TRUST BOARD
25 March 2020

ITEMS FOR APPROVAL

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Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/03/31**	
SUBJECT:	**Performance Assurance Framework & Key Performance Indicator Review - 2020/21**	
DATE OF MEETING:	25th March 2020	
AUTHOR(S):	Dan Birtwistle, Senior Business & Performance Manager	
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee - Director of Finance & Commercial Development	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x x x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#115 Failure to provide adequate staffing levels in some specialities and wards. #134 (a) Failure to sustain financial viability. #134 (b) Failure to deliver the financial position and a surplus #224 Failure to meet the emergency access standard.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Performance Assurance Framework (PAF) and Integrated Performance Report (IPR) Key Performance Indicators (KPIs) are reviewed annually to ensure they remain relevant, up to date and fit for purpose. This paper outlines the proposed amendments to the PAF for 2020/21 as follows: • A refresh of the Introduction and Role of the PAF sections. • Merging of the Approach and Performance sections. • A new Roles & Responsibilities section. • Replacement of the Adverse Performance section with a new Performance Risks/Issues section. • The Remedial Action Plan section has been replaced with an expanded Performance Improvement Actions section which includes the options for an Improvement Committee and Intensive Support. This paper also outlines recommended amendments to KPIs on the Trust IPR, which have been supported by the Strategic People Committee, Finance & Sustainability Committee and the Quality Assurance Committee.	

PURPOSE: ***(please select as appropriate)***	Information	Approval X	To note	Decision
RECOMMENDATION:	The Trust Board is asked to: **1.** Approve the amendments to the Performance Assurance Framework. **2.** Approve the amendments to the KPIs on the Trust IPR.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee, Finance & Sustainability Committee, Quality Assurance Committee		
	Agenda Ref.	SPC/20/01/05 FSC/20/02/25 QAC/20/03/37		
	Date of meeting	Strategic People Committee 22/01/2020 Finance & Sustainability Committee 19/02/2020 Quality Assurance Committee 03/03/2020		
	Summary of Outcome	Amendments to KPIs for Workforce were supported by the Strategic People Committee on 22nd January 2020. Amendments to the PAF & KPIs for Access and Performance and Finance were supported by the Finance & Sustainability Committee on 19th February 2020. Amendments to KPIs for Quality were supported by the Quality Assurance Committee on 3rd March 2020.		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

REPORT TO BOARD OF DIRECTORS

SUBJECT	**Performance Assurance Framework Review 2020/21**	**AGENDA REF:**	BM/20/03/33

1. BACKGROUND/CONTEXT

The Performance Assurance Framework (PAF) outlines how the Trust develops and maintains an effective culture, systems and processes for monitoring, managing and improving performance across the organisation. The PAF is reviewed annually to ensure it remains relevant, up to date and reflects changes in the structure of the organisation. This paper outlines the proposal for amendments to the PAF for 2020/21.

The Trust's Integrated Performance Report (IPR) brings together indicators from a range of sources including; Contractual Standards, CQC Insight and NHSI's Oversight Framework. The IPR is reviewed at each Trust Board meeting under the headings of Quality, Access & Performance, Workforce and Finance & Sustainability.

IPR indicators are reviewed annually to ensure they are remaining relevant and to develop any new indicators as required. This paper outlines recommended amendments to the IPR KPIs which have been supported by the Quality Assurance Committee (Quality), Strategic People Committee (Workforce), Finance & Sustainability Committee (Access & Performance and Finance).

2. KEY ELEMENTS

Updates to the Performance Assurance Framework

The following amendments have been proposed to the Performance Assurance Framework and have been incorporate into the updated PAF in **Appendix A.** These amendments have been supported by the Executive Team and Finance & Sustainability Committee.

- The "Introduction" & "Role of Performance Assurance Framework" sections have been strengthened to provide further clarity and detail.
- The "Our Approach to Performance Management (Ward to Board)" section has been amalgamated with the "Performance Report" section to remove duplication. This section provides further detail regarding the relationships between the various groups in terms of escalating of performance risks/issues and the use of Performance Improvement Actions.
- There is a new "Roles & Responsibilities" section which outlines the roles and responsibilities of Trust staff in relation to Performance Management.
- The PAF now describes how performance is managed at sub-CBU level.
- The "Adverse Performance" section has been replaced with a new "Performance Risks/Issues" section which describes how Performance Risks/Issues are identified and managed.
- The "Remedial Action Plan" section has been replaced with "Performance Improvement Actions" which expands the tools available to address Performance

Risks/Issues. As well as Remedial Action Plans, the PAF also outlines the use of Informal Management, Deep Dive Reviews, Improvement Committees and Intensive Support Programmes.

2019/20 Key Performance Indicator Review

The Contracts & Performance Team has met with Executive and Operational leads to review current indicators and to ascertain requirements for new indicators. In addition, the 2020/21 NHS Standard Contract and Oversight Framework have been reviewed to understand changes which may affect performance monitoring. The recommendations have been supported by; Quality & Assurance Committee (Quality), Strategic People Committee (Workforce) and the Finance & Sustainability Committee (Access & Performance & Finance). 2019/20 indicators are outlined in **Appendix B**.

Indicators Removed

KPI	Rationale
Quality	
Safety Thermometer Adult	It is proposed that these 3 indicators are removed from the IPR. In the 2020/21 NHS standard contract, the Trust is no longer required to report on the safety thermometer in its current format. The Trust is still required to assure and monitor standards in relation to Falls, Pressure Ulcers, UTIs and VTE (these are already separate indicators on the IPR). The Trust is required to provide an annual report to commissioners in relation to performance in these areas.
Safety Thermometer Children	
Safety Thermometer Maternity	
Access & Performance	
None.	
Workforce	
None.	
Finance	
None.	

Indicators Updated

KPI	Proposed Changed	Rationale
Quality		
Healthcare Acquired Infections (CDI & Gram Negative)	The Red Amber Green (RAG) rating criteria will be refreshed for CDI once the Trust is notified of the specific target. Trust specific targets will be issued for the first time for gram negative bloodstream infections which will replace the current targets.	NHSI will provide Trust specific targets for CDI as in previous years. The RAG rating criteria will be updated once this is published. For the first time in the 2020/21 contract, Trust specific targets will be issued for gram negative bloodstream infections (e-coli, pseudomonas aeruginosa and klebsiella).
Friends & Family Test (Inpatients, ED)	The RAG criteria will remain 95% for Inpatients and 87% for ED for patients recommending the Trust by rating services as "Very Good" or "Good".	The FFT question is being updated nationally and will be: Overall, how was your experience of our service? The mandated response scale is: Very Good, Good, Neither Good or Poor, Very Poor, Don't Know.

Continuity of Carer	The RAG rating will be increased from 30% to 35% as per the 2020/21 national target.	This is in line with the national Service Development Improvement Plan (SDIP).
Access & Performance		
None.		
Workforce		
None.		
Finance		
None.		

New Indicators

KPI	RAG Criteria	Rationale
Quality		
None.		
Access & Performance		
28 Day Faster Diagnostic Standard	Green – 75% or above Red – 74% or below	The 28 day faster diagnostic standard is currently being field tested by the Trust and has been included in the 2020/21 draft standard contract. Therefore it is recommended that this standard is included in the IPR from April 2020.
Two Week Wait/Breast Symptomatic The two week wait and breast symptomatic standards were temporarily removed from the Trust IPR in August 2019 whilst the 28 day faster diagnosis standard was being field tested. This reduced the number of Access & Performance indicators from 21 to 19. These standards are included in the 2020/21 draft standard contract and it is therefore recommended that these indicators are re-instated to the Trust IPR. This will result in 3 indicators being added to the Access & Performance section for 2020/21 (1 new, 2 re-instated). **Clinically Led Review of Standards** During 2019/20, in addition to the 28 day faster cancer diagnostic standard, several other new standards are being field tested by NHS England as part of a review into NHS Access Standards. These are outlined in "Clinically Led Review of NHS Access Standards" published in March 2019. Testing will continue to take place until the end of March 2020 with public consultations taking place during Q4 2019/20. The Trust Board may be asked to approve further changes in year if required.		
Workforce		
Agency Rate Card Compliance	Green = 60% or Above Amber = 50%-59% Red = Below 50%	An agency rate card was implemented across Cheshire & Merseyside in December 2019 in order to reduce costs of agency staff across the network. This KPI is being introduced to ensure the Trust is in compliance with the rate card.

% Use of Apprenticeship Levy	Green = 85% or Above Amber = 50%-84% Red = Below 50%	Introduced in May 2017, the apprenticeship levy and the achievement of an associated workforce target have provided significant challenges to large public sector bodies including WHH. Whilst work continues towards full utilisation of the financial levy contribution and achievement of the 2.3% of workforce undertaking apprenticeships target, significant progress cannot be achieved without a wider organisational approach to apprenticeships. Significant work has been undertaken to ensure appropriate governance is now in place to review, monitor and exception report against organisational apprenticeship activity, it is felt that now is the right time to introduce organisational level KPI's to promote organisational ownership of the apprenticeship challenge, ensure the delivery of an organisational approach to apprenticeships and subsequently, achieve both full utilisation of the apprenticeship levy financial contribution and the workforce metric.
% Workforce carrying out an Apprenticeship Qualification	Green = 2.3% or Above Amber = 1.5%-2.2% Red = Below 1.5%	
Role Specific Training	Green = 85% or Above Amber = 70%-85% Red = Below 70%	The reporting for role specific training takes place at the Education Governance Committee alongside mandatory training. The topics covered as part of role specific training, although not part of core skills frame work, are vital for patient and staff safety and experience and therefore it is recommended these are sighted by the Trust Board.
Finance		
System Wide Financial Position	The proposed RAG criteria is in line with the Trust Financial Position IPR indicator as follows: Red: Off plan, in deficit positon Amber: On or better than plan, in deficit positon Green: Surplus position	The Trust is working closely with Warrington CCG, Halton CCG and Bridgewater Community Healthcare NHS Foundation Trust to ensure financial sustainability of the system and therefore it is important for the Trust Board to be sighted on the system-wide positon.

These changes will result in following number of indicators from 2019/20 to 2020/21:

	2019/20	2020/21
Quality	24	21
Access & Performance	19	22
Workforce	11	15
Finance	9	10
Total	**63**	**68**

3. ACTIONS REQUIRED

PAF - If approved by the Trust Board, the new PAF will come into effect from 1st April 2020.

IPR KPIs – If approved by the Trust Board, amendments to the IPR will be reflected in May's Board Report (April's Performance).

4. RECOMMENDATIONS

The Trust Board is asked to:

1. Approve the proposed changes to the Performance Assurance Framework.
2. Approve the proposed changes to the KPIs on the Trust IPR.

Appendix A

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Performance Assurance Framework – Update for March 2020

Performance Assurance Framework

1. Introduction

1.1 Background

This Performance Assurance Framework (PAF) sets out principles of accountability and the commitment by Warrington & Halton Teaching Hospitals NHS Foundation Trust to establish and maintain an effective culture, systems and processes for managing and improving performance across all levels of the Trust. The PAF was developed to provide clarity of accountability from Ward to Board and is underpinned by a focus on outcomes for patients and the public. All staff are required to understand their role and responsibility in relation to performance and its impact on patient care.

1.2 What is Performance Management/Improvement?

Performance management is about ensuring the delivery of timely, high quality, effective and safe patient care using Trust resources in an efficient manner. This includes understanding how the Trust is performing in relation to national and local indicators, the underlying causes of underperformance, and barriers to performance improvement. This is as an integral part of the day to day management of operational services.

1.3 Scope

The Performance Assurance Framework covers all performance requirements set out in the Trust's Operational Plan, NHS Improvement Oversight Framework, NHS Standard Contract, by the CQC and Foundation Trust Licence. Whilst the framework describes the links to individual accountabilities and the contributions that all staff makes to the delivery of Trust performance, it does not deal directly with individual performance management, which is covered in the agreed Trust performance management policy/incremental pay progression policy.

1.4 Dependencies

The successful implementation of the PAF is dependent upon the production of information dashboard and reports by the Trust's Information Team and the timely supply of data by the Trust's Finance, Quality and HR teams.

Through an increased use of broader business intelligence, including outcome measures which provide a wider insight beyond headline KPIs, delivery against the Performance Assurance Framework will be dependent upon the production of information dashboards and reports by the Trust's Information Team and on the accurate, timely input of information and outcomes into Trust systems.

1.5 Associated Polices and Strategies

Whilst the Performance Assurance Framework incorporates performance across the whole Trust, it is recognised that the Trust has policies and procedures in place that will contribute to the delivery of this Performance Assurance Framework. The Performance Assurance Framework will support achievement of the Trust vision, mission, objectives and values (**Appendix 1**).

2. Role and Function of the Performance Assurance Framework

2.1 Main Purpose

This Performance Assurance Framework sets out the approach the Trust undertakes in ensuring there are effective systems in place to monitor, manage and improve performance. Prompt reviews will be undertaken where performance is deteriorating, and appropriate actions will be implemented to bring performance back to an acceptable level. The Performance Assurance Framework will:

- Set out clear lines of accountability and responsibility for delivery of performance from Ward to Board.
- Ensure performance objectives are agreed and transparent measurements are set to monitor performance against these standards, targets and plans.
- Ensure performance delivery is focused and is seen as a continual process which is embedded in all aspects of organisational activity.
- Provide assurance to the Board, Governors, Stakeholders and the Public that the organisation has strong systems in place to deliver the highest standards of patient care.
- Support the achievement of the Trust objectives.
- Support the delivery of the requirements of the Trust Foundation Licence, NHS Improvement Oversight Framework, CQC Insight Report and the NHS Standard Contract.
- Provide focus on and assurance of best value for money ensuring that services meet the needs of the local population and local health economy.
- Support the delivery of an engaged and motivated workforce with the right skills and capacity to provide consistent, good quality care.
- Recognise good performance and improvement and share good practice.
- Sets out the process for managing performance risks/issues with a balance between challenge and support.

3. Our approach to Performance Management

3.1 Ward to Board Accountability Structure

The accountability structure provides a line of sight from Ward to Board and Board to Ward as set out in **Appendix 2** and is detailed as follows:

3.1.1 Trust Board Level

The Trust Board meets bi-monthly and receives the Integrated Performance Report (IPR) which is presented with explanation from the Executive Directors. The Trust Board may request one or more performance improvement actions (see 3.3.2) where there is sufficient concern with any KPI.

KPIs within the Board IPR are reviewed and agreed annually with Board Committees and the Trust Board. KPIs may be changed in year with the minuted approval of the appropriate Board Committee and the approval of the Trust Board.

The IPR Dashboard contains the following elements which are designed to provide the Trust Board with assurance around the performance of the Trust against the KPIs and to highlight areas of improvement and good practice:

- Exception Report – the front section of the document is an exception report which highlights KPIs which have been RAG rated Red as well as any movements in KPIs month to month.
- RAG Movements – this section shows a rolling 12 month RAG rating and the movement in performance against each KPI.
- High Level Summary – the IPR is split into 4 key areas; Quality, Access & Performance, Workforce and Finance. A high level summary is provided for each of these areas.
- Dashboard – The dashboard details current and historic levels of performance, reasons for under performance and/or performance deterioration, details of actions and investigations underway in order to improve performance against the KPI. The dashboard contains Statistical Process Control (SPC) charts which look at data over time to determine if a process is within control or not. These charts are used alongside traditional RAG ratings to identify areas for focus.

There is an annual rolling programme of auditing of KPIs to ensure there is assurance around the quality of the data and reporting processes which is facilitated by MIAA.

3.1.2 Board Committees (Finance & Sustainability, Quality Assurance and Strategic People)
Executive Directors and Senior Managers will present updates on performance relative to the Committee remit as appropriate. The Committee may request one or more performance improvement action (see 3.3.2) where there is sufficient concern with any KPI. The Committee will escalate to the Trust Board as appropriate.

Each Committee receives regular performance reports as part of its agenda. The KPIs contained in the Committee reports can be changed by approval of Committee members as there may for example be occasions where the Committee wants to report at a more granular level. Any changes to KPIs need to triangulate to the Board IPR. All changes must be minuted to include the rationale for the change.

3.1.3 KPI Sub-Committee
The KPI sub-committee chaired by the Trust's Chief Operating Officer will review performance at CBU level. The sub-committee may request one or more performance improvement actions (see 3.3.2) for any areas of concern. The KPI committee will escalate to the Executive Team as appropriate.

The KPI sub-committee receives the CBU level IPR. The KPI sub-committee may approve amendments to the CBU Level IPR with a minuted rationale, KPIs at CBU level should triangulate with the Trust Board IPR, however the KPI sub-committee may monitor additional indicators at a more granular level to understand performance in-depth.

3.1.4 Trust Operational Board
The Trust Operational Board (TOB), chaired by the Chief Executive Officer focuses development and delivery of the Trust's strategy and will review progress of strategic priorities, however the TOB will also receive exception reports from CBUs which will focus on any KPIs which are RAG rated Red. TOB may request one or more performance improvement actions (see 3.3.2) where there are any areas of concern. TOB will escalate to the Trust Board as appropriate. Please note that the purpose and function of the TOB will be reviewed during 2020/21 and the PAF will be updated accordingly.

3.1.5 Trust Executive Team & CBU Partnership Forum Review (QPS)
The CBU Partnership Forum chaired by the CEO will review each CBU's performance in depth in all areas. Discussions will take place to understand any barriers to performance improvement and will look at any additional support required to address these barriers. The CBU Triumvirate will be required to attend this forum twice a year and present their position, highlighting any areas of concern, as well as areas of good practice which can be shared across CBUs. Actions from the forum will be recorded by a member of the Performance Team. If urgent actions are required, the CBU will provide an update to the next available Executive meeting and will not wait until their next bi-annual review. Prior to the CBU Partnership Forum review, the CBU Triumvirate and Performance Team will prepare a report which contains information relating to progress around priorities identified in CBU business plans which in turn supports delivery of service level strategies and will also focus on the areas of performance around; Quality & Governance Operational Performance (Quality), People (People) and Finance (Sustainability). The report will also include information about current issues, risks challenges and future plans.

The Trust Executive Team may request one or more performance improvement action (see 3.3.2) where there are any areas of concern. The Executive Team may escalate to the appropriate Board Committee or the Trust Board.

The Trust Executive Team may ask CBUs to attend Executive Team meetings at any time outside of the review process where there is a concern around performance in any area.

3.1.6 CBU Level

The CBU Triumvirate is expected to manage the performance of their services and have appropriate structures/forums in place to do so. The CBUs will be able to access performance information to enable them to monitor and manage performance in real time. CBUs are required to take corrective action to improve areas of underperformance, working with corporate services and other Trust departments as appropriate. CBUs are required to attend a weekly Performance Review Group (PRG) chaired by the Deputy Chief Operating Officer to focus on areas of underperformance. CBUs should escalate any areas of performance concern to the appropriate forum as above. The CBU Triumvirate may request one or more performance improvement action (see 3.3.2) for an individual Ward, Department, Service or Team where there are any areas of concern.

3.1.7 Ward, Department, Service or Team Level

Ward/Department/Service/Team managers will be able to access appropriate performance reports at that level in order to ensure they are managing day to day performance. Wards/Departments/Services are accountable to the CBU Triumvirate, who will provide any support, along with corporate services as necessary.

The production of quality, meaningful and timely performance information is fundamental to the delivery of the Performance Assurance Framework. Information must be timely, accurate and complete; and follow the principles set out in the Trust's Information Governance and Data Quality Policy.

3.2 Roles & Responsibilities

Specific roles and responsibilities in relation to the ongoing monitoring, management and improvement for the performance of the Trust are as follows:

3.2.3 Chief Executive

The Chief Executive has overall statutory responsibility for performance across the Trust.

3.2.2 Executive Directors

Executive Directors have delegated authority and responsibility for areas within their portfolio for ensuring effective performance management structures, systems and processes are in place for reporting, managing and improving performance with robust arrangements in place for addressing performance concerns.

3.2.3 Director of Finance & Commercial Development

In addition to responsibilities outlined in 3.2.2, The Director of Finance & Commercial Development has delegated authority for ensuring the overarching Performance Management Framework is in place and Executive oversight of the Performance Team activities outlined in 3.2.4.

3.2.4 Performance Team

The Performance Team is responsible for the management, production and development of the Trust and CBU IPR as well as the management of the CBU partnership forum (QPS) process. The

Performance Team is the gatekeeper of the IPR and is responsible for ensuring any changes are approved via the appropriate governance process and once approved are actioned.

The Performance Team will provide training to the CBUs so that all staff have sight and understanding of the performance KPIs they are accountable for and are aware of the associated consequences of not achieving the required standards.

3.2.5 Business Intelligence/Information Team
The Information Team will develop, generate and publish the necessary local reports and dashboards to enable the CBU/Teams to monitor and manage performance and will provide data for the Trust and CBU level IPRs.

3.2.6 Corporate Services
Corporate services (Finance, Governance, HR, IM&T, Strategy) has responsibility for the production and validation of data for Trust & CBU IPR dashboards. Corporate services will provide the necessary support to CBUs in order to improve performance in their area.

3.2.7 CBU Triumvirate
The CBU Triumvirate has responsibility for the management and improvement of performance for their CBU and will implement appropriate performance improvement actions (see 3.3.2).

3.2.8 Ward/Department/Service/Team Managers
The Ward/Department/Service/Team managers have responsibility for the management and improvement of performance for their Ward/Department/Service/Team and will implement any improvement actions requested by the CBU Triumvirate.

3.2.9 All Staff
All members of staff contribute to managing and improving performance and are encouraged to suggest areas for improvement and ideas on how improvement can be made. All staff should have an understanding of how their role contributes to performance of the Trust and the impact this has on patient care.

3.3 Performance Risks/Issues
Where there is a risk to the Trust achieving a standard or target or where performance has fallen below the required standard, this should be highlighted as a performance risk/issue. All actions and interventions relating to performance risk/issues will focus on ensuring patient safety is paramount, be delivery focussed and proportionate to the level of risk identified and there will be a balance between challenge and support, recognising any organisation wide resource needs.

3.3.1 Identification and Management
A performance risk/issue can be identified by any member of staff at any level of the organisation (Ward to Board).

Where a performance risk/issue has been identified, it is the responsibility of the oversight group outlined below to oversee appropriate actions in order to resolve the issue as soon as possible.

Performance Issue/Risk Area	Oversight Group	Support
Ward, Department, Service or Team Level	CBU Triumvirate	Corporate Services
CBU Level	KPI Sub-Committee Executive Team	
Trust Level	Executive Team – reporting to: Finance & Sustainability Committee Strategic Peoples Committee Quality & Assurance Committee Trust Board	

3.3.2 Performance Improvement Actions

A. Informal

Some low/medium level performance issues/risks may be managed locally by reviewing processes and making the necessary operational changes. These performance risk/issues may be as a result of a temporary local issue such as a staff shortage or an unexpected increase in demand. In the first instance, these performance issues should be managed and resolved locally with the appropriate authority to do so.

B. Remedial Action Plan

Where a performance risk/issue cannot be resolved in the short term and it is likely to have a medium to long term impact on Trust performance, the oversight group will request a Remedial Action Plan. The Remedial Action Plan will outline actions to be taken, impact, timescales and review timescales and will be reviewed at an appropriate forum each month. Once the oversight group is satisfied that the actions are complete and performance has returned to a satisfactory level, the Remedial Action Plan will be closed.

C. Deep Dive Review

The oversight group may request at any time a deep dive investigation into areas where there is a continued performance concern. The oversight group will set out terms of reference including timescales. Once the review has been concluded, the oversight group will agree next steps; this may include the implementation of a Remedial Action Plan or the establishment of an improvement committee.

D. Improvement Committee

Where performance issues/risks need additional support in order to return to satisfactory levels, a time limited Improvement Committee will be established. The Improvement Committee will be made up of representatives from corporate and clinical services as appropriate and will be sponsored by an appropriate Executive Director or Senior Manager and will report progress to the oversight group.

E. Intensive Support

Where performance has not returned to a satisfactory level after the required support has been provided, the oversight group may place a CBU or Team into Intensive Support. Intensive Support is a recovery planning and delivering procedure and is a mechanism to direct additional management focus; it should not be used as a punishment. The oversight group will write to the CBU/Team to inform them of the decision and will outline the reasons this action has been taken. The CBU/Team

will be expected to report weekly to the oversight group actions taken to improve performance and the impact this has had. This effort will be supported by appropriate corporate resources. The CBU/Team will remain in Intensive Support until the performance issue has been resolved. Once the oversight group is satisfied that the performance issue has been sufficiently addressed, the oversight group will write to the CBU/Team to inform them of the decision to bring them out of Intensive Support.

The Intensive Support procedure may be deployed in the following circumstances:

- Where there are continued and persistent performance issues within one or more areas.
- Where there is a risk to patient safety, effective delivery of services or any other reasons where it is judged that the level of support is justified by the oversight group.
- Where delivery levels against operational performance targets is inadequate, and where no robust corrective plan has been agreed.
- Failure to operate within the financial parameters outlined or evidence of lack of financial controls.
- Any other circumstances where it is judged that a material risk exists which cannot be resolved via normal line management actions or where less intensive recovery actions have failed.

4. Structure and Governance to ensure delivery

4.1 Accountability, Responsibility and Reporting Structure

Appendix 2 sets out the Trust's Accountability, Responsibility and Information reporting structure. Each meeting will have a Terms of Reference, setting out clear roles and responsibilities, objectives and membership and the devolved responsibilities from Board to Ward.

5. Next Steps

This Performance Assurance Framework will be reviewed in March 2021.

Appendix 1

Our Vision: We will be the change we want to see in the world of health and social care

Our Mission: We will be OUTSTANDING for our patients, our communities and for each other

Our Strategic Objectives - (*What we need to do):*

1. We will… **Always put our patients first** through high quality, safe care and an excellent patient experience

2. We will… **Be the best place to work** with a diverse, engaged workforce that is fit for the future

3. We will… **Work in partnership** to design and provide high quality, financially sustainable services

Our Core Values - (*How we need to do it):*

Working Together: 'We will work together to ensure patients come first and our staff feel valued'

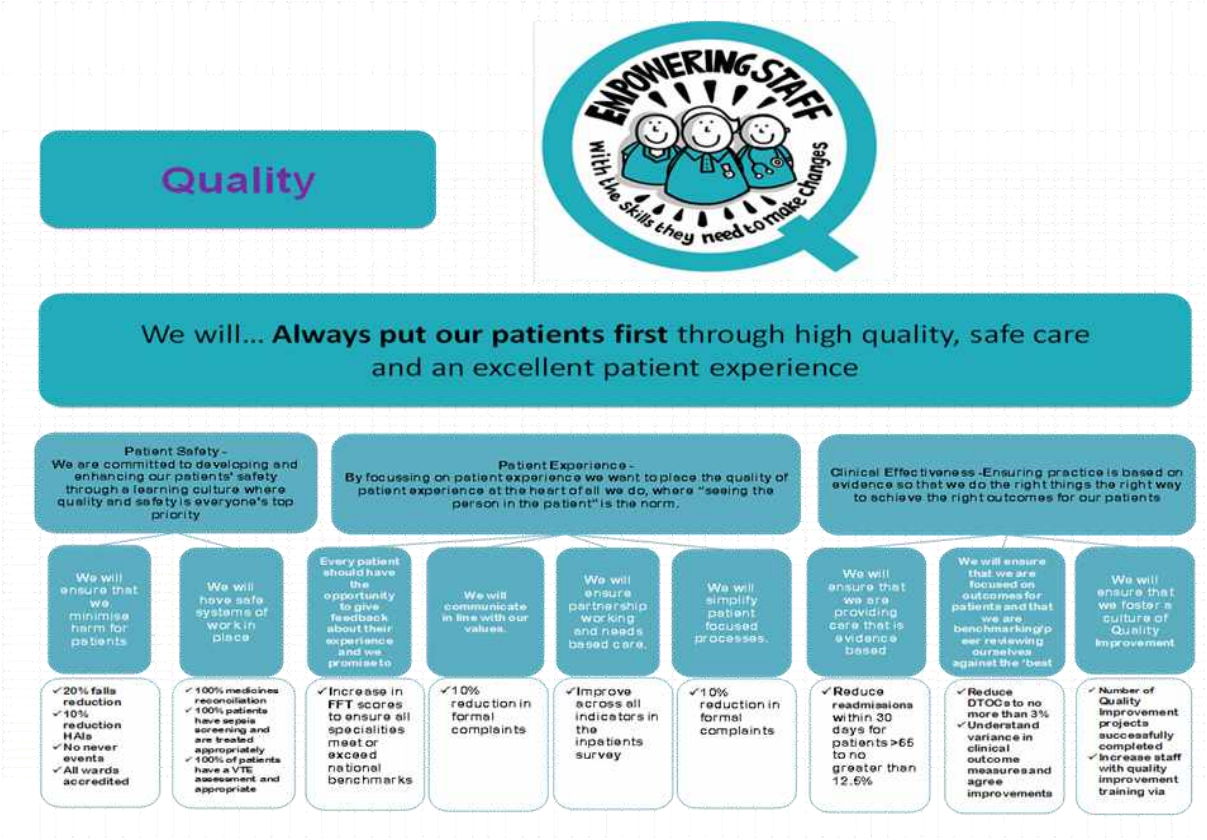
Excellence: 'We will provide excellent care'

Accountable: 'We will take responsibility to do the right thing in the right way at the right time'

Role Models: 'What others observe in us will inspire them to do better'

Embracing Change: 'We are always learning and improving for our patients, the public and eachother'

Our QPS Aims and Objectives:



Sustainability

We will… **Work in partnership** to design and provide high quality, financially sustainable services

Play a central role in our healthcare economies to support integrated place based care.

- Provider of integrated services, intermediate care and care home services.
  - ✓Grow proportion of services delivered in the community.
- Improved pathways for local residents so everyone receives the right support, care and treatment at the right time.
  - ✓Level of acute activity (non-elective admissions) to remain the same or reduce, in environment of growing
- Strong relationships and collaborative working with all partners
  - ✓Success of One Halton, Warrington Together and Cheshire and Mersyside health and care partnership

Work with other acute care providers to ensure that those services which need to be provided in an acute environment are the best they can be and are clinically and financially sustainable.

