 level 3 beds Friday Evening – Monday Evening and 36 level 3 beds Tuesday Evening – Friday Evening**

  This will sustain current demand (to Critical Care, EPOC and OIR) and to ensure that capacity is in place to deliver an additional 4% compared to 2021/22 levels of activity.

  The shift pattern assumes that the flexing down of beds will happen after 7:30pm. This will allow for delayed discharges to be transferred with the correct nursing establishment assigned.

- **Implement a review process in line with UHCWi 30/60/90 day methodology**

  The proposed ODP for 2022/23 is based on average use from the previous year. Following implementation, there will be a monthly performance review process in line with our UHCWi methodology, whereby the case will be assessed against the following key parameters:

  - Critical care beds in use over a daily basis
  - % of level 2 versus level 3 utilised (assumes 33% level 2 in the case)
  - Cancellations due to lack of critical care facility

  This will allow us to continuously review the bed capacity and staffing level requirements and assess as to whether our establishments are in line with levels of demand.

8. FINANCIAL COSTING FOR APPROVAL

8.1 Table 4 - Additional Resource Required for 34 (Fri-Mon) and 36 (Tue-Thu) L3 Critical Care Beds

Staffing	WTE	£000s
Nursing	16.87	856
Consultant	2.00	260
Junior doctor	5.00	350
ACCP	1.00	79
Support staff	1.86	109
Pay total	26.73	1,654
Consumables		328
Other non pay		63
Non pay total		391
Critical Care Total	26.73	2,045
OIR removal	-3.37	-143
Grand Total	**23.36**	**1,901**

8.2 Notes on Financial Costing:

****PLEASE NOTE****

These calculations are for the additional beds only and does not take into account any current baseline deficit against GPICS standards for our current Level 3 beds across both areas

Only the investment required to achieve the ODP for 2022/23 has been outlined within this paper. Additional income from increased activity levels/enhanced Critical Care tariff have not been included.

Exclusions from Costing:

- Outreach has not been included within costing, pending a full service review and business case for Critical Care outreach.
- Previously 1 WTE Pharmacist was allocated recurrently to Critical Care additional for the increase in beds. No further costs have been associated with this
- Additional Administrative and Matron leadership has been removed from the costing associated usually with additional beds, as it is felt that the proposed increase in beds can be managed within the current levels of staffing.

Nursing:

- Costing based on 2 extra beds 3 days per week and 4 extra beds 4 days per week. This is to ensure that bed reduction/flex down times are at 7:30pm, rather than 8am. This will allow for delayed discharges to be accommodated.
- Nursing rotas have been costed on split of 70/30 between B5 & B6 Nursing. This ratio of skill mix will provide the appropriate level of leadership and senior nursing per shift in order to manage the day to day running of the unit safely and with high quality patient experience. Direct care delivery within Critical Care requires 1:1 nursing for Level 3 patients and 1:2 for Level 2 patients. With the increase of Band 5 Registered Practitioners proposed, there will be a need to increase senior nurse cover within the Band 6 bracket; this is to provide both supervisory roles and deliver direct patient care as part of the overall workforce. Increasing the level of skills and providing experience at this level will ensure the development of a junior workforce and succession planning through inclusive nursing leadership for all levels. Providing effective leadership at the point of care whilst supporting an increased workforce will ensure the delivery of standardised, safe and effective care.
- Calculations are for the beds only and not the total WTE Staff required for the unit, including Coordinators, etc
- Costs are assumed at top of pay scale 2021/22 AfC pay rates. Costs could be lower if mid-point scale was applied
- AfC pay award for year 22/23 will be an additional cost to that outlined above
- Calculations based on long shifts as per GCC current rota

Consultants:

- Calculations are based on a robust working day rota, utilising 4 consultants per day (2 on an 8 hour shift, 1 on a 10 hour shift, 1 on 24 hour shift)
- The above mentioned rota (appendix 1) requires a total of 16 Consultants in ITU equivalent to 14 WTE Critical Care DCC + 2 Theatres DCC.
- We currently have 16 consultants in post, 2 of which are non-recurrently funded. We require these 2 posts to be recurrently funded in order to sustain this workload.

Junior Doctors & ACCP:

- Calculations are based on 1 doctor for 8 patients. This assumes a total of 48 patients in total (with a 33% Level 2 Ratio) which will require 6 doctors per shift.

- Of the 6 doctors required, this will be split between 2 Registrars (1 for GCC, 1 for CTCC) and 4 SHO's/ACCP's.
- It has already been established that we require 1 additional ACCP because of the baseline deficit. The additional 6 WTE's are required to cover the additional beds above, making a 1:6 rota 24/7.

Support Staff:

- Breakdown outlined within Appendix 2

8.3 Proposed Exit Strategy in line with funding requested

The case will be annually reviewed in line with yearly business planning and in the context of the changing operational pathways; for example, Introduction of EPOC beds within surgery will mitigate the need for some critical care beds/admissions.

Where a higher demand than average is continuously demonstrated, a further ODP plan for 23/24 will be submitted for review. Were it to be demonstrated that beds are a) under-utilised b) have lower dependency (Level 2 to level 3 ratio) needs or c) inefficient, the department would seek to reduce the levels of beds and workforce required deliver. This mitigation plan includes:

a. Not replacing/backfilling staff who wish to reduce their hours or vacate the department
b. The redeployment of staff to vacancies elsewhere such as theatres
c. The conversion of Consultant PAs to Anaesthetic time

Appendix 1 – ITU Consultant Team Job Planned rota

	On Call-LD	Clinical Day	CTCC-SD	GCC-SD	On Call-N	Handover	Total		
	08:00-20:00	08:00-18:00	08:00-16:00	08:00-16:00		08:00-08:30			
Mon	3.083	2.5	2	2	2	0.125	11.708		
Tues	3.083	2.5	2	2	2	0.125	11.708		
Wed	3.083	2.5	2	2	2	0.125	11.708		
Thurs	3.083	2.5	2	2	2	0.125	11.708		
Fri	3.083	2.5	2	2	2	0.125	11.708		
Sat	4	2	2		2	0.167	10.167		
Sun	4	2	2		2	0.167	10.167		
						Grand Total PAs =	78.875		
							97.65	PAs once annualised	
							15.94	People to cover*	
* Standard ICM Job Plan of 6.5 PA ICM , 1 PA second specialty, 2.5 SPA.									
The 6.5 PA ICM incl. 0.375 for facilitating discharges/follow ups/patient-related admin.									

Appendix 2 - Break down of Support Staff Costs

Support staff:	WTE	Cost
SLT B7	0.31	17,968
Physiotherapy B7	0.79	45,788
Occupational therapy B7	0.15	8,694
Psychology B8b	0.15	12,193

Dietetics B6	0.31	15,234
Mebs B7	0.15	8,694
Total	1.86	108,571

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 6 OCTOBER 2022

Subject Title	Patient Experience and Engagement Report 2022-23
Executive Sponsor	Mo Hussain, Chief Quality Officer
Author	Sam Caton, Head of Patient Relations
Attachment(s)	Patient Experience and Engagement Report
Recommendation(s)	The Board is asked to **NOTE** this report

EXECUTIVE SUMMARY

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

Complaints: The Trust received 110 complaints in Quarter 1 (126 in Quarter 4 2021-22) and responded to 98% within 25 working days. The performance indicator is 90% responded to within 25 working days. In Quarter 1 the Trust received 22 requests for further resolution of complaints (FLR) (25 received in Quarter 4 2021-22).

Primary themes: Of complaints received in Quarter 1, 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 Quarter 1. Patient Care including Nutrition / Hydration, was the third most complained about theme in Quarter 1.

Patient Advice and Liaison: The Patient Advice and Liaison Service (PALS) processed 768 enquiries in Quarter 1 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 Quarter 4 2021-22 and the Team have recruited five new starters. The PALS Team performance is expected to see continued improvement in Quarter 2 2022/23.

Primary themes: Appointments was the primary theme in Quarter 1. 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 Quarter 1.

Patient information leaflets: During Quarter 1, 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 Quarter 1.

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 Quarter 1 Patient Partners supported a Patient Visitor Survey and presented their findings to the Patient Experience and Engagement Committee. The aim of this survey was to measure if the new visiting hours introduced on both hospital 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 Quarter 1 to improve FFT response and recommender rates which include:

- Further Streamlining and developing reports for each of the Groups.
- 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 Quarter 2 2022-23.

PREVIOUS DISCUSSIONS HELD

- Reported to the Patient Experience and Engagement Committee on 18 August 2022.
- Reported to Quality and Safety Committee 29 September 2022.

KEY IMPLICATIONS	
Financial	Delivery of value for money
Patients Safety or Quality	To create a high-quality patient experience
Workforce	None
Operational	Operational performance

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

REPORT TO PUBLIC TRUST BOARD HELD ON 6 OCTOBER 2022

Patient Experience and Engagement Report (Complaints, Patient Advice and Liaison Service (PALS) and Patient Insight and Involvement) Quarter 1 2022-23

1. INTRODUCTION

1.1 Improving the experience of each individual patient is at the centre of the NHS Constitution. Obtaining feedback from patients and taking account of their views and priorities are vital for the delivery of high-quality services and for driving real service improvements.

This report will provide an overview of progress on the Patient Experience and Engagement objectives for University Hospitals Coventry and Warwickshire NHS Trust in Quarter 1 2022-23.

2. CONTENT

2.1 Compliments and Thanks

In Quarter 1, the Trust received 286 compliments that were added to Datix, the Trusts incident management system.

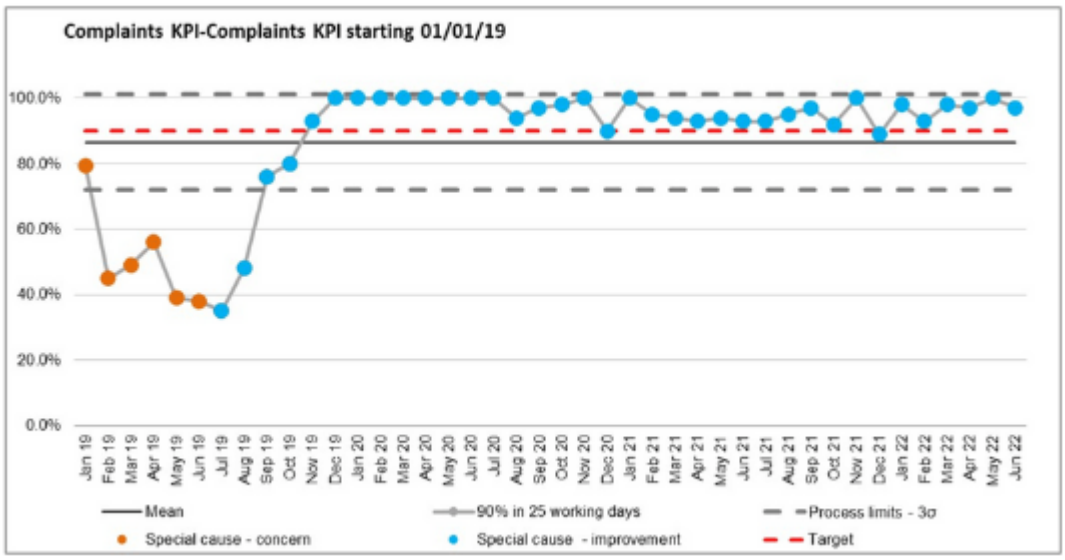
The top 10 specialties were:

Subject	Total
Gynaecology	72
Bowel Cancer Screening - Hub (Rugby)	41
Emergency Department	20
Obstetrics	14
UHCW@Home	11
Breast Screening	10
Orthopaedics	9
Endocrinology	7
Radiology	7
General Surgery	7

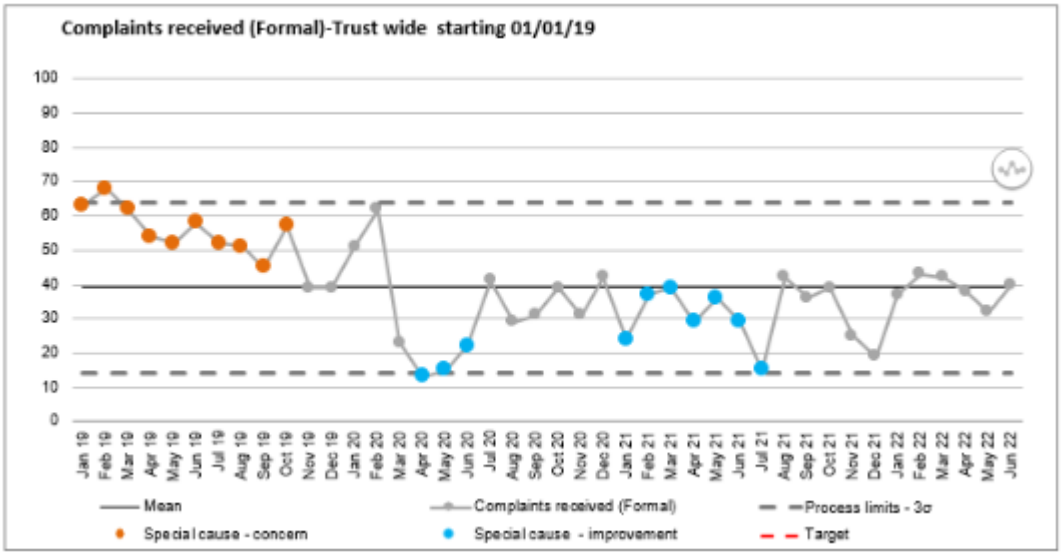
2.2 Complaints

The Complaints Team key performance indicator (KPI) is to process 90% of complaint investigations and provide a formal response within 25 working days from registration. The Team continues to deliver month on month compliance. During Quarter 1, 110 complaints were received of which 98% were provided a response within 25 working days.

The below statistical process chart (SPC) shows the performance of the complaints team against the KPI (response within 25 working days):



The below SPC chart show the total number of complaints received per month:



2.3 Complaints for further local resolution (FLR)

A complaint is categorised as 'further local resolution' if the complainant is not satisfied with the Trust's initial response and requests a further response to the issues raised or has further questions.

There are currently 46 FLR's awaiting a response due to low staffing levels within the Complaints Teams during 2021 for several months. A previous Complaints Officer will be supporting with FLR's for four months as of September 2022 to allow a return to normal service.

During Quarter 1, 22 FLR's were received, compared to 25 in Quarter 4 during 2021-22.

2.4 Top complaint themes and categories

The table below shows the themes of the complaints received during Quarter 1 (top themes and categories):

Top 3 Complaint themes	Top 3 Sub-categories of complaint themes
Communications	Communication with patient Communication with relatives/carers Conflicting information
Clinical Treatment - General Medicine Group	Other - Clinical Treatment Awareness under anaesthetic Delay or failure in treatment for infection
Patient Care including Nutrition / Hydration	Other - Patient Care incl Nutrition / Hydration Slips trips and falls - unwitnessed Delay or failure to undertake scan/x-ray etc

To share and improve our services from patient feedback the following actions have been completed during Quarter 1:

- Complaint Officers meet group representatives weekly and themes and escalations or concerns are shared, this includes PALS feedback.
- Data and themes shared in Trust monthly Quality Improvement and Patient Safety (QIPs) reports.
- Data and themes shared in Quarterly Patient Experience Reporting.
- Deep dive analysis of hot spots to enable services to better understand their patient's experience.
- Analysis shared and discussed at the Patient Experience and Engagement Committee (PEEC).
- Results presented at Quarterly Nursing and Midwifery meeting.

Complaints internal audit

In May 2022 an internal audit was commissioned for the Complaints Department at UHCW as part of the 2022/23 internal audit plan agreed by the Audit Committee.

The scope and objectives of the audit was to examine the extent to which the key control objective below has been met:

Key Control Objective	Risks
Complaints are managed effectively and in accordance with the Trust's Policy and principals of complaint management*.	• Reputational damage. • Poor service user experience.
Transparent reporting of complaints and consideration of themes is completed at an appropriate level and there is evidence that appropriate actions to address concerns have been taken.	

In July 2022 the results of the audit were shared, the results were that the audit provided **significant assurance** to the Trust which indicates; the audit did not highlight any weaknesses that would materially impact on the achievement of the system's key objectives.

2.5 **The Patient Experience and Engagement Committee (PEEC)**

The Patient Experience and Engagement Committee continue to meet monthly chaired by the Chief Quality Officer or Chief Nursing Officer. PEEC has two primary responsibilities - the development and oversight of:

- Commissioning and monitoring quality improvement priorities to improve patient experience based on learning and feedback, utilising UHCWi methodology.
- Patient and carer involvement / engagement at the forefront of all improvement work streams to shape responsive services and improve future patient experience metrics.

2.6 **Developments in Complaint data sharing**

During Quarter 1, the Patient Experience Team have:

- Further developed the PEEC Hotspot report to identify areas of focus from complaints and PALS.
- Continued to embed the Complaints Review Group (CRG) with attendance from the Deputy Chief Medical Officer, Head of Patient Relations, and Patient Safety to identify cases that require a more focused approach and cases that require collaboration between teams. This has been further matured during Quarter 1 to include a review of Ombudsman cases, both cases under investigation and case outcomes.

2.7 **Deep dive reporting**

To support the Trust to learn and better understand potential themes from complaints and PALS feedback the following areas underwent a deep dive analysis produced by the Patient Experience Team:

- Communication
- Cannula Care
- Patient Care including Hydration and Nutrition
- Emergency Department
- Neurosurgery
- Ward 43
- Access to Treatment and Drugs

The Neurosurgery and Ward 43 deep dive report was presented to PEEC by the Group Director of Operations for Trauma & Neuro Services. A number of actions were identified to

improve the patients experience including enhancing the visiting options for families and re-instating the volunteer support that was previously provided on the Ward.

The Emergency Department (ED) deep dive report was presented to PEEC in June 2022 due to an above average rise in the number of enquiries they were receiving. The main theme for ED in the last year was in relation to communication, this appeared to be on a downward trend with no communication issues reported for ED during April or May 2022.

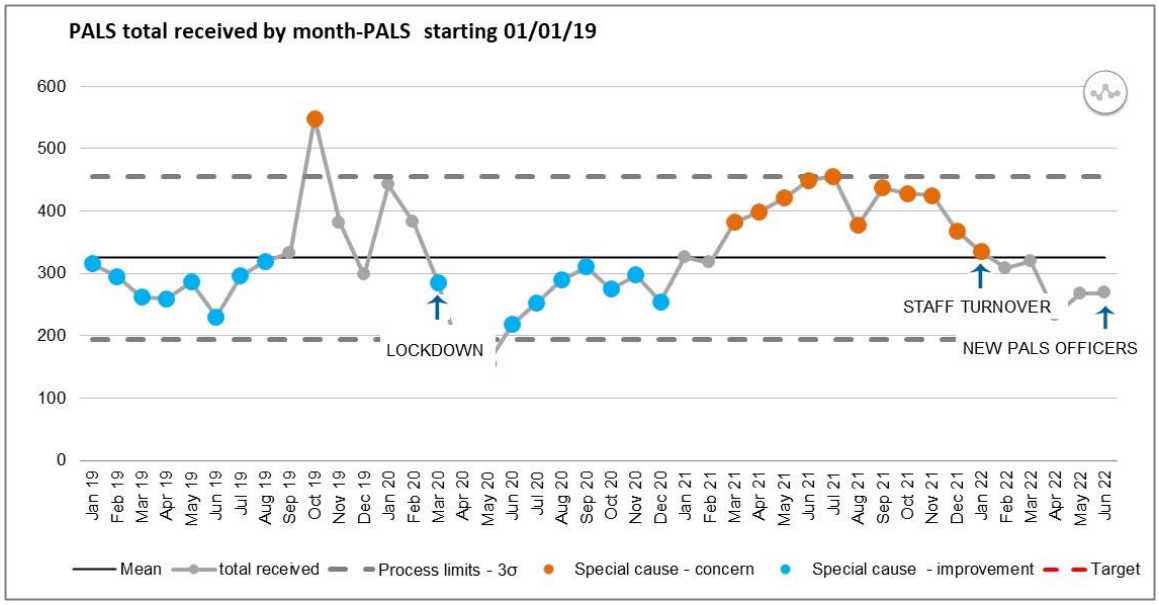
The cannula care and access to treatment and drugs provided PEEC with assurance that there were no themes or trends identified from the initial indications of the data.

2.8 **The Patient Advice and Liaison Service**

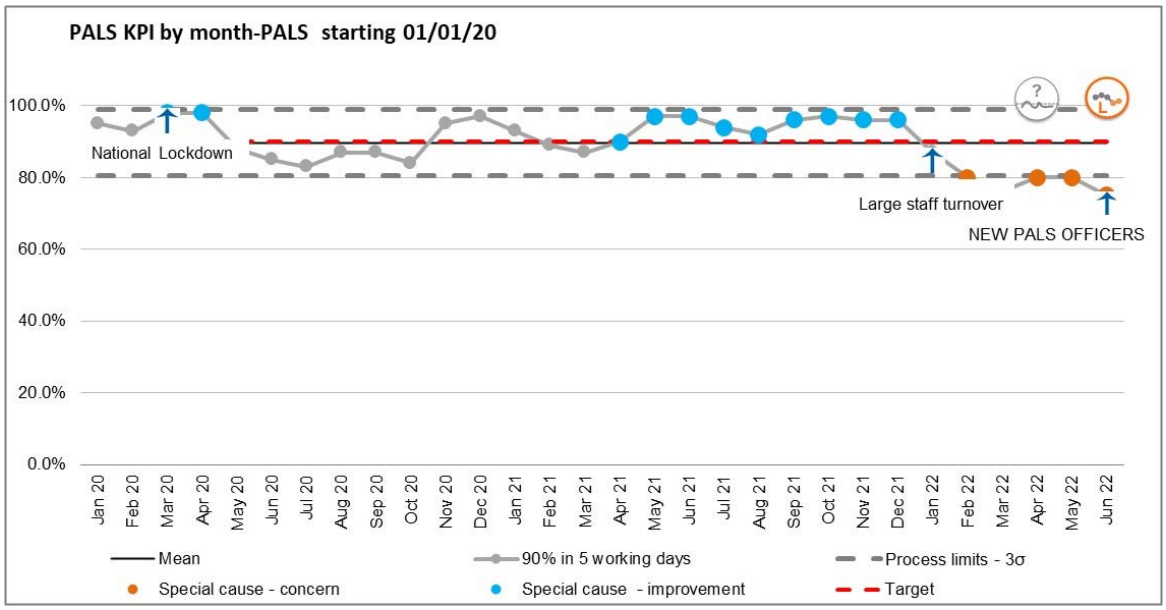
The PALS Team key performance indicator is to process 90% of enquiries within five working days. During Quarter 1, 78% of enquiries were processed within five days. This is attributed to staff turnover and absence and will continue to be monitored. A new PALS Coordinator commenced in post in Quarter 4 2021-22 and the Team have recruited five new PALS officers and are at full establishment for the Team. The PALS Team performance is expected to see continued improvement in Quarter 2 2022/23.

The Trust received 768 enquiries in Quarter 1 compared with 957 in Quarter 4 2021-2022, a decrease of 189.

The below SPC chart shows the total PALS queries received per month:



The below SPC chart shows PALS performance against the 5 day target:



2.9 Top PALS themes and categories

The table below details the top themes and categories received by the PALS team during Quarter 1:

Top 3 PALS Enquiry Themes	Top 3 Sub-categories of PALS Enquiries
Appointments	Communication with relatives/carers Communication with patient Delay in giving information/results
Communication	Communication with relatives/carers Communication with patient Delay in giving information/results
Values and Behaviours (staff)	Attitude of Medical Staff Attitude of Nursing Staff/midwives Attitude of Admin & Clerical Staff

The PALS data aligns to the data received for complaints to identify themes and trends and any areas that require a focus or deep dive as per point 2.6 and 2.7 of this report.

2.10 Patient Information Leaflets

During Quarter 1, 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 Quarter 1.

2.11 Patient Partners

The Patient Partner Forum meetings have continued every six weeks during Quarter 1 to receive updates from the Trust and to feedback what they have been involved with at UHCW.

All members are assigned to a work stream identified by the Patient Experience and Engagement Committee. As well as being involved with the Patient Partner Programme, the Patient Partners also support several groups within the Trust. These include Cancer Support Groups, the ReSPECT Forum, Healing Arts, and a number of Research Committees. A review of the group will commence in Quarter 2 with the newly appointed Patient Insight and Involvement Coordinator scoping and establishing a plan to improve involvement activities within the Trust.

During Quarter 1 Patient Partners supported a Patient Visitor Survey and presented their findings to the Patient Experience and Engagement Committee. The aim of this survey was to measure if the new visiting hours introduced on both Hospital sites meet the needs of loved ones and carers and to invite comments and concerns from visitors regarding the length of visiting times available. The themes gathered from the results is that overall people are happy with the visiting hours – as this is better than what it has been previously. The survey will be completed again in October 2022.

2.12 **National Survey Programme**

The NHS National Patient Survey Programme is part of the Government's commitment to ensure Hospital patient feedback informs continued development and improvement. CQC publishes patient experience surveys in secondary care under their National Patient Survey Programme. This includes surveys for Outpatients, Inpatients, Urgent and Emergency Care, Maternity and Children & Young People. In addition, NHS England publishes the Cancer Patient Experience Survey.

At the point that the National Survey programme results are received into the Trust, action plans are developed. The action plans detail the response to each theme outlining how the Trust plans to improve, a delivery lead and a target date for when the action will be completed. To understand findings and to make improvements the Patient Insight and Involvement Team will benchmark against CQC rated Outstanding Trusts to understand what more can be done to learn and improve the patient experience in the areas identified.

Urgent and Emergency Care Survey 2022

Samples will be drawn for the Urgent and Emergency Care Survey 2022 by September 2022, with fieldwork commencing for this survey between November 2022 - March 2023. Publication of results is yet to be confirmed.

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 survey. 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 in response to the survey findings:

- 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

This action plan is monitored by the Patient Experience and Engagement Committee to ensure progress on actions.

Below are the areas most improved scores in this survey:

Most improved scores	Trust 2021	Trust 2019
D2. Discharged without delay	62%	47%
C3. Felt they they were given appropriate advice and support at the start of labour	81%	75%
B14. Spoken to in a way they could understand (antenatal)	100%	97%
C20. Able to get help when needed (during labour and birth)	96%	93%
C22. Involved enough in decisions about their care (during labour and birth)	95%	93%

The Maternity 2022 survey will be published in 2023 although the exact date is yet to be confirmed. The Trust is awaiting the release of the embargoed results which are expected shortly.

Adult Inpatients 2021

The results for the Inpatient survey were released from embargo on 29 September 2022.

The Inpatient Survey results provide comparative data analysis and includes 73 organisations; UHCW response rate for this survey was 37% (total returns 1,176).

A total of 62 questions were posed, of these 45 can be positively scored, with 41 of these which can be historically compared.

Following receipt of the 2020 Inpatient Survey results an action plan was devised and is monitored through PEEC. In the below table Q11, Q38 and Q49 were identified in the 2020 results as areas which required improvement and are now our most improved scores. This suggests that that actions taken over the past year have had a positive impact upon patients experience of our services.

Most improved scores	Trust 2021	Trust 2020
Q37. Staff discussed need for additional equipment or home adaptation after discharge	88%	83%
Q11. Offered food that met dietary requirements	88%	84%
Q49. Asked to give views on quality of care during stay	11%	9%
Q47. Treated with respect and dignity overall	98%	97%
Q38. Given enough notice about when discharge would be	87%	85%

The table below shows the areas for the 2021 survey that are most declined for UHCW. An action plan has been developed to improve these areas with progress monitored through PEEC on a quarterly basis.

Most declined scores	Trust 2021	Trust 2020
Q12. Food was very good or fairly good	61%	69%
Q5. Not prevented from sleeping at night	42%	50%
Q7. Staff completely explained reasons for changing wards at night	83%	90%
Q3. Did not have to wait long time to get to bed on ward	73%	79%
Q2. Did not mind waiting as long as did for admission	62%	68%

Cancer Survey 2021

The National Cancer Survey is undertaken by Picker on behalf of NHS England with the latest results being published in July 2022; the results are not received under embargo as with other surveys before public release. The report response is led by Cancer Services and findings and actions are reported and monitored through PEEC on a quarterly basis.

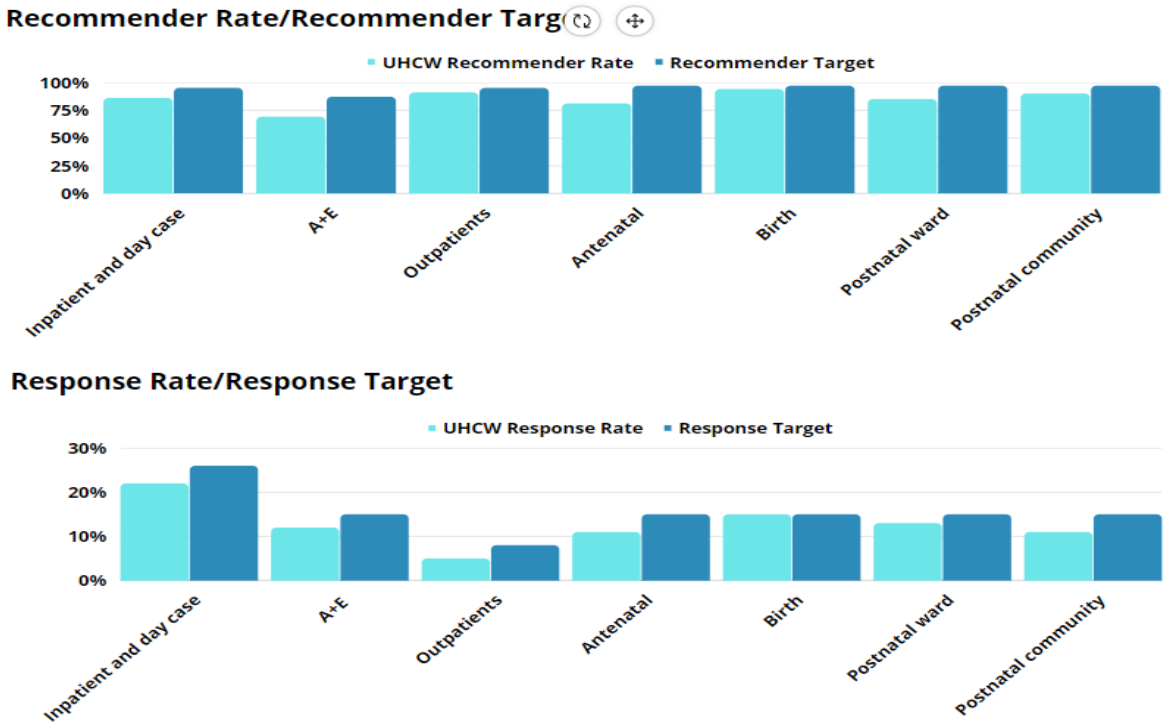
The findings demonstrate that as a Trust we are above the expected range for patients' having received a main point of contact within their care team, (with score of 95%). This is usually a clinical nurse specialist (CNS) as indicated in the questionnaire. The survey results also show that UHCW sits within the expected range for many of the questions, with a considerable number of them at the higher end of the range.

There are five areas where UHCW performed below the expected range. These are shown in the table below and actions are being devised by the Lead Cancer Nurse to address these: An action plan will presented to, and monitored through, PEEC.

Questions below Expected Range	Case mix adjusted scores			National score
	2021 score	Lower expected range	Upper expected range	
Q7. Patient felt the length of time waiting for diagnostic test results was about right	**74%**	79%	85%	**82%**
Q34. Patient was always able to get help from ward staff when needed	**69%**	71%	81%	**76%**
Q36. Hospital staff always did everything they could to help the patient control pain	**81%**	82%	90%	**86%**
Q37. Patient always treated with respect and dignity while in hospital	**85%**	86%	92%	**89%**
Q38. Patient received easily understandable information about what they should or should not do after leaving hospital	**84%**	85%	92%	**89%**

2.13 **Friends and Family Tests (FFT)**

In Quarter 1 the Trust's Friends and Family Test overall results for each touchpoint were as follows:



The Patient Insight and Involvement Team have put in place a number of measures during Quarter 1 to improve FFT response and recommender rates which include:

- Further Streamlining and developing reports for each of the Groups.
- Plans in place to introduce FFT in all areas, where we previously have not asked the survey before i.e., Paediatric Wards.
- 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 Quarter 2 2022-23.

2.14 Patient Led Assessment of the Care Environment (PLACE)

Good environments matter. Every NHS patient should be cared for with compassion and dignity in a clean, safe environment. Where standards fall short, they should be able to draw it to the attention of managers and hold the service to account. PLACE assessments will provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced. The assessments take place every year, and results are published to help drive improvements in the care environment. The results show how hospitals are performing both nationally and in relation to other hospitals providing similar services. These assessments were stood down during COVID-19 however have recommenced for 2022.

PLACE responsibility has recently transferred to the Patient Experience Team from Estates and Facilities. The assessment programme will be led by the Patient Insight and Involvement Team and supported by Estates and Facilities to ensure a smooth handover between teams.

The PLACE assessments are unannounced visits which will take place during October and November 2022 at UHCW, Coventry and Rugby St Cross, with results being shared through PEEC.

Author Name: Sam Caton/ Hayley Best
Author Role: Head of Patient Relations/ Associate Director of Quality – Patient Experience
Date report written: 12.09.2022

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 6 OCTOBER 2022

Subject Title	Research & Development (R&D) Annual Report 2021-22
Executive Sponsor	Kiran Patel, Chief Medical Officer
Author	Professor Harpal Randeva, Director of R&D Ceri Jones, Head of R&D The Research & Development Team
Attachment(s)	R&D Annual Report: 1st April 2021 - 31st March 2022
Recommendation(s)	The Trust Board should **NOTE** the contents of this report and continue to support the R&D strategy. Trust Board considers sharing the 2021-22 report with the ICS R&D board.

EXECUTIVE SUMMARY

The Research & Development Annual Report (2021-22) provides the Trust Board with a review of progress made during 2021-22 and assurance on delivery against the Research & Development (R&D) Strategy during this period.

This report provides an overview of activities during 2021-22, which is the final year of this R&D Strategy. In the context of a system re-starting non-COVID research post pandemic, we continue to deliver against our strategy.

Summary of Key Performance this year:

- Patient recruitment up 17% compared to 2020-21
- Whilst we are increasing the number of patients recruited into commercially-funded research, 18% fewer commercial trials met target within the agreed timeline this year.
- We are submitting increasing numbers of research grant funding applications to external funders and this year UHCW was 8th of NHS Trusts in England for Research Capability Funding received, being in the top 10 Trusts for the first time.
- This year, we further developed opportunities for researchers to access tissue for research through the Covid Digital Collaborative Biobank
- Although we supported many UHCW staff to develop research projects, research publications decreased slightly (down 3% on previous year).
- NIHR CRF funding was not secured for the next 5-year period (2022-2027), however, we successfully delivered our first phase 1 clinical trial and have funding identified to create a 2-bedded Inpatient Research Unit to support early phase research.

Quality:

- Target of zero serious breaches and critical findings maintained.
- Arden Tissue Bank was successfully inspected by the Human Tissue Authority in January 2022.
- Delivered large-scale national studies via our Trial Management Unit.
- Protected UHCW's Intellectual Property as required, e.g. HEARTT (UHCW's algorithm-based elective care scheduling tool aimed at reducing health inequalities) registered trademark filing.

We are proud that much of the work carried out this year received regional and national recognition.

Future:

To respond to the changing research environment, a more ambitious R&D Strategy was developed during 2021-22 and this will set our future direction as an organisation for the next 5 years.

PREVIOUS DISCUSSIONS HELD

The R&D Annual Update Report is received annually by the Trust Board.

KEY IMPLICATIONS	
Financial	Financial information is not provided in this report, but reported to Finance and Performance Committee. R&D broke even in 2021/22. We continue to focus on securing external commercial and grant income.
Patients Safety or Quality	Progress continues in developing systems to enable us to safely deliver our diversifying portfolio.
Workforce	N/A
Operational	Success is impacting on infrastructure and space.

RESEARCH & DEVELOPMENT ANNUAL REPORT 2021-22

INTRODUCTION

We are committed to establishing our Trust as an internationally recognised centre of excellence through supporting our staff, working in world class facilities and conducting leading edge, multi-professional, collaborative research focused on the needs of our patients.

This report provides the Trust Board with a review of progress made during 2021-22 and assurance on delivery against the Research & Development (R&D) Strategy during this period.

Research activity at UHCW NHS Trust is supported by the dedicated R&D team who work tirelessly to make research happen. However, all of this work is driven or supported by our colleagues throughout the Trust, without whom this success would not be possible. This year we are particularly grateful to all of Team UHCW who supported research on the wards and in critical care and those supporting research restart activities.

REPORT STRUCTURE

This report provides an overview of activities during 2021-22, which is the final year of this R&D Strategy, colour-coded sections provide updates on our 4 strategic areas:

1. Increase high quality research activity that impacts across the organisation

- ⇒ Summary Research Performance and KPIs - recruitment, set-up and delivery
- ⇒ Research Portfolio Development – grants developed and funding awarded

2. Provide quality management and support for research

- ⇒ Research Governance – quality
- ⇒ Intellectual Property, Digital and Data Driven Research Developments
- ⇒ UHCWi

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

- ⇒ Trial Management Unit
- ⇒ Arden Tissue Bank & COVID Digital Collaborative Biobank
- ⇒ Coventry & Warwickshire Clinical Research Facility
- ⇒ Human Metabolism Research Unit

4. Raise the profile of Research

- ⇒ Patient and Public Involvement and Engagement
- ⇒ Communications / Awards / Events / Esteem measures / Publications

SUMMARY

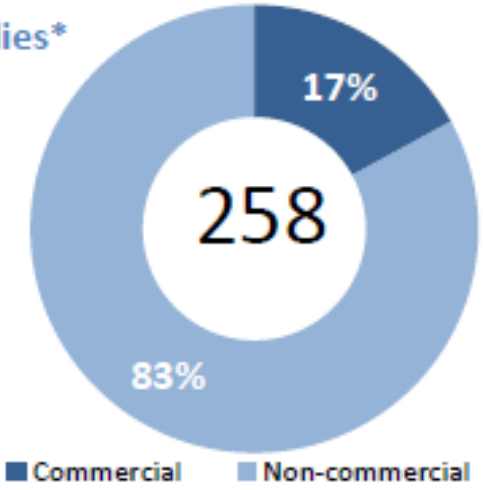
In the context of a research system restarting post-COVID, this report details key highlights of the Research & Development Team core activities during 2021-22.

To respond to the changing research environment, a more ambitious R&D Strategy was developed during 2021-22 and this will set our future direction as an organisation for the next 5 years.

Research Performance

2021-22

No of NIHR Active Studies*



*Studies open to recruitment during 21-22

5402 patients Recruited into NIHR Portfolio trials

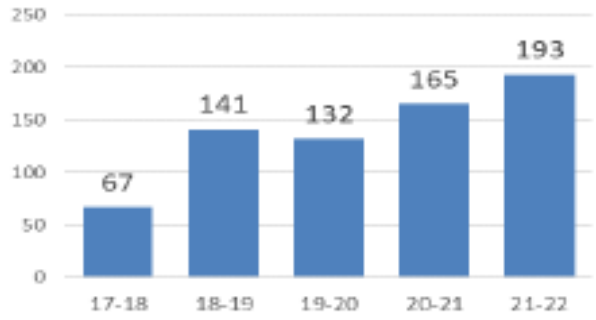
115% of Target | + 17% on 2020-21 recruitment

1404 COVID patients recruited

3998 non-COVID patients recruited

80 new studies opened

Commercial recruitment by year



Commercial trials recruited to time and target

71%

compared to 89% in Q4 2021-22

Grant applications

166 Applications Submitted

61 funded | + 24% on 2020-21 grant applications

£7.8m Funding awarded

144% of Target | + 7% on 2020-21 grant applications

191 Peer Reviewed publications

78% of Target | - 3% on 2020-21 publications

STRATEGIC AREA: INCREASE HIGH QUALITY RESEARCH

RESEARCH PERFORMANCE

In 2021-22, we continued to expand our research portfolio and increase opportunities for patients to take part in high quality research. We are proud to have recruited 5402 participants into NIHR Portfolio trials, representing 115% of the 4701 target set. Of these, 1649 (31%) participants were recruited into COVID studies. We are the 3rd highest recruiting site in the West Midlands and 2nd highest for commercial recruitment.

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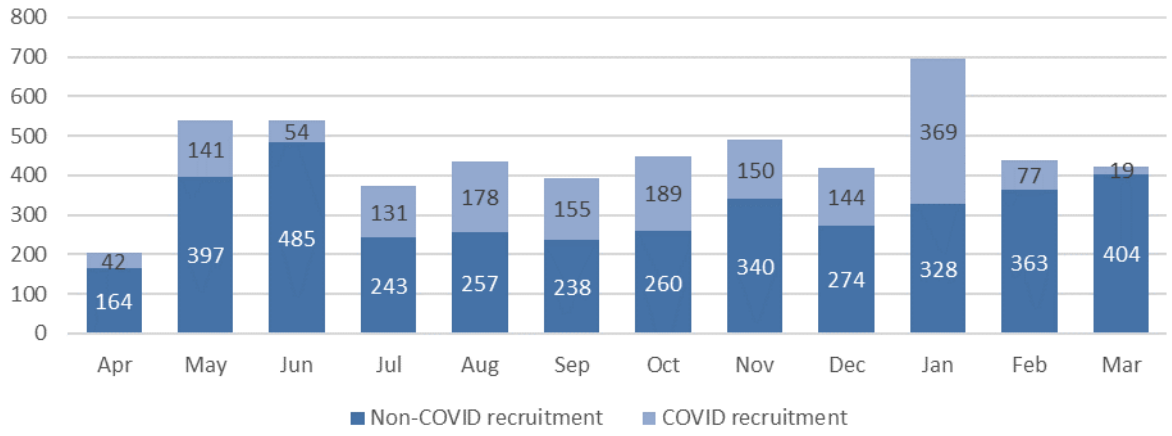
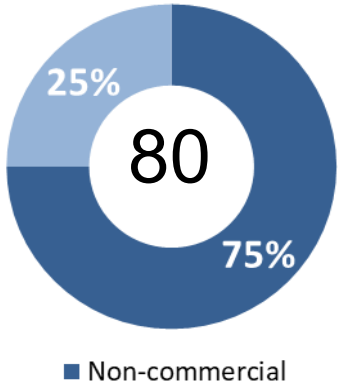


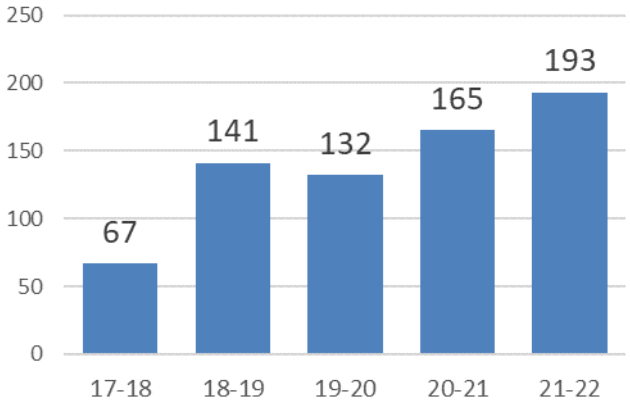
We have supported research across over 30 specialities. Over the last 12 months 80 new NIHR Portfolio studies have been approved and opened to recruitment. Of these 25% were commercial trials.