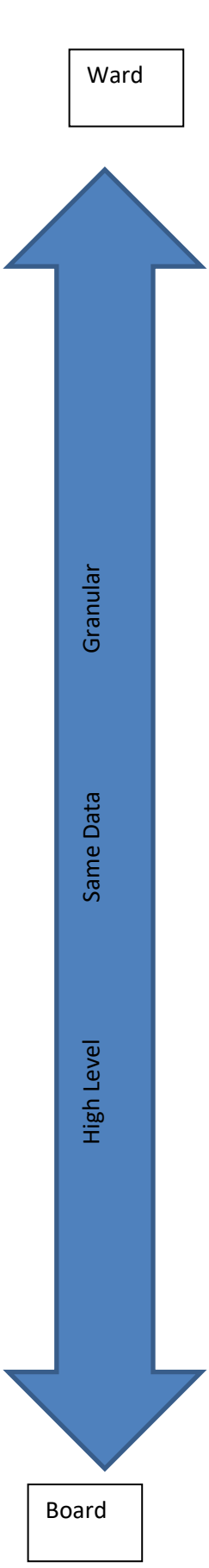
- Ensure services meet the demand of our populations.
  - ✓Repatriate Warrington and Halton activity to priority services.
- Provide services on behalf of others where our services are clinically and financially superior.
  - ✓Number of services which we deliver on behalf of partners
- Disinvest in or transform services which are not financially sustainable and do not currently provide high quality
  - ✓Retain and where appropriate, grow priority services.
- Share best practice and collaborate to ensure best outcomes for our populations.
  - ✓Understand unwarranted variation in clinical outcome measures across all specialities, measure and agree improveme
- Maintain and then improve financial position.
  - ✓Improve profitability of services.
  - ✓Maintain and then improve system financial position

Provide our services in an estate that is fit for purpose, supported by technology, and aligned to the needs of our developing populations.

- New hospital and wellbeing campus in Halton.
  - ✓Secure funding.
  - ✓Delivery of milestones on trajectory, including Strategic Outline Case.
  - ✓Updated
- New hospital in Warrington.
  - ✓Secure funding.
  - ✓Delivery of milestones on trajectory, including Strategic Outline Case.
  - ✓Identify site
- Recognised digital exemplar.
  - ✓Delivery of milestones in IM&T strategy on trajectory.

Please note: The priorities above will be reviewed and updated during 2020/21, once these are available, the PAF appendices will be updated accordingly.

Appendix 2 - Trust Accountability, Responsibility and Information Reporting Structure – Ward to Board



CBU/Ward/Departmental Meetings

- CBUs/Wards/department leaders
- Review performance at granular level weekly and take corrective action as appropriate
- CBU Managers report up to KPI

KPI Sub-Committee

- Full review of performance at CBU level specific
- Identify any risk/issues and agreement of remedial action plans
- Preparation for bi-annual OPS review
- Monitoring of remedial actions arising from QPS

CBU Partnership Forum & Executive Committee

- Executive Committee holds CBUs to account
- Performance reports at CBU Level
- CBUs attend bi-annually on a rotational basis

Board Committees

- Executive Director/Senior Leaders attend meetings
- Board Committees review their performance reports/dashboards
- Deep dives requested by Committee where concerns about performance
- Committees assure Board through key issues reports and escalates any issues to Trust Board

Trust Board

- Integrated Performance Report presented by Executive Directors
- Receiving concerns raised by Committee Chairs
- Board request additional actions and assurance where necessary
- Bi-Monthly meeting

Appendix B – IPR Indicators 2019/20

	2019/20 KPIs	Target/Threshold/Tolerance
	Quality Improvement	
1.	Incidents	Never Events – Zero Tolerance, No Incidents opened over 40 days
2.	CAS Alerts	All actions to be completed within timescales
3.	Duty of Candour	100%
4.	Adult Safety Thermometer	95%
5.	Children's Safety Thermometer	85%
6.	Maternity Safety Thermometer	74%
7.	Health Care Acquired Infections – MRSA	Zero Tolerance
8.	Health Care Acquired Infections – CDIFF	Trajectory
9.	Health Care Acquired Infections – Gram Negative Blood Infections	Trajectory
10.	VTE Assessment	95%
11.	Total Fall & Harm Levels	20% reduction for 2018/19 using 2017/18 as a baseline
12.	Pressure Ulcers	Trajectory
13.	Medication Safety	Reconciliation within 24 hours
14.	Staffing Average Fill Rates	90%
15.	Care Hours Per Patient Day	N/A
16.	Mortality Ratio - HSMR	Within expected range.
17.	Mortality Ratio - SHMI	Within expected range.
18.	NICE Compliance	90%
19.	Complaints: • Received • Dissatisfied • Total cases open • Total cases over 6 months old	Improvement Trajectory
20.	Friends & Family Test – Inpatients	95%
21.	Friends & Family Test – A&E	87%
22.	Mixed Sex Accommodation	Zero Tolerance
23.	Continuity of Carer	30%
24.	CQC Insight Composite Score	1.5

	Access & Performance	
25.	Diagnostic Waiting Times 6 Weeks	99%
26.	RTT Open Pathways	92%
27.	RTT Number of Patients Waiting 52 Weeks +	Zero Tolerance
28.	A&E Waiting Times – National Target	95%
29.	A&E Waiting Times – STP Trajectory	Improvement Trajectory
30.	A&E Waiting Times – Over 12 Hours	Zero Tolerance
31.	Cancer 14 Days	Temporarily removed due to 28 day faster cancer diagnostic standard.
32.	Breast Symptoms 14 Days	
33.	Cancer 31 Days First Treatment	96%
34.	Cancer 31 Days Subsequent Surgery	94%
35.	Cancer 31 Days Subsequent Drug	98%
36.	Cancer 62 Days Urgent	85%
37.	Cancer 62 Days Screening	90%
38.	Ambulance Handovers 30 – 60 Minutes	Zero Tolerance
39.	Ambulance Handovers – 60 Minutes or more	Zero Tolerance
40.	Discharge Summaries - % sent within 24 Hours	95%
41.	Discharge Summaries not sent within 7 Days	5% Tolerance
42.	Cancelled Operations on the Day for Non-Clinical Reasons	2% Tolerance
43.	Cancelled Operations on the Day for Non-Clinical Reasons – not readmitted within 28 days.	Zero Tolerance
44.	Urgent Operations Cancelled for a 2nd Time	Zero Tolerance
45.	Super Stranded Patients	Improvement Trajectory
	Workforce	
46.	Sickness Absence	Below 4.2%
47.	Return to Work	85%
48.	Recruitment	Below 65 days
49.	Vacancy Rates	Below 9%
50.	Retention	86%
51.	Turnover	Below 13%
52.	Bank & Agency Reliance	Below 9%
53.	Agency Shifts Compliant with the Cap	Above 49%
54.	Monthly Pay Spend (Contracted & Non Contracted)	Within budget
55.	Core/Mandatory Training	85%
56.	PDR	85%
	Finance	
57.	Financial Position	On plan and in a surplus position
58.	Cash Balance	On or greater than plan
59.	Capital Programme	Within 90% – 100% of plan
60.	Better Practice Payment Code	95%
61.	Use of Resources Rating	Use or Resources Rating 1 and 2
62.	Agency Spending	Equal to or less than agency ceiling
63.	Cost improvement Programme Performance to Date	On or above plan
64.	Cost Improvement Programme Plans in Progress (In Year)	On or above plan
65.	Cost Improvement Programme Plans in Progress (Recurrent)	On or above plan

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/03/32**	
SUBJECT:	**Audit Committee** **Terms of Reference and 2020-2021 Cycle of Business**	
DATE OF MEETING:	25 March 2020	
AUTHOR(S):	John Culshaw, Trust Secretary	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	√ √ √
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#115 Failure to provide adequate staffing levels in some specialities and wards. #134 (a) Failure to sustain financial viability. #134 (b) Failure to deliver the financial position and a surplus #135 Failure to provide adequate and timely IMT system. #224 Failure to meet the emergency access standard. #125 Failure to maintain an old estate. #701 Failure to provide continuity of services caused by the planned EU Exit. #145 (a) Failure to deliver our strategic vision. #145 (b) Failure to fund two new hospitals. #143 Failure to deliver essential services, caused by Cyber Attack. #414 Failure to implement best practice information governance and information security. #241 Failure to retain medical trainee doctors.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	In accordance with the Foundation Trust's Constitution 'Board of Directors – Standing Orders' Committees of the Board are required to review their Terms of Reference and Cycles of Business on an annual basis. The ToR and CoB has been reviewed and approved by the Audit Committee	
PURPOSE: ***(please select as appropriate)***	Information | Approval X | To note | Decision	
RECOMMENDATION:	The Trust Board is required to ratify the Terms of Reference and 2020-2021 Cycles of Business of the Audit Committee	
PREVIOUSLY CONSIDERED BY:	**Committee**	Audit Committee
	Agenda Ref.	AC/20/02/18
	Date of meeting	20 February 2020
	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

TERMS OF REFERENCE

AUDIT COMMITTEE

1. PURPOSE

The Audit Committee has primary responsibility for monitoring and reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

The Audit Committee shall provide the Board of Directors with a means of independent and objective review of assurance processes and risk management across the whole of the Trust's activities (clinical and non-clinical), both generally and in support of the Annual Governance Statement. In addition the Audit Committee shall:

- provide assurance of independence for external and internal audit;
- ensure that appropriate standards are set and compliance with them monitored in all areas that fall within the remit of the Audit Committee ; and
- monitor compliance with corporate governance requirements (e.g. compliance with the terms of the Licence; Constitution; codes of conduct; standing financial instructions; maintenance of registers of interest).

2. AUTHORITY

The Audit Committee is constituted as a standing committee of the Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings. The Audit Committee shall not have any executive powers in addition to those delegated in these terms of reference.

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any member of staff, and all members of staff are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice on any matter within its Terms of Reference to the total of £10,000 per annum, and to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

3. REPORTING

The Committee shall report to the Board of Directors and Council of Governors annually on how it discharges its responsibilities; specifically on its work in support of the annual governance statement, commenting on:

- The fitness for purpose of the assurance framework
- The completeness and 'embeddedness' of risk management in the organisation
- The integration of governance arrangements
- The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements
- The robustness of the processes behind the quality account

This annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

The Chair of the Audit Committee shall draw to the attention of the Board any issues that require disclosure or require executive action via a Key Issues Report.

4. DUTIES & RESPONSIBILITIES

The Committee's responsibilities fall broadly into the following areas:

Integrated Governance, Risk Management and Internal Control

The Audit Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the governance statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances, prior to submission to the governing body.
- The underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications.
- The policies and procedures for all work related to counter fraud and security as required by NHS Counter Fraud Authority

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key committees (for example, the Quality Assurance Committee) so that it understands processes and linkages. However, these other committees must not usurp the Audit Committee's role.

Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets the *Public Sector Internal Audit Standards, 2017* and provides appropriate independent assurance to the Committee, Accountable (or Accounting) Officer and governing body. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved
- Liaising with the Quality Assurance Committee Chair and the Chair of the Trust's Operational Board to plan and approve the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation, including areas identified in the assurance framework

- Considering the major findings of internal audit work (and management's response), and ensuring coordination between the internal and external auditors to optimise the use of audit resources
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- Monitoring the effectiveness of internal audit and carrying out an annual review.

External Audit
The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the governing body when appropriate)
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee
- Reviewing all external audit reports, including the report to those charged with governance (before its submission to the governing body) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
- Ensuring that there is in place a clear policy for the engagement of external auditors to supply non audit services.

Counter Fraud
The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Counter Fraud standards and shall review the outcomes of work in these areas.

Management
The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
The Committee may also request specific reports from individual functions within the organisation after taking briefings from Quality Assurance Chair or the Chair of the Trust's Operational Board.

The Committee will also periodically review the Trust's Standing Orders, Standing Financial Instructions, Scheme of Delegation and Standards of Business Conduct (Managing Conflicts of Interest) and examine the circumstances of any significant departure from the requirements of any of the foregoing, and whether those departures relate to a failing, an overruling or a suspension

Financial Reporting
The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

The Committee should ensure that the systems for financial reporting to the governing body, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

The Committee shall review the annual report and financial statements before submission to the governing body, focusing particularly on:

- The wording in the annual governance statement and other disclosures relevant to the terms of reference to the Committee
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted mis-statements in the financial statements
- Significant adjustments resulting from the audit
- Letters of representation
- Explanations for significant variances.

Raising Concerns (Whistleblowing)

The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

Periodically review the Whistleblowing register and the Freedom to Speak Up register.

Other

Review performance indicators relevant to the remit of the Audit committee.

Examine any other matter referred to the Audit committee by the Board of Directors, the Chair of the Quality Assurance Committee or the Chair of the Trust Operations Board and initiate investigation as agreed with the members of the Audit Committee.
Develop and use an effective assurance framework to guide the audit committee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from directors and managers and other investigatory outcomes so as to fulfil its functions in connection with these terms of reference.

Review the work of the CQC 'Moving to Outstanding' Committee in connection with the Audit Committee's assurance function.

Consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health [and social care] sector and professional bodies with responsibilities that relate to staff performance and functions.

5. MEMBERSHIP

The Committee shall be composed of all (5) the Trust's independent non-executive directors, at least one of whom should have recent and relevant financial experience (Monitor Code C.3.1), as follows:

- at least one member of the Trust's Quality Assurance Committee will be a member of the Trust's Audit Committee

- the Chair of the Trust shall not be a member

The Board will appoint one of the Non-Executive Director members of the Committee to be Chair of the Committee. Should the Chair be absent from the meeting the committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. Should the need arise, the Committee may approve a matter in writing by receiving written approval from all the members of the Committee, such written approval may be by email from the members Trust email account.

The Trust Chair may be invited to attend meetings of the Audit committee if required

The Lead Governor (or nominated deputy) may be invited to attend meetings of the Audit committee where items of specific interest or concern raised by Governors are being addressed.

6. ATTENDANCE

Only members of the Audit Committee have the right to attend meetings, but the following individuals shall normally be in attendance:

- Director of Finance & Commercial Development
- Deputy Director of Governance
- Representative(s) of the external audit service provider
- Representative(s) of internal audit service provider
- Representative(s) of counter fraud service provider
- Trust Secretary
- Secretary to the Board
- Governor Observer

The Chief Executive may also be invited to attend and should in any case, attend at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

The Audit Committee may require individual Trust Directors to attend in respect of specific agenda items and, in addition, will normally extend an open invitation to all Trust Directors to attend all meetings.

7. QUORUM

The quorum necessary for the transaction of business shall be two members.

8. FREQUENCY OF MEETINGS

Meetings shall be held at least five times per year with additional meetings where necessary.

The internal auditor and external auditor shall be afforded the opportunity at least once per year to meet with the Audit Committee without Executive Directors present.

9. ADMINISTRATIVE ARRANGEMENTS

Unless prior agreement is reach with the Chair of the Committee, Agenda and Papers will be sent out 5 working days before the date of the meeting. No papers will be tabled at the meeting without prior approval of the Chair. The Committee will be supported by the Secretary to the Trust Board and the Trust Secretary.

10. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements and report on this to the Trust Board.

These terms of reference will be reviewed every two years by the Council of Governors and the Trust Board.

DATE: 20.02.2020
Approved: 20.02.2020
REVIEW DATE: 2 years from Approval date

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NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

TERMS OF REFERENCE REVISION TRACKER

Name of Committee	Audit Committee
Version	V4
Implementation Date	Immediate
Review Date	February 2022
Approved By	Audit Committee – 20 February 2020

REVISION			
Date	**Section**	**Reason for change**	**Approved by**
16.1.2017	10	- Review date amended from at least annually to every 2 years - Committee to be supported by the Secretary to the Trust Board.	Audit Committee 16.01.2017
22.2.2018	4	- Change Quality Committee to Quality Assurance Committee - Internal Audit to include liaison with the Trust's Q&A and TOB committees - Audit Committee to review SORD, SFIs, Standards of Business Conduct (MCoI) arrangements - Review Freedom to Speak Up Register - Review performance indicators relevant to remit of AC - Commission any investigations or 'deep dives' or request any other committee to do so	Audit Committee 22.02.2018
	5	- Develop and use an effective assurance framework to guide the audit committee's work - Review the work of the Trust Board's other Committees - Consider any external reviews by regulators and/or professional bodies that relate to staff performance and functions.	
	6	Membership - The Trust Chair may be invited to attend meetings of the Audit committee if required - The Lead Governor (or nominated deputy) may be invited to attend meetings of the Audit committee where items of specific interest or concern raised by Governors are being addressed	

	10	Attendance – to include: - Director of Integrated Governance - Head of Corporate Affairs - Secretary to the Board - A minimum of 75% attendance is required by members of the committee Committee will review effectiveness annually and report on this to Trust Board and Council of Governors	
23.3.2018	6	Attendance – amendments: - Remove Director Corporate Affairs and Head of Corporate Affairs. - Add Executive Medical Director, Executive Lead, Corporate Affairs	Audit Committee
20.02.2020	6	Attendance – amendments - Delete Executive Medical Director, Executive Lead, Corporate Affairs - Change title of Head of Corporate Affairs to Trust Secretary - Replace Director of Integrated Governance with Deputy Director Governance - ADD Governor Observer - Amend Text re: Director attendance	Audit Committee 20.02.2020
20.02.2020	9	Administration Arrangements - Change title of Head of Corporate Affairs to Trust Secretary	Audit Committee 20.02.2020

TERMS OF REFERENCE OBSOLETE	
Date	**Reason**
20.02.2020	**V3, replace with V4, approved by Audit Committee 20.02.2020**

AUDIT COMMITTEE – CYCLE OF BUSINESS FEBRUARY 2020-MARCH 2021

	OWNER	FEB 2020	APRIL 2020	MAY 2020	AUG 2020	NOV 2020	FEB 2021
				YEAR END			
OPENING BUSINESS							
• Welcome, apologies, declarations of interest, cycle of business	**CHAIR**	X	X	X	X	X	X
• Review Minutes and Action Log	**CHAIR**	X	X		X	X	X
• Review rolling attendance log	**CHAIR**	X	X		X	X	X
• Approve Chair's key issue report items for escalation (post meeting)	**CHAIR**	X	X		X	X	X
QPS ASSURANCE							
• Update from Chairs of F&S, Q&A (inc Clinical Audit) & CFC	**TA/MB/CR/AW**	X	X		X	X	X
• Changes or Updates to BAF	**Trust Secretary**	X	X		X	X	X
INTERNAL AUDIT							
• Internal Audit Plan & Fees	**MIAA**	X					X
• Progress Report on Internal Audit follow-Up actions	**DoF + Comm Dvpmt**	X	X		X	X	X
• Internal Audit Progress Report on Follow-Up actions	**MIAA**	X	X		X	X	X
• Internal Audit Progress Report	**MIAA**	X	X		X	X	X
• Head of Internal Audit Opinion	**MIAA**		X				
• Internal Audit Charter Annual Report	**MIAA**		X				
• Insight Report	**MIAA**	X	X		X	X	X
EXTERNAL AUDIT							
• External Audit Plan & Fees	**GT**	X					X
• Report and Updates from External Audit	**GT**	X	X		X	X	X
• Annual Audit Letter (AC following year-end Audit Cttee)	**GT**				X		
• Renewal/Refresh of External Audit Contract (at term)	**GT/AMcG/JC**						
COUNTER FRAUD							
• **DRAFT** Annual Counter Fraud Plan	**MIAA**	X					X
• **FINAL** Annual Counter Fraud Plan	**MIAA**		X				
• Counter Fraud Progress Updates	**MIAA**	X	X		X	X	X
• Annual Counter Fraud Annual Report	**MIAA**		X				
FINANCE							
• Review Losses & Special Payments	**DoF + Comm Dvpmt**	X	X		X	X	X
• Review Quotation and Tender Waivers of Standing Financial Instructions	**DoF + Comm Dvpmt**	X	X		X	X	X
• Going Concern Report	**DoF + Comm Dvpmt**		X				
• Progress report on internal audit follow-up actions	**DoF + Comm Dvpmt**	X	X		X	X	X
QPS GOVERNANCE AND COMPLIANCE							
• Annual report and accounts timetable and plans	**DoF + Comm Dvpmt**	X					X
• **Draft** Annual Governance Statement	**Trust Secretary**		X				
• **Draft** Annual Report	**CEO**		X				

		FEB 2020	APRIL 2020	MAY 2020	AUG 2020	NOV 2020	FEB 2021
	OWNER			YEAR END			
• **Draft** unaudited Accounts & Financial Statements	**DoF + Comm Dvpmt**		X				
• Annual Report	**CEO**			X			
• Quality Account	**Dep Dir Governance**			X			
• **Draft** Annual accounts accounting policies	**DoF + Comm Dvpmt**	X					X
• **FINAL** and Audited Accounts & Financial Statements	**DoF + Comm Dvpmt**			X			
• Head of External Audit Opinion Statement	**GT**			X			
• Review other reports and policies as appropriate – eg changes to standing orders – as arise, Freedom to Speak Up	**ALL**	FTSU Policy					FTSU Policy
• Code of Governance Compliance + Compliance with Licence Annual Return – completion of FT4 Declaration, Condition G6 + certification of training of Governors	**Trust Secretary**			X			
• Risk Management Annual Report	**Dep Dir Governance**				X		
• Code of Governance Compliance Declaration – eg changes as required	**Trust Secretary** *(AS RQD)*						
• Review of Trust Registers (eg Conflicts of Interest)	**Trust Secretary**				X		
• Terms of Reference x 2 years (due Feb 2020 + Feb 2022)	**Trust Secretary**	X					
• Cycle of Business	**Trust Secretary**	X					X
• On-Call, Call-Out, Overtime Annual Report	**HRD+OD**				X		
• NW Skills Development Bi-Annual Report	**DoF + Comm Dvpmt**				X	X	
EFFECTIVENESS							
• Committee Chairs Annual Report for Board & Council of Governors	**CHAIR**			X			
• Meeting effectiveness - bi-annual review	**CHAIR**					X (rep Feb)	X
• Meeting effectiveness - annual review	**CHAIR**		X (rep Aug)		X		
DEEP DIVE REVIEWS							
• Commission and receive ANY additional scrutiny projects	**AS RQD Dep Dir Governance**						
CLOSING							
• Private discussions with Internal and External Auditors and Counter-Fraud specialist as required – but at least annually	**CHAIR**	X			X		X
• Any Other Business	**CHAIR**	X	X	X	X	X	X

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/03/33**	
SUBJECT:	**Terms of Reference and Cycle of Business 2020-21**	
DATE OF MEETING:	25 March 2020	
AUTHOR(S):	Michelle Cloney, Director of HR & OD	
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Director of HR & OD	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#115 Failure to provide adequate staffing levels in some specialities and wards. #145 (a) Failure to deliver our strategic vision.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	In order to provide assurance to the Trust Board, all Committees of the Board are required to refresh their Cycle of Business and Terms of Reference (ToR) on an annual basis to assure itself that it will support the discharge of its duties before presenting to the Trust Board for formal ratification. Proposed changes to the Strategic People Committee ToR Cycle of Business include: <u>ToR</u> • Amendments to Section 3, titles • Amendment to Section 3, Removal of reference to Head of Strategic HR Projects • Amendment to Section 8, Quorum, to bring in line with other assurance committees • Amendments to Section 10, Administrative Arrangements, submission timeframes Proposed amendments to the ToR are detailed in the Revision Tracker <u>Cycle of Business</u> • Inclusion of Workforce Key Performance Indicator Recommendations for 2020/21 (annual) • Inclusion of 6 months Committee Effectiveness Survey	
PURPOSE: *(please select as appropriate)*	Information	Approval ✓ / To note / Decision
RECOMMENDATION:	The Strategic People Committee presents the ToR and Cycle of Business for approval.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee
	Agenda Ref.	
	Date of meeting	18 March 2020
	Summary of Outcome	Changes outlined in section above ‘ Executive Summary’. SPC approved for

		onward progression to Trust Board.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Terms of Reference and Cycle of Business 2020-21	AGENDA REF:	BM/20/03/24 c

1. BACKGROUND/CONTEXT

In order to provide assurance to the Trust Board, all Committees of the Board are required to refresh their Cycle of Business and Terms of Reference (ToR) on an annual basis to assure itself that it will support the discharge of its duties before presenting to the Trust Board for formal ratification.

2. KEY ELEMENTS

Proposed changes to the Strategic People Committee ToR Cycle of Business include:

ToR

- Amendments to Section 3, titles
- Amendment to Section 3, Removal of reference to Head of Strategic HR Projects
- Amendment to Section 8, Quorum, to bring in line with other assurance committees
- Amendments to Section 10, Administrative Arrangements, submission timeframes

Proposed amendments to the ToR are detailed in the Revision Tracker

Cycle of Business

- Inclusion of Workforce Key Performance Indicator Recommendations for 2020/21 (annual)
- Inclusion of 6 months Committee Effectiveness Survey

3. ASSURANCE COMMITTEE

Strategic People Committee

4. RECOMMENDATIONS

Trust Board are asked to:
Approve the revised Terms of Reference
Approve the Work Plan for 2020/21

TERMS OF REFERENCE
STRATEGIC PEOPLE COMMITTEE

1. PURPOSE

The Strategic People Committee is accountable to the Trust Board and will maintain a strategic overview of the Trusts human resources and organisational development arrangements with a view to ensuring that these are designed to provide a positive working environment for colleagues, and that the Trust has in place at all levels the right people systems and processes to deliver, from a patient perspective, safe high quality care.

The Strategic People Committee will seek assurance on the:

- Trust's approach, plans and processes for the delivery of the People Strategy,
- Efficient and effective use of resources,
- CQC Well Led Domain specifically on culture, quality improvement and collaborative leadership development:
    - Key Lines of Enquiry (KLOE)1: Leadership, capacity, capability to deliver high quality sustainable care
    - Key Lines of Enquiry (KLOE)3: Culture of high quality sustainable care
    - Key Lines of Enquiry (KLOE)7: Are people who use services, public, staff and external partners engaged and involved to support high quality sustainable services.
    - Key Lines of Enquiry (KLOE)8: Robust systems and processes for learning, continuous improvement and innovation
- Controls and systems in place to support line managers to make effective decisions in the deployment of staff,
- Redesign of the workforce so that it remains fit for the future, and
- Plans to recruit and retain staff at all levels and how this is reducing the reliance on temporary workers, and

The Committee will oversee strategic actions to enable the trust to deliver the WHH Strategy and specifically the People Strategic Objectives. In addition the Committee will provide assurance to Trust Board that the Strategic People Objectives will support our quality outcomes of providing:

- Clinical effectiveness
- A safe organisation
- Excellent patient experience

The Committee will provide assurance to the Trust Board on the management of risks related to our people.

2. FREQUENCY OF MEETINGS

Meetings shall be held bi-monthly.

3. MEMBERSHIP

The following individuals, or their nominated Deputy, shall normally be in attendance at the meetings:

- Non-Executive Director (Chair)
- Non-Executive Director (Deputy Chair)
- Director of HR & OD
- Deputy Director HR & OD
- Chief Operating Officer

Date 18 March 2020 V6 Draft
Approved: SPC 18 March 2020
Review Date: 12 months following approval

- Executive Medical Director
- Chief Nurse
- Director of Strategy
- Director Finance & Commercial Development
- Director of Community Engagement + Fundraising

In attendance for specific agenda items scheduled in SPC annual workplan:

- Head of Education Development & Wellbeing
- Head of Medical Staffing and Education
- Head of HR Business Partners
- Head of Workforce Systems and Intelligence

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. Should the need arise, the Strategic People Committee may approve a matter in writing by receiving written approval from the quorate membership of the Committee, such written approval may be by email from the members Trust email account.

Other Directors including the Chief Executive or staff members may also be invited / expected to attend from time to time for appropriate agenda items; however, there is no requirement to attend the whole meeting.

4. QUORUM

A quorum shall be two (2) members. In the event that two Non-Executive Directors cannot attend a meeting of the Committee, one of the Non Executives Directors not normally members of the Committee may attend in substitution and be counted in the quorum.

5. AUTHORITY

The Strategic People Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Strategic People Committee. The Strategic Committee may also receive a specific request to provide further assurance on a defined area of work from the Audit Committee.

6. REPORTING

Governance

The Strategic People Committee will have the following reporting responsibilities:

A Chairs Key Issues Report will be formally recorded and circulated to the Trust Board of items discussed. The Chair of the Strategic People Committee shall draw to the attention of the Trust Board any issues that require disclosure to it, or require a decision or escalation.

The Strategic People Committee will report to the Trust Board annually on its work and performance in the preceding year.

7. DUTIES & RESPONSIBILITIES

Duties – decision making:

- To provide overview and scrutiny in areas of workforce performance referred to the Strategic People Committee by the Trust Board
- Receive and consider the workforce plans and make recommendations as appropriate to the Trust Board.
- To provide overview and scrutiny to the development of the People Strategy
- To ensure the People Strategy is designed, developed, delivered, managed and monitored appropriately
- To ensure that appropriate clinical advice and involvement in the People Strategy is provided
- To receive, agree and monitor progress on the People Strategy through receipt of exception reports and updates
- To ensure that the Trust attracts and retains our workforce using the principles of Model Employer to become the employer of choice.
- To ratify employment policies and procedures on behalf of the Trust
- To receive the annual National Staff Opinion Survey Results and to provide a set of recommendations for action by the Trust
- To receive, agree and monitor the staff engagement activity in the Trust and employee reward in order to be assured of the effectiveness of these activities on improved morale; increased Staff FFT results and improved patient experience.

Duties – advisory:

- Consider any relevant 'people' risks within the Board Assurance Framework and corporate level risk register as they relate to the remit of the Strategic People Committee, as part of the reporting requirements,
- To ensure that the framework for Education Governance is supporting the management of risks associated with our people and the quality of care provided to our patients.

Duties – monitoring:

- To monitor the Trust's performance against national standards so far as they relate to employment.
- To monitor the effectiveness of the Trust's workforce performance reporting systems ensuring that the Trust Board is assured of continued compliance through its annual reporting, reporting by exception where required.
- To review the performance indicators relevant to the remit of the Strategic People Committee
- To report any areas of significant concern to the Trust Board as appropriate via the Chair Key Issues Report.
- To receive a report on Employee Relations Cases in respect of numbers, workforce demographics, emerging themes, lessons learned and in particular those cases where suspension/exclusion is involved

Duties of members:

Ensuring, through agreed communication strategies, that key decisions and requirements are appropriately disseminated and that appropriate responses are implemented

Sub-Committees (Groups):

- Operational People Committee
- Premium Pay Spend and Review Group

Each Sub-Committee will submit a Chair Key Issues Report detailing any items of escalation or items requiring decision or action rather than minutes.

8. ATTENDANCE

A record of attendance will be kept, attendance of 75% per year is expected. Members unable to attend must send a nominated deputy who is able to make decisions on their behalf.

9. ADMINISTRATIVE ARRANGEMENTS

The Strategic People Committee will be supported by the Secretary to the Trust Board.

- The ToR will be reviewed annually by Trust Board
- A Cycle of Business (workplan) will be established

Papers to this Strategic People Committee must be submitted for inclusion one week in advance of the meeting. Papers will be distributed by 5pm on the Wednesday preceding the Strategic People Committee.

Papers are to be submitted in the following format:

1. Front sheet – with FOI exemptions duly applied if appropriate
2. Sub-Committees – Chairs key issues reports using the prescribed template
3. Members / HR & OD Service leads – reporting via the prescribed template
4. An Action Log will be maintained and distributed between meetings to enable members to respond.
5. Presentations must be sent to the Administrator ahead of the meeting
6. No tabled papers will be accepted unless in an emergency and with permission of the Chair of the Committee.

10. REVIEW / EFFECTIVENESS

The Strategic People Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. These terms of reference will be reviewed every 12 months by the Strategic People Committee.

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	STRATEGIC PEOPLE COMMITTEE
Version:	V6
Implementation Date:	March 2020 TBC
Review Date:	March 2021 TBC
Approved by:	Draft v3 approved by TRUST BOARD (July 2018) Draft v4 – to be presented to September TRUST BOARD Draft v5 - to be presented to May 2019 Trust Board Draft V6 – approved by SPC 18 March 2020 to be presented to Trust Board 25 March 2020
Approval Date:	19 September 2018 – SPC V4 approved 26 September 2018 – Trust Board V5 approved 20 March 2019 – SPC V6 approved 18 March 2020 at SPC

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**
May 2018	Draft TORs v1		Amendments – AW / MC
June 2018	Draft TORs v2		Amendments – AW / MC
July 2018	Draft TORs v3 – to include Appendix A: Governance Flow Chart - for use to proceed to seek approval		Amendments – AW / MC
July 2018	Appendix A – Amendment to Key – Explanation of Sub Committee / Groups to Assurance Committees		Amendments – AW / MC
September 2018	1. **Purpose** – clarification on Well Led KLOEs to be reported to SPC and further confirmation of role of SPC as an assurance committee 2. **Membership** – Written approval by quorate membership rather than full membership 3. **Duties & Responsibilities**		Amendments agreed by members of the Strategic People Committee 19 September 2018 Approved Trust Board (September 2018)

Date 18 March 2020 V6 Draft
Approved: SPC 18 March 2020
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	– Section on Decision Making. Clarity on SPC role to assure actions taken to recruit and retain our workforce Section on Monitoring. Scope of Employee Relations Case Report clarified and to be included in workplan 4. **Subcommittees** – to include Triangulation Group		
20 March 2019	**Section 3 – Membership**	Updated attendee titles	
20 March 2019	**Section 7 – Duties + Responsibilities**	Triangulation Group removed	
18 March 2020	**Section 3 – Membership**	Updated attendee titles	SPC 18 March 2020 Trust Board 25 March 2020
	Section 10 – Administrative Arrangements	Updated submission of papers timeframe	SPC 18 March 2020 Trust Board 25 March 2020
18 March 2020	**Section 3 - Membership**	Removal of reference to Head of HR Strategic Projects	SPC 18 March 2020 Trust Board 25 March 2020
	Section 4 - Quorum	To amend in line with other assurance committees	SPC 18 March 2020 Trust Board 25 March 2020
	Section 8 - Attendance	To insert the term 'nominated' before deputy	SPC 18 March 2020 Trust Board 25 March 2020

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**
	Version 5 replaced with Version 6	

Date 18 March 2020 V6 Draft
Approved: SPC 18 March 2020
Review Date: 12 months following approval

STRATEGIC PEOPLE COMMITTEE Work Plan 2020-2021

OPENING BUSINESS	Lead	18.03.2020	20.05.2020	22.07.2020	23.09.2020	18.11.2020	20.01.21	24.03.21
Apologies for Absence	Chair	√	√	√	√	√	√	√
Declarations of Interest	Chair	√	√	√	√	√	√	√
Minutes of the last meeting	Chair	√	√	√	√	√	√	√
Matters Arising / action log	Chair	√	√	√	√	√	√	√
STANDING ITEMS								
Director of HR & OD report	Director HR & OD	√	√	√	√	√	√	√
BAF & Risk Register – Staff	Trust Secretary/Deputy Director HR & OD	√	√	√	√	√	√	√
WHH People Strategy Report +Strategic Projects (People)	Deputy Director HR & OD	√		√		√		√
CQC – Getting to Good, Moving to Outstanding - Staff	Director HR & OD	√	√	√	√	√	√	√
Policies and Procedures Report (as required)	Deputy Director HR & OD	√	√	√	√	√	√	√
Employee Relations Report	Deputy Director HR & OD	√	√	√	√	√	√	√
National Staff Opinion Survey	Deputy Director HR & OD		√					
Freedom to Speak Up Bi-Annual Report	Chief Nurse	√			√			√
Equality Diversity and Inclusion Strategy Update	Deputy Director HR & OD		√	√		√		
Workforce Key Performance Indicator Recommendations for 2020/21 (annual)	Director HR & OD						√	
VIP + Celebrity Visits Policy Annual Report	Director of Community Engagement & Fundraising	√						√
Engagement and Recognition Annual Report	Director HR & OD	√						√
Trust Board Monthly Staffing Report – Key Issues Report	Chief Nurse	√	√	√	√	√	√	√
Hospital Volunteer Annual Report	Chief Nurse		√					
NATIONAL/STATUTORY REPORTS								
HENW/GMC Annual Reports	Acting Executive Medical Director							
GMC Patient Survey Response Report when required	Acting Executive Medical Director							
HENW Local Education Provider (LEP) Report SAR Report TBC by HENW	Acting Executive Medical Director							
HENW Monitoring Visit (Annual Assessment Visit)	Acting Executive Medical Director		√					
GMC National Trainee Survey	Acting Executive Medical Director				√			
GMC Revalidation Annual Report (Medical Appraisal)/NHSE Statement of Compliance + NHSE Annual Organisation Audit (AOA)	Acting Executive Medical Director					√		
EQUALITY DIVERSITY + INCLUSION – Regulated Reports (as required)								
Equality Duty Assurance Report (EDAR) PSED Standard (sign off)	Deputy Director HR & OD		√					
Workforce Equality Assurance Report (WEAR) PSED Standard (sign off)	Deputy Director HR & OD		√					
Equality Delivery System 2 (EDS2) – within OPC Chairs Log	Deputy Director HR & OD	√						√
Gender Pay Report – – within OPC Chairs Log	Deputy Director HR & OD	√						√
Workforce Race Equality Standard (WRES) in OPC Chairs Log	Deputy Director HR & OD			√				
Workforce Disability Equality Standard (WDES) in OPC Chairs Log	Deputy Director HR & OD				√			
Facilities Time Off Annual Report (for sign off)	Deputy Director HR & OD			√				
Guardian Quarterly Report, Safe Working Hours Jnr Doctors in Training	Acting Medical Director		Q4√		Q1 √	Q2√	Q3√	
GOVERNANCE								
Terms of Reference	Chair /Trust Secretary	√						√
Annual Cycle of Business	Chair/Trust Secretary	√						√
Committee Chairs Annual report to Trust Board	Chair	√						√
Committee Effectiveness – Annual survey	Chair/Trust Secretary		√ report in May	√ results				
Committee Effectiveness Survey – 6 month survey	Chair/ Trust Secretary							√ report May
Sub Committee Minutes/Closing								
Operational People Committee	Director HR & OD	√	√	√	√	√	√	√
Premium Pay Spend + Review Sub Committee	Deputy Director HR & OD	√	√	√	√	√	√	√
Review of meeting	Chair							

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/03/34**	
SUBJECT:	**Trust Board 2020-2021 Cycle of Business**	
DATE OF MEETING:	25 March 2020	
AUTHOR(S):	John Culshaw, Trust Secretary	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	√ √ √
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#115 Failure to provide adequate staffing levels in some specialities and wards. #134 (a) Failure to sustain financial viability. #134 (b) Failure to deliver the financial position and a surplus #135 Failure to provide adequate and timely IMT system. #224 Failure to meet the emergency access standard. #125 Failure to maintain an old estate. #701 Failure to provide continuity of services caused by the planned EU Exit. #145 (a) Failure to deliver our strategic vision. #145 (b) Failure to fund two new hospitals. #143 Failure to deliver essential services, caused by Cyber Attack. #414 Failure to implement best practice information governance and information security. #241 Failure to retain medical trainee doctors.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	In accordance with the Foundation Trust's Constitution 'Board of Directors – Standing Orders' Committees of the Board are required to review their Terms of Reference and Cycles of Business on an annual basis. The Board is asked to review its attached Cycle of Business for 2020-21.	

PURPOSE: *(please select as appropriate)*	Information	Approval X	To note	Decision

RECOMMENDATION:	The Trust Board is required to approve its Cycle of Business for 2020-21.	
PREVIOUSLY CONSIDERED BY:	**Committee**	N/A
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: *(if relevant)*	Choose an item.	

DRAFT PUBLIC TRUST BOARD – CYCLE OF BUSINESS JANUARY 2020-MARCH 2021

		JAN 2020	MARCH 2020	MAY 2020	MAY 2020	JULY 2020	SEPT 2020	NOV 2020	JAN 2021	MARCH 2021
	OWNER			YEAR END						
Engagement story (15 mins)		~~D+DDef~~ ED	~~MSK def~~		TBC	Trello	TBC	TBC	TBC	TBC
OPENING BUSINESS										
Chairman's Opening Remarks, Welcome, Apologies & Declarations	**CHAIR**	X	X	X	X	X	X	X	X	X
Minutes of Previous Meeting & Action Log	**CHAIR**	X	X	X	X	X	X	X	X	X
Chief Executive's Report (incl CQC Steering Group Report)	**CEO**	X	X	X	X	X	X	X	X	X
Chairman's Report (Inc CoG Report)	**CHAIR**	X	X	X	X	X	X	X	X	X
QPS ASSURANCE										
Integrated Performance Dashboard incl Monthly Nurse staffing report	**EXECS**	X	X	X	X	X	X	X	X	X
Spinal Services update	**COO**	X	X		X	X	X	X	X	X
PAF/ Review and refresh of Trust Integrated KPIs (April prior to formal signing in May)	**DOF**		X	X						X
QUALITY										
Annual Complaints Report	**CN**					X				
Learning From Experience Summary Report	**CN**		X Q3		XQ4		XQ1	XQ2		XQ3
Annual Health & Safety Report	**CN**					X				
DIPC Report Annual	**CN**					X				
DIPC Quarterly Report	**CN**		XQ3		XQ4		XQ1	XQ2		XQ3
Safeguarding Annual Report	**CN**					X				
QCQ Action Plan Update	**CN**	X	X		X	X	X	X	X	X
Mortality Review (Learning from Deaths Quarterly Report)	**Acting MD**		XQ3		XQ4		XQ1	XQ2		XQ3
Medicines Management + Controlled Drugs Annual Report	**Acting MD**				X					
Annual SIRO Report	**CIO**				X					
Quality Strategy Update	**CN**				X					
CNST annual submission TBC	**CN**					X				
PEOPLE										
NHS Staff Opinion Survey	**HRD + OD**				X					
Nurse Staffing Bi-Annual report	**CN**		X				X			
GMC Re-validation Annual Report incl Statement of Compliance	**EXEC MD**							X		
Engagement Dashboard Quarterly Report	**DCE+F**	Q3			Q4YREd	Q1		Q2		
Engagement Dashboard Year End Report	**DCE+F**				X					
Patient and Public Participation + Involvement Strategy Year End	**DCE+F**				X					

		JAN 2020	MARCH 2020	MAY 2020	MAY 2020	JULY 2020	SEPT 2020	NOV 2020	JAN 2021	MARCH 2021
	OWNER			YEAR END						
Report										
Patient and Public Participation + Involvement Strategy Review (due 03/2022)	**DCE+F**									
Guardian of Safe Working Quarterly Report	**GUARDIAN**	X Q3			X Q4	X Q1		X Q2	X Q3	
Freedom To Speak Up – Guardian Bi-annual Report (Jane Hurst)	**CN**		X				X			X
Hospital Volunteer Annual Report	**CN**		~~**X def May**~~		X					X
Equality Diversity + WEAR Reports annual publication	**HRD + OD**				X					
Patient Experience Strategy Annual Review	**Chief Nurse**		~~**X def May**~~		X					X
SUSTAINABILITY										
Operational Plan & Budgets Approval	**DOF**		X							X
Annual Capital Programme	**DOF**		X							X
Emergency Preparedness Annual Report	**COO**					X				
¼ ly Progress on Carter Rep Recommendations	**DOF**	XQ3			XQ4	XQ1		XQ2	XQ3	
COMMITTEE ASSURANCE REPORTS										
Audit Committee	**TRUST SEC**		X		X		X	X?		X
Quality Assurance Committee	**CN**	X	X		X	X	X	X	X	X
Finance & Sustainability Committee	**DoF**	X	X		X	X	X	X	X	X
Strategic People Committee	**HRD+OD**	X	X		X	X	X	X	X	X
YEAR END										
Annual Report & Accounts Sign Off (inc Quality Account)	**DOF/CN**			X						
Code of Governance Compliance + Compliance with Licence Annual Return – completion of FT4 Declaration, Condition G6 + certification of training of Governors	**TRUST SEC**			X						
GOVERNANCE										
Strategic Risk & BAF Update	**TRUST SECRETARY**	X	X		X	X	X	X	X	X
Annual Review Scheme of Reservation & Delegation (SORD) & Standing Financial Instructions (SFIs)	**DOF**		X							X
Risk Management Strategy Annual Report	**CN**					X				
Board Annual Cycle of Business	**TRUST SECRETARY**		X							X
Board Sub-Committee ToRs + Cycle of Business Ratification	**CHAIR/ TRUST SEC**	QAC	AC, SPC,		FSC		COG Cycle + ToR July last yr)		QAC	AC, SPC

		JAN 2020	MARCH 2020	MAY 2020	MAY 2020	JULY 2020	SEPT 2020	NOV 2020	JAN 2021	MARCH 2021
	OWNER			YEAR END						
Charities Commission Checklist (annually)	**DCE+F**								X	
WHH Charity Annual Report	**DCE+F**	X							X	
Charitable Funds Committee ToR (18 months due Sept 2021)	**CHAIR/TRUST SEC**									
Charitable Funds Committee Cycle of Business	**CHAIR/TRUST SEC**						X			
Committee Chairs Annual Reports:										
Quality Assurance Committee Annual Report	**CHAIR**					X				
Finance & Sustainability Committee Annual Report	**CHAIR**				X					
Audit Committee Annual Report	**CHAIR**				X					
Strategic People Committee	**CHAIR**		X							X
CLOSING BUSINESS										
Any other business & Date of next meeting	**CHAIR**	X	X		X	X	X	X	X	X

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/03/36**			
SUBJECT:	**Freedom To Speak Up**			
DATE OF MEETING:	25 March 2020			
AUTHOR(S):	Jane Hurst, Deputy DoF + Commercial Development			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***				
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper provides an update to Trust Board on the activity of the Freedom To Speak Up (FTSU) Team.			
PURPOSE: *(please select as appropriate)*	Information	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to note the work of the FTSU Team and the lessons learnt.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.			
	Date of meeting	18 March 2020		
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Freedom to Speak Up	AGENDA REF:	BM/20/03/36

1. BACKGROUND/CONTEXT

This paper provides an update to Trust Board on the activity of the Freedom To Speak Up (FTSU) Team.

2. KEY ELEMENTS

In 2019/20 (1 April 2019 to 31 January 2020) the FTSU team received the following disclosures.

Table 1 Disclosures in 2019/20

Quarter 1	5
Quarter 2	3
Quarter 3	18
January	3
Total	**29**

The cases can be grouped as follows:-

Table 2 Types of disclosures in 2019/20

Behaviour and relationships	16
Patient safety	3
Staffing levels	1
Health and Safety	3
Other	2
Patient Experience	1
Systems and process	1
Staff Safety	1
Estates	1
Total	**29**

The issues have been across different operational areas and all have been managed through discussion or support from HR or senior nursing. All the behaviour issues have been shared with HR for further review and investigation were appropriate. Since December there have been 7 disclosures from 1 CBU, due to the number of cases this has been escalated to the Chief Nurse and the Non-Executive Director responsible for FTSU. There have been several actions following the disclosures including development of an action plan to include temperature check, review of staff survey, exit interviews and staff turnover review. In addition we have confirmed that staffing levels are being checked daily to ensure patient safety, a new Programme Board set up to give leadership and direction and staff listening

sessions started on Monday 3rd February led by Chief Nurse with an option for one to one meetings.

There have been 4 patient safety concerns, one was reviewed and ward manager was made aware of concern of record keeping issue. One has been reviewed by the Deputy Chief Nurse and the third has been checked as part of the previously mentioned action plan.

The estates and communications issues have been passed on to the relevant departments.

National FTSU Quarter 3 data was as follows:-

4,120 cases were raised to Freedom to Speak Up Guardians / ambassadors / champions

- 915 of these cases included an element of patient safety / quality of care
- 1,496 included elements of bullying and harassment
- 147 related to incidents where the person speaking up may have suffered some form of detriment
- 469 anonymous cases were received
- 7 organisations did not receive any cases through their Freedom to Speak Up Guardian
- 212 organisations sent returns (196 NHS Trusts and 16 other organisations)

Appendix 1 shows the national data for quarter 3 by organisation, the Trust had 18 cases in quarter 3 when compared to other small Trusts in the North West this is high with only North West Boroughs Partnership and Southport and Ormskirk Hospitals experiencing higher numbers. In previous quarters the Trust numbers have been lower. Nationally quarter 3 figures were higher than quarter 1 (3173) and quarter 2 (3486).

The increase is expected to be linked to the significant engagement exercise in October, when the FTSU Guardian and Champions visited wards and departments across both sites and had stands over lunchtimes to raise awareness. The exercise also increased the number of champions and increased the accessibility to raise issues.

3. LESSONS LEARNT

Taking part in the national awareness month increased the number of issues raised and the growth in champions has increase the number of ways that staff can contact the team. An increase in cases being raised to champions rather than the guardian has been noted.

The importance of involving our HR team in the FTSU process was highlighted in a particular case where a member of staff who raised an issue was suffering additional distress linked to an outstanding HR investigation. The HR manager was able to link the issues, fast track the case and support the individual.

Where several cases have been raised in one team the process of escalation to Head of service and Executive lead has proven successful. Since the Executive Lead has held listening events and offered one to one meetings there has been no further issues raised via FTSU.

4. RECOMMENDATION

The Trust Board is asked to note the FTSU activity and the lessons learnt.

Region	Organisation Name	Size of organisation	Number of cases brought to FTSUGs / Champions per quarter	Number of cases raised anonymously	Number of cases with an element of patient safety/quality	Number of cases related to behaviours, including bullying/ harassment	Number of cases where people indicate that they are suffering detriment as a result of speaking up
North West	Aintree University Hospital NHS Foundation Trust	Small (up to 5,000 workers)	2	0	1	1	0
North East & Yorkshire	Airedale NHS Foundation Trust	Small (up to 5,000 workers)	12	3	2	7	0
North West	Alder Hey Children's NHS Foundation Trust	Small (up to 5,000 workers)	4	0	0	1	0
South East	Ashford and St. Peter's Hospitals NHS Foundation Trust	Small (up to 5,000 workers)	35	20	3	17	0
South West	Avon and Wiltshire Mental Health Partnership NHS Trust	Small (up to 5,000 workers)	15	1	2	12	
London	Barking, Havering and Redbridge University Hospitals NHS Tru	Medium (between 5,000 and 10,000 workers)	12	4	0	0	0
London	Barnet, Enfield and Haringey Mental Health NHS Trust	Small (up to 5,000 workers)	No data received	No data received	No data received	No data received	No data received
North East & Yorkshire	Barnsley Hospital NHS Foundation Trust	Small (up to 5,000 workers)	7	0	3	3	0
London	Barts Health NHS Trust	Large (more than 10,000 workers)	28	2	1	6	0
East of England	Basildon and Thurrock University Hospitals NHS Foundation T	Medium (between 5,000 and 10,000 workers)	14	3	0	5	0
East of England	Bedford Hospital NHS Trust	Small (up to 5,000 workers)	8	0	4	5	0
South East	Berkshire Healthcare NHS Foundation Trust	Small (up to 5,000 workers)	7	1	2	4	0
Midlands	Birmingham and Solihull Mental Health NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	No data received	No data received	No data received	No data received	No data received
Midlands	Birmingham Community Healthcare NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	20	1	3	10	0
Midlands	Birmingham Women's and Children's NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	36	0	18	13	0
Midlands	Black Country Partnership NHS Foundation Trust	Small (up to 5,000 workers)	19	4	9	6	0
North West	Blackpool Teaching Hospitals NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	69	1	37	28	5
North West	Bolton NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	13	0	1	11	2
North East & Yorkshire	Bradford District Care NHS Foundation Trust	Small (up to 5,000 workers)	7	2	3	2	0
North East & Yorkshire	Bradford Teaching Hospitals NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	17	10	5	5	2
North West	Bridgewater Community Healthcare NHS Foundation Trust	Small (up to 5,000 workers)	1	0	1	0	0
South East	Brighton and Sussex University Hospitals NHS Trust	Medium (between 5,000 and 10,000 workers)	16	0	3	2	0
South East	Buckinghamshire Healthcare NHS Trust	Medium (between 5,000 and 10,000 workers)	42	0	14	14	0
North East & Yorkshire	Calderdale and Huddersfield NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	18	10	6	2	0
East of England	Cambridge University Hospitals NHS Foundation Trust	Large (more than 10,000 workers)	27	12	8	15	0
East of England	Cambridgeshire and Peterborough NHS Foundation Trust	Small (up to 5,000 workers)	26	0	1	9	0
East of England	Cambridgeshire Community Services NHS Trust	Small (up to 5,000 workers)	3	0	0	1	0
London	Camden and Islington NHS Foundation Trust	Small (up to 5,000 workers)	2	1	0	1	0
London	Central London Community Healthcare NHS Trust	Small (up to 5,000 workers)	50	0	16	15	0
London	Chelsea and Westminster Hospital NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	8	1	2	4	0
North West	Cheshire and Wirral Partnership NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	12	2	1	4	0
Midlands	Chesterfield Royal Hospital NHS Foundation Trust	Small (up to 5,000 workers)	32	4	9	15	1
South West	Cornwall Partnership NHS Foundation Trust	Small (up to 5,000 workers)	8	1	0	7	0
North West	Countess of Chester Hospital NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	No data received	No data received	No data received	No data received	No data received
North East & Yorkshire	County Durham and Darlington NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	7	0	3	4	0
Midlands	Coventry and Warwickshire Partnership NHS Trust	Small (up to 5,000 workers)	8	2	5	2	0
London	Croydon Health Services NHS Trust	Small (up to 5,000 workers)	No data received	No data received	No data received	No data received	No data received
North East & Yorkshire	Cumbria, Northumberland, Tyne and Wear NHS Foundation Tru	Medium (between 5,000 and 10,000 workers)	24	0	1	7	0
South East	Dartford and Gravesham NHS Trust	Small (up to 5,000 workers)	33	3	6	1	0
Midlands	Derbyshire Community Health Services NHS Foundation Trust	Small (up to 5,000 workers)	15	2	3	4	1
Midlands	Derbyshire Healthcare NHS Foundation Trust	Small (up to 5,000 workers)	52	5	6	14	1
South West	Devon Partnership NHS Trust	Small (up to 5,000 workers)	39	0	2	21	0
North East & Yorkshire	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation	Medium (between 5,000 and 10,000 workers)	9	1	1	2	1
South West	Dorset County Hospital NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	No data received	No data received	No data received	No data received	No data received
South West	Dorset Healthcare University NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	23	1	6	8	0
Midlands	Dudley and Walsall Mental Health Partnership NHS Trust	Small (up to 5,000 workers)	13	1	0	9	0
East of England	East and North Hertfordshire NHS Trust	Medium (between 5,000 and 10,000 workers)	6	1	0	3	0
North West	East Cheshire NHS Trust	Small (up to 5,000 workers)	12	2	1	3	0
South East	East Kent Hospitals University NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	20	0	7	8	0
North West	East Lancashire Hospitals NHS Trust	Medium (between 5,000 and 10,000 workers)	69	0	16	23	0

Region	Organisation Name	Size of organisation	Number of cases brought to FTSUGs / Champions per quarter	Number of cases raised anonymously	Number of cases with an element of patient safety/quality	Number of cases related to behaviours, including bullying/ harassment	Number of cases where people indicate that they are suffering detriment as a result of speaking up
London	East London NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	No data received	No data received	No data received	No data received	No data received
Midlands	East Midlands Ambulance Service NHS Trust	Small (up to 5,000 workers)	No data received	No data received	No data received	No data received	No data received
East of England	East of England Ambulance Service NHS Trust	Medium (between 5,000 and 10,000 workers)	12	2	3	5	2
East of England	East Suffolk and North Essex NHS Foundation Trust	Large (more than 10,000 workers)	11	0	9	8	4
South East	East Sussex Healthcare NHS Trust	Medium (between 5,000 and 10,000 workers)	46	0	3	8	0
London	Epsom and St Helier University Hospitals NHS Trust	Medium (between 5,000 and 10,000 workers)	84	0	28	22	1
East of England	Essex Partnership University NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	18	12	7	4	0
South East	Frimley Health NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	27	2	6	8	0
North East & Yorkshire	Gateshead Health NHS Foundation Trust	Small (up to 5,000 workers)	5	0	2	3	0
Midlands	George Eliot Hospital NHS Trust	Small (up to 5,000 workers)	9	5	3	4	2
South West	Gloucestershire Health and Care NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	18	0	3	4	2
South West	Gloucestershire Hospitals NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	18	7	2	18	
London	Great Ormond Street Hospital for Children NHS Foundation Tru	Small (up to 5,000 workers)	31	31	4	27	0
South West	Great Western Hospitals NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	10	4	2	5	0
North West	Greater Manchester Mental Health NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	22	0	4	7	1
London	Guy's and St Thomas' NHS Foundation Trust	Large (more than 10,000 workers)	52	5	7	13	0
South East	Hampshire Hospitals NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	17	1	0	5	0
North East & Yorkshire	Harrogate and District NHS Foundation Trust	Small (up to 5,000 workers)	12	0	1	6	1
East of England	Hertfordshire Community NHS Trust	Small (up to 5,000 workers)	8	0	0	1	0
East of England	Hertfordshire Partnership University NHS Foundation Trust	Not Set	14	1	3	6	0
London	Homerton University Hospital NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	3	1		1	1
London	Hounslow and Richmond Community Healthcare NHS Trust	Small (up to 5,000 workers)	4	0	0	2	0
North East & Yorkshire	Hull University Teaching Hospitals NHS Trust	Medium (between 5,000 and 10,000 workers)	7	0	2	3	0
North East & Yorkshire	Humber NHS Foundation Trust	Small (up to 5,000 workers)	19	3	3	4	0
London	Imperial College Healthcare NHS Trust	Large (more than 10,000 workers)	No data received	No data received	No data received	No data received	No data received
South East	Isle of Wight NHS Trust	Small (up to 5,000 workers)	62	0	1	39	0
East of England	James Paget University Hospitals NHS Foundation Trust	Small (up to 5,000 workers)	2	0	1	2	0
South East	Kent and Medway NHS and Social Care Partnership Trust	Small (up to 5,000 workers)	No data received	No data received	No data received	No data received	No data received
South East	Kent Community Health NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	4	1	2	0	2
Midlands	Kettering General Hospital NHS Foundation Trust	Small (up to 5,000 workers)	19	7	6	4	0
London	King's College Hospital NHS Foundation Trust	Large (more than 10,000 workers)	28	0	3	8	0
London	Kingston Hospital NHS Foundation Trust	Small (up to 5,000 workers)	6	2	0	4	0
North West	Lancashire and South Cumbria NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	14	12	0	3	0
North West	Lancashire Teaching Hospitals NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	29	2	11	8	0
North East & Yorkshire	Leeds and York Partnership NHS Foundation Trust	Small (up to 5,000 workers)	7	0	2	1	0
North East & Yorkshire	Leeds Community Healthcare NHS Trust	Small (up to 5,000 workers)	34	0	4	0	0
North East & Yorkshire	Leeds Teaching Hospitals NHS Trust	Large (more than 10,000 workers)	21	0	8	5	1
Midlands	Leicestershire Partnership NHS Trust	Medium (between 5,000 and 10,000 workers)	32	2	13	6	0
London	Lewisham and Greenwich NHS Trust	Medium (between 5,000 and 10,000 workers)	19	4	11	9	4
Midlands	Lincolnshire Community Health Services NHS Trust	Small (up to 5,000 workers)	9	2	2	7	0
Midlands	Lincolnshire Partnership NHS Foundation Trust	Small (up to 5,000 workers)	13	1	5	6	0
North West	Liverpool Heart and Chest Hospital NHS Foundation Trust	Small (up to 5,000 workers)	5	0	0	0	0
North West	Liverpool Women's NHS Foundation Trust	Small (up to 5,000 workers)	8	0	2	1	0
London	London Ambulance Service NHS Trust	Small (up to 5,000 workers)	71	0	5	21	9
London	London North West Healthcare NHS Trust	Medium (between 5,000 and 10,000 workers)	11	0	6	4	0
East of England	Luton and Dunstable University Hospital NHS Foundation Trus	Medium (between 5,000 and 10,000 workers)	4	0	3	0	0
South East	Maidstone and Tunbridge Wells NHS Trust	Medium (between 5,000 and 10,000 workers)	No data received	No data received	No data received	No data received	No data received
North West	Manchester University NHS Foundation Trust	Small (up to 5,000 workers)	13	0	4	8	6
South East	Medway NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	17	8	11	8	0
North West	Mersey Care NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	43	43	8	10	24