We continue to prioritise and seek opportunities to increase our commercial portfolio and have seen consistent increases in recruitment across the last 5 years.

NIHR Portfolio Studies Opened



Commercial recruitment by year



STRATEGIC AREA: INCREASE HIGH QUALITY RESEARCH

RESEARCH DEVELOPMENT

The Research Development team supports and facilitates grant applications and promotes an active research culture. Priority is given to National Institute of Health and Care Research (NIHR) proposals in order to attract additional Research Capability Funding (RCF). Our goal is to maintain RCF at £1 million per annum.

Key Points for 2021-22:

⇒ 166 grants were submitted against a target of 152 (9% over target).

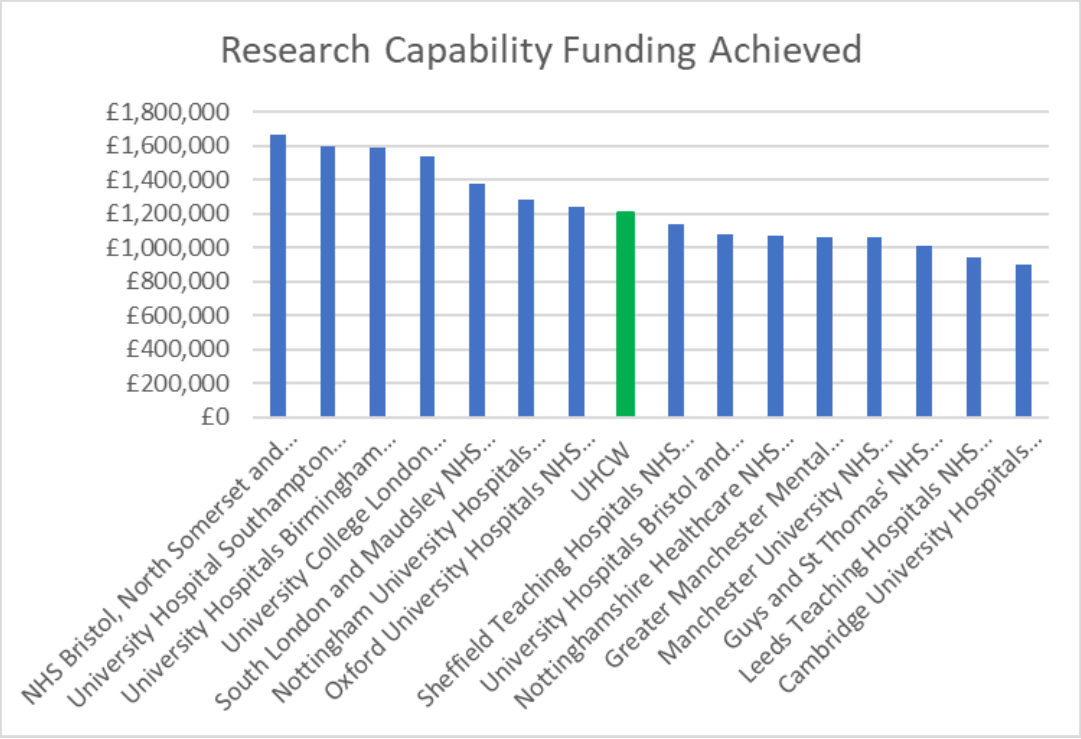
⇒ 61 grants have been funded (37% of the total submitted).

⇒ We are still awaiting the outcome for 9 grant applications.

⇒ Involved in 21 successful NIHR grants and 6 as host institution (with a total value of £11million) this year.

⇒ Of grants submitted, 65 were to NIHR programmes, 23 to UK Research & Innovation, 13 to large medical charities and 15 to industry funders. 4 applications were also made to the European Commission's Horizon Europe programme as the Trust expands its international expertise and reach.

⇒ UHCW's 2021-22 Research Capability Funding was approx. £1.2m and is also predicted to be over £1m in 2022-23. In terms of the value of the RCF received, UHCW was 8th of NHS Trusts in England, being in the top 10 Trusts for the first time ever:



STRATEGIC AREA: QUALITY MANAGEMENT & SUPPORT

RESEARCH GOVERNANCE

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

Over the last 12 months, the Governance and Sponsorship team have:

- Maintained our target of zero serious breaches and critical findings
- Setup the Research Governance Operational Group which is responsible for the operational planning, management and implementation of research governance policies and procedures across the Trust. The group provides a forum for discussion on research governance issues, ensuring a consistent approach across R&D, and provides assurance by report to Research Governance & Human Tissue (RG&HT) Committee.
- Introduced an effective quality management system to ensure a defined, communicated and implemented quality control and risk management system.
- Updated all our Standard Operating Procedures (SOPs) in line with the UK Policy Framework for Health & Social Care Research, European Medicines Agency, MHRA and the addendum to GCP. Also developed a SOP training matrix for both Clinical Delivery and Core teams to ensure compliance.
- Worked closely with Pharmacy and Lead Research Nurse to provide robust corrective and preventative actions (CAPA) for incidents reported to the Research Governance & Human Tissue (RG&HT) Committee.
- Continued to provide support for research teams learning lessons from incidents, internal reviews and monitoring visits.
- Provided dedicated support for researchers with the process, requirements and completion of Data Protection Impact Assessments
- Implemented a dedicated Health and Safety review to ensure the department is compliant by reviewing all hazards that are covered by our risk assessments and identify if the controls implemented following a risk assessment are effective.
- Continued to provide Sponsor oversight on all sponsored and co-sponsored studies

In summary the Research Governance and Sponsorship team continue to adapt its processes in line with research developments. Over the next 12 months the team will continue to further develop and enhance our quality management systems, develop and expand the governance team to successfully deliver the R&D strategy and strengthen our governance structure to continue to deliver high quality, safe research for our patients.

STRATEGIC AREA: QUALITY MANAGEMENT & SUPPORT

IP, DIGITAL & DATA DRIVEN DEVELOPMENTS

PathLAKE & PathLAKE+ (funded by UK Research & Innovation and Innovate UK)

The reputation and influence of the PathLAKE digital and computational pathology project continues to grow with the addition of 12 new members to the original PathLAKE Plus Consortium of 10 NHS Trusts. PathLAKE Plus builds on the original PathLAKE project to scale the adoption of digital pathology across the NHS with Consortium members benefiting from significant capital equipment grants and associated discounts through an NHS procurement framework. In return, participating Trusts will feed their data into the PathLAKE data lake where it will be accessible to research institutions and commercial organisations developing AI diagnostic tools to deliver improved patient outcomes.

Other examples of digital and data driven research projects in 2021-22 include:

ADLIFE (Horizon 2020)

The development of a range of digital solutions to facilitate care provision for patients and carers and their communication channels with their health and social care professionals targeted at patients with Chronic Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD).

CESCAIL (NIHR)

Capsule Endoscopy delivery at SCale through enhanced AI analysis. Coupling minimally-invasive colon capsule endoscopy (CCE) with Artificial Intelligence to improve early detection and diagnosis of bowel cancer.

PAIGE.AI Prostate Cancer Detection (NIHR)

Using the Paige prostate cancer detection and quantification and grading tool to assist prostate biopsy reporting across three NHS sites and compare performance of pathologists either using or not using the tool.

Digital and data driven projects in development:

HEARTT (UHCW Performance & Informatics Team)

The development of an algorithm-based elective care scheduling tool aimed at reducing health inequalities using a range of demographic and medical data. The concept has already attracted interest from over 100 other NHS Trusts and a strategy to protect and exploit UHCW's IP through registered trademark filing and commercial software licencing is in development.

STRATEGIC AREA: QUALITY MANAGEMENT & SUPPORT

UHCWi

The Research & Development Team has embraced UHCWi as a methodology for improvement. In total 12 individuals from the department have taken part in the 5 month Lean for Leaders programme. These have cascaded training to other departmental staff. The UHCWi Passport sessions are also promoted with a further 20 individuals have undertaken at least one session.

Teams discuss work at meetings using huddle boards, are looking to standardise work and continually address waste reduction.

In 2021-22, improvement projects in the department have focused on the invoicing process for research studies, efficiencies in signing off contracts and collaborations agreements and is currently focusing on improving the handover process between the pre -grant award (Portfolio Development) and post-award teams.

Working in partnership with administrators, UHCWi methodology has been used by our Trial Management Unit to streamline and improve the efficiency of the R&D archiving process.

For 2022/23, we are focussing on a data collection exercise to ascertain the demographics and postcodes of those patients participating in research so that we can monitor inclusion and representation.

STRATEGIC AREA: HIGH QUALITY FACILITIES

TRIAL MANAGEMENT UNIT (TMU)

The Trial Management Unit (TMU) provides in-house trial management and support to aspiring local clinicians to develop and deliver high quality research projects. In line with the TMU strategy, the team continues to support the delivery of a growing, increasingly complex portfolio of Trust-sponsored studies, with a demonstrated track record of delivering against targets.

The TMU currently manages and oversees 23 Trust-sponsored research studies, all at different stages in their timeline. 4 studies are in set-up, 6 actively recruiting, 3 in follow-up and the remaining in data analysis and close-out.

A total of 1188 patients were recruited to studies managed by the TMU in the 2021/22 financial year across all participating sites in the UK.

Improve quality in research delivery:

- The TMU has continued to support researchers with the development of grant proposals, ensuring they have a robust design and are feasible to deliver within budget. The team also provide a Study Support Service (SSS), reviewing study documents to speed Sponsor review. A session on Trial Management activities was presented to Doctors at a ST6/7 Regional R&I Masterclass.
- Following staff turnover, the TMU has successfully recruited two new Clinical Trial Coordinators (CTC) to support with the coordination of a portfolio of multi-centre studies. A third CTC is due to start in September 2022; new staff are supported by a comprehensive training package.
- Team building and boosting staff morale has been a key focus following the pandemic. This is to encourage shared learning and to implement a consistent service. New staff are actively utilising existing quality processes such as site set-up and amendment checklists. TMU Team building days were introduced in February 2022. These were well received with group discussions focused on Trial Management Group (TMG) meetings and recruitment reports, jointly developing a template recruitment tracker.
- Managing the R&D Randomisation Service, the team has recently supported two research projects with the set-up and implementation of envelope randomisation procedures for trials in Cardiology and Delirium research. A Randomisation function within EPR (PowerTrials) for single-centre trials was suggested by the TMU and is being explored by the EPR team.
- TMU Staff actively participate in webinars and conferences organised by the MRC-NIHR Trials Methodology Research Partnership, UK Trial Managers Network (UKTMN) and internal EPR (PowerTrials) team. One member of the TMU produced a Research Poster which was accepted at the UKTMN Annual Conference 2022.
- In partnership with the Governance and Sponsorship team, the TMU have developed a Research Ethics Committee (REC) Learning Log, to record ways in which our templates and guidance for researchers can be improved to minimise recurrent queries following REC review.
- TMU team members received nominations from three of our Chief Investigators for the UK Trial Managers' Network 'Trial Manager of the Year Award 2021'. This recognised the value our researchers place on the Trial Management function, to make sure our Trust-Sponsored studies are run efficiently and professionally.

STRATEGIC AREA: HIGH QUALITY FACILITIES

TRIAL MANAGEMENT UNIT (TMU)

Featured TMU Studies currently open to recruitment:

CESCAIL (RA545021) – Our first TMU-managed study using Artificial Intelligence which opened to recruitment in February 2022. This study compares the accuracy of standard clinician review and reporting of Colon Capsule Endoscopy (CCE) videos, with AI enabled pre-reading to support and potentially speed up clinician review. This NIHR funded study is in collaboration with CorporateHealth, an international company actively involved in CCE services, with whom we are also developing an exciting new project looking into home-delivery of CCE.

SINATRA (JH464519) Working in collaboration with the University of Warwick, who have developed a Terahertz skinometer which could potentially improve the diagnoses of skin cancers. This initial study aims to explore the feasibility of recruitment and trial procedures, while also assessing the skinometer's ability to quantify skin hydration. Recruitment to this study opened in March 2022.

QUALYCARE Kidney Study (EM552621) Led by one of our Centre for Care Excellence (CfCE) Associate Professors, this study aims to examine the quality of care received by people on dialysis in their end stages of life. Following the successful transfer of Sponsorship and documents from the University of Southampton, this multi-centre study opened to recruitment at UHCW in May 2022.

RECEDE (RA481020) REducing Colonoscopies in patients without significant bowEl DiseasE, is an NIHR funded multi-centre study which was successfully set-up and opened during COVID challenges and restrictions, opening to recruitment in September 2020. With over 15 sites in England recruiting, the overall target of 1915 should be reached by September 2022, when the final sample and data analysis will begin. The protocol has been published in the BMJ Open: http://dx.doi.org/10.1136/bmjopen-2021-058559

PULSE (GM433119) Co-Sponsored with Coventry University, this BHF-funded feasibility study underwent a substantial amendment to adapt the exercise intervention to be delivered remotely following the pandemic. The study opened to recruitment in May 2021 and aims to find out if patients with Postural Orthostatic Tachycardia Syndrome (POTS) will complete and benefit from an online supervised home physical activity programme. The amendment to the protocol has now been published: Protocol update for a randomised controlled feasibility trial of exercise rehabilitation for people with postural tachycardia syndrome: the PULSE study | Pilot and Feasibility Studies | Full Text (biomedcentral.com)

STRATEGIC AREA: HIGH QUALITY FACILITIES

ARDEN TISSUE BANK & COVID DIGITAL COLLABORATIVE BIOBANK

Following an independent review and approval by the Arden Tissue Bank Committee, **Arden Tissue Bank** provides ethically approved human tissues to researchers carrying out high quality research.

Activities this financial year include:

- Continued contracted storage and distribution of bone tumour samples for research on behalf of, and instructed by, the Royal Orthopaedic Hospital, Birmingham. Over 29,000 samples held, with monthly transfers of >100 samples/month.
- Contracted storage of neurological tissue surplus to diagnosis for University Hospital North Midlands (UHNM), with dispatch of cases for Whole genome sequencing as instructed by UHNM clinical team.
- Continued supply of consented human tissue samples to commercial applicants – with six cancer types, and one inflammatory disease pathway open since January 2021. This has been supported by a cost recovery model with funds received being split between contributing departments i.e. surgery, pathology and Tissue Bank.
- In addition a local commercial partner has been supplied with surplus to diagnosis STD samples to allow validation of their new diagnostic kit.
- Arden Tissue bank continues to supply non-transplantable kidneys to a commercial partner with 23 kidneys being supplied in the last 12 months that would have otherwise been discarded by NHS BT.
- Staff capacity has restricted expansion of tissue supply and the services offered by Arden Tissue Bank, and the team is reviewing processes and staff structures with the aim of reducing waste in systems, and building capacity to meet demand for tissue samples and services.

Arden Tissue Bank was successfully inspected by the regulatory body—the Human Tissue Authority in January 2022. This inspection resulted in no conditions on the licence.

Covid Digital Collaborative Biobank

- Ongoing collation, anonymisation & storage of over 50,000 COVID-19 samples from UHCW patients, with a further 12,000 samples to be catalogued . This collection was developed between March 2020 and March 2022 in collaboration with Coventry and Warwickshire Pathology Service healthcare scientists across multiple Pathology disciplines to provide an annotated COVID-19 Biobank to facilitate ongoing research into COVID-19 .
- Ethical approval of the Covid biobank was granted in May 2022 and allows external researchers straightforward access to Covid 19 samples via an application process.
- A data scientist has been externally funded to collate an anonymised dataset against all samples within the Covid biobank which will add value for researchers.

STRATEGIC AREA: HIGH QUALITY FACILITIES

COVENTRY & WARWICKSHIRE CLINICAL RESEARCH FACILITY

In 2021, the Trust approved the creation of a 2-bedded Inpatient Research Unit, to be created by repurposing research office space adjacent to the Research Treatment Centre. The new 'Coventry and Warwickshire Clinical Research Facility (CRF)' will be operational from Summer 2022. The Inpatient Research Unit will provide dedicated space for research patients and healthy volunteers to attend overnight research visits and ensure participant safety in early phase studies.

NIHR CRF funding was not secured for the next 5-year period (2022-2027) but the new Inpatient Research Unit will ensure we maintain our momentum to become a recognised world-class CRF and increase opportunities for our local community to participate in early phase and experimental medicine research.

Key highlights during 2021/22 include:

⇒ The Coventry and Warwickshire CRF supported the conduct of 63 studies in 2021/22, recruiting a total of 1064 participants.

⇒ The CRF opened it's first commercial Phase 1b, first-in-human study in May 2021, a highly complex and intensive study testing a new antibiotic formulation for chronic low back pain. We recruited the third participant in the world to receive the treatment and early results are positive.

⇒ As an AstraZeneca Phase I Centre for oncology studies, the CRF opened its first Phase 1 commercial oncology study in November 2021, providing a new drug for patients with ovarian cancer with limited treatment options.

⇒ The first COVID Vaccine Study at the Trust was centred in the CRF, with the CRF team supported dosing visits, ensuring specific research staff remained blinded to the treatment administered.

⇒ We are attracting more commercial Phase I studies for 2022/23, demonstrating that the CRF continues to be recognised by industry as an ideal location to conduct early phase studies.

⇒ In line with the CRF strategy, we continue to collaborate with other NIHR infrastructure, regionally as Midlands Health Alliance members, and nationally with the NIHR-British Heart Foundation Collaboration and UKCRF Network.

HUMAN METABOLISM RESEARCH UNIT

Our Human Metabolism Research Unit uses recirculated air flows which were assessed as extremely high risk during the COVID-19 pandemic. The Unit was closed for 2020/21 and the team were redeployed to MEBS and clinical areas for much of that time. When not redeployed, staff were able to successfully viva 4 PhD projects, work on academic networking, develop new collaborations and increase research journal output (8 papers to date in the period 2021), and attract £100K worth of funding from the Wellcome Trust and the EPSRC for AI related projects.

As restrictions eased, the HMRU team were able to carry out maintenance, complete publications and submit grant applications for additional funding. Prior to re-starting activities, a full risk assessment was completed and reviewed by the HMRU, COVID Research and Infection Prevention and Control Committees.

STRATEGIC AREA: RAISE THE PROFILE OF RESEARCH

PATIENT AND PUBLIC INVOLVEMENT & ENGAGEMENT

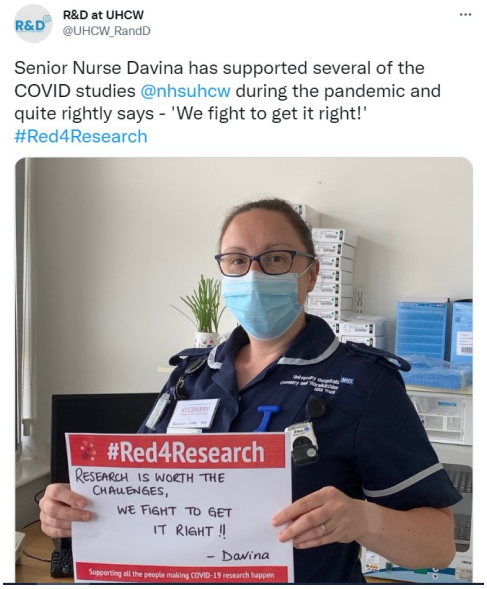
Involving patients in research, either as participants, as experts in their condition or as champions of research, ensures that our research meets the needs of our patients. As such, Patient and Public Involvement and Engagement (PPIE) continues to be priority for R&D.

UHCW Patient and Public Research Advisory Group (PPRAG) comprises ~50 patients, carers and members of the public who use their experiences and opinions to guide researchers. In 2021/22, PPRAG members contributed to 33 research projects. Six PPRAG meetings were held, providing 10 researchers the opportunity to present their research to the group and obtain important feedback from the attending members.

We have continued to utilise social media to engage with patients, members of the public, healthcare staff and other research active organisations, amongst others, to raise awareness of research. This includes actively using our @UHCW_RandD Twitter account, which now has over 2000 followers, making 236k Tweet impressions this year.

On 20th May we celebrated International Clinical Trials Day with a Twitter campaign to raise awareness of research. This included a video reflecting on 12 months of COVID research and a recording from one of our Research Champions explaining why research is important to them. We also worked with the Trust Communications Team to publish an article about one of our oncology research participants taking part in research during the COVID pandemic.

We also supported the Red4Research campaign in June to show our support and appreciation for all those participating in, undertaking and supporting COVID-19 research.



We have utilised our Twitter account, the Trust Facebook page and Trust Maternity Facebook page to promote opportunities for patients, the public and healthcare staff to get involved in research and also share in our successes.

In addition to using their experience and perspectives as patients to support raising awareness of research, our Research Champions continue to be represented on the R&D Strategy Committee, ensuring the opinions of our patients are considered throughout R&D.

STRATEGIC AREA: RAISE THE PROFILE OF RESEARCH

COMMUNICATION / AWARDS / EVENTS / ESTEEEM

Following a year's hiatus due to COVID, we hosted our annual Research Summit in September which was attended by over 100 delegates. Speakers from across the UK joined us to deliver a variety of talks which aimed to inspire our staff and help initiate conversations about research through interactive sessions. This was followed by an afternoon featuring the Centre for Care Excellence, which provided an opportunity for the newly appointed Professors and Associate Professors to join together for the first time.

We shared our experiences with the wider research community this year. Professor Ramesh Arasaradnam and clinical trial coordinator Chris Bradley reflected on the challenges COVID-19 has brought to NHS research in an NIHR blog (https://www.nihr.ac.uk/blog/making-research-happen-in-a-pandemic/27549), and Abi Jose shared her journey to becoming a CRF Research Sister as part of the NIHR 'Your Path in Research' campaign (https://local.nihr.ac.uk/case-studies/your-path-in-research-abis-story/28915).

Our first Phase 1 commercial study also provided an opportunity to showcase our involvement in early phase research through company press releases and local articles.

DRUG TRIAL AT UHCW COULD HELP EASE BACK PAIN

There were other notable achievements including:

- The Clinical Research Facility Team won Silver in the Pharmatimes Clinical Research Team category at the International Clinical Researcher of the Year awards 2021.
- In the annual Clinical Research Network (CRN) West Midlands' Awards, the R&D Team received the CRN's 'Operational Excellence in Research Award' acknowledging the work done by UHCW in the pandemic and post-pandemic period and for our continuous improvement work. Rob Klimek picked up a prize for his Wellbeing work during the pandemic and Professor Ramesh Arasaradnam was highly commended for leading National Institute for Health and Care Research (NIHR) portfolio studies in gastroenterology and for the IONIC study combining drugs and anti-viral therapy to treat COVID patients. Our Covid-19 Research Team were also highly commended in the 'Collaboration in Research 'category for multi-disciplinary, cross speciality work on urgent public health studies and Valneva vaccine trials
- Shivam Joshi and Chris Bradley (R&D Trial Management Unit) were nominated for the UK Trial Managers Network Trial Manager of the Year 2021.
- Jason Allen and Nic Aldridge were finalists at the HSJ Value Awards in the Digital Clinical Transformation Award for the Patient TRACKER™.
- Cardiology Research Nurse Nigel Edwards was a finalist in the Going the Extra Mile category at the UHCW Outstanding Service and Care Awards.

Classification: Official

Publication reference: PR1844

NHS England

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2022

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board of University Hospitals Coventry and Warwickshire NHS Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: N/A Comments: Prof Kiran Patel (RO) and Dr Richard de Boer (Deputy CMO, Appraisal Lead) continue to remain compliant in all modules of RO training and have regularly attended the required quota of NHSE Networking Events when these events have been available to attend. Action for next year: N/A

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Action from last year: Review of staffing levels within the Revalidation team for added administrative support to the Revalidation Officer with processes and procedures. To continue to review processes to ensure robust measures and processes are in place. Comments: A revalidation team consisting of Appraisal Lead, Associate Medical Director and Revalidation Officer. A new medical workforce team has been implemented to support the RO to carry out wider CMO responsibilities. This team continues to develop and embed processes to strengthen measures including governance around responding to concerns. UHCW have provided sufficient funds and the appropriate roles are available to support the function. One member of the team has been seconded out into another service and the role has now been backfilled. Action for next year: N/A

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Comments: A local database of all prescribed connections is held, and data is maintained monthly using the starters and leaver information generated by the workforce department. The revalidation officer also has access to the Trust's Local Business Intelligence reporting feature which captures real time data for starters and leavers.

Action for next year: N/A

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: N/A

Comments: The Medical Appraisal policy is up to date and in place with core content compliant with national guidelines

Action for next year: Ensure policy is still relevant over the next year and update where necessary

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: Scope external review of RO functions

Comments: Work with Regional team to understand inspection processes

Action for next year: Continue to work with regional network to ensure compliance of peer reviews.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: Proactively ensure locally employed doctors are benefitting from medical education programmes and appraisal. Currently there is no separate funding stream for the clinical supervision of non-training grade doctors; we seek to resource and ensure adequate supervision and training for this cohort of doctors.

Comments: The Trust undertakes appraisals for locally employed doctors that are connected via GMC where the trust acts as primary employer. However, this is an area that has been highlighted as requiring internal review to ensure that new appointees are aware of appraisal processes.

Actions for next year:

1. Undertake a review of the current processes to develop a robust process to ensure support occurs and is regularly monitored for locum or short-term doctors working in the organisation.

2. Explore funding options for dedicated clinical supervision non-training grade doctors.

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

Action from last year: Recognise further constraints on appraisals to provide further support for doctors yet encourage appraisal as a formative and supportive exercise for the individual. The RO also encourages appraisal to consider the impact of individuals on health inequality and population health, in line with national strategy.

Comments: The AoMRC appraisal template has been recently updated to the 2022 version; this is the main template for appraisal discussions. Whilst the focus of appraisals continues to be supportive, there remains the opportunity to explore how services and individuals can be supported to develop and improve.

When a doctor conducts an annual appraisal at the organisation the individual can include supporting information covering their practice, giving them the opportunity to reflect on any work carried out within their appraisal cycle. The medical revalidation team provides a doctor with any complaints, claims or incidents which have been made since their last appraisal which the doctor is required to reflect upon.

Action for next year: N/A

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Continue proactive Trust approach (working closely with all clinical groups to support doctors) to support doctors with appraisals for appraisal year 2021/2022. Establish governance to formalise our Medical Concerns meeting to receive an update on scheduled, delivered, postponed, and missed appraisals with escalation and management in line with GMC guidance.

Comments: The RO has established governance to formalise Medical Concerns meetings; the RO Advisory Group (ROAG). ROAG receives an update on scheduled, delivered, postponed, and missed appraisals with escalation and management in line with GMC guidance.

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

There are currently 6 doctors required to complete their appraisal due during the 2021/2022 appraisal cycle. If a doctor's annual appraisal does not take place as per their appraisal cycle, an update is provided to the responsible officer advisory group where the processes outlined within the appraisal policy are carried out. Areas of support are identified and carried out until completion of appraisal.

Action for next year: continue to closely monitor and support the 6 doctors who currently have their 2021/2022 appraisal outstanding.

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:

Comments: Medical Appraisal Policy is in place with core content, which is compliant with national guidelines, reviewed and accepted by the Trust Medical Negotiating Committee and Strategic Workforce Committee.

Action for next year: N/A

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Review of Appraiser to Appraisee ratios and report of any risks to RO at Medical SMT

Comments: UHCW currently have 145 trained appraisers. The ratio of appraisers to doctors is 1:6. The Trust continues to run in-house Appraiser training for new and current appraisers. The current appraiser training incorporates a network session where existing and new appraisers can reflect and raise concerns. Training takes place on a quarterly basis.

Action for next year: N/A

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Introduction of virtual Appraiser Support Groups and Quality assurance of appraisal by Associate Medical Director for Professional Standards.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

Comments: A Bi-Annual appraiser support groups has been introduced and will take effect on 17th Feb 2023 and 15th December 2023 – this will take place on the same day as appraiser training sessions. There will be 4 x training sessions per year to support network/development events, peer review and calibration of professional judgements.

Action for next year: Ensure support group takes place as per agreed dates, supporting the associate medical director where required.

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: New Audit to focus on new appraisers and continuation of existing QA with formal QA reports to RO at Medical SMT

Comments: 5% of medical appraisals have been reviewed on a quarterly basis by the Revalidation team, determining any areas of focus for continued improvement.

Action for next year: increase clinical audits to 10% of medical appraisals completed.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	UHCW
Total number of doctors with a prescribed connection as at 31 March 2022	848
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	691
Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022	134
Total number of agreed exceptions	23

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: RO (at Medical SMT) to receive update on revalidation recommendations and deferrals and any medical concerns to be governed via Responsible officer advisory group by RO, where appropriate Comments: GMC Connect is regularly reviewed for revalidation submission dates and evidence is provided to the responsible officer in a timely manner. Updates on revalidation recommendations and deferrals are provided in the responsible officer advisory group. Action for next year: quarterly updates to be provided by Revalidation officer regarding revalidation recommendations and deferrals within Medical SMT.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Schedule of forthcoming revalidations and recommendations to be formally signed by DCMO and RO with commensurate communication to doctors on behalf of the trust and RO. Comments: Doctors are issued with a Trust revalidation letter to confirm their revalidation submission to the GMC within 48 hours of submission. Revalidation submissions are predominantly made 1 month prior to submission date. Action for next year: if a revalidation recommendation is being submitted, the doctor will receive a letter confirming this within 48 hours of submission. If a deferral takes place, communication will be made with the doctor informing them of the decision to defer 2 weeks before submission date.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Comments: The quality department supports the clinical governance for doctors which is overseen by the Chief Quality Officer. There are multiple processes within the organisation which assures effective clinical governance e.g., Patient safety incident reporting, investigation and learning; induction, mandatory training, learning and development, complaints management, PALS, Quality improvement and patient safety meetings etc. The quality safety committee, which is a sub-committee of trust board, receives reports from the patient safety and effectiveness committee which is chaired by the Responsible Officer. The trust has a supportive learning culture in place with a patient safety reporting system; whilst giving the ability to raise other concerns through the freedom to speak up guardian. The trust triangulates complaints, incidents and legal claims Action for next year: Consultant information packs will be updated.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: See 4.1 (Trust-wide policies continue to apply to individuals on the GMC register: Raising Concerns Policy; freedom to Speak Up Policy - providing staff with access to a proper and widely procedure for voicing concerns when they encounter or suspect wrong-doing or malpractice – safe in the knowledge that they will not suffer personal detriment as a result of having done so.) Comments: University Hospitals Coventry and Warwickshire NHS Trust are committed to ensuring that concerns in relation to the conduct and capability of doctors and dentists are dealt with in a fair and consistent manner, in line with the national framework “Maintaining High Professional Standards in the Modern NHS”. Interaction take place between the quality department and workforce team to ensure conduct and performance of all doctors working within the organisation is regularly monitored. The responsible officer is sighted on any issues within both the responsible officer advisor group and medical concerns committee which occurs monthly and fortnightly respectively. Data packs are provided to the doctors in advance of their appraisal due date to include any incidents, complaints, and claims, along with any QIPS attendances since their last appraisal.

Action for next year: Consultant information packs will be updated to include all performance data (individual level including BADS).

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: please see 4.1

Comments: University Hospitals Coventry and Warwickshire NHS Trust are committed to ensuring that concerns in relation to the conduct and capability of doctors and dentists are dealt with in a fair and consistent manner, in line with the national framework "Maintaining High Professional Standards in the Modern NHS".

Action for next year: N/A

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: Annual audit of medical concerns to be undertaken from 22/23 onwards to be reported to the Board

Comments: Conduct and capability concerns are reported and reviewed at the Responsible Officers Advisory Group

A designated NED is aligned to all MHPS investigation

Action for next year: N/A

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: The Trust will be proactive in providing MPITs for all Medical and dental practitioners leaving the organisation and will proactively seek MPITs for those commencing employment at UHCW, led by the new Medical Workforce team. Comments: The Trust now adopts the use of MPIT forms and complies with any Transfer of Information requests via the "Information Requests Process" under Medical Appraisal & Revalidation. The current process adopts a 5 working day turnaround time for all requests and details are recorded locally on a database. Action for next year: N/A

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: N/A Comments: The Conduct and Capability Concerns Policy provides comprehensive steps and principles for dealing with concerns raised regarding doctors and dentists. This enables prompt actions to be taken in the interests of patients, staff and the practitioner - ensuring that safeguarding protocols are in place. Action for next year: N/A

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: To document receipt of MPITs as part of pre-employment checks

Comments: Pre-employment checks are undertaken in line with NHS employer's standards where qualifications/professional registrations are mandatory to be checked prior to commencement within the organisation, to ensure for safe working whilst allowing doctors to work at the appropriate level. A process has been implemented with the medical workforce team to request MPIT's as part of their medical recruitment pre-employment checks. If MPIT's have not been received, this is chased by the revalidation team.

Action for next year: N/A

Section 6 – Summary of comments, and overall conclusion

General review of actions since last Board report:

Comments

As we have transitioned out of the Covid-19 pandemic, normal activity in relation to appraisals has been resumed where the focus has been to get back on track.

There are currently zero appraisals without exceptions outstanding for the 2020/2021 appraisal year.

Appraisal and Revalidation processes continue to be applied to ensure consistency throughout. Compliance of appraisals remains a focus with support from the Groups in management of appraisals.

Actions still outstanding: Introduction of Virtual Appraiser Support Groups

Current Issues: N/A

New Actions:

Ensure Medical Appraisal policy is still relevant over the next year and update where necessary.

Explore regional network to ensure compliance of peer reviews.

undertake a review of the current processes to develop a robust process, ensuring support occurs and is regularly monitored for locum or short-term doctors working in the organisation.

Continue to closely monitor and support the 6 doctors who currently have their 2021/2022 appraisal outstanding.

Ensure support group takes place as per agreed dates, supporting the associate medical director where required.

Increase clinical audits to 10% of medical appraisals completed.

quarterly updates to be provided by Revalidation officer regarding revalidation recommendations and deferrals within Medical SMT

If a revalidation recommendation is being submitted to the GMC, the doctor will receive a letter confirming this within 48 hours of submission. If a deferral takes place, communication will be made with the doctor informing them of the decision to defer 2 weeks before their submission date.

Overall conclusion:

The appraisal template has been recently updated to the AoMRC 2022 version and this is the main template for appraisal discussions. The trust will ensure all outstanding appraisals are monitored closely and completed at the earliest opportunity. Reporting to the Responsible Officer Advisory Group has ensured oversight is provided to key stakeholders and support has been provided to doctors where necessary.

The trust has identified key actions which will be implemented over the next 12 months to support doctors in successfully completing their appraisal and revalidation.

Section 7 – Statement of Compliance:

The Board of University Hospitals Coventry and Warwickshire NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

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This publication can be made available in a number of other formats on request.

Publication reference: B1844

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 6 OCTOBER 2022

Subject Title	Annual Health, Safety, Fire and Security Annual Report 2021- 2022
Executive Sponsor	Tracey Brigstock, Chief Nursing Officer
Author	David Millage, Trust Health and Safety Manager David Black ,Trust Fire Manager Barry Newell, Trust Security Manager
Attachment(s)	Annual Health, Safety, Fire and Security Annual Report 2021 - 2022
Recommendation(s)	The Board is asked to **RECEIVE ASSURANCE** from the report.

EXECUTIVE SUMMARY

The Trust has a duty to comply with health, safety, fire and security requirements as an employer that are dictated within UK Statute and Statutory Instruments.

This report serves to assure the Board of general actions that have taken place during the 2021 – 2022 financial year to ensure the Trust continues to comply with required standards.

In general, the physical aspects of the Trust are controlled to a high standard, and where this is not the case remedial actions have been identified within the site Risk Register and general audit and inspection reports. This serves to bring the number of unsafe conditions down to a level where accidents and potential for prosecution can be reduced and eventually avoided.

Education and culture change are areas that still require work within the Trust, and there is an identified plan of work being implemented on these areas to stimulate topic ownership and reduce accident and the potential for prosecution due to unsafe actions.

The Trust have been working towards ISO 45001 which is the internationally recognised standard for health and safety during the 2021 – 2022 financial year and have now been fully accredited to this standard.

The Trust health and safety committee convened each quarter throughout 2021 – 2022 financial year and during this period was quorate for 3 meetings with the final meeting impacted by sickness / absence. Trade Union representatives attend and are supportive of this meeting.

The Trust should continue with all current operating processes for health, safety, fire and security and embrace the improvements that are being made through education of the trust staff to modify their attitude, behaviour and ultimately culture within the organisation.

The Board should be assured that health, safety, fire and security specialities topics are supported by suitably competent subject matter experts who are leading the Plan Do Study Act process of improvement for their fields of expertise, and as such the Trust is operating in line with legal duties imposed upon it with respect to health, safety, fire and security.

PREVIOUS DISCUSSIONS HELD

None

KEY IMPLICATIONS	
Financial	Prosecution and loss of resource if the Trust fails to deliver basic legal requirements
Patients Safety or Quality	Any breach of the Trust standards for health, safety, fire or security may result in accidents or incidents that prevent Trust staff from performing their operational roles, which may ultimately impact patient care
Workforce	All accidents and breaches of legislation will have an impact on the physical, mental and social wellbeing of our workforce
Operational	Staff are our most important and vulnerable resource, failure to manage health, safety, fire and security will potentially reduce staff availability

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

REPORT TO PUBLIC TRUST BOARD 6 OCTOBER 2022

ANNUAL HEALTH, SAFETY, FIRE AND SECURITY REPORT 2021 - 2022

1. INTRODUCTION

The Trust as an employer has a responsibility to ensure so far as reasonably practicable that it complies with the requirements of an employer defined under the Health and Safety at Work etc. Act 1974, all associated Statutes, and statutory instruments currently applicable to the Trust's undertaking. The Trust appoints named Competent Persons (Health and Safety Manager and Fire Manager) to advise the Trust on the steps it needs to undertake to meet the above cited legal requirements. Both of the Trust Competent persons have developed systems for the Trust, to be delivered at an operational level based on their areas of expertise, and these systems are monitored for compliance throughout each financial year, to identify areas that require improvement in line with the trust Plan Do Study Act process

The Trust health and safety team have been working towards ISO 45001 which is the international standard for health and safety, which through external accreditation has now been achieved covering all non clinical aspects of the Trust health and safety systems. This report serves to highlight current performance and projects that have been undertaken to eliminate unsafe conditions, and work streams that have and are still to come on line to minimise unsafe actions for our staff. The Board should take assurance from this report that all reasonably practicable steps are being undertaken to adequately control risk to the Trust, its staff and patients and where any opportunities for improvement are identified suitable processes exist to address shortfall at an operational level

2. CONTENT

2.1 INCIDENT TRENDS

There were a total of 541 non-clinical accidents during 2021/22 compared to 499 during 2020/21.

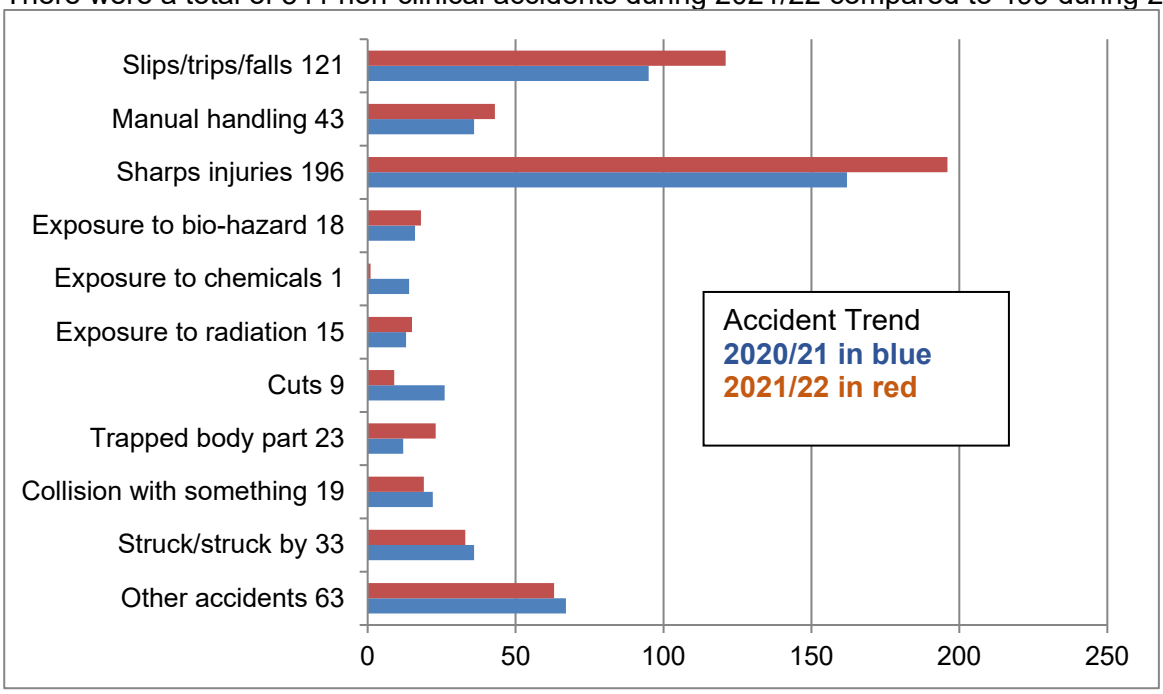


Table 1 Accident trend by type 2020/2021 and 2021/22

Sharps injuries, manual handling, slips, trips and falls continue to be the most common type of accident to occur, with data reviewed below

2.1.1 Sharps Causation Review

Datix reports for 12 months from 01/04/2021 – 31/03/2022.