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North West	Mid Cheshire Hospitals NHS Foundation Trust	Small (up to 5,000 workers)	7	5	5	0	0
East of England	Mid Essex Hospital Services NHS Trust	Small (up to 5,000 workers)	11	3	0	5	0
North East & Yorkshire	Mid Yorkshire Hospitals NHS Trust	Medium (between 5,000 and 10,000 workers)	52	0	26	27	5
Midlands	Midlands Partnership Foundation Trust	Medium (between 5,000 and 10,000 workers)	6	0	2	6	0
East of England	Milton Keynes University Hospital NHS Foundation Trust	Small (up to 5,000 workers)	0				
London	Moorfields Eye Hospital NHS Foundation Trust	Small (up to 5,000 workers)	14	0	5	7	0
East of England	Norfolk and Norwich University Hospitals NHS Foundation Tru	Medium (between 5,000 and 10,000 workers)	52	1	10	11	0
East of England	Norfolk and Suffolk NHS Foundation Trust	Small (up to 5,000 workers)	41	0	3	4	2
East of England	Norfolk Community Health and Care NHS Trust	Small (up to 5,000 workers)	19	0	12	0	0
South West	North Bristol NHS Trust	Medium (between 5,000 and 10,000 workers)	12	6	2	11	0
North East & Yorkshire	North Cumbria Integrated Care NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	40	1	13	27	1
North East & Yorkshire	North East Ambulance Service NHS Foundation Trust	Small (up to 5,000 workers)	No data received	No data received	No data received	No data received	No data received
London	North East London NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	41	3	7	15	11
London	North Middlesex University Hospital NHS Trust	Small (up to 5,000 workers)	23	0	12	11	0
Midlands	North Staffordshire Combined Healthcare NHS Trust	Small (up to 5,000 workers)	8	0	8	0	0
North East & Yorkshire	North Tees and Hartlepool NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	4	0	0	4	0
North West	North West Ambulance Service NHS Trust	Medium (between 5,000 and 10,000 workers)	60	0	9	13	0
East of England	North West Anglia NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	No data received	No data received	No data received	No data received	No data received
North West	North West Boroughs Healthcare NHS Foundation Trust	Small (up to 5,000 workers)	35	1	4	8	0
Midlands	Northampton General Hospital NHS Trust	Medium (between 5,000 and 10,000 workers)	26	2	9	19	0
Midlands	Northamptonshire Healthcare NHS Foundation Trust	Small (up to 5,000 workers)	26	1	4	2	0
South West	Northern Devon Healthcare NHS Trust	Small (up to 5,000 workers)	No data received	No data received	No data received	No data received	No data received
North East & Yorkshire	Northern Lincolnshire and Goole NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	14	0	3	3	0
North East & Yorkshire	Northumbria Healthcare NHS Foundation Trust	Large (more than 10,000 workers)	40	0	14	10	9
Midlands	Nottingham University Hospitals NHS Trust	Large (more than 10,000 workers)	No data received	No data received	No data received	No data received	No data received
Midlands	Nottinghamshire Healthcare NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	34	0	4	16	2
South East	Oxford Health NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	14	0	1	13	0
South East	Oxford University Hospitals NHS Foundation Trust	Large (more than 10,000 workers)	30	3	9	10	1
London	Oxleas NHS Foundation Trust	Small (up to 5,000 workers)	No data received	No data received	No data received	No data received	No data received
North West	Pennine Acute Hospitals NHS Trust	Medium (between 5,000 and 10,000 workers)	19	8	7	5	1
North West	Pennine Care NHS Foundation Trust	Small (up to 5,000 workers)	5	1	3	1	0
South West	Poole Hospital NHS Foundation Trust	Small (up to 5,000 workers)	26	2	3	12	0
South East	Portsmouth Hospitals NHS Trust	Medium (between 5,000 and 10,000 workers)	20	2	1	5	0
South East	Queen Victoria Hospital NHS Foundation Trust	Small (up to 5,000 workers)	2	0	0	2	0
Midlands	Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foun	Small (up to 5,000 workers)	4	4	1	6	0
North East & Yorkshire	Rotherham Doncaster and South Humber NHS Foundation Tru	Small (up to 5,000 workers)	24	0	11	11	0
South East	Royal Berkshire NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	17	1	3	7	0
London	Royal Brompton and Harefield NHS Foundation Trust	Small (up to 5,000 workers)	No data received	No data received	No data received	No data received	No data received
South West	Royal Cornwall Hospitals NHS Trust	Medium (between 5,000 and 10,000 workers)	26	1	11	4	1
South West	Royal Devon and Exeter NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	10	0	0	10	0
London	Royal Free London NHS Foundation Trust	Large (more than 10,000 workers)	23	15	4	13	0
North West	Royal Liverpool and Broadgreen University Hospitals NHS Trus	Medium (between 5,000 and 10,000 workers)	8	0	0	6	0
London	Royal National Orthopaedic Hospital NHS Trust	Small (up to 5,000 workers)	8	0	1	7	0
East of England	Royal Papworth Hospital NHS Foundation Trust	Small (up to 5,000 workers)	18	0	3	8	4
South East	Royal Surrey County Hospital NHS Foundation Trust	Small (up to 5,000 workers)	39	0	15	14	0
South West	Royal United Hospitals Bath NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	68	0	1	12	0
North West	Salford Royal NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	12	1	5	4	1
South West	Salisbury NHS Foundation Trust	Small (up to 5,000 workers)	18	1	4	15	4
Midlands	Sandwell and West Birmingham Hospitals NHS Trust	Medium (between 5,000 and 10,000 workers)	8	8	3	4	2
North East & Yorkshire	Sheffield Children's NHS Foundation Trust	Small (up to 5,000 workers)	12	1	6	0	0

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North East & Yorkshire	Sheffield Health and Social Care NHS Foundation Trust	Small (up to 5,000 workers)	28	3	5	2	0
North East & Yorkshire	Sheffield Teaching Hospitals NHS Foundation Trust	Large (more than 10,000 workers)	9	0	2	5	0
Midlands	Sherwood Forest Hospitals NHS Foundation Trust	Small (up to 5,000 workers)	No data received	No data received	No data received	No data received	No data received
Midlands	Shrewsbury and Telford Hospital NHS Trust	Medium (between 5,000 and 10,000 workers)	57	3	15	6	0
Midlands	Shropshire Community Health NHS Trust	Small (up to 5,000 workers)	1	0	1	0	0
South East	Solent NHS Trust	Small (up to 5,000 workers)	12	4	0	7	0
South West	Somerset Partnership NHS Foundation Trust	Small (up to 5,000 workers)	8	0	1	7	0
South East	South Central Ambulance Service NHS Foundation Trust	Small (up to 5,000 workers)	21	0	2	7	0
South East	South East Coast Ambulance Service NHS Foundation Trust	Small (up to 5,000 workers)	19	2	1	10	0
London	South London and Maudsley NHS Foundation Trust	Small (up to 5,000 workers)	17	3	7	9	1
North East & Yorkshire	South Tees Hospitals NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	6	1	3	5	0
North East & Yorkshire	South Tyneside and Sunderland NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	7	1	0	1	0
Midlands	South Warwickshire NHS Foundation Trust	Small (up to 5,000 workers)	14	1	4	2	0
London	South West London and St George's Mental Health NHS Trust	Small (up to 5,000 workers)	27	1	0	7	0
North East & Yorkshire	South West Yorkshire Partnership NHS Foundation Trust	Small (up to 5,000 workers)	13	0	4	9	0
South West	South Western Ambulance Service NHS Foundation Trust	Small (up to 5,000 workers)	23	0	2	4	0
East of England	Southend University Hospital NHS Foundation Trust	Small (up to 5,000 workers)	34	0	0	5	0
South East	Southern Health NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	152	2	32	29	0
North West	Southport and Ormskirk Hospital NHS Trust	Small (up to 5,000 workers)	25	0	8	10	0
London	St George's University Hospitals NHS Foundation Trust	Large (more than 10,000 workers)	15	1	2	9	1
North West	St Helens and Knowsley Teaching Hospitals NHS Trust	Medium (between 5,000 and 10,000 workers)	6	3	2	3	1
North West	Stockport NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	8	0	2	7	1
South East	Surrey and Borders Partnership NHS Foundation Trust	Small (up to 5,000 workers)	17	0	15	4	1
South East	Surrey and Sussex Healthcare NHS Trust	Small (up to 5,000 workers)	22	0	10	16	0
South East	Sussex Community NHS Foundation Trust	Small (up to 5,000 workers)	44	0	4	12	0
South East	Sussex Partnership NHS Foundation Trust	Small (up to 5,000 workers)	12	0	8	6	1
North West	Tameside and Glossop Integrated Care NHS Foundation Trust	Small (up to 5,000 workers)	12	0	3	6	0
South West	Taunton and Somerset NHS Foundation Trust	Small (up to 5,000 workers)	15	0	4	8	1
London	Tavistock and Portman NHS Foundation Trust	Small (up to 5,000 workers)	7	0	3	5	0
North East & Yorkshire	Tees, Esk and Wear Valleys NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	27	18	5	20	0
North West	The Christie NHS Foundation Trust	Small (up to 5,000 workers)	15	0	0	8	0
North West	The Clatterbridge Cancer Centre NHS Foundation Trust	Small (up to 5,000 workers)	7	2	0	4	0
Midlands	The Dudley Group NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	25	1	3	5	0
London	The Hillingdon Hospitals NHS Foundation Trust	Small (up to 5,000 workers)	12	0	6	8	0
North East & Yorkshire	The Newcastle upon Tyne Hospitals NHS Foundation Trust	Large (more than 10,000 workers)	14	4	4	5	0
East of England	The Princess Alexandra Hospital NHS Trust	Small (up to 5,000 workers)	19	0	1	18	0
East of England	The Queen Elizabeth Hospital King's Lynn NHS Foundation Tru	Small (up to 5,000 workers)	5	1	1	1	0
North East & Yorkshire	The Rotherham NHS Foundation Trust	Small (up to 5,000 workers)	No data received	No data received	No data received	No data received	No data received
South West	The Royal Bournemouth and Christchurch Hospitals NHS Four	Small (up to 5,000 workers)	14	0	1	6	0
London	The Royal Marsden NHS Foundation Trust	Small (up to 5,000 workers)	16	6	0	10	0
Midlands	The Royal Orthopaedic Hospital NHS Foundation Trust	Small (up to 5,000 workers)	22	0	8	3	0
Midlands	The Royal Wolverhampton NHS Trust	Medium (between 5,000 and 10,000 workers)	22	2	3	17	8
North West	The Walton Centre NHS Foundation Trust	Small (up to 5,000 workers)	4	0	0	1	0
South West	Torbay and South Devon NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	15	0	2	7	0
Midlands	United Lincolnshire Hospitals NHS Trust	Medium (between 5,000 and 10,000 workers)	15	0	3	5	1
London	University College London Hospitals NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	28	0	3	1	0
South East	University Hospital Southampton NHS Foundation Trust	Large (more than 10,000 workers)	No data received	No data received	No data received	No data received	No data received
Midlands	University Hospitals Birmingham NHS Foundation Trust	Large (more than 10,000 workers)	14	0	5	12	3
South West	University Hospitals Bristol NHS Foundation Trust	Large (more than 10,000 workers)	19	0	2	4	0
Midlands	University Hospitals Coventry and Warwickshire NHS Trust	Large (more than 10,000 workers)	No data received	No data received	No data received	No data received	No data received

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Midlands	University Hospitals of Derby & Burton NHS Foundation Trust	Large (more than 10,000 workers)	61	17	16	19	3
Midlands	University Hospitals of Leicester NHS Trust	Large (more than 10,000 workers)	No data received	No data received	No data received	No data received	No data received
North West	University Hospitals of Morecambe Bay NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	38	9	11	8	3
Midlands	University Hospitals of North Midlands NHS Trust	Large (more than 10,000 workers)	30	1	8	20	0
South West	University Hospitals Plymouth NHS Trust	Medium (between 5,000 and 10,000 workers)	No data received	No data received	No data received	No data received	No data received
Midlands	Walsall Healthcare NHS Trust	Small (up to 5,000 workers)	18	5	12	2	1
North West	Warrington and Halton Hospitals NHS Foundation Trust	Small (up to 5,000 workers)	18	11	1	10	0
East of England	West Hertfordshire Hospitals NHS Trust	Small (up to 5,000 workers)	17	7	2	3	0
London	West London Mental Health NHS Trust	Small (up to 5,000 workers)	No data received	No data received	No data received	No data received	No data received
London	West London NHS Trust	Small (up to 5,000 workers)	No data received	No data received	No data received	No data received	No data received
Midlands	West Midlands Ambulance Service NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	1	1	0	1	0
East of England	West Suffolk NHS Foundation Trust	Small (up to 5,000 workers)	No data received	No data received	No data received	No data received	No data received
South East	Western Sussex Hospitals NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	10	10	0	2	0
South West	Weston Area Health NHS Trust	Small (up to 5,000 workers)	No data received	No data received	No data received	No data received	No data received
London	Whittington Health NHS Trust	Small (up to 5,000 workers)	28	2	2	19	0
North West	Wirral Community NHS Foundation Trust	Small (up to 5,000 workers)	15	4	2	3	0
North West	Wirral University Teaching Hospital NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	36	0	6	18	4
Midlands	Worcestershire Acute Hospitals NHS Trust	Medium (between 5,000 and 10,000 workers)	No data received	No data received	No data received	No data received	No data received
Midlands	Worcestershire Health and Care NHS Trust	Small (up to 5,000 workers)	7	5	0	4	0
North West	Wrightington, Wigan and Leigh NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	No data received	No data received	No data received	No data received	No data received
Midlands	Wye Valley NHS Trust	Small (up to 5,000 workers)	18		3	9	
South West	Yeovil District Hospital NHS Foundation Trust	Small (up to 5,000 workers)	2	0	1	1	0
North East & Yorkshire	York Teaching Hospital NHS Foundation Trust	Medium (between 5,000 and 10,000 workers)	No data received	No data received	No data received	No data received	No data received
North East & Yorkshire	Yorkshire Ambulance Service NHS Trust	Medium (between 5,000 and 10,000 workers)	25	0	2	3	0

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/03/37**	
SUBJECT:	Learning From Deaths - Q3 2019-20	
DATE OF MEETING:	25th March 2020	
AUTHOR(S):	Phill Cantrell, Lead Clinician Mortality / Hayley McCaffrey, Head of Clinical Effectiveness & Quality	
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Acting Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	. #145 (a) Failure to deliver our strategic vision.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides an overview of the Trust mortality data, including; • Total number of deaths of patients. • Number of reviews of deaths. • Number of investigations of deaths. • Lessons learned, actions taken, improvements made. During Quarter 3, 2019/20; • 293 deaths occurred within the Trust. • 60 deaths met the criteria to be subject to a structured judgement review (SJR) through the Mortality Review Group. • Following a structured judgement review being completed, 10 deaths reviewed during the quarter were to subject to further investigation using root cause analysis (RCA) methodology. The Trust is not an outlier for Hospital Standardised Mortality Ratio (HSMR) or Summary Hospital-level Mortality Indicator (SHMI), meaning that there aren't a disproportionate number of deaths associated with any particular diagnosis code. Assurance Statement: Moderate There are systems in place to monitor deaths within the Trust. However, further development is required in relation to the dissemination of learning via the Mortality and Morbidity Meetings within the CBUs. This will form part of wider improvement plans relating to CBU governance.	

PURPOSE: ***(please select as appropriate)***	Information	Approval	To note x	Decision
RECOMMENDATION:	Board members are asked to note the contents of the briefing paper.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/20/03/45		
	Date of meeting	3rd March 2020		
	Summary of Outcome	Paper to be taken to Trust Board for assurance and note		
FREEDOM OF INFORMATION STATUS (FOIA):	Partial FOIA Exempt			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 22 – information intended for future publication			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Learning From Deaths - Q3 2019-20	AGENDA REF:	BM/20/03/37

1. BACKGROUND/CONTEXT

The National Quality Board report published in March 2017 - National Guidance on Learning from Deaths; A Framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting, investigating and learning from deaths in care stated that;

"Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality noted that the focus on aggregate mortality rates was distracting Trust boards "from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals".

This report followed the findings of the CQC report published in December 2016 - Learning, Candour and Accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. The report found that none of the Trusts contacted by the CQC were able to demonstrate best practice in identifying, reviewing and investigating deaths or in ensuring that learning was implemented. The purpose of the publication was 'to help to initiate a standardised approach, which will evolve as we learn'.

All Trusts were tasked with reviewing their processes and to implement systems to review, understand and learn from deaths that occurred. National Guidance set the requirements of this:

- Governance and capability.
- Improved data collection and reporting.
- Death certification, case record review and investigation.
- Engaging and supporting bereaved Families and carers.

The content of this report provides an overview of the process and systems that are in place to ensure that deaths are reviewed appropriately.

2. KEY ELEMENTS

The Trust use the HED (Healthcare Evaluation Data) system to asses our overall mortality data, highlighting any themes or trends that support the requirement for focused reviews. This also enables benchmarking against other Trusts.

Using both the HED and the Datix Risk Management system to obtain data, this report will include;

- The total number of deaths of patients.

- The number of reviews of deaths.
- The number of investigations of deaths.
- The themes identified from reviews and investigations.
- The lessons learned, actions taken, improvements made.

3. IMPACT ON QPS?

Learning from deaths helps to make changes that will ensure high quality, safe care and an excellent patient experience.

4. MEASUREMENTS/EVALUATIONS

4.1 Total number of deaths and investigation levels

During the period 1st April 2019 to 31st December 2019, 705 of WHH patients died. This comprised of the following number of deaths in each quarter of that reporting period:

- 174 in the first quarter
- 238 in the second quarter
- 293 in the third quarter

By 31st December 2019, 148 care record reviews (SJR) and 7 investigations (Serious Incidents) were carried out in relation to 705 of the deaths included above. They occurred in each quarter of that reporting period as follows:

- 35 SJRs and 3 Serious Incidents (1 case was subject to both an SJR and Serious Incident Investigation)
- 53 SJRs and 3 Serious Incidents
- 60 SJRs and 1 Serious Incident (a further 3 are under review)

Details of the SJRs and RCAs are provided within this report.

4.2 Investigations of deaths

Structured Judgement Reviews - Structured Judgement Reviews are presented to the Mortality Review Group (MRG) where an assessment of care is made. Any actions or lessons learned are identified and sent to the appropriate forum. Particular groups of patients are reviewed at the MRG:

- All deaths of patients subject to care interventions with elective procedures. These are identified using the electronic patient record which provides a daily update as to patients that have died.

- Patients undergoing an emergency laparotomy.
- SHMI/HSMR outliers identified using the HED system.
- Deaths where learning will inform existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the Trust;
- Death of a patient with mental health needs (this covers Inpatients who are detained under the Mental Health Act) identified via the Trust Patient Safety Manager. If the death may have been due to, or partly due, to problems in care including suspected self-inflicted death it will be investigated as a serious incident.
- Trauma deaths will be reviewed and presented at MRG on a quarterly basis.
- Patients who have died aged between 18 and 55 years.
- Patients who have died with no DNACPR in place.
- Once a quarter, a further sample of other deaths will be selected that do not fit the above identified categories, to ensure we take an overview of where learning and improvement is needed most overall.
- All Coroners' reports received post-inquest will be triangulated with the SJR to enhance the learning.
- Any concern that a member of staff may have in relation to a patient death will be reviewed through the mortality process.
- At the request of the Medical Director or Chief Nurse.

During Quarter 3, 129 Structured Judgement Reviews were completed by members of the MRG between 1st October and 31st December 2019. **Table 1** details their overall care rating:

Table 1

Oct / Nov / Dec 19	Overall Assessment Care Rating Following SJR					Total
	1: Very Poor	2: Poor	3: Adequate	4: Good	5:Excellent	
	0	5	31	82	9	*129

*This number is a higher number than in previous months due to the number of case reviews presented in Quarter; Trauma, Paediatric deaths, Focussed Reviews etc. These reviews are brought to the Mortality review group on a quarterly basis. A Focussed Review into COPD was also completed which increased the number of cases discussed at MRG. It is important to note that not all cases were reviewed at MRG due to problems in care; the majority were considered at MRG to provide further assurance.

Cases rated as *1: Very Poor* or *2: Poor* are reviewed by MRG and then referred to the Governance Department for further discussion and possible further investigation. Consideration is also given to external reporting via StEIS where appropriate.

Cases rated as *3: Adequate* are referred to MRG for further discussion

Cases rated as *4: Good* and as *5: Excellent* are disseminated for learning through the Mortality & Morbidity Meetings.

Focused Reviews - The MRG analyses data in relation to Mortality and where is it indicated that there is a high SHMI/HSMR (i.e. greater than expected number of deaths) in a diagnosis group, a request is made for a Focused Review to be undertaken. Table 1 details the current Focused Reviews that are underway at present.

Table 2

Diagnosis Group	Trigger	Observed deaths/ expected deaths	Date due for completion	Learning Identified
R Codes	SHMI	33/18.75	September 2019	Full report to be presented to Mortality Review Group in October 19.
Chronic Obstructive Pulmonary Disease & Bronchiectasis	SHMI	41/31.29	September 2019	Full report to be presented to Mortality Review Group in October 19.

The Trust is no longer showing an outlier for R Codes but the Focused Review will continue to see if any further learning can be identified. A report was provided to the Quality Assurance Committee in January 2019 highlighting the issues regarding R Codes and documentation.

The issue regarding documentation was raised from findings at the MRG whereby it was felt that there was a general lack in diagnostic decision making, leading to the R codes detailed below being used (R codes are conditions and signs or symptoms included in categories R00 to R94):

(a) cases for which no more specific diagnosis can be made even after all the facts bearing on the case have been investigated;

(b) Signs or symptoms existing at the time of initial encounter that proved to be transient and whose causes could not be determined;

(c) Provisional diagnosis in a patient who failed to return for further investigation or care;

(d) Cases referred elsewhere for investigation or treatment before the diagnosis was made;

(e) Cases in which a more precise diagnosis was not available for any other reason;

(f) Certain symptoms, for which supplementary information is provided, that represent important problems in medical care in their own right.

In order to address this issue work has been undertaken which has positively impacted upon the use of R codes and documentation, this includes:

- Quality Academy - Clinical Coding project
- Prioritised Coding
- Ward Round Accreditation
- Finished Consultant Episodes
- Mortality Event
- Patient Safety Summit
- Working Diagnosis and CDC Forms

Further detail of this work can be seen in **Appendix 1**

4.4 Cases subject to Root Cause Analysis investigation

Where MRG have concerns that problems in care may have attributed to a persons' death, discussion is held with the Governance Department and where appropriate a Root Cause Analysis (RCA) investigation is undertaken. RCAs are shared with patients/families, commissioners and where applicable HM Coroners and regulators/external agencies such as NHS Resolutions.

An update on outstanding cases from 2018/19 and also from Quarter 1, Quarter 2 and Quarter 3 2019/20 that were deemed to have identified problems in care which may have contributed to death or are still outstanding can be seen in **Appendix 2.**

4.5 Learning from Deaths

A summary of learning from deaths for Quarter 3 can be seen in **Appendix 3.**

Areas for learning included an update on reviews for Learning Disability deaths, inappropriate admissions and a summary of the recent Focussed Review for Chronic obstructive pulmonary disease COPD.

5. TRAJECTORIES/OBJECTIVES AGREED

5.1 SHMI / HSMR Summary

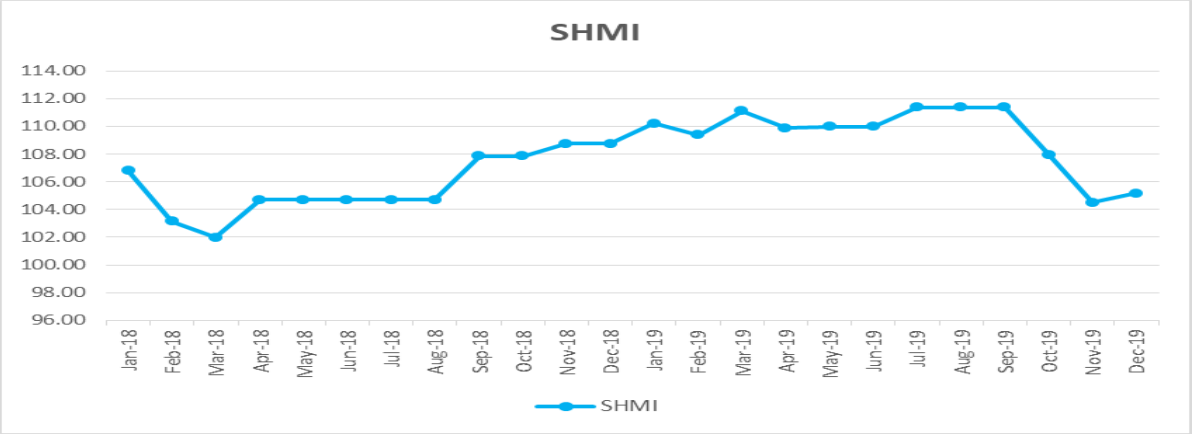
In 2010 the Department of Health endorsed the national review of HSMR commissioned by the NHS Medical Director who committed to implementing SHMI as the single hospital level of mortality indicator to be used across the NHS. Therefore, although we continue to consider HSMR, it is the SHMI which is being used and evaluated nationally as the mortality indicator.

SHMI (Summary Hospital Mortality Indicator)

This considers all observed deaths in hospital and within 30 days of discharge. Adjustments are made only for age, admission method and comorbidities. Still births, specialist community, mental health and independent sector hospitals, day cases, regular day and night attenders are excluded.

Table 3 shows the Trust position since October 2017 and demonstrates our current position as 105.18; we are not an outlier for SHMI. There is no current data available to compare against our peer group; this should be available by the next reporting period.

Table 3

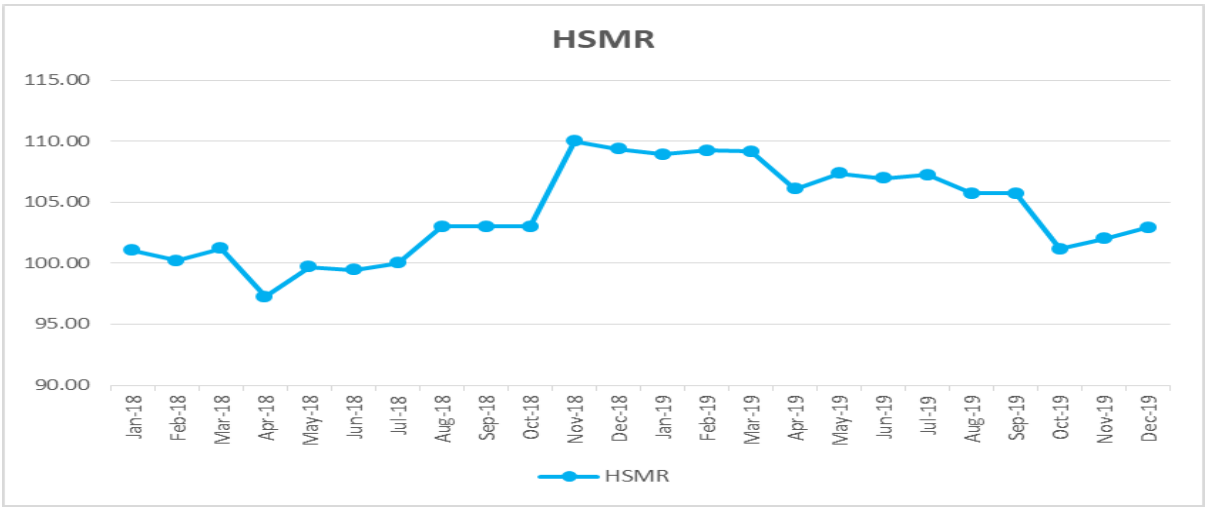


HSMR (Hospital Standardised Mortality Ratio)

All patient stays culminating in death at the end of a patient pathway defined by the primary diagnosis for the stay. It uses 56 diagnosis groups which account for about 80% of in-hospital deaths; therefore it does not included 'all' deaths.

Table 4 shows the Trust position since October 2017 and demonstrates our current position at 102.92. Our peers' average is 100.31. The Trust is 11th out of the 20 hospitals in our peer group, which is an improved position on the previous quarter where we were 14th out of the 20 hospitals in our peer group.

Table 4



The Trust is not showing as an outlier in any of the diagnosis groups that are monitored by HSMR.

The above results are based on data up to August 2019. NHS Digital have not provided data in relation to 'out of hospital deaths'. This has been acknowledged and they are working to provide a file to HED who provide the mortality reports. As a result the SHMI module has not been updated and therefore is not the most up to date position.

6. MONITORING/REPORTING ROUTES

Learning from Deaths is monitored by the MRG which reports monthly to the Patient Safety and Clinical Effectiveness Sub-Committee, Quarterly to the Quality Assurance Committee and annually in both the Quality Account and to the Clinical Commissioning Group via the Clinical Quality Focus Group.

Assurance Statement: Moderate
There are systems in place to monitor deaths within the Trust. However, further development is required in relation to the dissemination of learning via the Mortality and Morbidity Meetings within the CBUs. This will form part of wider improvement plans relating to CBU governance.

7. TIMELINES

The Mortality Review Group meets monthly to review deaths that have been subject to a Structured Judgement Review.

8. ASSURANCE COMMITTEE

Reports to both the Patient Safety and Clinical Effectiveness Sub-Committee and the Quality Assurance Committee.

9. RECOMMENDATIONS

Our HSMR data has shown signs of improvement evidencing an improved position when compared against our peers. Our SHMI data has also shown signs of improvement but due to delays in national reporting we are unable to compare against our peers and as such will provide further updates accordingly.

The Board are asked to note this report.

Appendix 1

- **Quality Academy - Clinical Coding project** - Two Junior Doctors (SAMP) to investigate the 'R' Code (signs & symptoms) coding issue. As a result of the findings from the project a Grand Round in relation to R Codes and documentation was presented. Also created was a training package for the Junior Doctors which is presented by a member of the MRG group and Clinical Coding. Work is still ongoing to develop an e-learning teaching package to further support staff.

- **PRIORITISED CODING** – Bereavement notes will be prioritised for coding which will support the mortality review process. Clinical Coding and a member of the MRG group review all deaths with a primary 'R' code in 1st and 2nd episode and refer back to the responsible consultant for review.

- **WARD ROUND ACCREDITATION** - Alex Crowe, Medical Director and May Moonan, Associate Medical Director, are currently overseeing a project to commence a Ward Round Accreditation Scheme. Medical ward rounds are complex clinical activities, critical to providing high quality, safe care for patients in a timely, relevant manner. They provide an opportunity for the multidisciplinary team to come together to review a patient's condition and develop a coordinated plan of care, while facilitating full engagement of the patient and/or carers in making shared decisions about care. Adopting these principles will improve patient safety, patient experience, shared learning, collaborative working and efficient use of resources. Success requires a concerted cultural change, with clinical staff, managers and hospital executives all fully engaged and focused on improving the quality of ward rounds. The review of documentation will form part of the accreditation process on each Ward Round.

- **FINISHED CONSULTANT EPISODES** - A Task and Finish group to look at Finished Consultant Episodes is established, led by the Trust Mortality Lead. A SOP has been developed to enable ward clerks to edit the system instead of multiple episodes being created each time a patient is moved. Although this will take some time to action it is believed that this will have a positive impact on HSMR/SHMI going forwards.

- **WORKING DIAGNOSIS AND CDC FORMS** - MRG members are working with the Lorenzo team to develop CDC forms from a mortality perspective. To reduce R codes the team is looking at removing the possibility for clinicians to input words such as 'likely' or 'possibly' into their working diagnosis.

- **PATIENT SAFETY SUMMIT** – The Mortality Review Group aim to host a Mortality element with the Safety Summit in November 2019/20 where all learning from Mortality is shared again and educational sessions will be held with staff to promote areas such as Coding and documentation.

- **MORTALITY EVENT** – In February 2020 the Mortality Review Group will be hosting a multi-agency shared learning event. A Save the Date card with further details will be issued shortly.

Appendix 2

STEIS Reference	INC Description	Deemed as having problems in care
2018/19 - Q4 - There were no cases of harm due to having problems in care.		
2018/26921	The patient had a past medical history of Alzheimer's disease, COPD, myeloma, hypothyroidism and a 6 month history of weight loss and was admitted through WHH ED under GP referral for overnight delirium suffering from hallucinations on 12/09/18 the patient was transferred to Halton with a plan for discharge. On the morning of 04/11/18, the staff nurse in charge of the patient's care identified that the patient appeared drowsier. Medication had been taken, however the patient struggled to eat and began coughing when attempting to eat. On the afternoon of 04/11/18, an NHS Professionals (NHSP) Health Care Assistant (HCA) arrived on the ward to begin a shift and received handover and induction. The HCA was asked to assist the patient with eating. The patient was observed being assisted with feeding by the HCA, but when staff went into the bay (approximately 1-2 minutes later), the patient was found to have died and food was seen inside and around their mouth. The patient was DNACPR. This case was not subject to an SJR as a 72 hour review was already underway.	Inquest was heard 11th November 2019. The conclusion was accidental death – no formal concerns for the Trust.
2019/20 – Q1 – Of the 3 cases in Q1 there was one case of harm due to having problems in care. However, 1 is awaiting Inquest.		
2019/8122	The patient was admitted to Warrington Hospital on 31/03/2019 after a fall at home, shortness of breath and increased confusion. The patient was admitted to AMU. On 02/04/2019 the patient had an unwitnessed fall and was found on the floor at the end of the bed. Following a brief loss of consciousness the patient displayed acute confusion, pain to right shoulder, laceration to right arm and hematoma to right temporal region. The x-ray confirmed the patient also sustained a fractured clavicle. The CT scan showed a large right hemispheral, falcine and left tentorial subdural haematoma which had progressed since the previous imaging. In the right front parietal region there was an impression of extension of haemorrhage. The CT results however were not documented in the patient's records until 04/04/2019. The patient's condition deteriorated and the patient sadly passed away on	Subject to inquest – no date set as yet.

	08/04/2019. This case was not subject to an SJR as a 72 hour review was already underway.	
2019/11932	Patient care reviewed in MRG. A brief summary of the issues found; The patient died of Sepsis and Pneumonia following a fall Relatively little medical input for 3 days Went for 3 days without repeated bloods Problems with pain management Considered for discharge but she had an overwhelming infection No IV access for 3-4 days This case was subject to an SJR and MRG requested that this be reviewed by Governance. This was subsequently deemed to be a Serious Incident.	Problems in care.
2019/13089	In July 2015, an ultrasound scan was completed and reported seeing a probable haemangioma in the right lobe of the liver. The patient attended both her own GP and out of hours GP numerous times, before attending the Spire for a privately funded scan on 28th January 2016. This revealed multiple liver metastases and Histology later confirmed neuroendocrine carcinoma. The review, following this incident being raised following a claim, concluded that it could not be assured that the original probable haemangioma was not actually metastases, as there was one later noted in exactly the same location on the later scan. The patient sadly died on 16th May 2016. This case is historical and before we undertook SJRs.	No problems in care.
2019/20 – Q2 - Of the 3 cases in Q2 1 investigation is complete and it was deemed no problems in care and 2 are awaiting Inquest.		
2019/15506	On 03/07/19, the patient was admitted for an endoscopic retrograde cholangiopancreatography (ERCP). A pancreatic stent was inserted during the procedure following failed attempts to cannulate the common bile duct (CBD). The patient was observed following the procedure for 4 hours. The patient's observations were reported to be stable following the procedure and had tolerated diet and fluids. At 17:15, on the same day following the procedure, the patient telephoned the hospital and spoke to an endoscopy nurse, complaining of vomiting, feeling unwell and some discomfort. The patient was readmitted with a diagnosis of post-procedure pancreatitis and initially referred to the medics. On 04/07/19 at 00:13, the patient was accepted by the surgical registrar. The patient's condition deteriorated - the patient was admitted to HDU at 14:00 and a CT scan was performed. On 05/07/19 at 10:00, there was a discussion with the patient's family and the patient's current condition was discussed. The patient was in multiple organ failure (MOF) for his kidneys, liver, lungs and heart - the patient was not responding to current treatment. A planned withdrawal of treatment was agreed. At 11:35, the patient sadly passed away. The patient's death has been referred to HM Coroner. The case was not subject to an SJR as it did not meet the criteria for review.	Subject to inquest – no date set as yet.
2019/15878	The patient attended Warrington Hospital Emergency Department (ED) by ambulance at their GPs request. The patient arrived in ED 18.41 and remained in the hub as there was no	No problems in

	space in the 'majors' or 'resus' areas. On review of the incident, the patient should have been accommodated in one of these areas. Full triage occurred at 19.11, and observations on ambulance documentation and triage documentation are reported to be the exact same. Observations were later taken at 20:15 (NEWS score=3), 21:30 (NEWS score=6) and at 23:30 (NEWS score=3) - Although on review of the incident, NEWS at 23:30 was calculated as scoring 5. The following observations were at 02:45. Bloods were taken at 21:05; HB had dropped further to 45 (blood pressure was trending downward since admission, saturations dropped and respiration rate had increased). Although the medical registrar reviewed the patient's blood results, documentation of this could not be found on review and planned antibiotics and fluids do not appear to have been administered. The patient went into cardiac arrest at around 02:45 and was reviewed by ITU - But was not for ITU admission due to commodities and the recent cardiac arrest. The patient had a further cardiac arrest in the department at around 04:50 and sadly passed away. This case was not subject to an SJR as a 72 hour review was already underway.	care.
2019/16094	Patient was sat at the side of the bed with the Occupational Therapist. Patient went to reach down to put slippers on, lost her balance and started to fall forward. Occupational Therapist attempted to facilitate balance, but the patient continued to fall forward. Patient assisted to the floor. This case was not subject to an SJR as a 72 hour review was already underway.	Subject to inquest – no date set as yet.
2019/20 – Q3 - Of the 8 cases in Q3 3 investigations are complete and it was deemed there was a problem in care with one of the cases but no problems in care for the remaining two. There are 5 cases where the investigation is ongoing.		
2019/22277	The patient attended with a following a fall at home. The patient was diagnosed with bilateral undisplaced neck of femur fractures. During the bilateral dynamic hip screw (DHS) procedure, two of the same implants were required for each hip. There was one 135 degree 2 hole plate available and one 130 degree 2 hole plate available. Both hips required a 135 degree 2 hole plate. Surgery was completed with the plates available; the surgeon checked the x ray and completed the procedure.	Never Event No problems in care.
2019/23948	Patient had a chest x-ray, which was highlighted to ward A7 on 20th July 2019 as a follow up CT scan was recommended. Not requested until 13th Aug and then as a non-urgent scan, so that the scan took place on 16th Sept 2019. The CT scan findings showed a mass which was suspicious for lung cancer.	Problems in care.
2019/24357	Patient previously fit and well except for being overweight, died the day after discharge from ED (on 4th June). The patient had complained of retrosternal and epigastric pain radiating to the back, which had been constant all day. These are features of possible aortic dissection, which is a possible cause of her sudden death. If the diagnosis is considered, there is a small chance these patients can survive if they are transferred to LHCH and remain stable. Potential missed diagnosis which requires investigation.	No problems in care.
2019/25094	On 8th October 2019 the patient was admitted to hospital following a GP referral. On 16th October, the patient was transferred to the respiratory ward and a chest drain was inserted for therapeutic aspiration. The patient remained unwell and	Investigation in Progress

	was transferred to ICU. On 20th October the patient's condition deteriorated and was sedated and ventilated. A second chest drain was inserted for treatment of pleural effusion. The procedure was noted as 'uneventful', however the patient became unstable overnight – bloods showed an Hb drop. The patient was stabilised and a scan took place to find the source of bleeding. On 22nd October, the attending doctor took a call from a Consultant Liver Surgeon at Aintree Hospital who had reviewed the images. The Consultant Liver Surgeon believed that the drain was not in the liver, but may have grazed the liver on entry - an intercostal vessel that bled thought to be most likely. The plan was for removal on the following day. On 31st October the patient's condition again deteriorated and became unresponsive.	
2019/26167	On 15th January 2019, the patient attended for a chest x-ray following a referral from the GP with a history of persistent cough, COPD and ex-smoker. The x-ray was reported by the Radiology Consultant as 'No acute pulmonary pathology'. On 9th August 2019, the patient attended the Trust again for a chest x-ray following a further referral from the GP, following significant weight loss. Imaging showed mediastinal lymphadenopathy. At the review it was agreed that the mediastinal lymphadenopathy which was seen on the x-ray from August 2019 was also present on the earlier x-ray in January 2019. It was also reported that there was likely already advanced node involvement at the time of the first x-ray in January 2019 which would not have been curative at that time either and it is unlikely that there would have been anything other than standard palliative chemotherapy offered. There was a delay in diagnosis of approximately 6 months which then caused a delay in treatment.	Investigation in Progress
2019/26705	Staff heard a bang in the female toilet and found the patient on the floor, alert and orientated, lying on her left side and complaining of pain to the left hip.	Investigation in Progress
2019/26709	Case discussed in Radiology REAL meeting. Patient had CT urogram in March 2019 - kidneys reported as normal. Subsequent CT in Nov 2019 identified renal mass, which with hindsight was visible on previous imaging.	Investigation in Progress
2019/28124	Patient on the Dementia ward was sat in their chair, stood up, lost balance and fell to the floor. The patient was quickly reviewed and a CT Scan was completed. The CT identified a complex impacted sub capital left neck of femur fracture.	Investigation in Progress

Appendix 3 – Learning from deaths

We found….	We are doing….
Cardiology were showing as an outlier according to Mortality data.	Cardiology asked for a number of their cases to be reviewed – these were undertaken by 2 MRG reviewers. Care was considered to be good in all cases and this has been discussed at MRG and fed back to Cardiology.

84 year old patient, advanced end stage dementia. Care home resident. 3rd admission in /12 with falls. Frailty unit first and then ED. DOLs in situ. DNACPR agreed with NOK. Day 21 – decision made to palliate.	This was deemed as an inappropriate admission and that there was no clear management plan or working diagnosis on post take ward round. Feedback provided to Halton CCG regarding inappropriate admission. Quality control regarding the post take ward will be addressed by the ongoing FCE Work Group which has been established by MRG.
There is a national backlog of Learning Disability deaths to be reviewed under the LeDeR process.	We ensure that all LD deaths have undergone an SJR to review the care provided to the patient. In order to address the backlog within the region the CCG have commenced a pilot of a monthly panel will be held to review pts LD deaths and the panel will be made up of CCG, Hospital and LD staff. The reviews will incorporate all elements of LeDeR so the SJR will be used to support this along with a wider case review of other episodes of care during the patient's life time at the Trust.
The COPD Focussed Review followed a review of mortality data which indicated that the Trust was an outlier for deaths relating to COPD and Bronchiectasis.	20 cases were reviewed – 14 (70%) were found to be of good care, 5 (15%) were of average care and 1 (5%) was poor care. COPD was the main condition treated in 18 (90%) of patients reviewed. The cause of death of the patients reviewed matched the admission diagnosis in 12 of 17 (71%) of cases, three patients died in the community and as a result the cause of death cannot be confirmed. 6 (30%) patients were reviewed by palliative care, 1 patient was referred to palliative care but passed away before their review. 11 (55%) of patients reviewed were rated as receiving 'good' or 'Excellent' end of life care There were 5 Trauma deaths, 4/5 cases reviewed were deemed as good care and one was adequate in accordance with the SJR scoring.

QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/20/03/42**			
SUBJECT:	**Infection Prevention and Control**			
DATE OF MEETING:	3 March 2020			
AUTHOR(S):	Lesley McKay Associate Chief Nurse for Infection Prevention and Control/Associate Director for Infection Prevention and Control			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse/Director for Infection Prevention and Control Choose an item.			
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides a summary of infection prevention and control activity for Quarter 3 (Q3) of the 2019/20 financial year and highlights the Trust's progress against infection prevention and control key performance indicators. In Q3 the Trust reported:- • 17 Clostridium difficile cases. 4 cases have been reviewed by the CCG and 3 agreed to have no lapses in care. The Trust remains under the annual threshold • Nil return for MRSA bacteraemia cases • 4 MSSA bacteraemia cases. There is no national reduction target • 11 E. coli bacteraemia cases. This is a slight reduction from Q2. The Trust remains under the annual threshold A 5% E. coli bacteraemia reduction target has been set as a priority in the Quality Strategy for 2019/20. Action plans, which focus on learning from Gram Negative Bloodstream Infections (GNBSI) incidents, are in place. In the region of 340 positive influenza results were confirmed and acted upon. The introduction on seasonal in-house testing (7 day service) has significantly contributed to timely patient review and implementation of infection control precautions. The Infection Prevention and Control Team have carried out a number of promotional activities to support reductions in healthcare associated infections and Antimicrobial Stewardship. Overall compliance for attendance at mandatory infection control training is 87%. There is a decrease in Level 2 compliance to 80%. The Infection Prevention and Control Team are providing additional training sessions and CBU triumvirate leads have been contacted and requested to ensure improved compliance. The audit programme is highlighting concerns relating to the environment, ward kitchens and handling of linen. Actions are in place to address audit findings. The Infection Prevention and Control Strategy review is in progress.			
PURPOSE: (please select as appropriate)	Information √	Approval	To note √	Decision

RECOMMENDATION:	The Quality Assurance Committee is asked to note the contents of the report, exceptions highlighted and progress made.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	**Submit to Trust Board**	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

SUBJECT	Infection Prevention and Control Q3 report 2019/20	Agenda Ref:	QAC/20/03/42

1. BACKGROUND/CONTEXT

This report provides an overview of infection prevention and control activity for Quarter 3 (Q3) of the 2019/20 financial year (FY). The report highlights the Trust's progress against Healthcare Associated Infection (HCAI) reduction targets, learning from incidents and an update on activity for audit, education, surveillance and policy reviews.

NHSI use Clostridium difficile infection rates as one of a number of metrics to assess Trust performance. Both avoidable and unavoidable cases are taken into account for regulatory purposes. The Trust is assessed for breaches of the Clostridium difficile objective using a cumulative year to date (YTD) trajectory.

The zero tolerance threshold for avoidable cases of Meticillin resistant Staphylococcus aureus (MRSA) bacteraemia remains in place.

There is a national ambition to halve gram-negative bloodstream infections (GNBSIs). The Antimicrobial resistance 5 year plan provided a revised timescale to meet this objective and advises a systematic approach is required to deliver a 25% reduction by 2021-2022 with the full 50% by 2023-2024.

2. KEY ELEMENTS

HCAI data

RAG rating of Trust performance for HCAIs by month is shown in Table 1.

Table 1: HCAI data by month

Indicator	Target	Position	A	M	J	J	A	S	O	N	D	Total
C. difficile	≤44	Above trajectory	3	1	4	4	6	1	10	5	2	36
MRSA bacteraemia	Zero tolerance	Above trajectory	0	0	0	0	2	0	0	0	0	2
MSSA bacteraemia	No target	No target	0	0	1	2	3	5	1	2	1	15
E. coli bacteraemia	5% reduction ≤46	Above trajectory	4	6	5	3	2	8	4	6	1	39
Klebsiella spp. bacteraemia	5% reduction ≤13	Above trajectory	1	1	1	3	1	1	2	1	0	11
P. aeruginosa bacteraemia	5% reduction ≤4	On trajectory	0	0	1	0	0	2	0	0	0	3

Breakdown by ward is included at appendix 1.

Clostridium difficile

- 17 cases reported in Q3 (15 hospital onset/ healthcare associated: 2 community onset/ healthcare associated). The trust remains under the annual threshold of 44 cases
- All hospital apportioned cases undergo post infection review. Action plans for care improvements are aligned to findings from the reviews
- 2 cases from Q3 were considered avoidable following internal review, 4 cases were submitted to the CCG and 3 agreed unavoidable
- 9 cases are awaiting internal review and where considered unavoidable, will be submitted to the CCG panel for consideration

The Chief Nurse/DIPC chairs a meeting weekly to review healthcare associated infection investigation reports. Themes identified from the C. difficile case reviews include: stool documentation, timely sampling and isolation. Learning from these meetings is shared with clinical teams via CBU Governance meetings.

Bacteraemia Cases

Gram positive bacteraemia

Meticillin resistant Staphylococcus aureus (MRSA) bacteraemia

- Nil return submitted for Q3. 2 hospital onset cases reported FY to date

Meticillin sensitive Staphylococcus aureus MSSA bacteraemia

- 4 hospital onset cases in Q3. Post infection reviews are in progress
- No national reduction target/threshold

Gram negative bacteraemia (GNBSI)

E coli bacteraemia

- 11 hospital onset cases in Q3

Klebsiella Spp.

- 3 hospital onset cases in Q3

Pseudomonas aeruginosa

- 0 hospital onset case in Q3

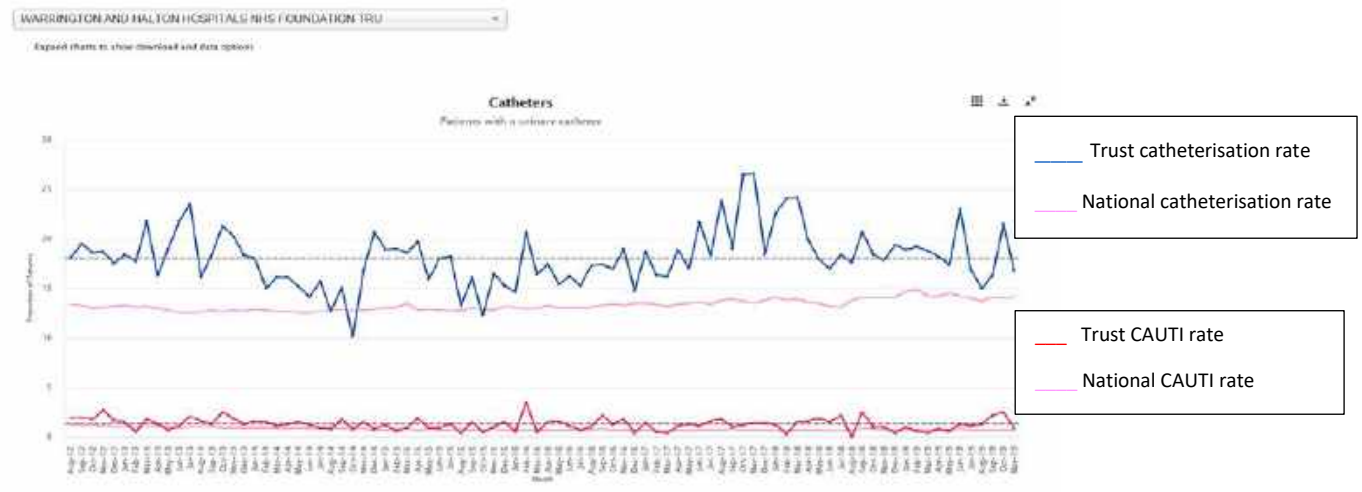
There was a slight decrease in E. coli cases in Q3 and a downward trend noted over each quarter this year. All E.coli bacteraemia cases undergo post infection review. Action plans for care improvements are aligned to findings from the reviews and include urinary catheter care, timely blood culture sampling and education on the UTI pathway. These work streams are in progress.

Activity to reduce use of urinary catheters has seen a fluctuation in use over the last quarter according to the latest Safety Thermometer data (Figure 1). From October – November the national average ranged from 14% to 14.2%. The Trust use ranged from 16.8% to 21.5%. Whilst the trust remains above the national average in November, figures dropped below the upper control limit. Catheter associated urinary tract infections (CAUTI) decreased slightly in November.

Comparative data on HCAI cases and rates from November 2018 to October 2019 across the Northwest is included in appendix 2. Appropriate comparison with other similar sized Trusts (local delivery system partners), shows a slightly higher number of MRSA bacteraemia cases. However the Trust has a significantly lower number of C. difficile cases and MSSA, E.coli, Klebsiella spp. and Pseudomonas aeruginosa bacteraemia cases than one of our Local Delivery System partners.

Benchmarking has been carried out with an NHS Trust in Manchester. Both Trusts are aligned in approaches to delivery of the infection prevention and control services and strategies for healthcare associated infection reduction. Work has commenced with the Advancing Quality Alliance (AQuA) and the Trust's Quality Academy. Innovation wards (A4, A8, B14 and Halton Intermediate Care Unit) have been selected for phase 1 of the collaborative with the first meeting scheduled for January 2020.

Figure 1 Urinary Catheter Safety Thermometer data



Outbreaks/Incidents

Norovirus

There were 4 wards with confirmed cases of norovirus in Q3.

Table 2: Norovirus incidents by month

	A	M	J	J	A	S	O	N	D
Outbreaks	6	4	0	0	0	0	0	0	4

Wards with confirmed cases of norovirus are reviewed twice daily by the Infection Prevention and Control Nurses. Surveillance for additional cases is carried out and infection control standards are monitored. The Communications Team have provided support by use of social media messages to members of the public advising not to visit if unwell.

Influenza

During November and December there was a significant increase in workload to review suspected influenza cases. In the region of 340 positive influenza results were confirmed and acted upon. The Infection Control Team worked closely with operational management to support safe placement of patients to prevent outbreaks. The introduction on seasonal in-house testing (7 day service) has significantly contributed to timely patient review and implementation of infection control precautions.

Scabies

Following identification of a case of scabies in September and prophylactic treatment of staff, concerns were identified about on-going transmission when a second patient case was reported in October. The patients were in adjacent beds and the second case arose within the incubation period. A second incident meeting was held in October and the situation reported to Public Health England. A decision was taken to carryout mass treatment which involves application of scabicidal lotion to all patients and staff. All staff that had had contact with the patients were also treated. The ward will remain under surveillance (until the end of January) and to date no additional cases have been reported.

Surveillance

The capital funding bid has been approved to purchase software to support surveillance. A surveillance Nurse commence in post in November. This appointment will drive forward surveillance of surgical site infection in addition to the mandatory orthopaedic surveillance of hip and knee surgery.

Infection Prevention and Control Training

Overall compliance with mandatory infection control training is above the 85% threshold and has remained around 90% for the last 12 months.

Table 3 Infection Control Training compliance

Infection Control Training	A	M	J	J	A	S	O	N	D
Overall % of staff trained	91%	91%	89%	90%	90%	89%	91%	88%	87%

Attendance for Level 2 (patient facing staff), has fallen from 87% in October to 80% in December. The Infection Prevention and Control Team are providing additional training sessions to support CBUs with lower levels of compliance. The decreasing trend in compliance has been highlighted at Infection Control Sub-Committee. All CBU Triumvirate Leads have been contacted and requested to ensure improved compliance.

Infection Prevention and Control Audits

A total of 9 audits were completed (table 4) in Q3. There is a schedule in place for completing audits. In addition, audits are carried out in response to evolving concerns e.g. increase in infections identified. Audit reports are returned to Ward Mangers who are responsible for developing action plans to address areas requiring improvement.

Action plans are monitored at the Infection Control Operational Group Meetings. Repeat audits are carried out where low compliance with standards are identified.

Table 4 Infection Control Audits

Ward	B12	C21	Cardiac Catheter Laboratory	B11	B10	Discharge Lounge	Frailty Unit	A9	ICU
Environment	70%	85%	70%	100%	92%	91%	79%	80%	84%
Ward Kitchens	82%	93%	81%	100%	85%	N/A	96%	96%	76%
Handling/Disposal of Linen	100%	94%	75%	100%	94%	94%	86%	78%	100%
Departmental Waste	100%	94%	100%	100%	88%	93%	100%	94%	78%
Safe Handling Disposal of Sharps	80%	92%	100%	100%	100%	100%	92%	100%	83%
Patient Equipment (General)	95%	85%	98%	100%	91%	100%	93%	90%	94%
Patient Equipment (Specialist)	100%	N/A	100%	100%	N/A	N/A	100%	N/A	100%
Personal Protective Equipment	100%	100%	100%	100%	100%	100%	100%	100%	78%
Short Term Catheter Management	100%	100%	100%	100%	N/A	N/A	100%	94%	83%
Enteral Feeding	100%	N/A	100%	100%	N/A	N/A	N/A	N/A	94%
Care of Peripheral Intravenous Lines	N/A	N/A	82%	100%	100%	N/A	N/A	100%	100%
Non-Tunnelled Central Venous Catheters	100%	N/A	100%	N/A	N/A	N/A	N/A	N/A	100%
Isolation Precautions	92%	100%	100%	100%	100%	N/A	N/A	100%	100%
Hand Hygiene	97%	86%	97%	100%	91%	100%	100%	97%	100%
Overall Compliance	94%	93%	93%	100%	94%	97%	95%	94%	95%

Areas for care improvement include: the environment, ward kitchens, handling and disposal of linen and sharps safety. Action taken to drive improvements includes:-

- Masterclass held with Matrons and Lead Nurses to review the Matron's Charter (2004) and the 10 Key responsibilities of the Matron (2015). ICU was re-audited following a low audit score in Q2. Scores remain below minimum accepted standard. However scores have improved since the last audit. A repeat audit has been scheduled
- Ward kitchens have been added to the capital programme. Two kitchens per annum will be upgraded over the forthcoming years. Interim improvement work has been carried out
- Guidance information has been provided to Housekeepers on storage of linen
- Health and Safety are leading on an action plan to improve sharps management and a separate programme of audit is in place

Environmental Hygiene

Cleanliness monitoring is carried out by the Facilities team. These audits review domestic cleaning, nursing cleaning and the general estate.

- Overall cleanliness score for Warrington
    - Very high risk areas - 98%
    - High risk areas – 95%

- Overall cleanliness score for Halton
    - Very high risk areas - 97%
    - High risk areas – 95%

The Draft National Standards of Healthcare Cleanliness document has been reviewed and a Task and Finish Group is being set up to implement recommendations. This will involve signing up to a commitment to cleanliness charter and displaying star ratings for cleanliness for each clinical area.

Infection Control Policies

The following documents were approved by the Infection Control Sub-Committee in November:-

- Laundry Policy - revised
- Working with Dogs in Healthcare Policy – new policy

Antimicrobial Stewardship

The Quarterly Point Prevalence Audit (November) was deferred due to the Warrington Site role out of Electronic prescribing. Nil specific concerns have been highlighted from Antibiotic Ward Rounds.

Awareness raising events

The Infection Prevention and Control Team have been proactive during Q3 and carried out a number of awareness raising activities including:-

- ANTT competency assessor training in partnership with the Clinical Education Team
- Training Foundation Year 1 doctors on blood culture sampling and Antimicrobial Stewardship
- Hospital radio broadcast on the importance of hydration, handwashing and invasive device removal
- Training Patient Safety Nurses on blood culture sampling

- Contribution to Trust Wide Safety Brief Hot Topic – Influenza and Outpatient IV antibiotic service (
- Infection Prevention and Control Strategy engagement sessions
- World Antibiotic Awareness Week – Promotional Stand
- Trial without (urinary) catheter removal, TWOC around the clock

External visits

- Duty of Care visit to Laundry Contractor – nil concerns identified
- Benchmarking exercise with a Manchester NHS Trust

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

- Work continues to meet the recommendations of the external review of Infection Prevention and Control reported in 2018
- Aseptic Non-Touch Technique (ANTT) assessor training sessions will continue
- A draft of the revised Infection Prevention and Control Strategy will be circulated for comment

4. IMPACT ON QPS

Q: A reduction in HCAIs will demonstrate a positive impact on patient outcomes

P: Improved attendance at training assists staff in fulfilling mandatory training requirements

S: Reduction in HCAIs supports sustainability by avoidance of contractual financial penalties

5. MEASUREMENTS/EVALUATIONS

- Mandatory reporting of healthcare associated infection (HCAI) to Public Health England
- The Infection Prevention and Control Team meet fortnightly to monitor cases of HCAI. Action is implemented in response to increased incidences of HCAIs and infection control related incidents
- The Infection Control Sub-Committee meets bi-monthly (6 times per annum) and discusses HCAI surveillance data and learning from HCAI incidents
- Meetings take place weekly with the DIPC to review HCAI incident investigation reports and actions are agreed to support care improvements
- Healthcare Associated Infection data is included in the Ward Dashboard data (C. difficile with a plan to include E. coli bacteraemia data)

6. TRAJECTORIES/OBJECTIVES AGREED

- The Clostridium difficile threshold for 2019/20 is ≤44 cases

The apportionment algorithm has changed (reduction in one day from admission i.e. samples taken from 3rd day of admission onwards will be apportioned to the Trust – previously this was from 4th day). Any cases arising within 28 days of a patient discharged will be classified as community onset/ healthcare associated and will also be apportioned to the Trust.

- The zero tolerance to avoidable MRSA bacteraemia cases remains in place

- GNBSI 5% reduction target has been set as a priority within the Quality Strategy

Work streams will continue to:-

- Progress GNBSI reduction
- Reduce the incidence of Clostridium difficile infection and implement learning from incidents
- Promote Antimicrobial Stewardship and challenge inappropriate prescribing
- Partnership working with Urgent and Emergency Care CBU to support timely blood culture sampling
- Monitor invasive device management/bacteraemia reduction
- Continue ANTT competency assessor training
- Implement an infection control surveillance systems
- Support staff training in Infection Prevention and Control where CBU compliance is lower than 85%
- Promote excellent standards in uniform/workwear and the Bare Below the Elbows campaign
- Support assessment of decontamination standards
- Complete actions from the external review
- Set up a surgical site infection surveillance programme
- Review policies as per the work schedule

7. MONITORING/REPORTING ROUTES

High level briefing papers from the Infection Control Sub-Committee are submitted to:-

- Quality and Assurance Committee
- Health and Safety Sub-Committee
- Patient Safety and Clinical Effectiveness Committee

DIPC reports are submitted quarterly to the Quality and Assurance Committee and Trust Board.

Verbal updates are provided to Trust Board monthly as part of the Integrated Performance Report.

A Director of Infection Prevention and Control Report is submitted to Trust Board annually.

Exception reports will be submitted to the Quality and Assurance Committee when increased incidences of infection are identified.