Total of 157 incidents related to needles of various sorts.
This compares with a total of 193 in 2019-2020 and 165 in 2020-2021 which is showing a slight downward trend (Other sharps i.e. blades, excluded from data as causation differs)

Incidents by Device Type

A total of 59 different contributory factors were identified from the Datix records.

26 of the contributory factor headings indicated a breach of Trust Policy or the Sharp Instruments in Healthcare Regulations.

Top 3 number of incidents as a line item are

- Unknown cause = 25 (16% of Total)
- Patient moved = 17 (11% of Total)
- During disposal = 10 (6% of Total)

Top 3 number of incidents where a single link can be identified

- Sharps not put into sharps box straight after use = 32 (20% of Total)
- Not activating safety device = 16 (10% of Total)
- Puncture during disposal = 13 (8% of Total)

Causation

57 contributory factors were identified.

Causation identified;

- 17 line incidents due to an Unsafe Condition (30 % of Causation)
- 40 line incidents due to an Unsafe Action (70% of Causation)

Further Engineering Controls

- New safety needles are being trialled within the Trust that may have some impact on the number of accidents associated with needle stick injury
- A new system for melting needles down to the plastic cuff is being trialled within 8 locations within the Trust to reduce the potential for needles to be left out on working surfaces or result in accidents within the waste chain

Further Behavioural Controls

- This data indicates that a very high percentage of the Trust sharps related accidents is associated with human behaviour, which is an area that is being targeted through the Trust general risk assessment training and the process of dynamic assessment within the operational areas.

- This is also addressed at Team Huddles as each employee is reminded that their own Health and Safety is important to both themselves and the Trust.

- Task focus whilst working with sharps is an area for concern and will be targeted for communication and behaviour change going forward within the Trust.

2.1.2 Slips, Trips and Falls Causation Review

Datix reports for 12 months from 01/04/2021 – 31/03/2022

Total of 115 slips, trips and falls were reported by staff or visitors.
This compares with a total of 130 in 2019-2020 and 118 in 2020-2021 which is showing a slight downward trend

65 incidents occurred in clinical areas (i.e. wards) and 50 in non-clinical areas (i.e. Stairs)

Type of incident

- Slip = 51 (41% of Total)
- Trip = 34 (30% of Total)
- Fall from height = 17 (15% of Total)
- Falls = 13 (11% of Total)

Top 3 number of incidents where a single link can be identified

- Wet floor = 19 (17% of Total)
- Water = 11 (10% of Total)
- Object on floor = 10 (9% of Total)

Causation

33 contributory factors were identified and in 8 cases there was no known cause stated.

Causation identified;

- 22 line incidents due to an Unsafe Condition (19 % of Causation)

- 9 line incidents due to an Unsafe Action (8 % of Causation)
- 2 line incidents due to a combination of Unsafe Condition and Action (1 % of Causation)

Further Engineering Controls

- Flooring within the hospital is reviewed within the general Health and Safety Inspections that take place each month, and in general all flooring is found to be in a safe and serviceable condition
- Improved floor mats have been fitted to each of the hospital entrances that has significantly reduced the number of slip events for people entering or exiting the hospital. These mats are still under review with a view to increasing their footprint in some of the heavy traffic areas such as main reception.
- Floor cleaning process through ISS is also monitored as part of the ongoing Health and Safety Inspections
- In general hospital floor finishes are not able to be changed out for full anti slip material as this type of flooring will compromise Infection prevention and control within the hospital area

Further Behavioural Controls

- Many of the unsafe conditions with liquid and material on the floor that results in a slip, will have initially been caused by an unsafe action (spillage) which is either not cleaned away or identified prior to the person slipping. Staff are being encouraged to “See it and sort” it rather than letting the accident unfold at a later point in time
- This is also addressed at Team Huddles as each employee is reminded that their own Health and Safety is important to both themselves and the Trust.

2.1.3 Manual Handling Review

Datix reports for 12 months from 01/04/2021 – 31/03/2022

A total of 43 manual handling incidents were reported of which 33 occurred in clinical areas and 10 in non-clinical areas such as corridors.
This compares with a total of 60 in 2019-2020 and 36 in 2020-2021 which is showing a slight upward trend

Type of Incident

- Lifting a person = 20 (47% of Total)
- Lifting an object = 5 (11% of Total)
- Push/pull a person = 9 (21% of total)
- Push/pull an object = 9 (21% of Total)

Top 3 number of incidents where a single link can be identified

- Patients medical condition* i.e. Obesity, aggression = 8 (18% of Total)
- Using broken equipment = 6 (14% of Total)
- Patients collapse or fall = 5 (12% of Total)

Causation

Causation identified;

- 25 line incidents due to unsafe action (58 % of Causation)
- 18 line incidents due to unsafe condition (42 % of Causation

Further Engineering Controls

- Flooring within the hospital is reviewed within the general Health and Safety Inspections that take place each month, and in general all flooring is found to be in a safe and serviceable condition which allows for free movement of any load during transit
- Some hospital beds / equipment have been found to have sticking or poorly maintained wheels, which have accounted for a portion of our accidents associated with pushing. This has been raised to Vinci as an ongoing issue and beds are taken out of service and repaired where identified
- Handling and moving training is ongoing for all hospital staff

Further Behavioural Controls

- As part of the handling and moving training delivered by the Trust, staff are instructed to fully assess any handling situation they may face prior to committing to the task. 72% of the Trust accidents associated with unsafe actions could have been prevented by staff applying this principle in practice during daily operations
- The Trust is due to appoint a new Handling and Moving Lead during 2022 who will have this data communicated to them so that a suitable accident reduction strategy may be formulated
- This is currently addressed at Team Huddles as each employee is reminded that their own Health and Safety is important to both themselves and the Trust.

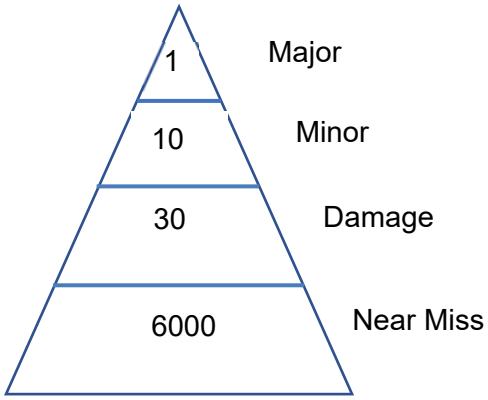
2.1.4 Accident and Near Miss Comparison

2021 / 22 Accidents / Incidents have been reviewed against the Bird Model of accident ratios (Shown below), which is seen as the general standard for accident ratios across the field of Health and safety, although there are very few sectors which follow Bird's model exactly.

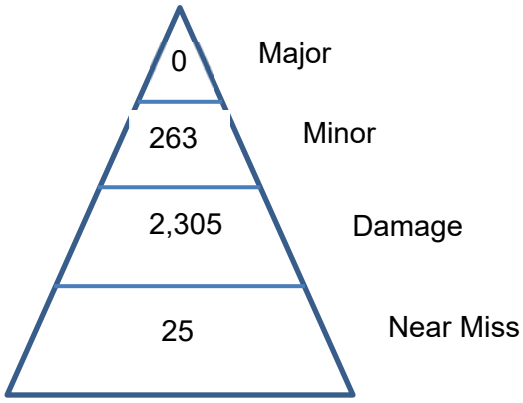
As expected within an environment designed to deliver care, we are seeing no catastrophic accidents across the Trust, which is predominantly due to the controlled hazards within our working environment and the associated lower risk that Trust staff are exposed to.

The number of injury related accidents when shown across our workforce place us at 0.021 accidents per member of staff which compares against the national average of 0.085 across all workplaces (there are no specific numbers for the care sector available from HSE at this time).

Damage in isolation is not easy to draw down from the Datix process so the data below is taken from our help desk numbers which may not be 100% accurate but serves as a good indication on the scale of Near Misses we should be seeing as a Trust, based on Bird's Ratio.



Bird 1966



UHCW 2021/22

The Trust Datix system does not capture data in exactly the same format that was utilised by Bird and damage data is taken from help desk reporting. It is the intention of the health and safety team to undertake trend analysis of the damage data that is captured to try to reduce our injury figures year on year which should also have an impact on some areas of damage that occurs within the Trust

Near Miss is being reviewed with the trust Datix team with a view to improve the capture of data associated with near misses within the Trust in an effort to trend and reduce our number of loss events going forward

2.2 RIDDOR

The tables below show the number of incidents reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) and who was affected. The number of reportable accidents for 2021/22 has remained static with comparison to 2020/2021 .

Category	2019/20	2020/21	2021/22	Trend
Over 7 day Injury	21	20	21	↑
Specified Injury	5	8	9	↑
Dangerous Occurrence	12	7	5	↓
Fatality	0	0	0	-
Total	39	35	35	-

RIDDOR incidents by category

	2019/20	2020/21	2021/22	Trend
Staff	37	31	31	-
Patients	2	4	4	-
Other	0	0	0	-
Total affected	39	35	35	-

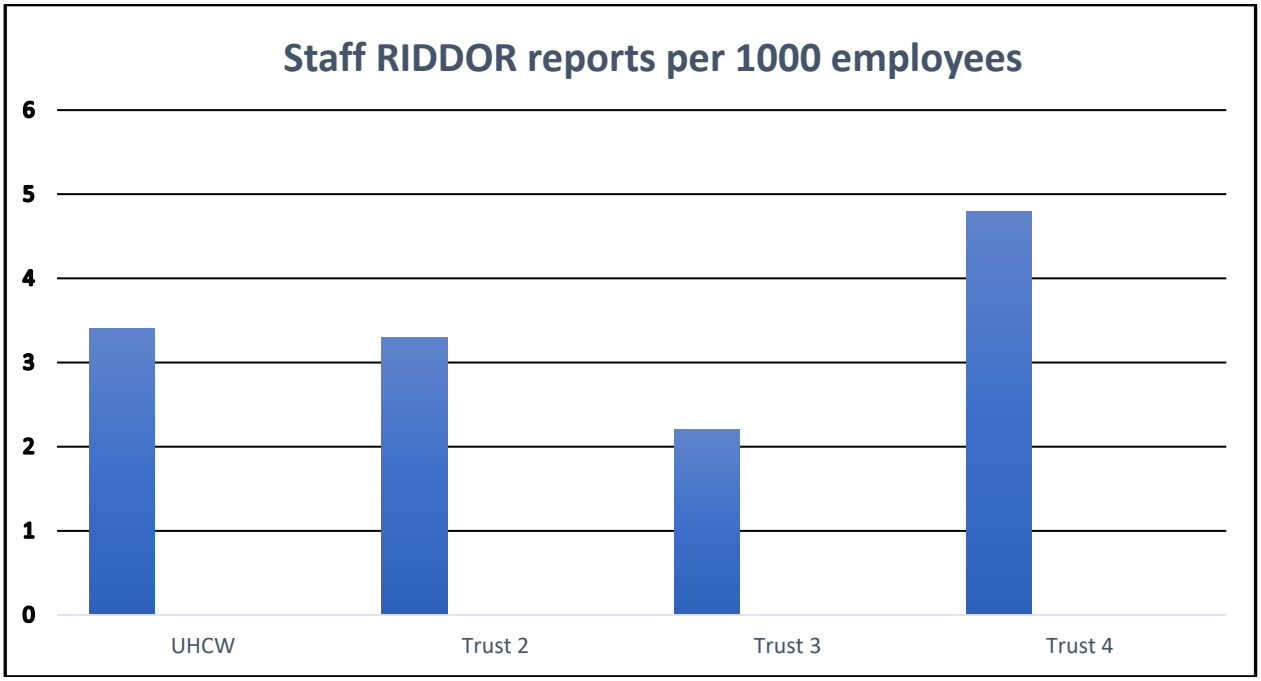
RIDDOR Incidents by Type of Person Affected

Actions taken following incidents included;

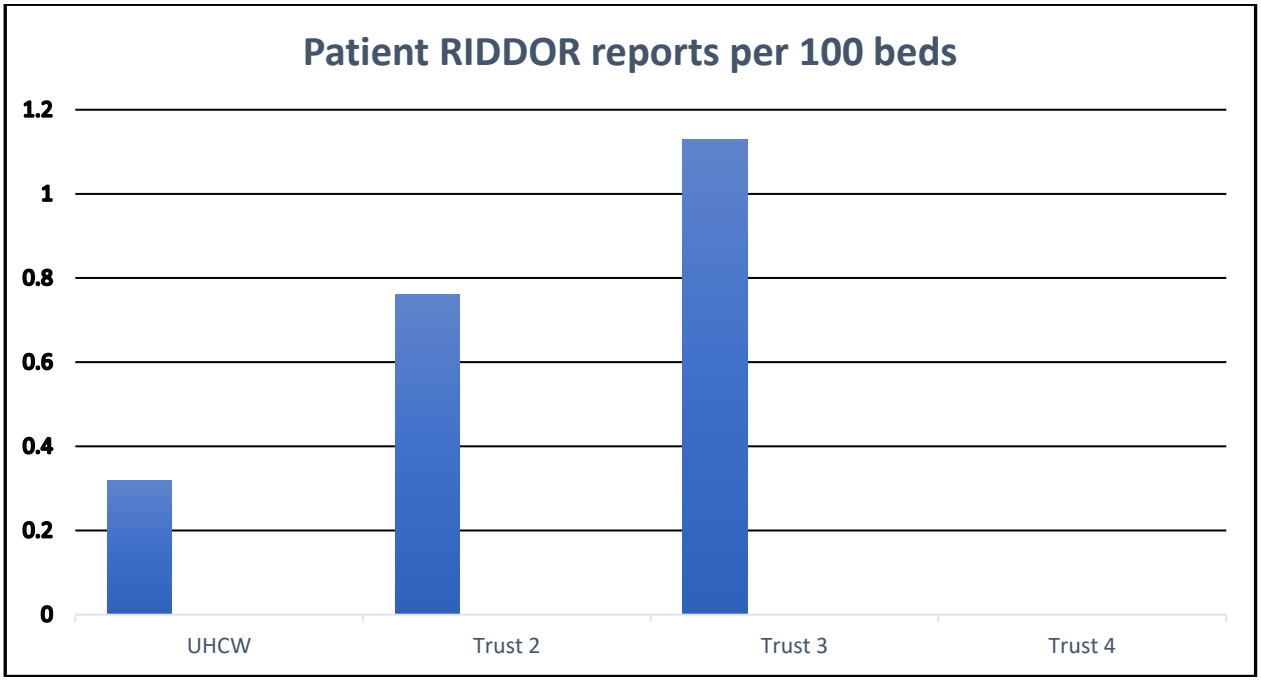
- Risk assessments were reviewed and revised, where necessary
- CoSHH Risk assessor training was delivered
- Staff reflected on the correct use and disposal of sharps
- Site traffic / road crossing study has been undertaken with associated report and remedial action plan
- Staff have been reminded to use the appropriate protective equipment when dealing with body fluids
- Increased Mask Face Fit testing capacity and the range of personal protective equipment available
- Increased usage of Falls alarms to prevent patient falls
- Increased implementation of cohorted bays for patients at risk of falls

2.2.1 Benchmarking

A simple benchmarking exercise was carried out covering 2021 / 22 Data regarding the number of RIDDORs reported by UHCW in comparison with three other healthcare settings.



The number of RIDDORS reported per 1000 employees



The number of patient RIDDORS reported per 100 beds

RIDDORs are reported by the Health and Safety Department. and this is the same process as the other hospitals.

It is difficult to generalise when every hospital has a different patient group, physical design, facilities and staff group. However, based on this benchmarking exercise it would appear that UHCW is reporting a similar number of RIDDOR events as the hospitals involved with this review.

UHCW has a system in which all serious patient incidents are presented at a weekly Significant Incident Group and a member of the Health and Safety team attend this meeting to advise on RIDDOR. Therefore, the number of patient incidents for UHCW is considered accurate. Occupational Health inform the Health and Safety team of any “Dangerous Occurrence” involving blood borne viruses. It is the Area Managers responsibility to inform Health and Safety if there is a potential RIDDOR reportable event involving staff and training has been delivered on the subject plus a guidance document has been produced on e-library. All Datix accidents (excluding patient falls) are also reviewed by the Health and Safety team for potential RIDDOR reporting and followed up if necessary.

Overall there is an effective and robust system for reporting the appropriate number of RIDDOR incidents across both hospitals and satellite sites.

2.3 CONTACTS WITH HSE / FIRE OFFICER

There have been no visits undertaken by HSE during the period of time covered by this report at either UH or the Hospital of St Cross.

During this period of time a new Fire Officer has been appointed by West Midlands Fire and Rescue service to cover the UHCW hospital.

There have been 3 proactive meetings with this Fire Officer since their appointment to review the controls being implemented by the UHCW team with regard to inspection and maintenance of fire dampers across the hospital which the Fire Officer is very supportive of.

During the height of the COVID 19 pandemic the West Midlands Fire and Rescue service had suspended inspection visits to the hospital, but it is proposed that this will recommence during October 2022 and will occur monthly thereafter.

2.4 STATUTORY INSPECTIONS

Under United Kingdom Statute and Statutory Instrument there is a requirement associated with our hospitals and their infrastructure to undertake suitable and sufficient inspection and tests of certain identified plant, equipment, and processes.

This is managed by the Trust through Project Co, who engage with Vinci Facilities Management Ltd and their subcontractors to deliver inspections and undertake remedial actions as shown within the table below.

This is an ongoing process that the Trust monitor during regular targeted meetings with both Project Co and Vinci Facilities Management.

Topic	Managed By	Inspected By	In Date
Water Management	VFM	Sub Contract	Yes
Ventilation	VFM	Sub Contract	Yes
Fire Equipment	VFM	Sub Contract	No
Lifting Equipment	VFM	Sub Contract	Yes
Medical Equipment	MEBS	MEBS and Sub Contract	Yes
Portable Electrical Equipment	VFM	VFM	Yes
Medical Gas	VFM	VFM	Yes
Emergency Lighting	VFM	VFM	Yes
Pressure Systems	VFM	VFM	Yes

At the time of this report there were a small number of dampers that require further work which number 1.8% of total .

Some of this is attributed to COVID 19 area controls, some to general accessibility on the day of inspection and some due to physical accessibility to dampers around other infrastructure.

A report was produced covering the number and type of the dampers that were out of inspection, and a strategy for getting the outstanding dampers back within scope was developed.

This strategy was then communicated and reviewed with the West Midlands Fire and Rescue Officer who agreed with the actions being taken to resolve this issue and has continued to monitor these actions during 2022 to the completion of the programme.

By the end of October 2022 all dampers with the exception of 39 will be inspected with status reported to the West Midlands Fire Officer.

The remaining 39 require significant alterations to hospital services which will be planned in with building works as they take place over a period of years. This has been highlighted to the West Midlands Fire officer and as these dampers are not in any one clustered area the hospital is considered within control due to the position all other fire controls are in

The Board should be assured that all reasonably practicable steps have been and continue to taken with regard to this issue.

2.5 SAFETY NOTICES

No general Non Clinical safety notices have been received covering the period of this report and none have been notified by the Trust

2.6 AUDIT

General internal health and safety audits of the Trust are conducted every 2 years which gives each area time to improve on any actions which may require specialist support or budgetary consideration so there is nothing to report this year against general auditing

During the 2021 -2022 financial year the Trust has engaged in ISO 45001 external accreditation, which has involved internal auditing of our health and safety systems by the Trust Health and Safety team, with associated systems improvement where shortfall against the ISO 45001 standard was identified.

External accreditation audit has also been undertaken during 2022 where Trust health and safety systems have been found to be fully aligned to the ISO 45001 standard that has been worked towards and accreditation has been granted covering both hospital non clinical health and safety systems.

Whilst this in its own right does not guarantee compliance with all statutory requirements it is certainly viewed by the HSE as a standard that indicates a good level of safety management within the organisation

2.7 INSPECTIONS

The Trust Health and Safety Inspection Tool has been improved for Trust usage within the period of time that this report covers, and inspections continue to be undertaken monthly across both UH and The Hospital of St Cross sites

All inspections are delivered by a team comprising the Trust Health and Safety Manager and Advisor, Trade Union Safety representatives and where available the immediate area manager

95 Inspections have been completed between 01/04/2021 – 31/03/2022 over both main hospital sites and satellites

Average compliance scoring across the inspected areas is running at 86% and it is anticipated to see this number rise during subsequent years inspections.

In general areas where scores are low, the consistently identified issues are poor housekeeping and damaged equipment that has not been taken out of service.