8. TIMELINES

2019/20 Financial Year

9. ASSURANCE COMMITTEE

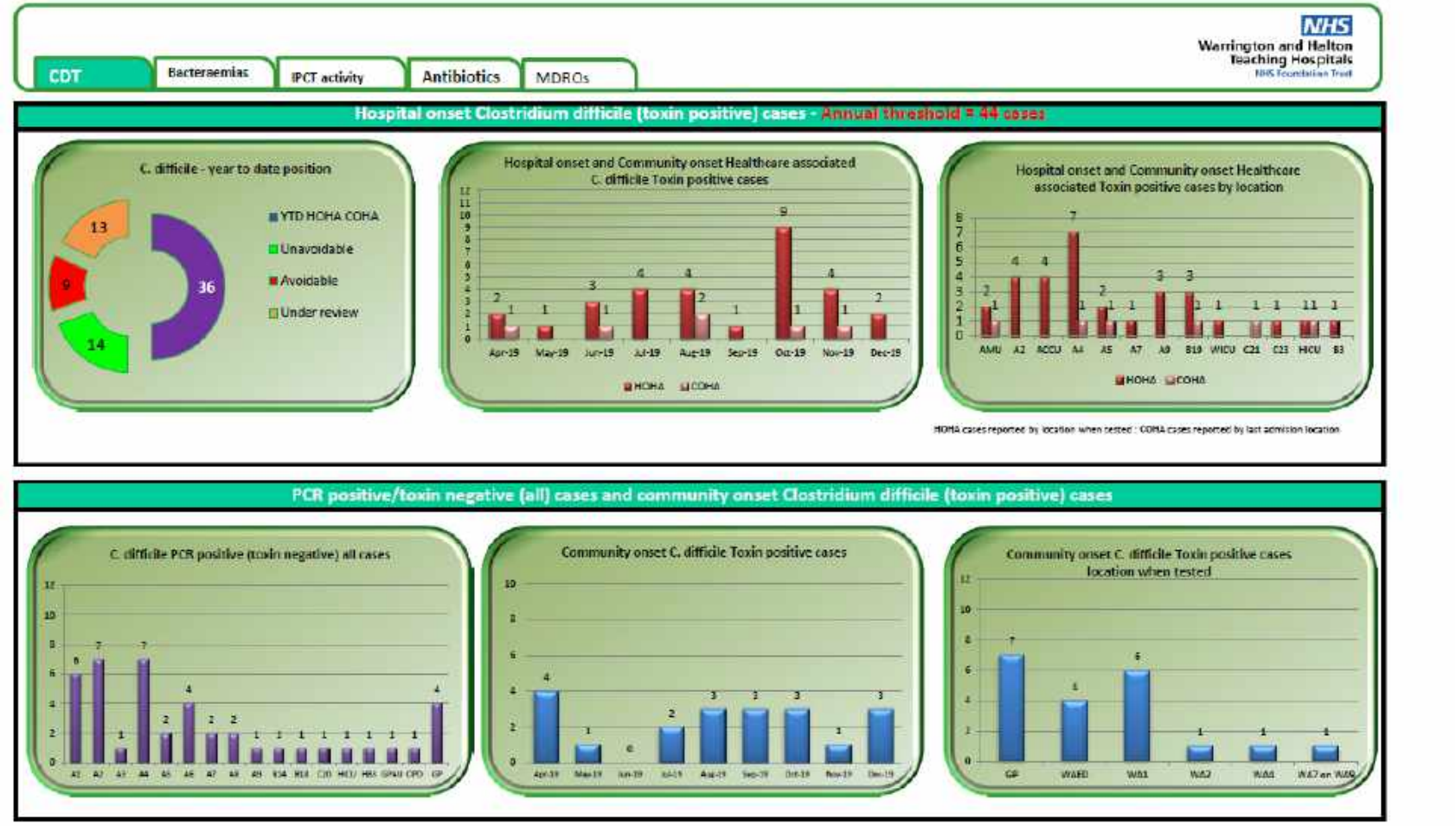
- Infection Control Sub-Committee

10. RECOMMENDATIONS

The Quality Assurance Committee is asked to: note the content of the report; the exceptions reported and the progress made.

APPENDIX 1 Healthcare Associated Infection Data April – December 2019

Clostridium difficile Cases



Hospital onset/Healthcare associated = HOHA
Community onset/Healthcare assocaiated = COHA
Community onset/Healthcare associated cases are linked to the ward the patient was most recently discharged from

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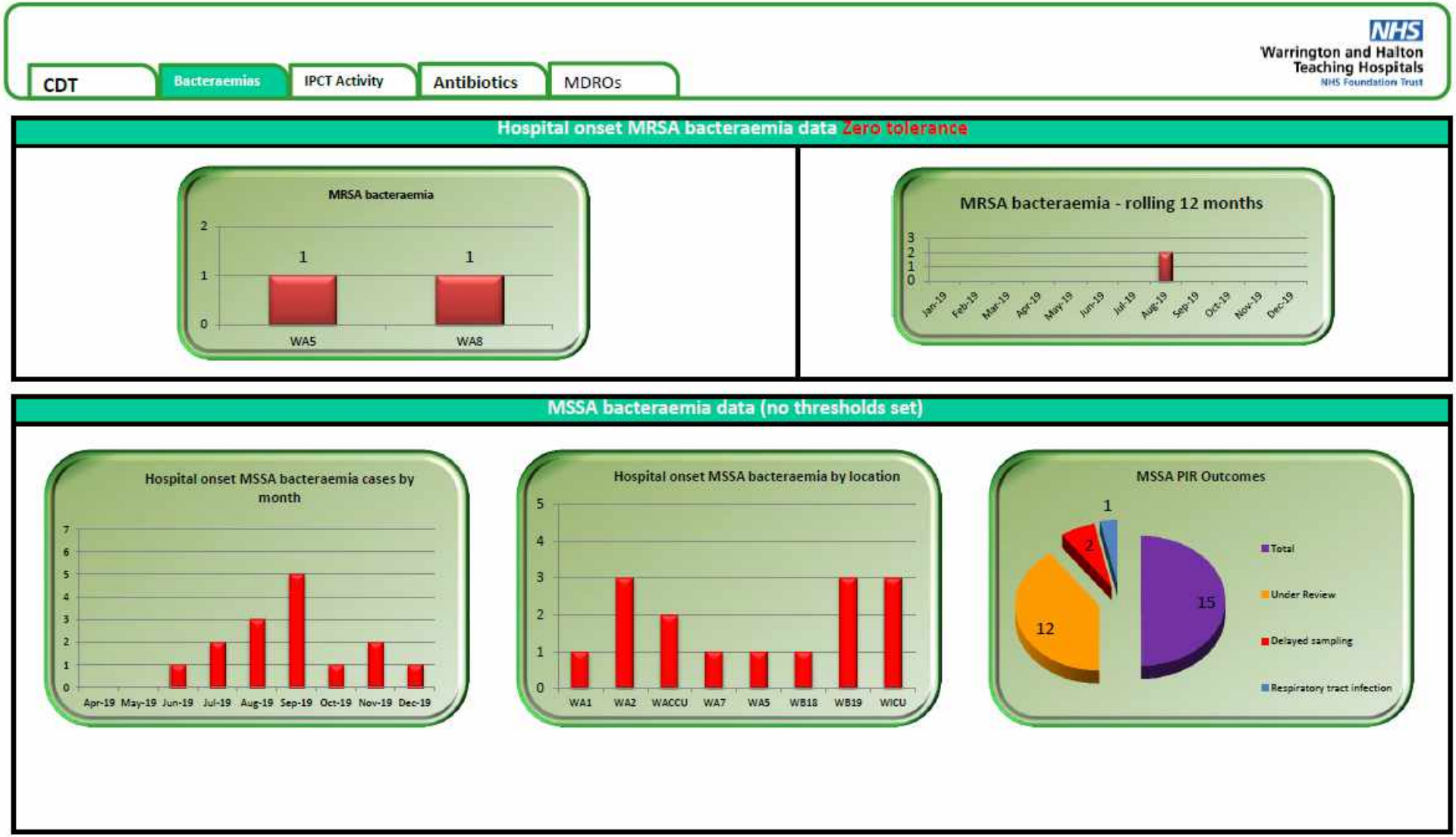
Gram Positive Bacteraemia Cases



Gram Negative Bacteraemia Cases

APPENDIX 2 COMPARISION OF HEALTHCARE ASSOCIATED INFECTION DATA ACROSS THE NORTHWEST

Clostridium difficile July – September 2019

Organisation Name	July to September 2019 Counts	Rates	Significance
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	28	41.2	
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	0	0.0	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	31	56.3	High (0.025)
BOLTON NHS FOUNDATION TRUST	25	50.5	High (0.025)
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	12	27.9	
EAST CHESHIRE NHS TRUST	0	0.0	
EAST LANCASHIRE HOSPITALS NHS TRUST	24	30.9	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	35	48.5	High (0.025)
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	2	18.9	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	43	24.8	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	7	16.1	
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	10	21.3	
PENNINE ACUTE HOSPITALS NHS TRUST	29	30.0	
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	21	33.2	
SALFORD ROYAL NHS FOUNDATION TRUST	10	14.9	Low (0.025)
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	6	18.7	
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	14	22.5	
STOCKPORT NHS FOUNDATION TRUST	14	26.8	
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	11	32.1	
THE CHRISTIE NHS FOUNDATION TRUST	6	43.2	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	4	63.9	
THE WALTON CENTRE NHS FOUNDATION TRUST	2	16.6	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	14	26.2	
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	11	25.0	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	15	23.1	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	11	29.2	
North West	385	29.0	

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MRSA – Annual rolling rate (November 2018 – October 2019)

Organisation Name	November 2018 to October 2019 Counts	Rates	Significance
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	3	1.1	
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	0	0.0	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	1	0.4	
BOLTON NHS FOUNDATION TRUST	1	0.5	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	3	1.6	
EAST CHESHIRE NHS TRUST	1	0.9	
EAST LANCASHIRE HOSPITALS NHS TRUST	1	0.3	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	1	0.3	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	1	3.5	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	9	1.3	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	3	1.7	
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	1	0.6	
PENNINE ACUTE HOSPITALS NHS TRUST	2	0.5	
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	1	0.4	
SALFORD ROYAL NHS FOUNDATION TRUST	2	0.8	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	1	0.7	
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	1	0.4	
STOCKPORT NHS FOUNDATION TRUST	0	0.0	
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	3	2.1	
THE CHRISTIE NHS FOUNDATION TRUST	1	1.8	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	0	0.0	
THE WALTON CENTRE NHS FOUNDATION TRUST	0	0.0	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	0	0.0	
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	3	1.6	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	3	1.1	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	1	0.7	
North West	43	0.8	

MSSA – Annual rolling rate (November 2018 – October 2019)

Organisation Name	November 2018 to October 2019 Counts	Rates	Significance
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	35	12.8	
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	10	15.5	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	16	7.0	
BOLTON NHS FOUNDATION TRUST	15	7.5	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	8	4.2	Low (0.001)
EAST CHESHIRE NHS TRUST	11	10.1	
EAST LANCASHIRE HOSPITALS NHS TRUST	31	10.0	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	25	8.7	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	17	38.4	High (0.001)
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	3	10.6	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	89	12.9	High (0.025)
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	12	6.7	
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	19	10.5	
PENNINE ACUTE HOSPITALS NHS TRUST	19	5.0	Low (0.001)
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	25	9.9	
SALFORD ROYAL NHS FOUNDATION TRUST	21	8.0	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	13	9.7	
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	30	12.3	
STOCKPORT NHS FOUNDATION TRUST	14	6.4	
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	19	13.0	
THE CHRISTIE NHS FOUNDATION TRUST	9	16.2	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	3	11.6	
THE WALTON CENTRE NHS FOUNDATION TRUST	9	17.5	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	35	17.0	High (0.025)
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	16	8.6	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	20	7.7	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	19	12.5	
North West	543	10.1	

E. coli bacteraemia - Annual rolling rate (November 2018 – October 2019)

Organisation Name	November 2018 to October 2019 Counts	Rates	Significance
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	66	24.2	
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	7	10.9	Low (0.025)
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	53	23.2	
BOLTON NHS FOUNDATION TRUST	40	19.9	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	32	17.0	
EAST CHESHIRE NHS TRUST	19	17.5	
EAST LANCASHIRE HOSPITALS NHS TRUST	73	23.6	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	63	22.0	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	6	13.5	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	10	35.3	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	135	19.6	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	39	21.9	
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	41	22.6	
PENNINE ACUTE HOSPITALS NHS TRUST	70	18.3	
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	67	26.5	
SALFORD ROYAL NHS FOUNDATION TRUST	48	18.2	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	28	20.8	
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	65	26.6	
STOCKPORT NHS FOUNDATION TRUST	52	23.9	
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	29	19.9	
THE CHRISTIE NHS FOUNDATION TRUST	31	55.8	High (0.001)
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	5	19.4	
THE WALTON CENTRE NHS FOUNDATION TRUST	12	23.4	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	40	19.4	
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	48	25.8	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	52	19.9	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	34	22.4	
North West	1165	21.7	

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Klebsiella bacteraemia - Annual rolling rate (November 2018 – October 2019)

Organisation Name	November 2018 to October 2019 Counts	Rates	Significance
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	27	9.9	
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	11	17.1	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	23	10.1	
BOLTON NHS FOUNDATION TRUST	15	7.5	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	12	6.4	
EAST CHESHIRE NHS TRUST	10	9.2	
EAST LANCASHIRE HOSPITALS NHS TRUST	20	6.5	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	11	3.8	Low (0.001)
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	5	11.3	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	2	7.1	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	96	13.9	High (0.001)
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	10	5.6	
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	12	6.6	
PENNINE ACUTE HOSPITALS NHS TRUST	31	8.1	
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	20	7.9	
SALFORD ROYAL NHS FOUNDATION TRUST	22	8.3	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	10	7.4	
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	21	8.6	
STOCKPORT NHS FOUNDATION TRUST	21	9.6	
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	12	8.2	
THE CHRISTIE NHS FOUNDATION TRUST	11	19.8	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	4	15.5	
THE WALTON CENTRE NHS FOUNDATION TRUST	3	5.8	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	14	6.8	
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	16	8.6	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	16	6.1	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	9	5.9	
North West	464	8.7	

Pseudomonas aeruginosa - Annual rolling rate (November 2018 – October 2019)

Organisation Name	November 2018 to October 2019 Counts	Rates	Significance
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	10	3.7	
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	1	1.6	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	5	2.2	
BOLTON NHS FOUNDATION TRUST	2	1.0	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	1	0.5	Low (0.025)
EAST CHESHIRE NHS TRUST	2	1.8	
EAST LANCASHIRE HOSPITALS NHS TRUST	6	1.9	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	15	5.2	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	2	4.5	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	2	7.1	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	30	4.4	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	3	1.7	
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	6	3.3	
PENNINE ACUTE HOSPITALS NHS TRUST	6	1.6	
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	6	2.4	
SALFORD ROYAL NHS FOUNDATION TRUST	5	1.9	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	7	5.2	
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	10	4.1	
STOCKPORT NHS FOUNDATION TRUST	2	0.9	Low (0.025)
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	3	2.1	
THE CHRISTIE NHS FOUNDATION TRUST	6	10.8	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	6	23.2	
THE WALTON CENTRE NHS FOUNDATION TRUST	0	0.0	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	4	1.9	
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	4	2.2	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	8	3.1	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	3	2.0	
North West	155	2.9	

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/03/39**			
SUBJECT:	**Learning from Experience Report - Q3 2019/20**			
DATE OF MEETING:	25 March 2020			
AUTHOR(S):	Layla Alani, Deputy Director Governance			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.			X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#145 (a) Failure to deliver our strategic vision.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The following report provides an overview of the Learning from Experience Report. The information within the Learning from Experience report is extracted from the Datix system and other Clinical Governance reports for Incidents, Complaints, Claims, Health & Safety, Mortality and Clinical Audit related to Quarter 3, 2019/20.			
PURPOSE: *(please select as appropriate)*	Information	Approval	To note X	Decision
RECOMMENDATION:	The Board of Directors are asked to: • Discuss and note the contents of the report			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/20/03/40		
	Date of meeting	03 March 2020		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

SUBJECT	Learning from Experience Report Q3	AGENDA REF:	BM/20/03/39

1. BACKGROUND/CONTEXT

This report relates to the period 1st October – 31st December 2019 (2019/20 Q3). It contains a quantitative and qualitative analysis (using information obtained from the Datix risk system) including incidents, complaints, claims and inquests. The report includes a summary of key issues identified in Quarter 3 with specific recommendations based upon the findings.

The purpose of the report is to:

- Identify themes arising from; Incidents, Complaints, Claims, Health & Safety, Mortality and Clinical Audit data that have been reported during Quarter 3.
- Make recommendations to the CBUs highlighting areas of focus for improvement.
- Provide a summary of incidents, complaints and claims reported during the review period, highlighting any trends apparent from the review of the data.

2. KEY ELEMENTS

2.1 Items for Assurance from 2019/20 Q3

2.1.1. Clinical Incidents

- The number of minor harm incidents continued to decrease in Q3, with 319 reported compared to 332 in Q2.

- There was an increase in incident reporting within the Trust in Q3 (2527 in Q2 vs 2623 in Q3), demonstrating an open and honest culture that is committed to learn and improve. Figures for 2019/20 show an average of 860 incidents per month across the organisation, with 98.5% resulting in no harm or minor harm.

- Radiology in Q3 identified two serious incidents where there had been a delay in the diagnosis of a lung cancer. Both incidents involved inpatient referrals. CT scans were recommended by the Radiologist reporting the patient's initial chest x-rays and were highlighted via the Radiology alerts system. However, the messages regarding these alerts were not actioned by the clinical teams as they were not communicated effectively.
    - Radiology currently have a process for GP patients whereby if a chest x-ray is suspicious for lung cancer, a CT scan will be requested on behalf of the clinician

and ensure that the scan is completed and performed within an agreed timescale. Radiology has agreed to extend this pathway to include inpatient and outpatient referrals and work is currently taking place to progress this. This will both reduce the overall time to diagnosis and mitigate future risk of an alert being overlooked.

- An SOP has been completed for the Radiology department and there will be Trustwide communication of this in February 2020.

- Medication - A patient with atrial fibrillation was admitted for 12 days following a fall. Throughout the admission, the patient's warfarin was not prescribed, his VTE risk assessment was not complete and enoxaparin was not prescribed for thromboprophylaxis. Examples of learning and actions from the 72 hour review included:
  - Medication Safety Officer attended the AMU teaching session to provide learning from the incident. This included discussion regarding the use of Summary Care Records.
  - The incident was discussed with the ED team and shared with the junior doctors involved in the on-call process.
  - Single point lesson on the use of Summary Care Records has been circulated via the Trust Safety Huddle and to all clinical staff.
  - Pharmacy processes have been reviewed to ensure appropriate patient care from pharmacy with EPMA.

- Urology - 77 year old patient initially had gone into retention after micro-laryngoscopy. A Urology referral was made but this was delayed by 6 weeks due to waiting times for consultant review. The patient attended six times to the Trust after catheter insertion but did not receive an urgent Urology referral during these attendances. The gentleman was found to have slow growing prostate cancer which was then treated. The following actions were taken as a result of this:
  - Recruitment of another nurse to the TWOC clinic.
  - New process in place to ensure consultant oversight of patients requiring urgent review.
  - Shared learning to the Urology and the ED team.

- Highlighted learning / actions from Pressure Ulcer incidents:
  - Accurate documentation on care and comfort charts is being reinforced including prescribed care.
  - Training is being commenced from company representatives on new anti-embolism stockings and anti-friction bootees.

- Information Governance - A trend in incidents involving misplaced / lost handover sheets printed from Lorenzo was identified by scrutinising incident reports prepared for the Information Governance and Corporate Records Sub-Committee. The following actions were taken:
    - Caldicott Guardian and SIRO made aware via Information Governance forum.
    - Trust wide alerts issued.
    - Messages about correct disposal of handover sheets shared at Ward Manager's meeting.
    - IT engaged so that changes to Lorenzo could be made in order that the name of the staff member printing the handover sheets is displayed on the document.

2.1.2. Complaints and PALS

- The majority of CBUs improved their performance for responding to complaints on time. The Trust currently has 0 breached complaints.
- There was an 18% decrease in complaints opened Trust wide in Q3 (107 in Q3 versus 131 in Q2). The Trust currently has no complaints over 6 months old.
- Themes identified in complaints mirror those found across PALS and incident reporting; delays in treatment, appointments issues and communication issues.
- There has been further improvement in the timeliness of responding to concerns during Q3 compared to Q2; CBUs have been reminded of the timescales required to ensure continual improvement.
- Actions from complaints are monitored via the speciality governance dashboards and the Clinical Governance Department, reporting to the Complaints Quality Assurance Group. Complaints actions are also circulated Trustwide on a weekly basis.
- The Trust currently has 4 open PHSO cases. The PHSO finalised 2 investigations during Q3; one investigation was discontinued and the other was not upheld and there were no failings identified.

2.1.3. Mortality

- As part of the mortality review process, 71 cases were discussion at MRG. Most of these cases were rated "Adequate" with some "Good" also being discussed. 4 SJRs were reported as 'poor'.
- DOLS/LD has become one of the largest triggers for an SJR. No DNACPR and Under 55s are the second largest triggers for an SJR.
- The Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratios (HSMR) are within expected range and stabilising. This will continue to be monitored. NHS digital will release SHMI data monthly rather than quarterly to enable timelier reporting.

- Learning from MRG is now being disseminated to Primary Care. Feedback is sent to all GPs via the Primary Care GP Newsletter which is coordinated by Warrington CCG.

2.1.4. Clinical Audit

- There are a number of audits ongoing across the Trust. For Q3 this briefing makes reference to the National Audit of Care at the End of Life (NACEL). WHH scored favourably in four of the nine themes including; communication with the dying person, communication with families and others, Governance and workforce/specialist palliative care. A bespoke training programme has been planned for Q4 to ensure continual improvement.

2.2 Key Learning from SI Investigations & Inquests concluded in 2019/20 Q3

- **Patient death / Issues highlighted at Inquest in Q3** - Patient attended for surgery and following the procedure the patient was slow to wake up. The patient was reviewed by the anaesthetic team in recovery and an urgent CT scan was completed. The CT scan confirmed that the patient suffered a stroke. The stroke team took over joint management of the patient on ITU. The patient showed some improvement and was transferred to the stroke ward. The patient's management was changed accordingly, receiving fluids and oral intake. The patient's condition was closely monitored, however the patient deteriorated and sadly passed away 3 weeks later. From the 72 hour review and subsequent inquest, the following lessons were learned:
    - Unexpected events in clinical care on the wards, theatres or other clinical environments must be reported on the Trust reporting system to facilitate early review.
    - Documentation by the theatre recovery nurse was well documented with times of interventions, which helped to answer the family and coroner's questions.
    - The Palliative Care team should have been consulted for their input sooner for support to the patient's family and for the staff involved in the patient's care.

- **Complication of Procedure / Deteriorating patient - Lessons Learned**
    - Escalate deteriorating patients in a timely manner to the Consultant on call.
    - Following assessment of a critical patient for admission to ITU, limitations of treatment with the Consultant on-call must be discussed at an early stage. This may prompt a plan for further management and discussion with relatives.
    - Metaraminol infusion should not be prescribed at rates greater than 15 ml/hr. This would prompt alternative and early action to address a deteriorating patient.

- **Delayed diagnosis of lung cancer - Lessons Learned**
  - Radiology to recommend appropriate follow up imaging for chest x-rays with infection in high risk groups as per Royal College of Radiologists (RCR) guidelines.
  - All clinical teams need to have a robust process to ensure recommendations from imaging findings are acted upon.
  - The importance of thorough documentation in terms of actioning Radiology alerts, discussion of results with patients and any other actions taken.
  - The importance of working systematically and in a measured way when under pressure to minimise the risk of errors and omissions.

- **Never Event: Wrong site procedure - Lessons Learned**
  - In an event such as an equipment failure in theatre, it is a priority to fully resolve the issue prior to proceeding with the next steps.
  - To focus on safety processes especially in circumstances where an intervention is not progressing as planned or there are distractions.
  - The productive operating theatre programme evaluation demonstrated improvements in safety and reliability of care, team working and efficiency.
  - In experiencing distractions, equipment failure and time pressure the anaesthetist should have stabilised the patient on the second anaesthetic machine and then initiated the 'Stop before you Block' check.
  - In November 2019 the S.A.F.E campaign was launched at the Patient Safety Summit. S.A.F.E is an acronym for Stop and Focus Everyone. In simple terms, it's a straightforward way to call a halt when potential mistakes are about to happen, to allow the team to concentrate on the task in hand.

2.3 Items for Escalation from 2019/20 Q3

2.3.1. Clinical Incidents

- There was an increase of 2 incidents causing Moderate to Catastrophic harm in Q3 (39 in Q2 vs 41 in Q3).
- The Trust reported 345 incidents open in CBUs in Q2. To date this has decreased to 294, with significant improvements in incident management noted across the organisation.
- In Q3 incidents relating to pressure ulcers increased by 18% and infection control increased by 11%, whilst incidents relating to falls, diagnostics, staffing and medications all reduced in the quarter.
- Incident reporting figures for AMU showed a reduction in Quarter 3 which may suggest under-reporting. This will be closely monitored by the governance team. Despite the reduction in reporting figures AMU did report a significant increase in patient falls at 57%. C21 also reported a 75% increase in patient falls in Quarter 3. Whilst these figures are high the increase is likely to be due to a greater number of patients naturally more at risk of falls usually seen during the winter months. Two of these falls resulted in harm one of which occurred on the Forget Me Not Unit.

2.3.2. Non-Clinical Incidents

- From 1st October to 31st December 2019, there were 365 non-clinical incidents reported. The top 2 categories were Security Incidents and Infrastructure / Health & Safety Incidents. Education continues with security to ensure that reporting is accurate. Needlestick injury was one of the top sub-categories for Health & Safety Incidents. A Trustwide Sharps Audit in relation to the use and disposal of sharps was conducted in 61 areas in November 2019. 21 of these areas were fully compliant.

2.3.3. Complaints

- Staff attitude complaints and appointment date issues have shown an increase in Q3.
- Training on First Impressions and Customer Care continues to be rolled out across the Trust.
- Complaints around clinical treatment have reduced in Q3 - mirroring Q3 incident reporting which saw clinical care issues reduce.

2.3.4. Claims

- Payments for clinical claims settled with damages totalled: £2,073,731.23 including costs
- Payments for non-clinical claims settled with damages totalled: £7,000.00 including costs. Learning from individual claims continues to be disseminated.

2.3.5. Mortality

- Medical Care, Integrated Medicine and Community and Urgent and Emergency Care continue to report the highest number of mortalities, though this is not disproportionate when considering the type and number of patients cared for in these areas.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Items to escalate to Quality Assurance Committee where there are active/potential risks (with proposed actions to address)			
Item to escalate	**Assurance (RAG)**	**Action**	**Deadline Date**
Trust-wide Sharps Audit in relation to the use and disposal of sharps. In total 61 areas were visited over a two day period. 21 of these areas were compliant (34%).		Whilst improvement in compliance has been noted, it has been agreed that these audits will continue on an unannounced basis for further assurance of continued improvement and sustainability.	Ongoing
Pressure Ulcer Incidents - Patients in ED at risk of pressure ulcers should be nursed on Repose trolley topper or dynamic mattress and hospital bed. This must be recorded in the patients' notes.		Learning from pressure ulcer incidents is cascaded to the ward team by the ward manager and via safety brief. Lessons learnt are also cascaded via Trustwide safety brief. The Tissue Viability Clinical Nurse Specialist provides face to face pressure ulcer prevention training and tissue viability link in with other clinical group meetings. The new pressure relieving mattress contract due to commence early 2020. Once implemented this should help to rectify this problem as one of the criteria is that the mattress must provide both alternating pressure and continuous low pressure therapy without having to upgrade from one mattress to another.	February 2020

Item to escalate	Assurance (RAG)	Action	Deadline Date
SHMI and HSMR		A Task and Finish group to look at Finished Consultant Episodes is established, led by the Trust Mortality Lead. A SOP has been developed to enable ward clerks to edit the system instead of multiple episodes being created each time a patient is moved. Work on Lorenzo is required to enable the editing function to be available to the appropriate staff. MRG members are also working with the Lorenzo team to develop CDC forms from a mortality perspective. To reduce R codes the team is looking at removing the possibility for clinicians to input words such as 'likely' or 'possibly' into their working diagnosis.	March 2020 April 2020
Complaints relating to staff attitude and behaviour have continued to increase in Q3 compared to Q1 and Q2. Training on First Impressions and Customer Care continues to be rolled out across the Trust.		Training on First Impressions and Customer Care continues to be rolled out across the Trust. When a specific concern is highlighted in a complaint it is recommended that the member of staff attend this training. This training is being provided by the Education Department on a monthly basis.	Monthly - Ongoing
EPMA – patient allergies not confirmed		A report to be constructed to identify from EPMA, patients admitted without allergy status being confirmed.	February 2020

4. IMPACT ON QPS?

In relation to quality we aim to provide high quality, safe care and an excellent patient experience. By providing a Learning from Experience report, we are ensuring quarterly key Trustwide learning from incidents, complaints, claims, mortality and clinical audits. Through this reflective analysis from the previous quarter, we are able to capture learning and generate improvements which will support the aims concerning quality.

5. MONITORING/REPORTING ROUTES

The information within this Learning from Experience report is provided and overseen by the Clinical Governance Team and Clinical Audit Department.

Learning from investigations is provided monthly at each Specialty and CBU governance meeting through monthly learning newsletters. Learning from SI investigations is also reported to the Patient Safety and Clinical Effectiveness Sub-Committee on a monthly basis.

Key learning from governance information at a Trustwide level is captured and analysed on a quarterly basis, and is submitted to the Quality Assurance Committee – contained within this report and the accompanying slides.

6. TIMELINES

Trustwide learning was captured and analysed from the period October 2019 to December 2019 (2019/20 Q3).

7. ASSURANCE COMMITTEE

A quarterly report will be submitted to the Quality Assurance Committee, then to the Board of Directors.

8. RECOMMENDATIONS

The Board of Directors are asked to discuss and note this highlight report and accompanying slides**.**

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HIGH QUALITY SAFE HEALTHCARE
QUALITY PEOPLE SUSTAINABILITY

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Learning From Experience Q3 Report

Layla Alani

Deputy Director of Governance

February 2020

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Overview

The following slides provide an overview of the information extracted from the Datix system and other clinical governance reports for Incidents, Complaints, Claims, Health & Safety, Mortality and Clinical Audit related to Quarter 3, 2019/20. They should be viewed in conjunction with the High Level Briefing Report.

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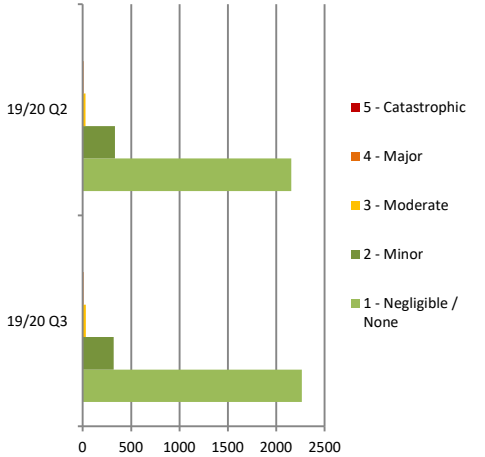
Incident Headlines

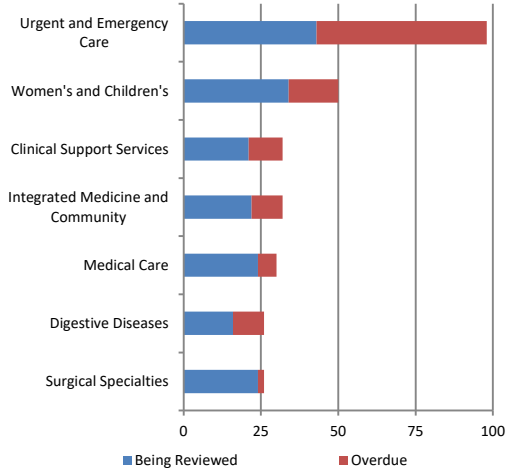
How many staff are raising incidents Q2 vs Q3?