Both of these areas have an impact on the accident data shown within this report, which is explained to area managers during inspections and as part of the follow up report which is issued by the Health and Safety team to the area manager within a week of the inspection, to support remedial actions.

These inspections not only provide the Trust an indication of compliance with physical requirements but also serve as simple awareness training for the areas inspected.

2.8 IMPROVEMENTS TO SERVICE

During the period of time covered by this report the Trust have been preparing for external accreditation to ISO 45001, which has driven a series of internal reviews and system improvements as detailed below

- Extended auditing process of high level safety management systems
- Improved inspection template
- Improved accident / incident recording
- Development of improved reporting by Vinci and ISS through Project Co on H&S
- Simplification of Trust specific policy (Water, Medical Gas etc)
- Delivery of bespoke equipment training to clinics and MEBS

All of the above items have reduced waste and improved delivery of our health and safety systems across the trust

2.9 TRAINING

During the period of time covered by this report general health and safety refresher training has continued to be addressed through the mandatory training process through ESR. This provides a baseline of training (refreshed every 2 years) for all staff across the Trust.

Health and safety 3 year training is at 93%
Fire Annual training is at 96%

A training needs analysis was undertaken by the Health and Safety team early in 2021 and it was identified that the immediate need for training centred around assessments that were already being undertaken within the Trust.

As a result of this the Health and Safety team have developed and implemented bespoke health and safety training covering the following:

2.9.1 General Risk Assessment

This training is designed to cover any stakeholder within the Trust who has been assigned responsibility at Ward / Department / Service level for the delivery/ leading and update of general risk assessments covering the tasks undertaken within the areas that they represent.
This training is specific to UHCW and covers our process to improve the quality of event when risk assessments are undertaken by out teams.
This is delivered by the Health and Safety team as it is felt this has more impact than external resource that may not understand Trust issues or have the ability to support any needs identified through training

2.9.2 Dynamic Risk Assessment

Based on the fact that a high percentage of our staff are front line facing the trust Dynamic Risk Assessment training was developed to allow trained general risk assessors to cascade the process of dynamic assessment within their work teams.
This training adopts a Support, Assess, Formulate and Execute (S A F E) approach to get all staff to think of their own health and safety needs as a high agenda item both within the workplace and outside

The aim of this training is to start to modify attitudes and behaviour within the workplace, getting staff to take responsibility for their actions to reduce negative outcomes

This is delivered by the Health and Safety team as it is felt this has more impact than external resource that may not understand Trust issues or have the ability to support any needs identified through training

2.9.3 Hazardous Substance Assessment

This training is designed to cover any stakeholder within the Trust who has been assigned responsibility at Ward / Department / Service level for the delivery/ leading and update of assessments detailed within the Control of Substances Hazardous to Health Regulations covering the materials that are used or produced within the areas that they represent.
This training is specific to UHCW and covers our process to improve the quality of event when CoSHH assessments are undertaken by our teams
This is delivered by the Health and Safety team as it is felt this has more impact than external resource that may not understand Trust issues or have the ability to support any needs identified through training

2.9.4 Equipment training

During health and safety inspections of the hospital several pieces of equipment were identified that by law require specific training (I.e. Grinding wheels) and as this had not been delivered the equipment had been taken out of service, resulting in hardship within the departments and quality impact on patient deliverable

Training on the identified bespoke equipment has been developed and delivered to 100% of the teams that have been identified as users of this equipment, which has allowed this equipment to be put safely back into service.

Training has also been developed and delivered for the MEBS team covering certain pieces of equipment they need to use to undertake daily operations in a safe manner

2.9.5 Display Screen Assessor

This training is designed to cover any stakeholder within the Trust who has been assigned responsibility at Ward / Department / Service to review and support display screen assessments undertaken by users within their area.

This training is specific to UHCW and covers our process to improve the quality of event when risk assessments are undertaken by our teams

This is delivered by the Health and Safety team as it is felt this has more impact than external resource that may not understand Trust issues or have the ability to support any needs identified through training

- 8 General risk assessment courses has trained a total of 62 staff
- 4 CoSHH assessment courses has trained a total of 39 staff
- 3 DSE courses has trained a total of 9 staff
- 4 Abrasive wheel courses has trained a total of 15 staff
- 1 work at height course has trained a total of 3 staff

Bespoke health and safety training has also been developed to deliver to all Trust managers which will be launched during 2022 / 23 period

2.10 PROJECTS

There are no physical projects included within this report as the Health and Safety team perform a supporting role with all non-clinical projects that are undertaken within the Trust, as required and some clinical related services where health and safety subject matter expertise is required.

This is in line with the requirements placed upon the Trust under the Management of Health and Safety Regulations 1999 that requires competent health and safety assistance and support across the undertaking.

The Health and Safety team have been working on several small safety related issue during the time that this report covers as follows

2.10.1 Risk Management

Update and full delivery of a comprehensive system to manage general risk in pursuance of the above cited instrument, this includes

- Review and update of Trustnav documentation covering general risk
- Development and implementation of further generic general risk assessments
- Direct delivery of bespoke general risk assessor training
- Support for newly trained lead risk assessors once in post

This input is starting to show an improvement with the quality of event delivered across departments with regard to general risk assessment and control, which in turn will start to impact on the accident statistics evidenced within the body of this report

2.10.2 Hazardous Substances

Update and full delivery of a comprehensive system to manage hazardous substance risk in pursuance of the Control of Substances Hazardous to Health Regulations 2002 this includes

- Review and update of Trustnav documentation covering hazardous substance risk
- Development and implementation of further generic hazardous substance risk assessments
- Direct delivery of bespoke hazardous substance assessor training
- Support for newly trained lead risk assessors once in post
- Review and request for bespoke incoming chemical store that is external to main hospital building

This input is starting to show an improvement with the quality of event delivered across departments with regard to hazardous substance assessment and control.

2.10.3 Corridor Storage / Housekeeping

The issue regarding excessive storage on the main acute hospitals corridors continues to be a concern and remains a stubborn risk on the Trust Risk Register

The amount of equipment purchased in, and the critical lack of suitable storage facilities, particularly within the wards and departments is the main contributing factor causing this concern

We have developed a cross functional team to address poor housekeeping and storage on hospital corridors, which has included Project Co, Vinci, ISS and Trust input and
a model of equipment control has been trialled on the 4th floor and is now being cascaded down to all floors within the hospital which indicates locations for out of use beds and equipment, coupled with a side area for damaged equipment to be placed for removal to repair or scrap, with facility also to bring repaired equipment back onto the wards in the same manner

Monitoring of compliance is an ongoing process through the cross functional team and clinical staff, which is being expanded during 2022

2.10.4 Site Roads / Crossings

Due to a number of accidents within the time period for this report, that took place on road crossing points within the hospital area, a traffic study was commissioned through Project Co and Vinci Facilities Management, to undertake a full review of site roads, crossing, signage and other ancillary road furniture.

This was completed during March 2022 and a full report was submitted by the contractor undertaking the review.
This report has been studied by a multi-disciplined team comprised of Trust Estates , Project Co and Vinci with a set of actions agreed and undertaken including:

- Foliage that has been allowed to impact sight lines from junctions and car parks has been cut back and will be maintained at a level to facilitate line of sight for both drivers and pedestrians
- Identified crossings have been remarked to improve visibility (where required)
- Flower baskets on carriageway fences have been moved away from crossings to improve visibility at the crossing
- Certain crossings at the rear of the sight have been relayed to eliminate confusion and improve visibility
- All crossing point lights have been upgraded with new lamps (there is further work in progress to replace all of these light fittings with Halo LED units that are significantly more visible)
- Certain sight signage has been upgraded as per report recommendations

The general improvement has made the site roads safer for both pedestrians and vehicle users, and there are further works planned for the 2022 /23 period

2.10.5 Use of Electric Domestic Kitchen Equipment in Non Rated Areas

As a result of increased staffing levels from the original design specification of the hospital it has been identified through the health and safety inspections being conducted across the site, that there has been an increase in the use of domestic electrical appliances within areas of the hospital that were not designed with higher rated fire controls for the use of this type of equipment, which is out of step with our current fire policy.

To address this the Health and Safety and Fire Manager have undertaken a joint risk assessment that identifies that the actual fire risk associated with electrical equipment can be suitably controlled as long as the equipment is suitably sourced through NHS procurement process and is then included within the inspection and test protocols that exist for portable electrical equipment.

Based on this assessment a schedule of equipment that may be used within office and rest room areas across the Trust has been produced (some equipment is still prohibited in the vicinity of smoke detectors as there is a potential for them to be triggered by steam etc)

There is a process flow that supports this which is being launched through the site Health and Safety Committee

Trust policy is due for review within the 2022/23 period where this change of process will be addressed also

2.10.6 Health and Safety Committee

The trust health and safety committee is chaired by the trust Chief Nursing Officer and is supported with regular membership covering Estates, Non clinical Health and Safety, Occupational Health and Trade Union Representatives, that invite group representatives to meetings throughout the year to provide equal coverage across the Trust

This group meet in pursuance of the Safety Representatives and Committee Regulations 1977 and have a role that enables consultation on all health and safety related issues between trust management teams and the workforce through the office of the trade union.

Reports are received and actioned each quarter from subject matter experts covering works as they progress within the trust and any associated suggestions for improvement from the committee membership
Further to this a report is received from 2 of the Trust groups each quarter covering the group safety performance.
During 2021-2022 financial year the group reporting process has been simplified as part of the ISO 45001 improvements and to drive consistency in information being presented to the health and safety committee

This committee is also responsible for a number of safety related policies that are reviewed and passed as required

The committee is functioning well and is operating within its terms of reference

2.11 HEALTH AND SAFETY SUMMARY

Based on the work being undertaken general site health and safety, the Trust is in a position to demonstrate that it is taking reasonably practicable steps to discharge its duties as an employer with regard to statutory process and the daily operation of the hospitals and the health and safety of its staff

2.12 FIRE

The Trust as an employer has a responsibility to ensure so far as reasonably practicable that it complies with the requirements of an employer defined under the Regulatory Reform (Fire Safety) Order 2005 as applicable to the Trust’s undertaking.

The Trust appoints a named Competent Persons (Fire Safety Manager) to advise the Trust on the steps it needs to undertake to meet the above cited legal requirements

The Trust Competent Persons has developed systems for the Trust, to be delivered at an operational level based on their areas of expertise, and these systems are monitored for compliance throughout

each financial year, to identify areas that require improvement in line with the Trust Plan Do Study Act process

This report serves to highlight current performance against fire standards within the Trust

2.12.1 Fire Training

Staff fire training continues with staff receiving their mandatory fire training by one of three main ways:-

- Online via the Trust Intranet - ESR
- Via the mandatory training booklet published by the Learning & Development Department
- Face to face fire lectures delivered by the Trust Fire Safety Manager in the CSB

The percentage of staff trained fluctuates monthly between 92% to 96%

2.12.2 Fire Incidents

One fire occurred during this reporting period. Details are as follows:-

22/07/2022 @ approx. 1500 hours- an electrical fault occurred in a GAB alarm device which overheated and melted within the new MDU. This caused extensive smoke to be circulated around the unit which resulted in the unit being evacuated.

The fire procedure for the hospital was carried out correctly and all staff, including the Hospital Fire +Response Team reacted in a fast and efficient manner.

The GAB alarm contractors were called and immediately attended. A full inspection of all GAB alarms in the area and their associated electrical wiring took place and the devices in the unit and the surrounding departments were inspected and found to be operating correctly.

2.12.3 Fire Alarm Activations

During the last calendar year the fire service attended the following fire alarm activations:-

Fire Alarm Activations	University Hospital	St Cross
Cooking Fumes / Burnt toast	2	0
Defective Electrical Appliance	1	0
Fire Alarm / System Fault	9	8
Chemical / Aerosols	1	2
Smell of Burning	1	1
Environment / Storm Damage	0	1
Testing / Working on Alarm System	0	2
Accidental	8	1
Dust	5	0
Steam from Kettles	2	0
Smoking	0	0
Water Leak	2	0
Abandoned /Call Challenged	0	2
Unknown	3	3
Total	**34**	**20**

The above information is collated from information supplied by West Midlands and Warwickshire fire authorities.

The fire alarm activation figures shown in the table above continue to be within the acceptable limits for 2 large hospital sites. Nonetheless, the Trust Fire Safety Manager continues to work with the local fire authority to discuss what can be done to reduce unwanted fire signals even further.

2.12.4 Fire Service Familiarisation Visits

During the reporting period, the Trust undertook regular familiarisation visits for the local fire service.

These visits were facilitated by the Trust Fire Safety Manager with local fire crews from Binley, Coventry, Foleshill and Canley fire stations.

Working closely with the Fire Service in this way enables the Trust to:

- co-ordinate and review the emergency fire fighting plan for UHCW premises
- to mitigate the effects of a fire and the implications that any fire could have for the Trust and PFI partners
- co-ordinate with the fire service, regarding any changes in working practices and processes, or changes of use of Trust premises

Fire inspections undertaken by the West Midlands Fire and Rescue Officer are due to re commence during 2022/23 period

2.12.5 Fire Risk Assessments

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

Fire risk assessments are reviewed based on the frequency shown in the table below

Occupancy Type	Maximum review frequency (years)	Examples
All Sleeping Accommodation	1 - 2	Wards, in-patient accommodation, ITU's, CCU's
Outpatients, clinics, and areas where patients are dependent on others	2 - 3	Outpatient clinics, minor treatment and day surgery
Offices, and non clinical areas	3 - 4	Offices, administration areas, workshops, storage areas, CSSD, outside storage buildings, restaurant and cafes

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

A master record of all fire risk assessment data is held by the Trust Fire Safety Manager. The fire risk assessment review process is logged on an audit spreadsheet which shows the date reviewed and the date due for the next review.

In accordance with the Regulatory Reform (Fire Safety) Order 2005 the Trust is only responsible for carrying out fire risk assessments in areas under which it has direct management control.

Areas such as plant rooms, electrical cupboards, service ducts, service risers, above false ceilings, and other areas which fall under the control of ISS, Vinci and Project Co are risk assessed by those respective organisations.

2.12.6 Consortium Health, Safety, Security & Fire Group

The performance and compliance of contracted partners is monitored and assurances sought via the Consortium Health, Safety, Security & Fire Group

This Group meets on a quarterly basis and is under the control of the PFI Landlord, Project Co.

2.12.7 Fire Safety Website

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

2.12.8 Fire Summary

The Trust Fire Manager has identified the salient points to deliver further control and assurances moving forward, which is recorded within the site Risk Register which in many instances work hand in hand with general health and safety controls.

The general fire infrastructure for both sites is managed by the Trust Fire Manager who has designed and implemented processes for Trust managers and staff to follow so as to control site fire risk to a tolerable level.

2.13 SECURITY MANAGEMENT

Provision of a safe and secure environment that supports the safe delivery of services remains a core value that informs the work of the Trust Security Manager (TSM) and Security teams. The security management function continues to work towards reducing the number and frequency of incidents and improving physical security measures.
The TSM continues to promote and develop partnership working with ward and departmental managers through formal and informal channels to monitor incidents and trends and identify the key underlying causes leading to incidents of violence, aggression and harassment.
Work with external partners to improve support measures for UHCW staff and patients continues through the mechanism of the Crime and Incident Reduction Group, hosted at the UHCW Coventry site.

2.13.1Security Incident Reporting

Security Management Incidents are reported and investigated locally and trend analysis carried out to inform policy and crime reduction strategies.

2.13.2 Crime and Incident Reduction Group

The Crime and Incident Reduction Group (CIRG), chaired by the TSM is a forum that facilitates information sharing and partnership working between ourselves and key community partners. Our contacts with the police and community partners continues to play an important part in security management at the Trust. Partnership working has allowed us to identify known and potential security management issues in advance and implement strategies for preventing difficult situations developing or effectively managing them at an early stage to the benefit of patients, staff and visitors at UHCW NHS Trust sites.

2.13.3 Police Support

The advanced support of the local policing team has been sporadic with minimal attendance at the CIRG meetings. The reactive urgent support has been better with attendance on site when necessary and the upfront sharing of information being available. The TSM will continue to work with the local policing unit on shared initiatives when appropriate.

2.13.4 Violence and Aggression working Group

The Violence and Aggression Working Group have been reviewing the effectiveness of existing arrangements for managing incidences of violence aggression and abuse and supporting staff. There have been several streams of work including an awareness campaign, introduction of body worn CCTV into the Emergency Department and looking at disengagement and restraint training (MAPPA) for staff.
The Emergency Department now have their own Violence and Aggression Review Group (VARG) where they discuss the Datix incidents reported in the department and agree on sanctions. After all incidents of violence, aggression and abuse staff involved receive a post incident de-brief. This is separate to any investigation and is aimed at supporting the physical and emotional welfare of the member of staff. This is essential to monitor and support staff wellbeing and welfare and should include support from the Trust Wellbeing team.
A post incident care team of companions has been developed, made up of staff volunteers prepared to support staff involved in incidents from immediately after through to the conclusion of any support needs or proceedings.
This is working very well and would be an excellent model to use for all the groups.

2.13.5 Security Awareness

Raising staff ‘security awareness’ continues to be a key theme and measures are in place to promote a proactive approach to security. A combined programme of training, information and promotional communication events are carried out throughout the year and will continue for the foreseeable future. Visits to wards and departments continue to be carried out by the TSM and ISS security team to offer support and promote the security message.

2.13.6 CCTV

Close Circuit Television System (CCTV) – The Trust currently incorporates fixed and rotational cameras for the use in prevention and detection of crime. The SMD is the overall owner of the system with the TSM data controller. ISS manage the operation of the system generally with the TSM monitoring compliance of the Trust CCTV policy.
The external cameras were replaced in 2021 as part of the life-cycle programme with internal cameras planned for 2022.

2.13.7 Janus/Access Control System

There have been a number of issues identified with the access control system resulting in the Trust writing to Project Co-requesting assurances that the system is working correctly and there is no risk to Trust staff. Work continues on the replacement of this in 2022/23.

2.13.8 Car Park Security

There were a number of incidents of vehicle and catalytic converter theft from the hospital's car parks resulting in increased CCTV and physical patrols. The TSM continues to work with the police to identify offenders using the site CCTV.

Car Park at Rear of Hospital

The car park at the rear of the hospital has alleviated the parking pressures which for many years was a cause of concern for service users and staff.

2.13.9 Baby Tagging

There have been no issues with the baby tagging system.

2.13.10 Mortuary Security Improvements

The Mortuary at Rugby St Cross has had CCTV and access control fitted to bring it in line with the security arrangements at University Hospital.

2.13.11 Security Performance

In 2021 ISS security service exceeded the first warning level for the third time in seven years. Meetings were held to review compliance of the security service SLA. To sustain the work to date a series of measures for the forward monitoring of the service were developed involving all stakeholders. Work continues on this improvement programme in 2022/23

2.13.12 Security Summary

The protection of patients, staff and visitors is key to the delivery of safe patient services and will continue to be the focus of security management work at UHCW. As a large diverse organisation there are many challenges for security management and when combined with greater demand for resources and national and local changes to the support available, the next year is expected to prove a difficult and challenging time. The annual work plan will focus on the findings of the work of the violence and abuse working group. This should identify and inform the main priorities for security management moving forward. In the interim period the TSM and ISS security team will continue to deliver active and re-active support to wards and departments, working collaboratively with colleagues and community partners where there are mutual interests.

3 IMPLICATIONS (HEALTH, SAFETY , FIRE AND SECURITY)

Based on the work being undertaken on general site health, safety, fire and security the Trust is in a position to demonstrate that it is taking reasonably practicable steps to discharge its duties as an employer with regard to statutory process and the daily operation of the hospitals and the health, safety and security of its staff and those affected by its undertaking

4 OPTIONS (HEALTH, SAFETY AND FIRE)

As suitable and sufficient health, safety and fire controls are a mandatory requirement within the United Kingdom there are no options available to the Trust other than to continue to deliver against the required standards so far as is reasonably practicable

5 CONCLUSIONS (HEALTH, SAFETY AND FIRE)

The management of health, safety, fire and security is the responsibility of all Trust staff; however, managers have an extended responsibility and duty of care to manage these areas for their staff. In general, this is accepted by all levels of management within the Trust and evidence obtained during inspections and audits would indicate that in the main this duty is being well discharged.

The current level of general management controls adopted within the Trust delivers against the requirements placed upon the Trust as and employer under Health, Safety, Fire and Security Legislation which is also supported by are accreditation to ISO 45001.

6. RECOMMENDATIONS (HEALTH, SAFETY, FIRE AND SECURITY) – PLAN FOR 2022/23

- Continue to develop, refresh and deliver high quality health , safety, fire and security training for all staff levels within the Trust
- Continue to deliver statutory health , safety and fire requirements across both hospitals
- Continue to deliver all national safety alerts as they are identified
- Continue to drive a step change in attitudes, behaviours and culture associated with health, safety, fire and security
- Continue to deliver audits and Inspections across all areas of the Trust on a rolling programme, adopting the PDSA model for repeat inspections looking for less than 30% repeat of identified opportunities to improve
- Maintain ISO 45001 accreditation

As part of normal operations the Subject Matter Experts involved with health, safety fire and security are always looking at new ways to improve Trust standards, reduce risk, create an interdependent culture and reduce waste within the Trust.
To achieve this there is a general programme of work that is being looked at for the 2022/23 period as shown within the table below

Topic	SME Lead
Further delivery of site traffic controls	H&S
Sharps awareness campaign	H&S
Evaluation of needle melting trial	H&S
Health, safety and fire attendance to team huddles	H,S&F
Uplift of handling and moving training	H&S
See it, Sort approach to spillages and wet floors	H&S
Bespoke HS&F training for front line managers	H,S&F
Detailed review of explosive atmosphere controls	Fire
Expansion of violence and aggression related training for staff	Security
Mental health impact review and risk review	H&S
Audit of site fire controls	H,S&F

The output for these improvements should be a reduction in both number of accidents resulting from site operations, the lost time associated with these accidents and the general wellbeing of our workforce

The Board is asked to receive assurance from this report that all reasonably practicable steps are being undertaken to adequately control risk to the Trust, its staff and any person affected by the Trust undertaking and where any opportunities for improvement are identified suitable processes exist to address shortfall at an operational level.

Author: Mr David Millage Trust Health and Safety Manager

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 6 OCTOBER 2022

Subject Title	Care Quality Commission (CQC) Registration Report
Executive Sponsor	Mo Hussain, Chief Quality Officer
Author	Matthew Corden, Assurance Manager
Attachment(s)	Care Quality Commission (CQC) Registration Report
Recommendation(s)	The Board is asked to **NOTE** and **APPROVE** the CQC Registration Report.

EXECUTIVE SUMMARY
The Trust is required to regularly review its CQC registration, including delivery of regulated activity from locations and CQC defined service types. The report details updates and amendments made to the Trust's CQC registration.
PREVIOUS DISCUSSIONS HELD
N/A

KEY IMPLICATIONS	
Financial	N/A
Patients Safety or Quality	The trust is required to maintain fundamental standards to deliver safe and effective care. There are regulatory implications if the Trust does not meet the required standard in line with its registration.
Workforce	N/A
Operational	N/A

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

REPORT TO PUBLIC TRUST BOARD

Care Quality Commission (CQC) Registration Report

1. INTRODUCTION

1.1 Under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009, University Hospitals Coventry and Warwickshire NHS Trust (UHCW) is required to comply with the fundamental standards and regulations set by law.

1.2 NHS Trusts should take the opportunity to annually review their registration requirements set out in the regulations and as detailed in their Statement of Purpose, and registration documentation held by CQC.

2. CONTENT

2.1 A review of the Trust's CQC registration has been completed to ensure compliance with Regulation 6: Requirement where the service provider is a body other than a partnership (HSCA 2008 (RA)) and Regulation 12: Statement of Purpose (CQC 2009). The review covered changes to the Trust's registration between September 2021 and 2022, Registered Locations, Regulated Activity, and CQC Service Types.

2.2 Summary of CQC Registration Changes

2.3 A summary of changes made to the Trust's CQC registration between September 2021 and 2022 is provided below (Table 1):

Table 1: Summary of CQC Registration Changes, September 2021 – 2022

Date	Change Requested
07/03/2022	Notification to update to Statement of Purpose summitted including: • Change of Nominated Individual from Nina Morgan (Chief Nursing Officer) to Mo Hussain (Chief Quality Officer). • Registration of new location (Urgent Treatment Centre (RKB36)) and inclusion in statement of purpose.
04/04/2022	Notification to register Urgent Treatment Centre as a location withdrawn as per written CQC guidance that it should be a satellite service.
27/04/2022	Notification to register Urgent Treatment Centre as a location resubmitted on advice from CQC registration team and local inspection team.
07/09/2022	New Certificate of Registration received, including changes to Nominated individual and new location.

2.4 Under Regulation 12: Statement of Purpose and Regulation 15: Notice of changes (CQC 2009), the Trust is required to inform the CQC of any changes to its Statement of Purpose, and of any changes to the Nominated Individual. In March 2022, a notification was submitted with an updated Statement of Purpose including the change of Nominated Individual from Nina Morgan to Mo Hussain.

2.5 **Regulated Activity and Registered Locations**

2.6 Section 8(1) of the Health and Social Care Act 2008 describes a regulated activity (RA) as "an activity involving, or connected with, the provision of health or social care". For example, the Surgical procedures RA covers the following procedures when carried out by a healthcare professional:

- Surgical procedures for the purpose of:
    - treating disease, disorder or injury
    - cosmetic surgery
    - religious observance (for example, circumcision)
    - sterilisation or reverse sterilisation.

2.7 As per the regulation, if any regulated activities specified in Schedule 1 are carried on, providers must register unless an exception or exemption applies.

2.8 The current Certificate of Registration (CRT1-13918276456) was issued by CQC 7 September 2022 and includes all registered locations and regulated activity provided at or from them. The provider, University Hospitals Coventry and Warwickshire NHS Trust – RBK, has three registered locations:

- University Hospital (RKB01)
- Hospital of St Cross (RKB03)
- Urgent Treatment Centre (RKB36)

2.9 The Urgent Treatment Centre (RKB36) was registration in September 2022 as a new location and provides Treatment of disease, disorder or injury as Regulated Activity.

2.10 On review of CQC regulated activity, no other changes or additions have been made to the Regulated Activity in the last 12 months.

2.11 A breakdown of regulated activity provided by each location is provided below (Table 2):

Table 2: Summary of Regulated Activity by Location

Regulated Activity	University Hospital (RKB01)	Hospital of St Cross (RKB03)	Urgent Treatment Centre (RKB36)
Maternity and midwifery services	Yes	Yes	No
Termination of pregnancies	Yes	No	No
Services in slimming clinics	Yes	No	No
Family planning	Yes	Yes	No
Treatment of disease, disorder or injury	Yes	Yes	Yes
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Yes	Yes	No
Surgical procedures	Yes	Yes	No
Diagnostic and screening procedures	Yes	Yes	No
Management of supply of blood and blood derived products	Yes	Yes	No

2.12 **CQC Service Types**

The Urgent Treatment Centre (RKB36) was added in September 2022 as a new location and as per the scope of registration, is registered with an Urgent care services (UCS) service type.

2.13 On review of CQC service types, no other changes or additions have been made in the last 12 months.

2.14 A breakdown of service types provided by each location is provided below (Table 3):

Table 3: Summary of Service Type by Location

CQC Service Type	University Hospital (RKB01)	Hospital of St Cross (RKB03)	Urgent Treatment Centre (RKB36)
Acute services (ACS)	Yes	Yes	No
Urgent care services (UCS)	No	No	Yes

3. IMPLICATIONS

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

3.2 In order to be able to deliver healthcare services to the population of Coventry and beyond, the Trust must be registered with the CQC and have in place a current Statement of Purpose.

3.3 The responsibility for ensuring the regular review of the Trust's CQC Statement of Purpose lies with the Nominated Individual and the Quality Department.

3.4 Governance

The Trust is required by law to be registered with the CQC, without this registration it is unable to fulfil its statutory duties.

3.5 Regular contact with the CQC Relationship Owner is in place via provider engagement meetings to share progress within the Trust, monitor risks identified in outcome data and discuss concerns or feedback from the public.

3.6 As part of the CQC's new strategy and in response to Covid-19, a more flexible approach to monitoring and seeking assurance of regulated activity was launched. This response included the introduction of the Dynamic Monitoring Approach (DMA) which is a formal review of core services and an opportunity for the CQC relationship owner to gain assurance on the delivery of services. The Trust has participated in four DMA meetings with Neurosurgery, Medicine, Maternity and Surgery.

3.7 The Trust receives a bi-monthly CQC Acute Insights Report which contains Trust level data on activity, staffing and performance monitoring indicators (such as Mortality rates, Outcome measures and National Audit activity) which are all mapped against the CQC's five key questions and key lines of enquiry (KLOEs). The report is shared across the Trust and used to support the assessment of data quality and the identification of areas of improvement through the Trust governance processes. This report also forms part of the CQC provider engagement meetings.

4. CONCLUSIONS

4.1 Two changes to the Trust's registration have been made between September 2021 and 2022, including the change of Nominated Individual and the addition of a third location from which Regulated Activity is delivered.

4.2 Engagement with the CQC to provide assurance of regulated activity continues through routine engagement meetings with the CQC relationship owner and the Trust will work with the CQC in the introduction of the new strategy.

5. RECOMMENDATIONS

5.1 The Board is asked to NOTE and APPROVE this annual CQC Registration update report.

Author Name: Matthew Corden
Author Role: Assurance Manager
Date report written: 21 September 2022

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 6 OCTOBER 2022

Subject Title	Receipt of Human Tissue Authority (HTA) Licence
Executive Sponsor	Professor Kiran Patel, Chief Medical Officer
Author	Sarah Rogers, Medical Directorate Business Manager
Attachment(s)	HTA Report including governance structure
Recommendation(s)	The Board is asked to **NOTE** the contents of the report

EXECUTIVE SUMMARY

UHCW holds 4 HTA Licences and 2 HFEA licences. The change of a Designated Individual within the Trust highlighted issues and triggered a CAPA plan (Corrective & Preventive Actions) submission to HTA. Corporate HTA licence holder requested a review of HTA governance in the Trust.

HTA licence assurance and oversight was previously held by:

- The Research Governance & Human Tissue Committee (led by R&D and reporting into PSEC); please note only one HTA license pertains to research activity (Post Mortem).
- Risks, operational issues and finance were held at group level, across 3 groups, where activity is delivered. There was no corporate or centralised risk register.

Internal restructure has resulted in:

- A new HTA committee with Research and Quality Directorate membership; direct HTA reporting line into PSEC and subsequently Trust Board.
- A centralised DATIX risk register for corporate oversight of all HTA licence risks
- Centralised finances and shared folder resource; all HTA licence documentation, SOPs & governance in one place. Inspection reports are also corporately visible.

PREVIOUS DISCUSSIONS HELD

N/A

KEY IMPLICATIONS	
Financial	N/A
Patients Safety or Quality	The new structure will improve quality oversight of HTA
Workforce	The Trust has now outlined responsibilities for HTA roles.
Operational	Centralised oversight

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

REPORT TO PUBLIC TRUST BOARD

Receipt of HTA Licence: Governance Arrangements

1. INTRODUCTION

1.1 The HTA licenses a number of activities relating to human tissue. The HTA are responsible for carrying out inspections to ensure licence conditions are being met. These activities are laid out in the Human Tissue Act and associated Regulations.

1.2 The activities licensed by the HTA are:

- Carrying out of an anatomical examination.
- Making of a post-mortem examination.
- Removal of relevant material from a deceased person.
- Storage of relevant material from a deceased person (other than for a specific ethically approved project).
- Storage of anatomical specimens.
- Storage of relevant material from a living person for research (other than for a specific ethically approved project).
- Public display of a body or material from a deceased person.
- Procurement, testing, processing, storage, distribution, import and export of tissues and cells for human application.

1.3 The core of what the HTA does is laid down in three pieces of legislation. These are:

- The Human Tissue Act 2004 (HT Act) and associated Regulations.
- The Human Tissue (Quality and Safety for Human Application) Regulations 2007
- The Quality and Safety of Organs Intended for Transplantation Regulations 2012

1.4 The Trust holds 4 HTA licenses as outlined in appendix 1 (and 2 HFEA). *Please note there are no satellite arrangements at present.*

2. CONTENT

2.1 Following the change of our Human Application License Designated Individual (DI), this prompted an exploration into the current SOPs and Trust wide governance arrangements.

2.1.1. HTA licence assurance and oversight was previously held by:

- The Research Governance & Human Tissue Committee (led by R&D and reporting into PSEC); please note only one HTA license pertains to research activity (Post Mortem).
- Risks, operational issues and finance were held at group level, across 3 groups, where activity is delivered. There was no corporate or centralised risk register.

2.1.2. There were no Trust documents specifically referring to DI or PD role responsibilities; new DIs/PDs unaware of full scope of responsibilities.

2.2 Quality Directorate involvement only enacted when CAPA (Corrective And Preventive Actions) plans required (usually after inspection); identified that the Quality Directorate require more oversight of HTA functions to enable deployment of a robust support mechanism to group/specialty level during times of inspection.

2.3 New HTA license assurance and oversight:

- New HTA committee with Research and Quality Directorate membership; direct HTA reporting line into PSEC and subsequently Trust Board. (Draft ToR can be found in appendix 4)
- Trust documentation drafted regarding HTA roles and responsibilities (appendix 2/3)
- A centralised DATIX risk register for corporate oversight of all HTA licence risks
- Centralised finances to facilitate streamlined invoicing
- Centralised shared folder resource for groups and corporate functions: all HTA licence documentation, SOPs & governance in one place.
- Inspection reports are also corporately visible.

2.4 For noting:

2.4.1. The CAPA plan for Human Application licence submitted was by the Trust in September 2022.

2.4.2. Currently DIs do not receive any additional PA or responsibility allowance for HTA work. Some PD's have HTA responsibilities written into their existing job description but no additional responsibility payment.

2.4.3. HTA SOP reviews are ongoing: SOPs for Anatomy Licence are currently being reviewed and will be ready for November 2022.

2.4.4. The Trust does not have a donation pathway for deceased patients currently (donations to research & teaching); the Anatomy PD is working to set up a pathway so donors can be referred from the Trust to the national repository in Nottingham.

2.4.5. The Human Application DI wishes to apply for a storage licence at UHCW (satellite) to store amniotic membrane tissue for use during elective and emergencies. The tissue needs to be stored at -80C and at present all the facilities are at the Arden Bank (restricted to research purposes by research licence). Theatres will have to purchase a freezer to store clinical tissue; a temperature-controlled alarm system in the ophthalmology room and an electronic track and trace system is required (quotes requested).

3. IMPLICATIONS

3.1 If the Trust is not compliant with HTA Licence requirements, activities will be suspended.

4. HTA INSPECTION DATES

4.1 HTA inspections occur every 3 to 5 years, based on activity and risk.

4.2 Summary of HTA inspection dates per licence are as follows:

Licence No	Licence Type	HTA Inspection Dates	Expected Next Inspection Date
30018	Post Mortem	Aug 2009, Sep 2012, Aug 2016, Jan 2022	Jan 2025-2027
30019	Anatomy	Nov 2016	Nov 2019-2021 OVERDUE
40039	Transplant	Feb 2013, Sept 2018	Sept 2021-2023 DUE
12319	Human Application	Aug 2011, Aug 2013, Sep 2015	Sept 2018-2020 OVERDUE

4.3 All inspection reports are available on the HTA website - they are written in terms of non-compliances only and do not reflect any areas of good practice.

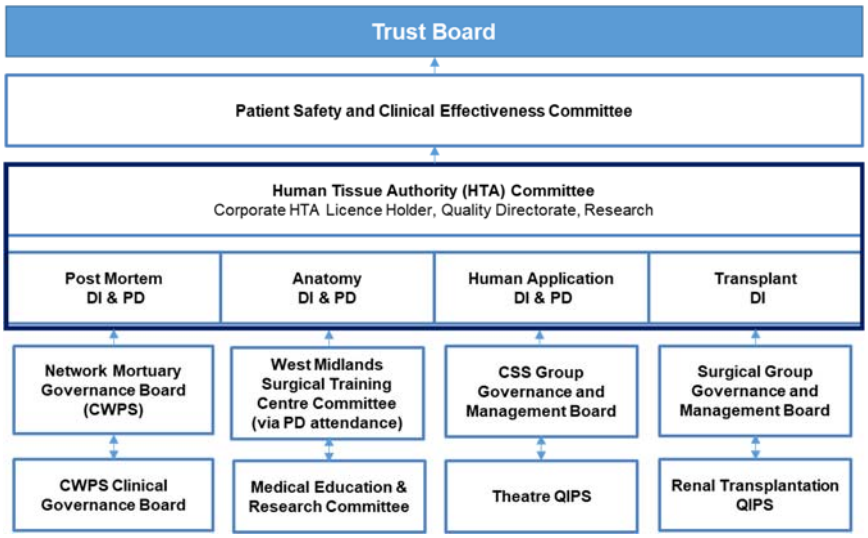
4.4 The Trust should anticipate HTA inspections for Anatomy, Transplant & Human Application Licences. The DIs and corporate HTA licence holder will receive 12 weeks' notice for an inspection from the HTA.

4.5 The Human Fertilisation & Embryology Authority (HFEA) carry out inspections every two years, and issue licences for up to 4 years. (Last inspection April & May 2021).

5. GOVERNANCE

5.1 The (new) HTA Committee will start from November 2022, reporting into PSEC as per figure 1.

Figure 1: Human Tissue Act (HTA) Governance Organogram



6. RECOMMENDATIONS

6.1 Trust Board is requested to NOTE the new governance structure.

Author Name: Sarah Rogers
Author Role: Medical Directorate Business Manager
Date report written: 26th September 2022

Appendix 1a: HTA Governance Framework Overview

CORPORATE HTA LICENCE HOLDER: Kiran Patel				
HTA Licence	**Post Mortem** **Licence Number: 30018**	**Anatomy** **Licence Number: 30019**	**Human Application** **Number: 12319**	**Transplant** **Licence Number: 40039**
Licenced Premises	University Hospital, CV2 2DX [MAIN]	University Hospital, CV2 2DX [MAIN]	Hospital of St Cross, CV22 5PX [MAIN]	University Hospital, CV2 2DX [MAIN]
Licensed Activities	1. Making of a Post Mortem Examination 2. Removal of Relevant Material 3. Storage of a Body or Relevant Material	1. Training teaching and Surgical dissection, Surgical endoscopy, prosecution and surgical reconstruction. 2. Management of Donor pathway from receipt to hand over to contractor for cremation 3. Storage of a Body or Relevant Material 4. Storage of an Anatomical Specimen	1. Procurement 2. Import	1. Donor Characterisation 2. Making arrangements to transport an organ 3. Organ Characterisation 4. Preservation of an organ 5. Retrieval of an organ 6. Implantation of an organ 7. Making arrangements to transport an organ 8. Organ Characterisation 9. Preservation of an organ
Designated Individual	**Hesham El Daly**	**David Snead**	**Mrinal Rana**	**Debabrata Roy**
Persons Designate	**Leslie Ramos** Cellular Pathology **Katie Dias & Samantha Bell** Mortuary **Sean James** Tissue Bank	**Simon Ford** (Acting PD) WM STC	**Alison Bolsover** Orthopaedics TBC Ophthalmology -	**None Appointed**
Activities performed under license	Post mortems Tissue Banking (research)	Surgical Training: Training and teaching Surgical dissection, Surgical endoscopy, prosecution and surgical reconstruction; Donor tissue management via donor pathway from receipt to hand over to contractor for cremation; Body mapping of donor tissue across surgical courses.	Historically Autologous Chondrocyte Implantation Corneal/Amniotic Membrane Transplants	Organ Transplantation
Specialty / Group where activity is delivered	Pathology, (CWPS), Clinical Diagnostic Services Arden Tissue Bank (Research)	West Midland Surgical Training Centre	Orthopaedics, Trauma & Neuro Services Ophthalmology, Surgical Services	Renal Transplant, Surgical Services

Appendix 1b: Human Fertilisation & Embryology Authority (HFEA) Governance Framework

NOMINAL HFEA CLINICAL LICENSE HOLDER: KIRAN PATEL		
HFEA License	**HFEA Unit** **Licence: 013**	**HFEA Research** **Licence Number: R0155-4-A**
Licensed Premises	University Hospital, CV2 2DX	University Hospital, CV2 2DX
Person Responsible	**Ben Lavender** **(UHCW)**	**Geraldine Hartshorne** **(University of Warwick/UHCW)**
Activities performed under license	Clinical provision of Infertility Services	Creation, storage, and use of embryos in ethically approved research projects
Specialty / Group where activity is delivered	Centre for Reproductive Medicine, Women & Children's Group	Centre for Reproductive Medicine, Women & Children's Group

Appendix 2: Designated Individual (HTA) Responsibilities [Draft]

Role Title: **Designated Individual (HTA)**
Department: Licence Dependent
Accountable to: The Corporate Licence Holder

Purpose of Post

The Designated Individual (DI) in relation to a licence, means the person under whose supervision the licensed activity is authorised to be carried on. DIs have a legal duty to ensure that statutory and regulatory requirements are met.

The role of the DI is crucial to the successful implementation of the HTA's licensing systems; they are responsible for supervising licensed activities and ensuring suitable practices are taking place.

Summary of Accountabilities and Responsibilities

Section 18 of the Human Tissue Act provides that it shall be the duty of the DI to secure:

a) that the other persons to whom the licence applies are suitable persons participate in the carrying on of the licensed activity;
b) that suitable practices are used in the course of carrying on that activity, and;
c) that the conditions of the licence are complied with.

The **Designated Individual** is a person who is in a position to ensure that the activities carried out under the licence complies with the regulatory requirements and must:

1. be in a position within the licensed organisation to ensure that the activities are conducted properly by individuals who are suitable (and appropriately trained) to carry out those activities and that all necessary legislative and regulatory requirements are complied with;
2. have knowledge and understanding of the Human Tissue Act, 2004 and the relevant HTA's Codes of Practice;
3. have time to carry out the role of DI in addition to their substantive role;
4. ensure compliance with licence conditions;
5. demonstrate managerial capability, ensuring quality and supervisory responsibility to effect change;
6. have links to senior management/board level;
7. know when to seek specialist advice to perform his/her role.
8. act as a key point of contact for enquiries to the HTA;
9. be responsible for investigating and reporting adverse events (including to the HTA, as appropriate);
10. act as Chair to the Combined Schools Human Tissue Authority Management Committee
11. meet regularly with the Licence to provide briefings and updates as part of the monitoring of the operation and compliance with the licence;
12. be informed of and authorise, as appropriate, all research and related activities in the University using human tissue, in accordance with the Standard Operating Procedures (SOPs).