- There was a 4% increase in incident reporting within the Trust in Q3 (2527 in Q2 vs 2623 in Q3).
- There was a slight **increase** in incidents causing Moderate to Catastrophic harm in Q3 (39 in Q2 vs 41 in Q3)
- The number of minor harm incidents continued to decrease in Q3.



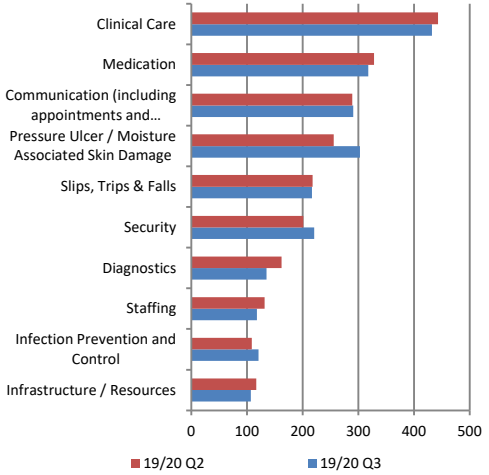
How many incidents are open Q2 vs Q3?

- The Trust reported 345 incidents open in CBUs in the Q2 LFE. To date that has decreased to 294. The graph below shows the 7 CBUs with open incidents and the number of which are overdue.
- Providing feedback and closing incidents in a timely manner remains an important focus and work will continue to ensure that performance improves.
- Significant improvements are noted across the organisation for incident management.



What type of incidents are we reporting Q2 vs Q3?

- As stated, there was an increase in the amount of indents reported. Incidents relating to pressure ulcers, security and infection control increased in Q3.
- However, incidents relating to clinical care, medication, diagnostics and staffing all decreased in Q3.
- In Q3, 'Health and Safety' was launched as a new stand-alone reporting category to capture more non-clinical incidents across the Trust.



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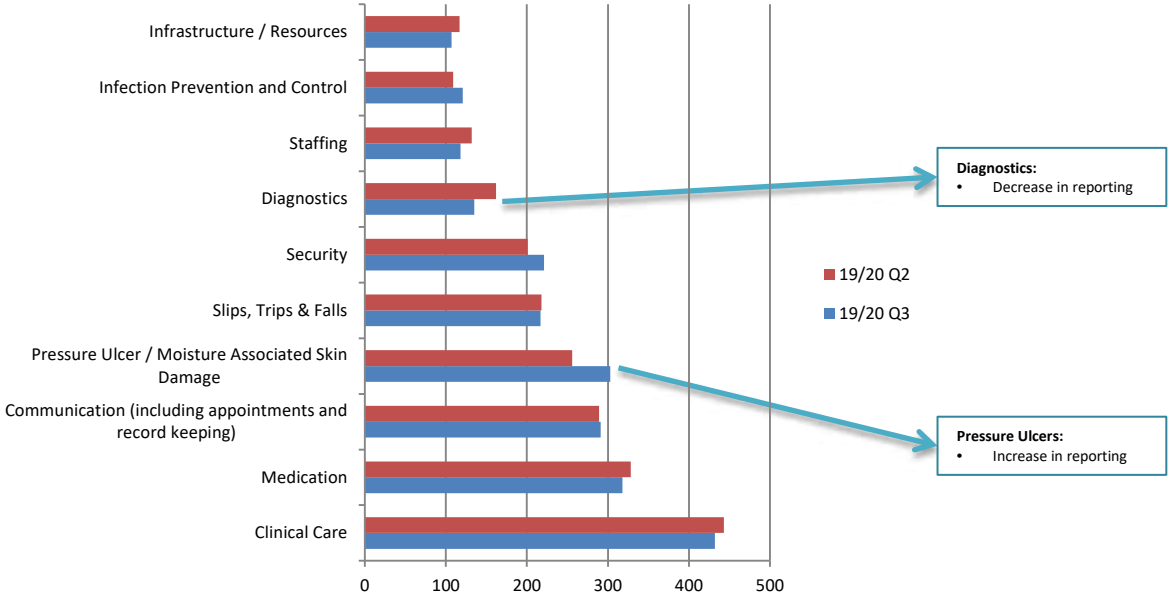
Incident Category Analysis Q2 vs Q3

The information shows the top categories reported incidents how they differ between the 2 quarters.



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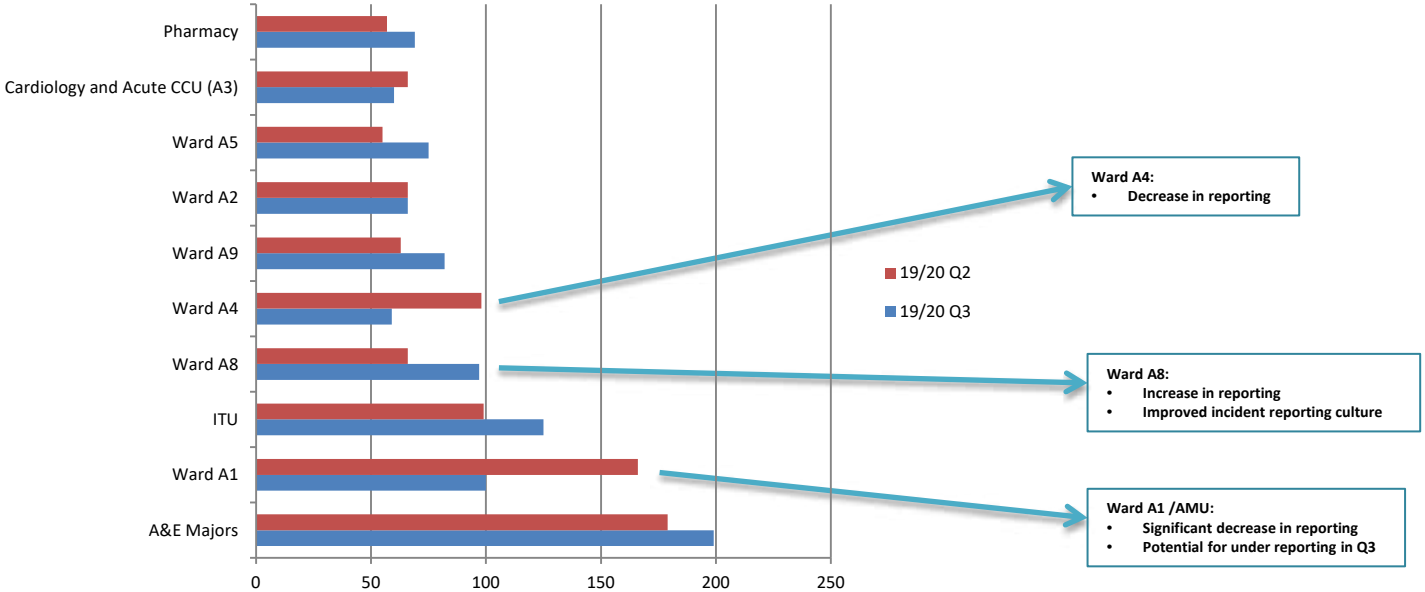
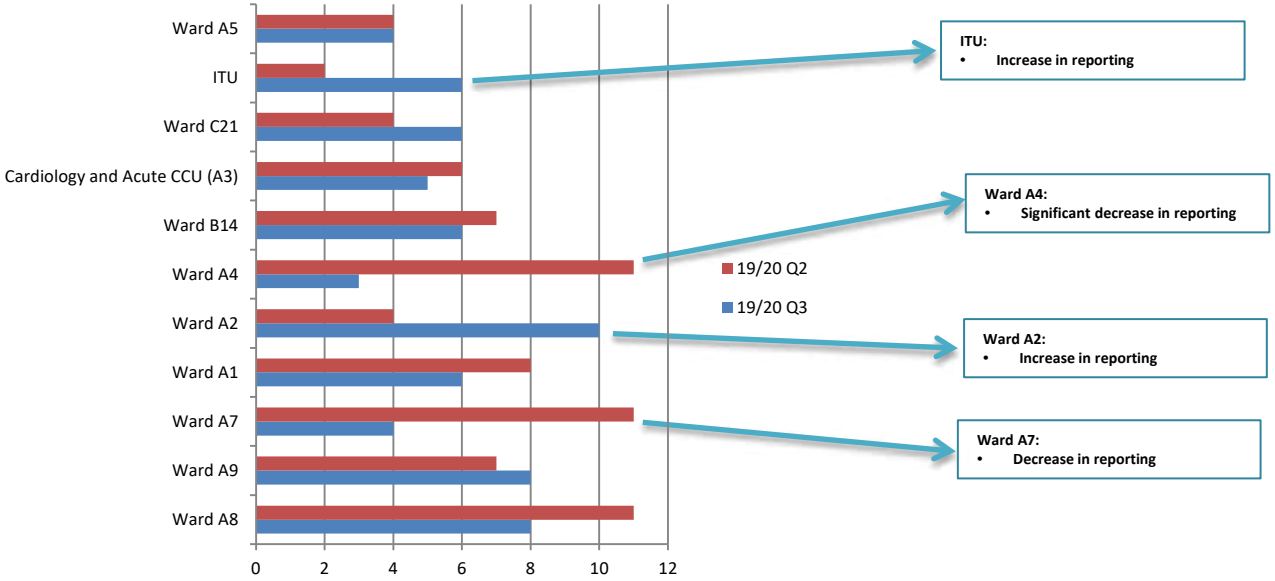
Incident Location Analysis Q2 vs Q3

The information shows the top reporting locations and how they differ between the 2 quarters.



Staffing Incidents Location Analysis Q2 vs Q3

The information shows the top reporting locations in relation to staffing incidents and how they differ between the 2 quarters.



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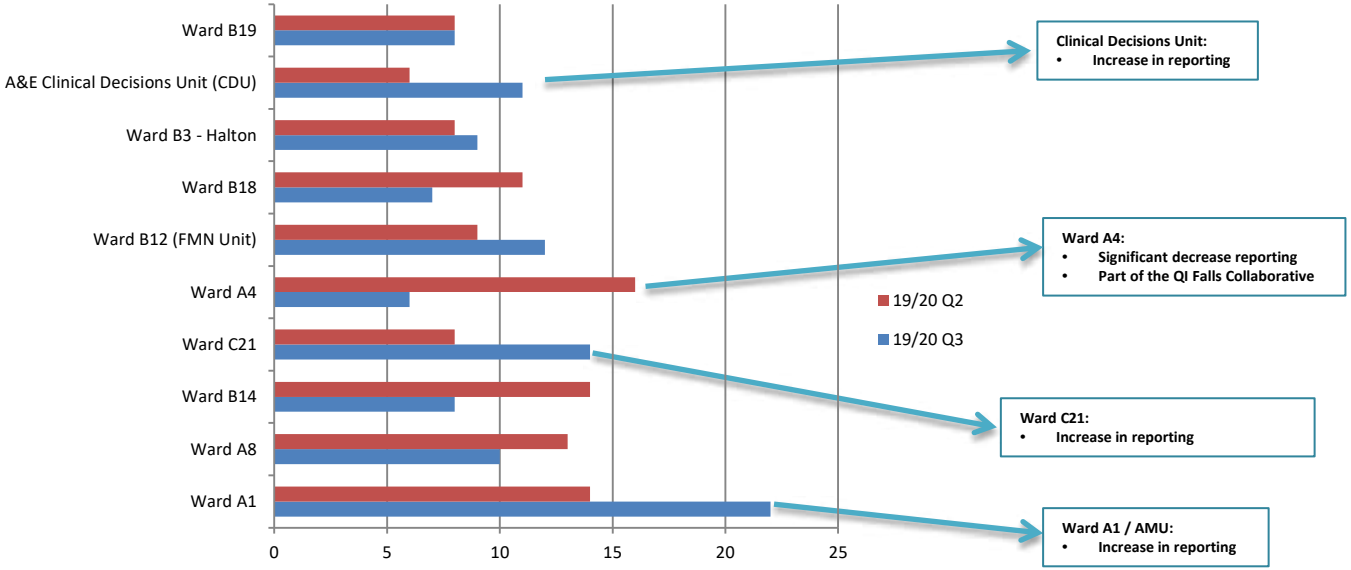
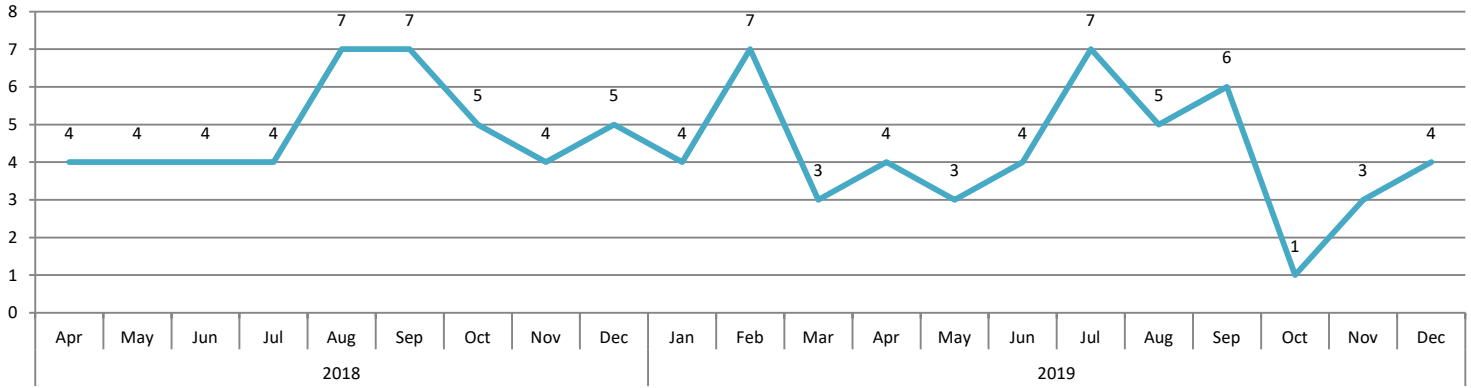
Patient Falls Location Analysis Q2 vs Q3

The information shows the top reporting locations in relation to patient falls and how they differ between the 2 quarters.

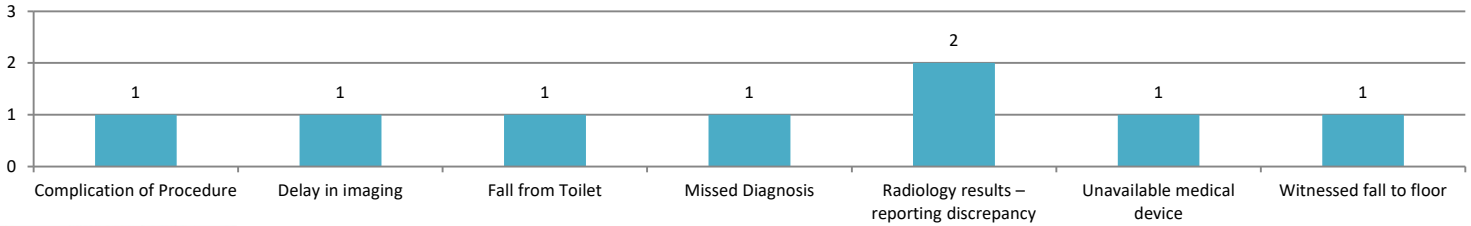


Serious Incident (SI) Reporting

SIs reported by Month



SI Cause Groups Q3



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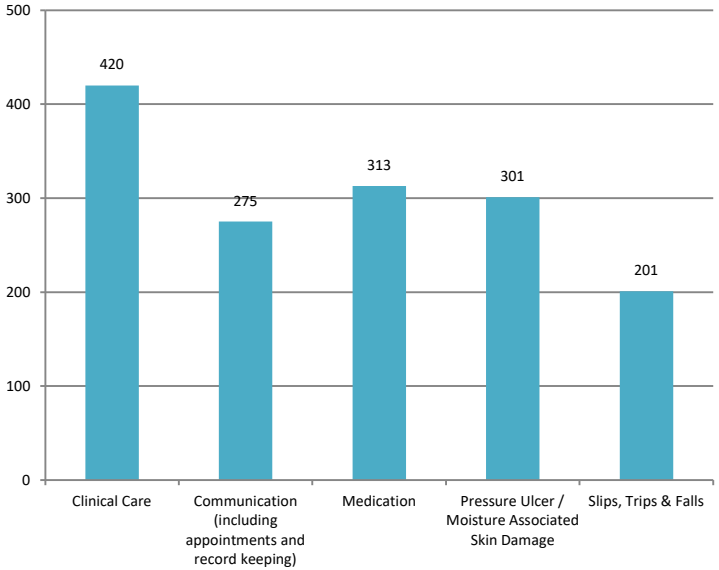
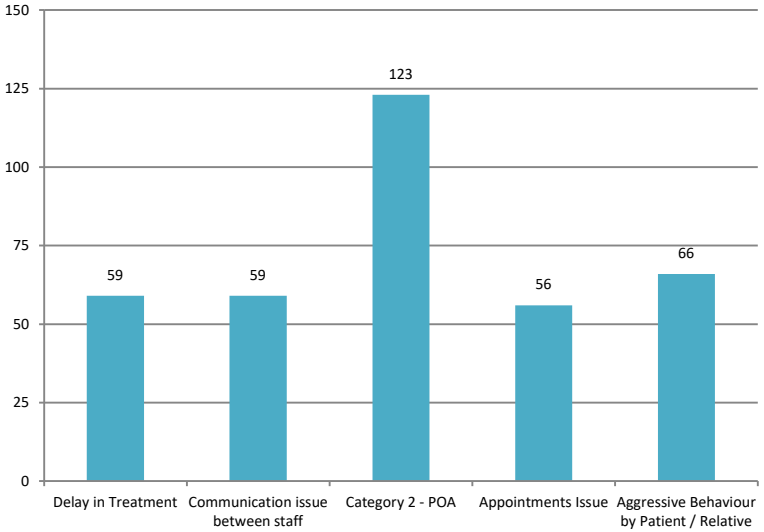
Across the 8 CBUs in Q3

A total of 2438 incidents were reported across the 8 CBUs in Q3, this has increased from 2382 from Q2.

The top 5 categories and subcategories in Q3 were reported as follows:





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Learning from Incidents

Never Event

A patient was admitted with bi-lateral fractured neck of femurs. The equipment and devices required for the procedure were confirmed as available; that is 2x 135 degree angle orthopaedic implants.

At surgery, the right side was completed with the 135 degree angle implant as planned. The left side was completed and following the procedure it was realised that a 130 degree implant was used on the left side instead of the planned 135 degree implant. Whilst 130 degree implants can be used for treatment the incident was deemed a never event due to the checking process based on the NHS England's criteria.

Lesson Learned

- An incident can be deemed a never event without harm to a patient.
- The theatre safety processes should always be followed without exception regardless of how experienced the member of staff.
- There should be a ***pause and check*** when there are changes within the theatre environment.

Medication Overdose

Patent admitted with agitation, confusion and hallucination and pneumonia. CT scan was requested and the patient was very agitated. Lorazepam was prescribed for patient's agitation. Staggered doses were given to an overall amount of 13 mgs. The patient's GCS dropped. MET team called. Flumazanil for reversal was given with good effect.

Lessons Learned

- Reflection for the staff involved
- Consider dose, patient's age, medication the patient already had and alternatives when prescribing medication for an acute episode

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Learning from Incidents

Safeguarding

A patient with hypothyroidism and Down's Syndrome attended the hospital with a decline in baseline mobility and urinary incontinence. The patient was discharged following review as mobility was assessed to be back to base line. Community LD nurse was contacted and gave advice on community physiotherapy. The patient returned a week later with double incontinence. The patient was diagnosed with a traumatic L1 fracture with acute cord compression and transferred to Walton Hospital.

Lessons Learned

- Consider alternative diagnosis such as occult fracture (even if no history of trauma or fall) when there is an unexplained reason for a patient's sudden decline in baseline mobility function.
- It is important to acknowledge the information and history given by patients, carers and their family regarding a normal baseline function when considering alternative diagnoses. The patient's urinary incontinence was thought to be related to his reduced mobility and an alternative was not considered.
- Reasonable adjustments should be made for patients with learning disabilities in order to undertake investigations. The patients' community LD team should be consulted during their admission.

Patient Death

Patient attended for surgery and following the procedure the patient was slow to wake up. Reviewed by anaesthetic team in recovery and urgent CT scan was completed. CT scan confirmed that the patient suffered a stroke. Stroke team took over joint management on ITU. The patient showed some improvement and was transferred to the stroke ward. The patients' management changed accordingly and she did receive fluids and was given oral intake. Her condition was closely monitored. Despite this, the patient's condition did subsequently deteriorate and 3 weeks later the patient sadly passed away.

Lessons Learned

- Unexpected events in clinical care on the wards, theatres or other clinical investigation environments should be reported on the Trust reporting system to facilitate early review.
- Documentation by the theatre recovery nurse was well documented with times of interventions, which helped to answer the family and coroner's questions.
- The Palliative Care team should have been consulted for their input sooner for support to the patient's family and for the staff involved in the patient's care.

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Learning from Incidents

We found….	We Acted….
A 75 year old gentleman was admitted to hospital with known heart failure and shortness of breath. Fell on the ward. An investigation found no clear missed opportunities, however there was still some incidental findings and learning from the incident.	
1) Excessive CT Scans: If the initial CT scan request had recorded the history of Stage 4 Melanoma with pulmonary metastases there could have been a CT Scan with contrast completed preventing three further CT Head Scans	Reminders circulated through the governance programme: when requesting CT scans be sure to provide a full pertinent history = radiologists have all the information required for accurate reporting.
2) External advice was sought but not well documented	Share with staff: there is a 'Specialist external advice' form in the electronic patient record for documentation of advice from external specialists.
3) All clinical assessments completed daily but much of it is copied and pasted from the electronic patient record (Lorenzo) and this is how the CT scan appears to have been overlooked	The risks of using the cut and paste technique when completing the Lorenzo clinical information was fed back to all clinicians through the speciality meetings and the CBU Governance meetings.
4) The ceiling of care paperwork had not been fully completed	Staff who complete the ceiling of care paperwork must complete them thoroughly in a timely and appropriate manner and any changes required need to be signed and dated at the time.
Positive Findings The open and frank end of life care and discussions around the decision making and the prognosis enabled the patient to discuss his wishes for his care with his family.	The end of life discussions between the patient and the staff assisted him and his family to fully understand that this was a life limiting illness which then enabled both the patient and family to accept the diagnosis and have frank and open discussions regarding future preparations and wishes.

Learning from Incidents

We found….	We Acted….
➢ 80 year old patient with history of recurring bladder cancer was admitted with significant haematuria under the care of Urology. Anti-platelets were withheld due to concerns regarding ongoing frank haematuria and a low Hb. ➢ When the patient was reviewed by an Anaesthetist for syncopal episode they highlighted that the patient had not been discussed by Cardiology despite recent Coronary Artery Stent inserted. ➢ Although the decision to withhold anti-platelets was found to be reasonable, the decision should have been best made by a multi-disciplinary team to consider fully all risks.	➢ Shared learning provided at the Urology governance meeting ➢ Shared learning in speciality governance agendas. ➢ Individuals received feedback regarding the incident for further reflection.
❑ 77 year old patient initially had gone into retention after micro-laryngoscopy. A Urology referral was made but was 6 weeks delayed due to lack of consultant appointment capacity. ❑ The patient attended six times to the Trust (two TWOC appointments and 4 ED attendances) after catheter insertion but did not receive an urgent Urology referral at any of the attendances. ❑ The gentleman was found to have slow growing prostate cancer which was then treated	❑ Recruitment of another nurse to the TWOC clinic. ❑ New process in place to ensure consultant oversight of patients requiring urgent review. ❑ Shared learning to the Urology Team and ED

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Learning from Incidents

We found….	We Acted….
➢ Patient was admitted for left shoulder arthroscopy, decompression and mini open excision. ➢ The patient was given local anaesthetic block to the wrong side which was recognised during positioning in preparation for surgery. ➢ The 'stop before you block' process which has been implemented and well established was not followed due to a series of distractions and managing equipment failure.	➢ Learning from the incident cascaded back to anaesthetic, surgery and theatre departments. ➢ Consideration of all equipment required for the procedure at the safety huddle to ensure that equipment is available for use.
❑ 61 year old woman had a fall near the toilet which caused a fractured humerus. ❑ The patient fell when mobilising unaided despite the physiotherapy assessment recommending mobilisation with assistance of 2. It was deemed that if consideration was given to enhanced level care assessment the patient may have been under enhanced care and therefore been more closely monitored.	❑ Re-training for the staff on the enhanced care policy and completion of the enhanced care risk assessments. ❑ Shared learning with the teams involved and across the CBU.

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Learning from Incidents – Children's Health

What happened…	Learning action points
Risk of pressure sores from under hub of cannulas	Duoderm to be placed under the hub of cannulas to reduce the risk.
Staff decontaminating an incubator after an infant transferred to a different hospital, found a suture needle under the main tray. Sharp discarded safely by staff – no harm caused. Incubator decontaminated appropriately	Correct steps completed following identification of the sharp instrument in the incubator. All staff reminded to adhere to the Trust sharp safety policy.
Delay in transferring a paediatric patient with mental health issues to ward.	Initial phone call to ward undertaken by healthcare assistant leading to confusion of clinical situation. Lesson learned is for appropriate escalation and management of patient to be completed by clinician in timely manner.
Mislabelling of bloods, patient had to be re-bled and there was a delay in results	Ensure that bloods are labelled at the bedside to ensure the correct identifiers are on the sample prior to sending to the laboratory.

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Learning from Incidents – Women's Health

What happened…	Learning action points
A woman was transferred to main theatres (due to both maternity theatres unavailable) for treatment of retained placenta and postpartum haemorrhage. There was a delay in transfer due to waiting for transfer monitor. Emergency drugs and equipment had to be taken to main theatres.	Delivery suite shift leaders to request transfer monitor as soon as decision made to transfer woman to main theatre. Emergency drugs and equipment now stored in main theatres.
Inappropriate activation of Massive Haemorrhage Policy (MHP). Four units of red cells were ordered for a patient. Whilst the request was being processed the Clinical Team telephoned to activate Major Haemorrhage. Emergency blood was offered but declined because the patient wasn't currently bleeding; a bleed was predicted hence red cells and Fresh frozen plasma (FFP) were requested as per the MHP (grade 4 placenta previa). When informed this was not an appropriate activation, the Consultant insisted it was and that the FFP be processed. Products not used. The FFP expired in stock and discarded and the red cells were returned to stock the following day.	**Learning for the Clinical Team:** Activation of the MHP is for patients actively bleeding in a life threatening situation. Blood e.g. cross-matched/emergency/group specific can be obtained without activating the pathway. This can be made available if the Clinical Team is concerned about bleeding in Theatre.
A woman with previous caesarean section attended labour ward with continuous suprapubic pain and fetal malposition. There was a delay of 10 minutes to transfer to theatre for emergency caesarean while administering steroid injection.	Learning point discussed with obstetric registrar to transfer to theatre immediately in the presence of fetal malposition and continuous pain.

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Learning from Incidents - Radiology

We found….	We are doing….
Two serious incidents where there had been a delay in the diagnosis of a lung cancer. Both incidents involved inpatient referrals. CT scans were recommended by the Radiologist reporting the patient's initial chest x-ray and highlighted via the Radiology alerts system. Messages regarding these alerts were not communicated effectively and not actioned by the clinical teams.	Radiology currently have a process for GP patients where if a chest x-ray is suspicious for lung cancer, Radiology will request the CT scan on behalf of the clinician and ensure the scan is completed and performed in an agreed timescale. Radiology has agreed to extend this pathway to include inpatient and outpatient referrals and work is currently taking place to progress this. This will both reduce the overall time to diagnosis and mitigate against the risk of an alert being overlooked.

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Learning from Incidents - Medications

We found…..	We acted…..
A patient who had atrial fibrillation was admitted for 12 days after a fall. For the whole of the admission, his warfarin was not prescribed, his VTE risk assessment was not completed and he was not prescribed enoxaparin for thromboprophylaxis.	**Learning and actions from the 72 hour review included:** • Medication Safety Officer attended AMU teaching session to provide learning from the incident and discussed use of Summary Care Records. • Incident to be discussed with ED lead and to be shared with the junior doctors who are involved in the on call process. • AMU ward manager to remind staff on their safety huddle to complete full VTE risk assessments on admission to the ward. • Single point lesson on use of Summary Care Records to be circulated via the Trust Safety Huddle and to all clinical staff. • Pharmacy processes have been reviewed to ensure appropriate patient care from pharmacy with EPMA.
A significant number of patients were being prescribed/administered medication without their allergies being confirmed on EPMA.	• Highlighted at Trust Safety Huddle, Pharmacy Safety Huddle and Medical Handover and a poster regarding allergy status on EPMA was circulated to all clinical staff. • Wards/clinical areas were visited to provide medical/nursing staff with training on allergies on EPMA. • A report is being constructed to identify from EPMA, patients admitted without allergy status being confirmed.

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Learning from Incidents – Pressure Ulcers

- Daily pressure ulcer/device ward round on ICU.
- 1:1 training on ICU on preventing device related pressure ulcers (focussing on junior staff).
- Training from company representatives on new anti-embolism stockings and anti friction bootees.
- Phase 3 of Pressure ulcer collaborative commenced in January 2020.
- New Cheshire and Merseyside pressure patient information leaflet to be implemented.
- Accurate documentation on care and comfort charts to be reinforced including prescribed care.
- New pressure relieving mattress contract due to commence early 2020.

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Learning from Incidents – Information Governance

We Found	We Acted….
A trend in incidents involving misplaced/lost handover sheets printed from Lorenzo was identified by scrutinising incident reports prepared for the Information Governance and Corporate Records Sub-Committee.	• Caldicott Guardian and SIRO made aware via Information Governance forum. • Trust wide alerts issued. • Messages about correct disposal of handover sheets shared at Ward Manager's meeting. • IT engaged so that changes to Lorenzo could be made in order that the name of the staff member that prints handover sheets is displayed on the sheet.
An increase in incidents of 'Phishing' emails (emails sent to users in order to secure usernames, passwords or personal information) sent to staff and malevolent cyber activity directed at NHS organisations more generally.	• Alerts issued to staff containing reminders to delete suspicious email, not to click on links contained in them and to use the Report Phishing button within NHS mail. • GCHQ cyber training event arranged for Trust Board members and has been delivered. • Alerts issued related to increased cyber threat.