DI's or a named contact will need access to the HTA Portal. They will use the HTA portal to securely send data and reports to the HTA e.g.

- submitting compliance updates
- submitting annual activity data
- reporting Serious Adverse Events or Reactions
- reporting post mortem HTA Reportable Incidents

For further information on the role of the DI, please go to the HTA website.

It is expected that all DI's complete ongoing HTA CPD, to include Medical Research Council e-learning module "Research & Human Tissue Legislation" as evidenced by a successful assessment on the Learning Management System (LMS). Certification must be obtained.

Appendix 3: Person Designated (HTA) Responsibilities [Draft]

Role Title: **Person Designated (HTA License)**
Department: Licence Dependent
Accountable to: The relevant licence Designated Individual & Corporate Licence Holder

Purpose of Post

- A Person Designated (PD) is a person designated by the DI to whom the licence applies, and to whom the authority conferred by the licence extends.
- PDs do not have the legal duties of the DI as set out in the HT Act (Section 18), but the role of the PD carries with it the ability to "direct" others in relation to the HT Act.
- PDs assist DIs in ensuring compliance with HTA standards. PDs can assist with developing procedures, as well as reporting incidents. If you have satellite sites, there should be at least one PD for each site.

Summary of Accountabilities and Responsibilities
The role of the Person Designated is:

1. To assist the DI in ensuring that the activities are conducted properly by individuals who are suitable (and appropriately trained) to carry out those activities and that all necessary legislative and regulatory requirements are complied with
2. To ensure that all conditions of the licence are complied with
3. To have knowledge and understanding of the Human Tissue Act, 2004 and the relevant HTA's Codes of Practice
4. To assist in developing and implementing SOPs to ensure compliance with the HT Act
5. To offer advice and guidance to those working with human samples, which may be at a satellite site
6. To advise those working with human tissue about how and why they need to follow procedures and systems agreed by the DI to comply with the HT Act.
7. To assist the DI in ensuring compliance with licence conditions through undertaking regular scheduled internal audits
8. Ensure all reportable incidents HTARI and otherwise are notified to the DI and a Datix is submitted. Carry out root cause analyses of relevant HTARI/Datix incidents and put into place remedial actions
9. Prepare and notify the Trust of all HTA Inspections, supporting the DI throughout the inspection process
10. Use the HTA portal to securely send data and reports to the HTA e.g. submitting compliance updates/annual activity data, reporting Serious Adverse Events or Reactions/post mortem HTA Reportable Incidents

In addition, the PD will, as required by the DI:

- Provide quarterly reports on the activities undertaken by the licence under which they operate to the HTA Governance Committee.

It is expected that all PD's complete ongoing HTA CPD, to include Medical Research Council e-learning module "Research & Human Tissue Legislation**" as evidenced by a successful assessment on the** Learning Management System (LMS)**. Certification must be obtained.**

Appendix 4: Terms of Reference – HTA Committee

NHS
University Hospitals Coventry and Warwickshire NHS Trust

University Hospitals Coventry & Warwickshire NHS Trust
Human Tissue Authority (HTA) Committee
Terms of Reference

1. Purpose

1.1 The primary purpose of the HTA Committee is to provide the Trust Board with assurance that all aspects of quality, research, clinical and regulatory activity relating to the use of Human Tissue is compliant to the HTA licences and legislation, and to the Human Fertilisation & Embryology Authority (HFEA):

- The Human Tissue Act 2004 (HT Act) and associated Regulations.
- The Human Tissue (Quality and Safety for Human Application) Regulations 2007
- The Quality and Safety of Organs Intended for Transplantation Regulations 2012
- The Human Fertilisation and Embryology (HFE) Act 1990 (as amended)
- The Human Fertilisation and Embryology Act 2008

1.2 The HTA are responsible for carrying out inspections to ensure licence conditions are being met. These activities are laid out in the Human Tissue Act and associated Regulations

1.3 The activities licensed by the HTA are:

- Carrying out of an anatomical examination.
- Making of a post-mortem examination.
- Removal of relevant material from a deceased person.
- Storage of relevant material from a deceased person (other than for a specific ethically approved project).
- Storage of anatomical specimens.
- Storage of relevant material from a living person for research (other than for a specific ethically approved project).
- Public display of a body or material from a deceased person.
- Procurement, testing, processing, storage, distribution, import and export of tissues and cells for human application.
- Human tissue and organs to be used for transplantation within the UK & compliance with laws ensuring quality & safety of organs, tissue and cells to be used in transplantation

1.4 The HFEA are responsible for ensuring that all fertility clinics and human embryo research centres comply with the legalisation above. HFEA provide guidance to clinics and research centres on how to meet the legal requirements in their Code of Practice.

1.5 The committee will seek assurance that the Trust is compliant in the management of human tissue, with oversight of all systems and processes that ensure effective management of Human Tissue in compliance with legal and regulatory requirements; ensuring they operate effectively, and that action is taken to address areas of concern.

1.6 Strategic risks to quality and/or safety are identified and reported to Trust Board, or the Patient Safety and Effectiveness Committee and assurance of risk mitigation provided.

2. Membership

2.1 Membership of the HTA Committee includes:

- HTA Corporate Licence Holder (Chief Medical Officer) - Chair
- Designated Individual for the Human Application Licence
- Designated Individual for the Post Mortem Licence
- Designated Individual for Anatomy License
- Designated Individual for the Transplant Licence
- Person(s) Designated for the Human Application Licence
- Person(s) Designated for the Post Mortem Licence
- Person Designated for Anatomy License
- Person Designated for the Transplant Licence (*if appointed)*
- Responsible individual for the Human Fertilisation and Embryology Research Licence
- Responsible individual for the Human Fertilisation and Embryology Treatment Licence
- Director of Quality / Associate Director of Quality
- Director of Research & Development / Head of Research & Development
- Head of Clinical Effectiveness and Assurance
- Medical Directorate Business Manager

2.2 The membership of the committee will be reviewed regularly.

2.3 Attendance in addition to the core group members will take place when required, to allow broad discussion of specific issues on the agenda.

2.4 Members are required to attend a minimum of 50% of meetings, and where unable to attend, submit their apologies in advance of the meeting or send a nominated deputy (PD or similar).

3 Chair

3.1. The HTA Committee will be chaired by the HTA Corporate Licence Holder (CMO).

3.2. In the absence of the CMO, the XXX will act as vice chair.

4 Secretariat

4.1. The Chair(s) will provide secretarial support from within the Medical Directorate.

5 Quorum

5.1. The HTA Committee has no executive powers other than those specifically delegated to it via these terms of reference.

5.2. The HTA Committee will be deemed quorate if five members are present, of which one will be the Chair or Vice-Chair.

5.3. Deputies can be included within the required quorum

6 Frequency of Meetings

6.1. The HTA Committee will have a schedule of quarterly meetings.

6.2. The Chair may call extraordinary meetings if required.

7 Conduct of Meetings

7.1 The agenda for meetings will be determined by the Chair(s); there will be a standard agenda.

7.2 The terms of reference will be formally reviewed by the Group each year and may be amended by the group at any time to reflect changes in circumstances which may arise.

7.3 A formal log of amendments to the approved Terms of Reference must be retained by the Secretary for audit purposes.

7.4 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with the agenda item for discussion and supporting papers, will be forwarded to each member of the HTA Committee and any other person required to attend, at least seven days (five working days) before its meeting.

8 Minutes of Meetings

8.1 The meeting Secretary will record the names of those present and in attendance.

8.2 The meeting Secretary will take brief notes of the meeting. It is not expected that these meetings will have full minutes. Decision and action logs will be maintained.

8.3 Actions of the meeting shall be agreed by the Chair within one week of the meeting occurring and shall be circulated promptly to all members of the Group thereafter. This will allow sufficient time for actions to be addressed prior to next meeting and the formal distribution of papers.

8.4 The Secretary will maintain an action log of key actions, reporting completed and outstanding actions at each Group meeting.

9 Duties

9.1 The duties of the HTA Committee are to:

- Oversee compliance with the Human Tissue Act within the Trust
- Oversee compliance with the Human Fertilisation and Embryology Act within the Trust
- Review the progress of HTA and HFEA audit programmes, reporting on an annual basis to the Patient Safety & Clinical Effectiveness Committee as per the work plan
- Reviewing risks and mitigations to receive assurances on key operations, escalating significant risks for inclusion in the Trust Risk Register.
- That key measures for regulatory compliance are monitored through receiving summarised information and making decisions on issues based on recommendations received

9.2 In discharging this responsibility, the Group will consider national developments and prevailing governance and legislative standards.

9.3 The HTA Committee will receive reports for approval on audit and monitoring against governance and legislative standards.

1.1

9.4 The HTA Committee will:

- Receive a regular data set/report to provide assurance that the above duties are being undertaken
- Report progress and escalate issues and concerns to the Patient Safety and Clinical Effectiveness Committee (PSEC)
- Receive delegated powers from the Patient Safety and Clinical Effectiveness Committee
- Prepare and have oversight of the HTA annual audits
- Prepare and have oversight of HTA and HFEA inspections
- Support the clinical groups in respect to the above duties
- Direct the sub-groups in respect to the above duties

9.5 Exclusions

The HTA Committee or its members will not:

a. Develop or approve workforce plans

b. Develop or approve operational plans

c. Make investment or disinvestment decisions

10 Reporting

10.1 The HTA Committee will be accountable to the Trust Board.

10.2 The HTA Committee will report to the Patient Safety and Clinical Effectiveness Committee.

Terms of Reference approved: [Insert date]
Version number:

11 Revision history

Version	Date	Summary of changes
1.0	27/09/2022	Creation of draft document

University Hospitals Coventry and Warwickshire NHS Trust

REPORT TO PUBLIC TRUST BOARD
HELD ON 6 OCTOBER 2022

Subject Title	Timetable of Board and Committee meetings 2023-24
Executive Sponsor	David Walsh, Director of Corporate Affairs
Author	David Walsh, Director of Corporate Affairs
Attachment(s)	Draft timetable (including remaining period in 2022/23)
Recommendation(s)	The Board is asked to **APPROVE** the timetable of Board and Committee meetings for 2023-24 and **NOTE** proposals for topics for upcoming Board Development and Board Strategic Workshop dates.

EXECUTIVE SUMMARY

Attached is a document detailing the planned dates for Board, Board Strategic Workshops, Board Development Days and meetings of the various Board committees. For completeness, the existing planned dates for the rest of 2022/23 are also included. The document also proposes the division of face-to-face and virtual committee meetings (all ordinary Board meetings are not face-to-face)

The existing schedule principles have been retained, namely:

- All whole Board meetings take place on the first Thursday of the month, with public/private Board meetings on the 'even' months and strategic workshops/Board Development on the 'odd' months
- All committees except Audit and Risk Assurance Committee take place on the final Thursday of the month (except in December to avoid meetings between Christmas and New Year)
- All Audit and Risk Committee meetings take place on the penultimate Thursday of the month.

<u>Upcoming Board Development/Board Strategic Workshop</u>

Some initial consideration has been given to potential items which will need to be covered at future meetings of the above and these are shared now for information.

The November 2022 Board Development session has been set aside to focus on utilising Insights Discovery to explore how best the Board can operate effectively together.

At the January Board Strategic Workshop session, it is proposed to focus on finance areas and consider two items previously raised as Board actions – a Financial Plan forward view, and an overview of the PFI position.

PREVIOUS DISCUSSIONS HELD

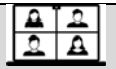
The timetable is approved annually.

Items for consideration at Board Strategic Workshops and Board Development sessions are developed in liaison with the Chair, the Chief Executive, the Chief Strategy Officer and others. Their inclusion in this report is for information.

KEY IMPLICATIONS	
Financial	None directly arising.
Patients Safety or Quality	None directly arising.
Workforce	None directly arising.
Operational	None directly arising.

	Month	Board			Committees				
		Public/Private	Board Strategic Workshop	Board Development	Quality and Safety Committee	Finance and Performance Committee	People Committee	Audit and Risk Assurance Committee	Committee meeting type
2022	Oct	6				27	27	20	
	Nov			3	24	24			
	Dec	1					22		
2023	Jan		5		26	26		19	
	Feb	2				23	23		
	Mar		2		30	30			
	Apr	6				27	27	20	
	May			4	25	25			
	Jun	1, 22*				29	29	22*	
	Jul		6		27			20	
	Aug	3				31	31		
	Sep		7		28	28			
	Oct	5				26	26	19	
	Nov			2	30	30			
	Dec	7					21		
2024	Jan		4		25	25		18	
	Feb	1				29	29		

Notes: Shading shows 22/23 year. ARAC and Board on 22/6/23 subject to change depending on national timetable for annual plan submission.

	Mar		7		29	29			

Notes: Shading shows 22/23 year. ARAC and Board on 22/6/23 subject to change depending on national timetable for annual plan submission.

DRAFT
PUBLIC TRUST BOARD AGENDA

01 DECEMBER 2022

MEETING	MEETING DATE	ITEM NO.	ITEM	GUEST	LEAD	AUTHOR	FORMAT	ACTION	TIME	DUR.
PUBLIC	1Dec 2022	0					Verbal		10:00	00:00
PUBLIC	1Dec 2022	1	Patient Story		Mo Hussain	Lisa Cummins	Enclosure	Note	10:00	00:10
PUBLIC	1Dec 2022	2.1	Apologies for Absence: GH		Chair		Verbal	Assurance	10:10	00:00
PUBLIC	1Dec 2022	2.2	Confirmation of Quoracy		Chair		Verbal	Assurance	10:10	00:00
PUBLIC	1Dec 2022	2.3	Declarations of Interest		Chair		Verbal	Assurance	10:10	00:00
PUBLIC	1Dec 2022	3.1	Minutes of previous meeting 06 October 2022		Chair		Enclosure	Approve	10:10	00:00
PUBLIC	1Dec 2022	3.2	Action Matrix		Chair		Enclosure	Assurance	10:10	00:00
PUBLIC	1Dec 2022	3.3	Matters Arising		Chair		Verbal	Assurance	10:10	00:10
PUBLIC	1Dec 2022	4	Chair's Report		Chair		Enclosure	Assurance	10:20	00:10
PUBLIC	1Dec 2022	5	Chief Executive Officer Update		Andy Hardy		Enclosure	Assurance	10:30	00:15
PUBLIC	1Dec 2022	6.1	Audit and Risk Assurance Committee Approved Minutes 17 August 2022		Afzal Ismail	David Walsh	Enclosure	Assurance	10:45	00:00
PUBLIC	1Dec 2022	6.2	Audit and Risk Assurance Committee Meeting Report 20 October 2022		Afzal Ismail	David Walsh	Enclosure	Assurance	10:45	00:00
PUBLIC	1Dec 2022	6.3	People Committee Approved Minutes 26 September 2022		Jenny Mawby-Groom	David Walsh	Enclosure	Assurance	10:45	00:00
PUBLIC	1Dec 2022	6.4	People Committee Meeting Report 27 October 2022		Jenny Mawby-Groom	David Walsh	Enclosure	Assurance	10:45	00:00
PUBLIC	1Dec 2022	6.5	Quality and Safet Committee Approved Minutes 29 September 2022		Carole Mills	David Walsh	Enclosure	Assurance	10:45	00:00
PUBLIC	1Dec 2022	6.6	Quality and Safet Committee Meeting Report 24 November 2022		Carole Mills	David Walsh	Enclosure	Assurance	10:45	00:00
PUBLIC	1Dec 2022	6.7	Finance and Performance Committee Approved Minutes 29 September 2022		Jerry Gould	David Walsh	Enclosure	Assurance	10:45	00:00
PUBLIC	1Dec 2022	6.8	Finance and Performance Committee Approved Minutes 27 October 2022		Jerry Gould	David Walsh	Enclosure	Assurance	10:45	00:00
PUBLIC	1Dec 2022	6.9	Finance and Performance Committee Meeting Report 24 November 2022		Jerry Gould	David Walsh	Enclosure	Assurance	10:45	00:05
PUBLIC	1Dec 2022	7	Board Assurance Framework		David Walsh	David Walsh	Enclosure	Assurance	10:50	00:10
PUBLIC	1Dec 2022	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	11:00	00:15
PUBLIC	1Dec 2022	9	Emergency Preparedness Resilience and Response (EPRR) Annual Report		Gaby Harris	Luke Peachey	Enclosure	Approve	11:15	00:05
PUBLIC	1Dec 2022	10	End of Life Care		Tracey Brigstock	Rebecca Bourton	Enclosure	Assurance	11:20	00:05
PUBLIC	1Dec 2022	11	Nursing and Midwifery Safe Staffing Report		Tracey Brigstock	Paula Seery	Enclosure	Assurance	11:25	00:10
PUBLIC	1Dec 2022	11.5	Break						11:35	00:10
PUBLIC	1Dec 2022	12	Patient Led Assessments of the Care Environment (PLACE) Annual Report		Tracey Brigstock	David Powell	Enclosure	Assurance	11:45	00:10
PUBLIC	1Dec 2022	13	Maternity Safety Report and Plan		Tracey Brigstock	Suzanne Wilson	Enclosure	Assurance	11:55	00:10
PUBLIC	1Dec 2022	14	Mortality (SHMI and HSMR) Update		Kiran Patel	Sharron Salt	Enclosure	Assurance	12:05	00:10
PUBLIC	1Dec 2022	15	Medical Eduction Report		Kiran Patel	Sailesh Sankar	Enclosure	Assurance	12:15	00:10
PUBLIC	1Dec 2022	16	Patient Safety Report		Mo Hussain	Claire Evans	Enclosure	Assurance	12:25	00:10
PUBLIC	1Dec 2022	17	Corporate Risks Report		Mo Hussain	Claire Evans, Lisa Cummins	Enclosure	Assurance	12:35	00:10
PUBLIC	1Dec 2022	18	Cancer Services Report		Gaby Harris	Helen West	Enclosure	Assurance	12:45	00:10
PUBLIC	1Dec 2022	19	Draft Board agendas		Chair	Corporate Affairs	Enclosure	Note	12:55	00:00
PUBLIC	1Dec 2022	20	Meeting Reflections		Char		Verbal	Discuss	12:55	00:05
PUBLIC	1Dec 2022	21	Questions from the public		Chair		Enclosure	Note	13:00	00:05
PUBLIC	1Dec 2022	21.5	LUNCH BREAK				Verbal		13:05	00:30

02 FEBURARY 2022

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 27 October 2022		Jenny Mawby-Groom	David Walsh	Enclosure	Assurance	10:45	00:00
PUBLIC	2 Feb 2023	6.4	People Committee Meeting Report 22 December 2022		Jenny Mawby-Groom	David Walsh	Enclosure	Assurance	10:45	00:00
PUBLIC	2 Feb 2023	6.5	Quality and Safety Committee Appproved Minutes 24 November 2022		Carole Mills	David Walsh	Enclosure	Assurance	10:45	00:00
PUBLIC	2 Feb 2023	6.6	Quality and Safety Committee Meeting Report 26 January 2023		Carole Mills	David Walsh	Enclosure	Assurance	10:45	00:00
PUBLIC	2 Feb 2023	6.7	Finance and Performance Committee Approved Minutes 24 November 2022		Jerry Gould	David Walsh	Enclosure	Assurance	10:45	00:05
PUBLIC	2 Feb 2023	6.8	Finance and Performance Committee Approved Minutes 22 December 2022		Jerry Gould	David Walsh	Enclosure	Assurance	10:50	00:00
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	Safeguarding Adults & Children Bi-Annual Report		Tracey Brigstock	Lisa Pratley	Enclosure	Assurance	11:25	00:10
PUBLIC	2 Feb 2023	10	Freedom to Speak Up Guardian		Mo Hussain	Lorna Shaw	Enclosure	Assurance	11:35	00:10
PUBLIC	2 Feb 2023	11	Update on Digital Strategy	James Matthews	Mo Hussain	James Matthews	Enclosure	Assurance	11:45	00:05
PUBLIC	2 Feb 2023	12	Guardian of Safe Working Hours Report		Kiran Patel	Andreas Ruhnke	Enclosure	Assurance	11:50	00:10
PUBLIC	2 Feb 2023	13	Medicines Optimisation Committee Annual Report 2022-23		Kiran Patel	Mark Easter	Enclosure	Assurance	12:00	00:10
PUBLIC	2 Feb 2023	14	Draft Board agendas		Chair	Corporate Affairs	Enclosure	Note	12:10	00:00
PUBLIC	2 Feb 2023	15	Meeting Reflections		Char		Verbal	Discuss	12:10	00:05
PUBLIC	2 Feb 2023	16	Questions from the public		Chair		Enclosure	Note	12:15	00:05
PUBLIC	2 Feb 2023	16.5	LUNCH BREAK				Verbal		12:20	00:30