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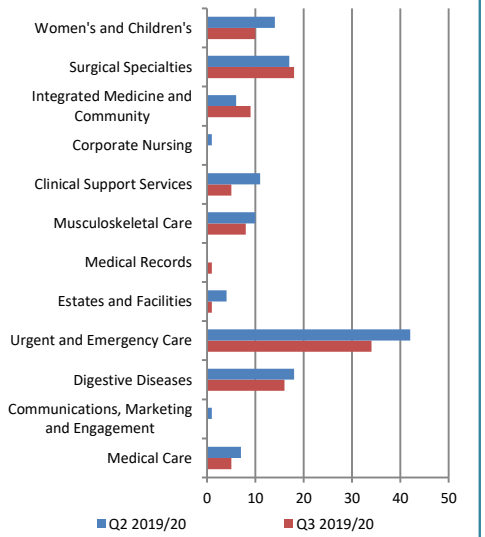
Complaints Headlines Q2 vs Q3

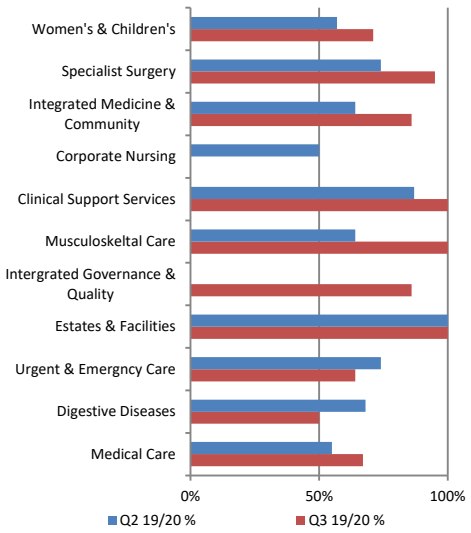
How many people are raising complaints Q2 vs Q3?

- There was an 18% decrease in complaints opened Trust wide in Q3 (107 in Q3 versus 131 in Q2).
- Integrated Medicine and Community and Surgical Specialties saw an increase in the number of complaints received in Q3.
- Urgent and Emergency Care, Digestive Diseases, Medical Care, MSK, Women's and Children's saw a decrease in the number of complaints.



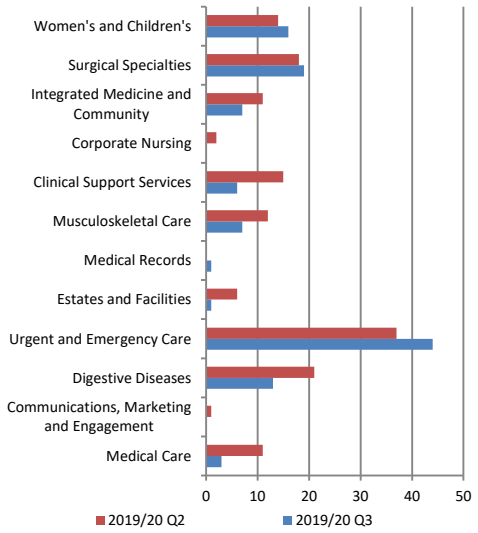
Are we Responsive Q2 vs Q3?

- A majority of the CBUs increased their performance for responding to complaints on time.
- The Trust currently has 0 breached complaints
- There are no complaints over 6 months old



How many complaints has the Trust closed Q2 vs Q3?

- There was a decrease in the number of complaints closed in the Trust in Q3 (117 in Q3 versus 148 in Q2).
- All CBUs have decreased in the number of complaints closed in Q3. Medical Care and Digestive Diseases have seen the highest decrease.
- Urgent and Emergency Care have increased the amount of complaints they have closed.



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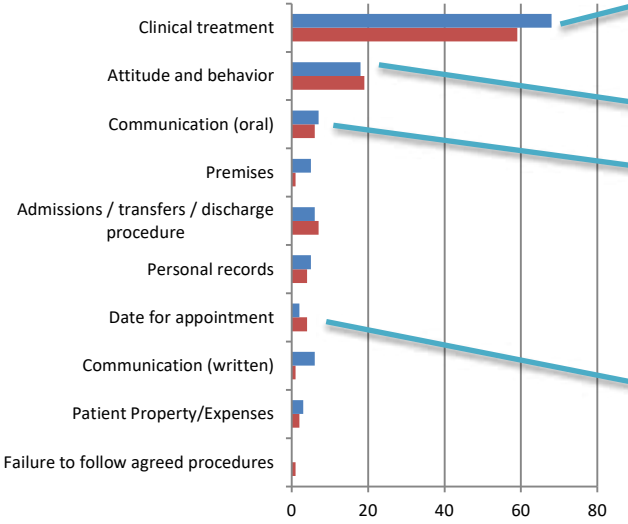
Complaints Analysis Q2 vs Q3

The information shows the top subjects in complaints in Q2 vs Q3.
Note: Complaints can have more than one subject.



Clinical treatment:
- There was a decrease in the number of complaints received in Q3 compared to Q2 regarding clinical treatment (59 in Q3 verses 68 in Q2). Concerns include coordination of medical treatment, delay in treatment and treatment did not have expected outcome,
- Insensitive to patients needs and communication issues can also be linked to when the Trust is on full capacity.

Communication and Attitude and Behaviour:
- Poor communication and staff attitude and behaviour has increased by one in Q2 compared to Q1.
- Training on First Impressions and Customer Care continues to be rolled out across the Trust.

Date for an appointment:
- In Q3 there has been an increase in complaints relating to receiving an appointment date.

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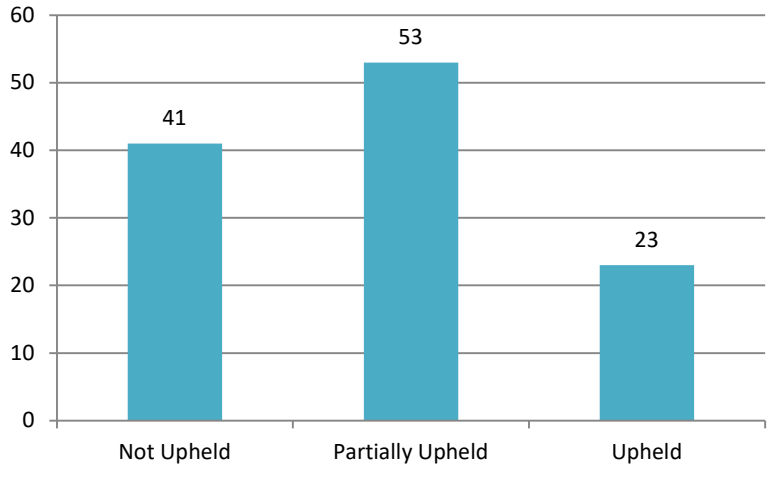
Complaints Outcomes Q3

Once a complaint has concluded (either following a local resolution meeting or once a formal written response has been sent) the outcome will be recorded in line with the findings of the investigation.

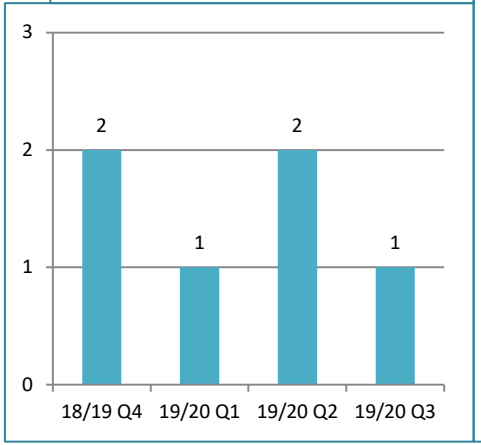
A complaint will be “upheld”, “upheld in part” or “not upheld”.



PHSO Q3

So how many complaints do they investigate?

The PHSO has commenced 1 investigations into the Trust in Q3. The PHSO closed 2 investigations during Q3.

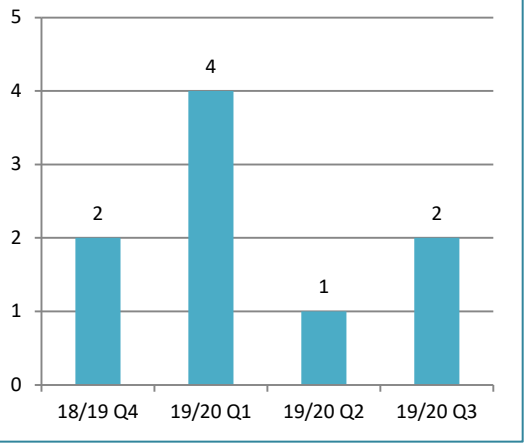


Complainants dissatisfied with the Trust's response have the right to ask the Parliamentary Health Service Ombudsman (PHSO) to consider their complaint. The PHSO will consider the complaint file, medical records and any other relevant information as necessary. The PHSO may decide not to investigate further and no further action will be required from the Trust. Alternatively, recommendations might be made for the Trust to consider. The PHSO may decide to conduct a full investigation which might result in the Trust being required to make an apology, pay compensation and / or produce an action plan to describe what actions are planned to rectify the situation and prevent further occurrences.

NOTE: The PHSO have changed how they investigate complaints and when investigations start; therefore previous graphical data may have changed in this report.

And what are the outcomes?

The Trust currently has 4 open PHSO cases. The PHSO closed two investigations during Q3; one investigation was discontinued and the other was not upheld and there were no failings identified.



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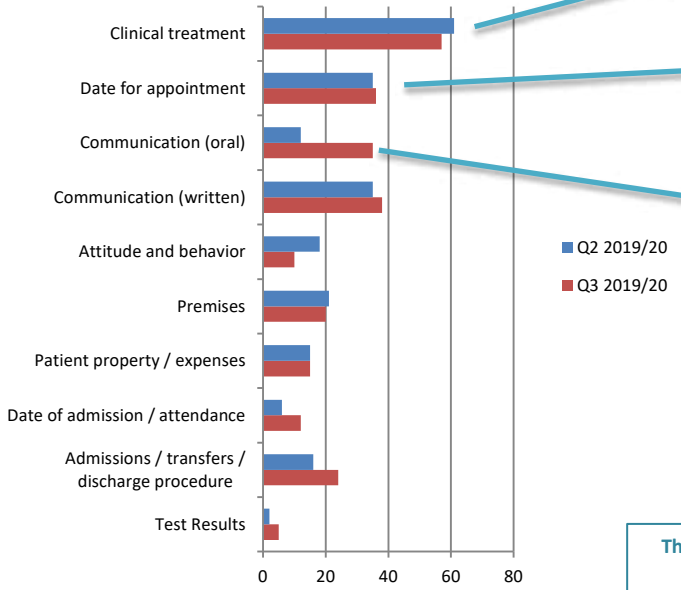
PALS Analysis Q3

The information shows the top subjects in PALS. **Note:** PALS can have more than one subject.



Clinical Treatment:
- Co-ordination of medical treatment
- Delay in treatment
- Poor nursing care
- This is also mirrored in the complaints analysis.

Date for appointment:
- Unacceptable time to wait for an appointment
- Appointment date continues to be rescheduled
- Cancellation of appointment

Communication:
- Lack of clear explanation
- Patient has been sent no communication
- Test results not communicated to patient
- Patient not verbally told things

The average response time for a PALS concern of those closed:

Q2	Q3
7 days	4 days

PALS to Complaints:

Q2	Q3
2	1

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Learning from Complaints and PALS

You Said….	We Did….
A family raised concerns that when they attended the Emergency Department staff informed them that they could not arrange an interpreter to attend and sign for their deaf mother.	We contacted the Deafness Resource Centre (DRC) who provided us with copies of the DRC user guide that are now prominently displayed at the reception in ED so that staff can easily access information. Staff have also received further training in relation to how to book interpreters.
A family reported that their requests for a meeting with a doctor/surgeon on the Intensive Care Unit (ICU) were not promptly actioned.	We have redeveloped the ward round checklist to include the question 'when did the patient's family last receive an update or any communication'.
A new mother expressed concern that staff lacked knowledge regarding limiting the duration of feeds to a breast fed baby who has lost a significant amount of weight.	We have reviewed the weight loss pathway to ensure that formula supplementation is kept to a minimum. We have also provided further training to our staff and they know to contact the Infant Feeding Team for further support.

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Complaints Headlines

- 107 complaints were opened during Q3 2019/20, which is a decrease of 18% compared to Q2.
- In Q3, there has been a decrease in the number of opened complaints relating to wrong diagnosis compared to the previous quarters.
- There has also been a decrease in the number of poor nursing care complaints in Q3 compared to Q2.
- There has been an increase in the number of complaints regarding staff attitude in comparison to the previous quarter. In Q3 there has been an increase in complaints relating to co-ordination of medical treatment compared to the previous quarter.
- Delay in treatment has also seen an increase compared to Q2.
- In Q3 there has been an increase in the number of concerns regarding delay in discharge and test results not communicated to the patient. There continues to be a theme regarding co-ordination of medical treatment and appointment concerns being raised with PALS.
- The Trust received 10 dissatisfied complaints in Q3 2019/20; which is an increase of 100% compared to Q2 where there was 5. To note, there was 10 in Q1.
- In Q3, 1 complaint was closed and deemed to require a concise RCA investigation.

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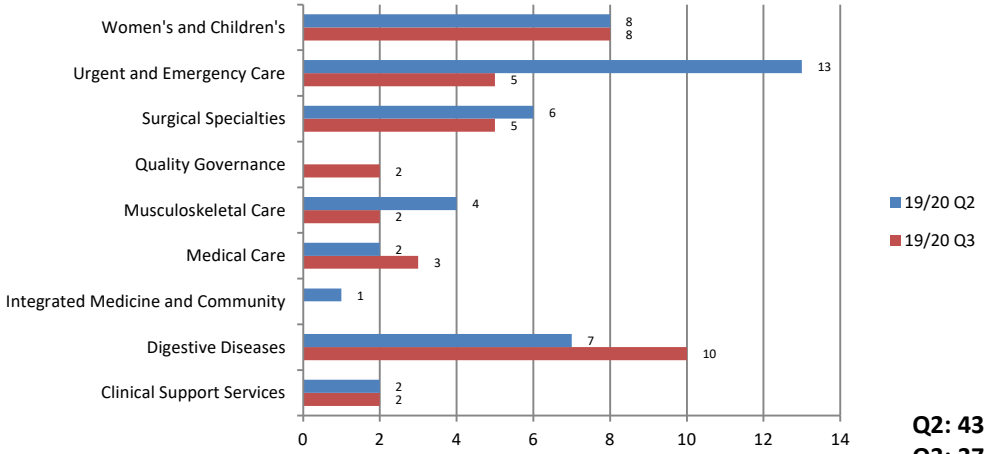
Analysis of Claims Received Q3

Clinical Claims Received 2019/20 Q2 v Q3



There has been a deceased in Clinical Claims received (43 in Q2 vs 37 in Q3).
37 Claims received via:

- 1 Requested Coroners Funding
- 3 Incident*
- Letter of Claim
- 31 Requests for notes
- 1 Direct request from Patient/Relative

* 2 of which were reported under Early Notification Scheme

There has been 560 request for notes via Medico-Legal Services

Q2: 43 Received
Q3: 37 Received

Non-Clinical Claims Received 2019/20 Q2 v Q3

There has been an increase in Non-Clinical Claims received:
Q2: 2 Received
Q3: 6 Received

Type	Q2	Q3
Employers Liability	1	4
Occupiers Liability	0	1
Public Liability	1	1

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Claims Closed Q3

Clinical Claims Closed Q3 2019/20

Clinical Business Unit	Repudiated	Settled With Damages	Withdrawn	CBU Total
Clinical Support Services	0	0	1	1
Digestive Diseases	1	3	7	11
Integrated Medicine and Community	0	2	0	2
Medical Care	0	0	3	3
Musculoskeletal Care	1	0	13	14
Surgical Specialties	2	1	7	10
Urgent and Emergency Care	0	4	9	13
Women's and Children's	3	3	9	15
Trust Total	**7**	**13**	**49**	**69**

Payments for clinical claims settled with damages totalled £2,073,731.23

Non-Clinical Claims Closed Q3 2019/20

1 Non-Clinical Claims closed which as settled with damages totalling £7,000.00

Clinical Business Unit	Details
Urgent and Emergency Care	Member of staff assaulted by a patient

Action taken on Clinical Claims

Digestive Diseases

Delay in treatment lung cancer	• Develop an agreed Trustwide SOP for diagnostic test results which is audited annually with the CBUs • Check and amend the local Histopathology SOP to ensure that staff have a clear detail of reporting codes, including email alerts. • A regular local Thyroid MDT to be put in place as an additional safety net to review all FNAC results • Develop tracking system which would show if the clinicians requesting the Histopathology / Cytology report has checked it. • Consideration to be given to a flagging system from Histopathology for unexpected malignancies.

Integrated Medicine and Community

Failure to diagnose PE	• VTE assessment and prescribing of Clexane to be highlighted to all junior medical staff • FY1 not to undertake early morning ward rounds following a night shift • This case was presented at mortality and morbidity meeting to ensure lessons learned are disseminated across the division.

Urgent and Emergency Care

Negligent positioning of orthopaedic boot	• Clinical educator to re-train staff on application of ski boot • Demonstrations given at safety brief

Urgent and Emergency Care

Failure to act on abnormal ECG	• Case to be discussed at a multi-disciplinary meeting led by the serious case review meeting as shared learning, led by the Emergency Department with AEDGP's and cardiology consultants in attendance. • Department to identify Medical Coordinator 24/7 to lead non-case load work. • Share this case & report anonymously via CBU governance meeting to highlight the importance of taking time to review investigations and the hazards of doing so when distractible by other events. • All annotations on examinations or test results must be timed, dated and signed, with name printed or stamped by the clinician who has undertaken the review. • In the presence of further GP diversion schemes, a formal Standard Operating Procedure should be in place - specifically detailing suitable presenting complaints and access to pathways. • Exploration of the feasibility of a dedicated chest pain assessment unit on the Warrington Hospital site. • Safety Briefing regarding ECG interpretations held, Safety Alert regarding ECG interpretations sent, WHHFT revising Acute Coronary syndrome pathways following the Merseyside and Cheshire Cardiac Network meeting

Women's and Children's Health

Labelling error resulting in unnecessary procedure	Observational studies organised by the leads in ED and Ambulatory care
Failure to give anti-coagulation medication	• Individual staff to review the investigation report and undertake reflection of the case • For the postnatal ward to consider standardising their hand over to include update on each patient's medications and their requirement for LMWH • Learning to be shared with the department during the 'medicines management' session of the maternity mandatory training

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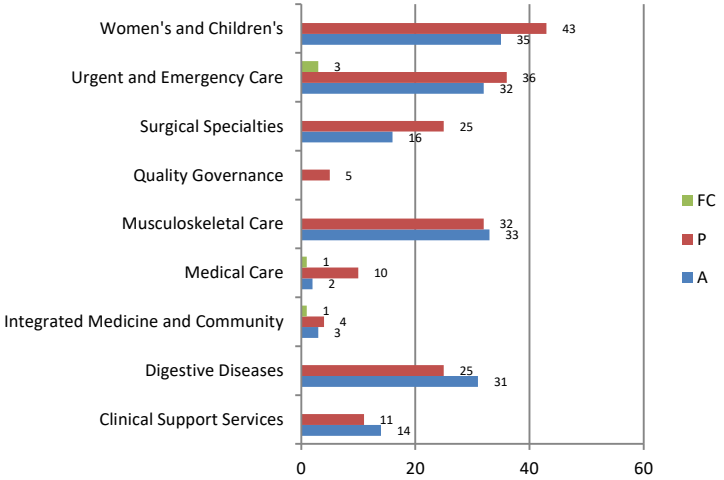
Open Claims

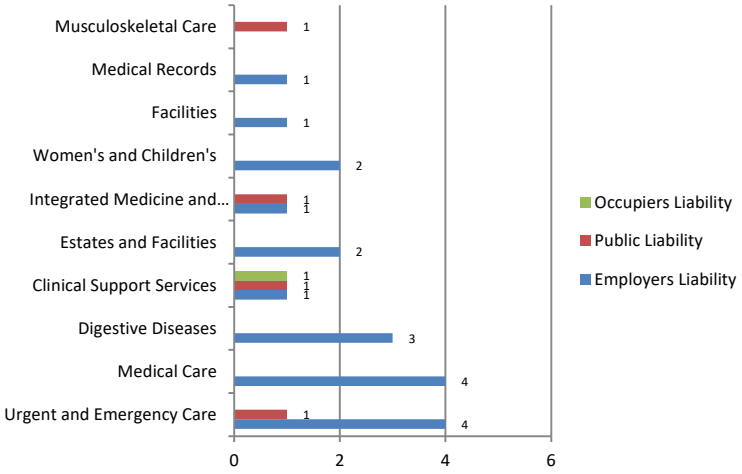
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Number of Open Claims as of 31 December 2019

362 **Clinical Claims** open
166 Actual (Formal Claim) | 191 Potential (Request for notes) | 5 Coroners Funding



25 **Non-Clinical Claims** open
20 Employer Liability | 4 Public Liability | and 1 Occupier Liability



Key:
FC – Coroners Funding
P – Potential = Request for notes
A – Actual = Formal claim, Letter of Claim / Proceedings

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Mortality Headlines

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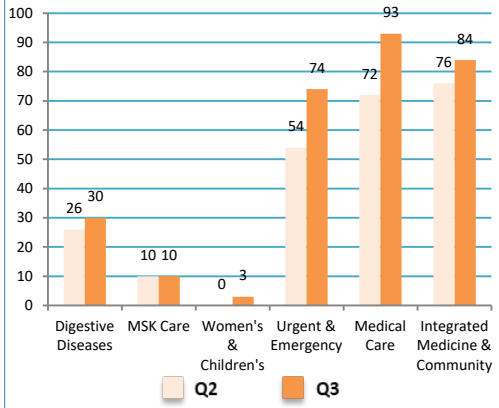
Warrington and Halton Teaching Hospitals NHS Foundation Trust

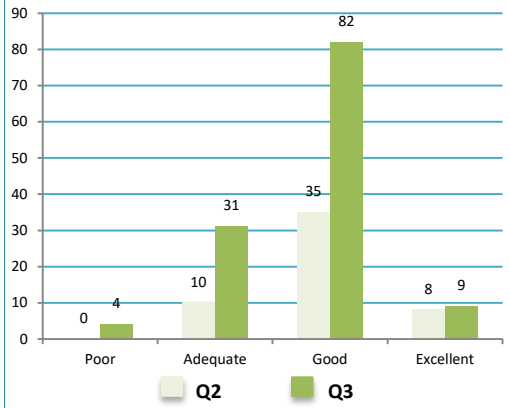
Q3 CBU Mortalities

As expected, the three CBUs with the most mortalities are the ones with the greatest throughput and largest number of patients with multiple comorbidities: Medical Care, Integrated Medicine & Community and Urgent & Emergency Care.



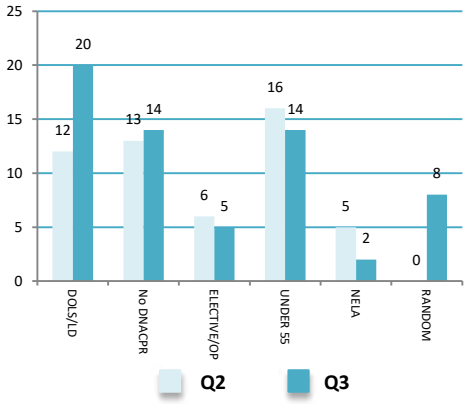
Q3 SJRs – Overall Care Grading

The majority of SJRs conducted have found that our overall standard of care is rated as "Good" followed by "Adequate", although "Excellent" care was also evident within the reviews.
71 cases came for discussion at MRG. Most of these cases were rated "Adequate" with some "Good" also being discussed.



Q3 Triggers for SJRs

The below chart displays the triggers for conducting SJRs across Quarter3. Comparing to Quarter 2, DOLS/LD has become one of the largest triggers for an SJR. No DNACPR and Under 55s are the second largest triggers for an SJR. The 'Random' cases are those selected for quality checking or where an SJR has been requested that is outside of the normal criteria i.e. linked to a complaint.



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Learning from Deaths

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We found….	We are doing….
Cardiology were showing as an outlier according to Mortality data. 	Cardiology asked for a number of their cases to be reviewed – these were undertaken by 2 MRG reviewers. Care was considered to be good in all cases and this has been discussed at MRG and fed back to Cardiology.
84 year old patient, advanced end stage dementia. Care home resident. 3rd admission in /12 with falls. Frailty unit first and then ED. DOLs in situ. DNACPR agreed with NOK. Day 21 – decision made to palliate. This was deemed as an inappropriate admission and that there was no clear management plan or working diagnosis on post take ward round.	Feedback provided to Halton CCG regarding inappropriate admission. Quality control regarding the post take ward will be addressed by the ongoing FCE Work Group which has been established by MRG.
There is a national backlog of Learning Disability deaths to be reviewed under the LeDeR process. Learning Disabilities Mortality Review (LeDeR) Programme	We ensure that all LD deaths have undergone an SJR to review the care provided to the patient. In order to address the backlog within the region the CCG have commenced a pilot of a monthly panel will be held to review pts LD deaths and the panel will be made up of CCG, Hospital and LD staff. The reviews will incorporate all elements of LeDeR so the SJR will be used to support this along with a wider case review of other episodes of care during the patient's life time at the Trust.
The COPD Focussed Review followed a review of mortality data which indicated that the Trust was an outlier for deaths relating to COPD and Bronchiectasis. 	20 cases were reviewed – 14 (70%) were found to be of good care, 5 (15%) were of average care and 1 (5%) was poor care. COPD was the main condition treated in 18 (90%) of patients reviewed. The cause of death of the patients reviewed matched the admission diagnosis in 12 of 17 (71%) of cases, three patients died in the community and as a result the cause of death cannot be confirmed. 6 (30%) patients were reviewed by palliative care, 1 patient was referred to palliative care but passed away before their review. 11 (55%) of patients reviewed were rated as receiving 'good' or 'Excellent' end of life care There were 5 Trauma deaths, 4/5 cases reviewed were deemed as good care and one was adequate in accordance with the SJR scoring.

Headlines of Learning from Deaths

- Mortality & Morbidity Meetings (M&M) are underway with feedback being provided back to MRG.
- SHMI and HSMR, are within the expected range and stabilising.
- COPD and Bronchiectasis Focussed Review completed and learning disseminated.
- Work has commenced to prepare for the first **Mortality Review Group Learning Event** on 25th February, 1.15-4.30, Post Grad Centre, Warrington Hospital.

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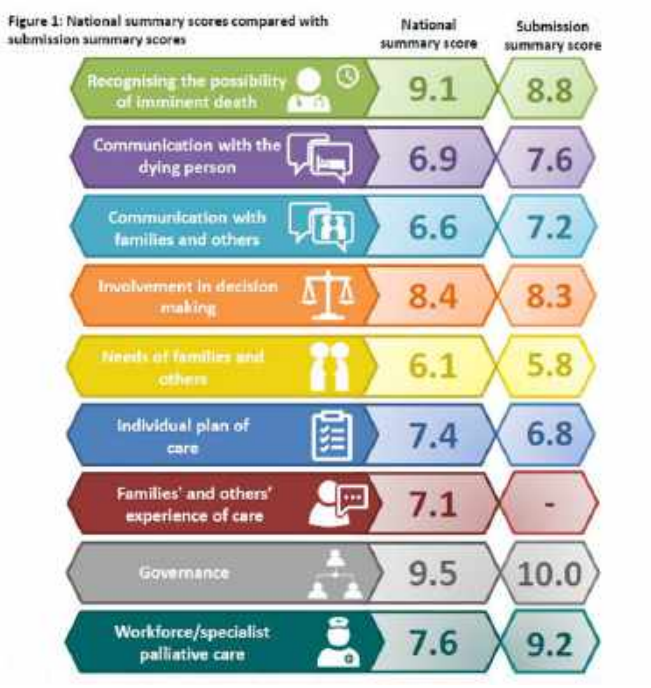
Learning from National Audits

National Audit of Care at the End of Life



NACEL is to improve the quality of care of people at the end of life in acute, mental health and community hospitals. The audit monitors progress against the five priorities for care set out in One Chance to Get it Right and NICE guideline (NG31) and Quality Standards (QS13 and QS144).

WHH scored favourably in four of the nine themes including; communication with the dying person, communication with families and others, Governance and workforce/specialist palliative care.

WHH fell below the national summary score in four themes including; recognising the possibility of imminent death, involvement in decision making, needs of families and carers and individual care plans.

A bespoke training programme has been planned for Q4 to improve on the four themes noted above. This will be monitored through the End of Life steering group meeting.

Learning from Local Audits

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The Radiological Investigation of Suspected Physical Abuse in Children: A re-audit

Background:
The skeletal survey (SS) is a forensic radiological study performed when there is a suspicion of physical abuse in children. It involves acquiring a series of radiographs on two separate visits to the hospital 11-14 days apart. Radiological evidence is vital for clinical and medico-legal management. It is important we maintain a high standard of practice as the images and reports we generate may be used in court. Our departmental protocol was recently updated and is now based on the 2017 RCR/SCoR guidelines.

Key Findings:
- Ongoing issue with attendance for follow-up imaging (although this has improved since the previous audit)
- Improved double-reporting from radiologists but worse availability of the report within 24 hours.
- The results for double reporting and report availability within 24 hours were worse for the follow-up skeletal surveys compared with the initial skeletal surveys.
- Limit on number of SS per day? (3x SS in one day in 2019 – 1 not double reported)
- Limitations: Small sample size and the audit covered a transitional phase when the new guidelines were first introduced.

Recommendations:
- Meet with the safeguarding team to agree a process for dealing with patients who DNA their follow-up skeletal survey.
- Agree a process for ensuring each skeletal survey is allocated to a consultant who is given time to report it, and a second reporter (ideally one of the radiologists with a special interest in paediatrics) is notified when the first report has been verified.
- Limit skeletal surveys to two per day in pre-defined slots (1x AM, 1x PM) to aid planning.

Assurance:

Moderate	There is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some aspects of the system objectives at risk.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

We are WHH & We are PROUD to make a difference

Non-Clinical Incidents Q3

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From 1st October to 31st December 2019, there were 365 non-clinical incidents reported. The top 2 categories were:

Security incidents = 105

The top sub-categories are:

- Aggressive Behaviour by patients/relatives
- Verbal Abuse
- Loss

Infrastructure/Health and Safety incidents = 74

The top sub-categories are:

- Injury to staff
- Damage to environment
- Needlestick Injury

Sharps Audit – November 2019

On 13th and 14th November 2019, the Health and Safety Department carried out another unannounced Trust-wide Sharps Audit in relation to the use and disposal of sharps. In total, 61 areas were visited over a two day period. There was evidence of a slight improvement whereby the Trust had gone from 14 areas to 21 areas of 100% compliance.

It was disappointing though to find areas of non compliance, some of which were:

- 21 areas had temporary lids left open when not in use;
- 12 had no labels completed upon assembly;
- 5 areas had loose lids which had the potential of the contents to be spilled out; and
- 4 areas had items protruding from the lids.

The Sharps Audit report was tabled at the Health and Safety Sub Committee and Infection Control Sub Committee meetings for discussion. Moving forward, it has been agreed that these audits will continue on an unannounced basis until there has been a noticeable improvement within the Trust.

We are WHH & We are PROUD to make a difference

Stay Alert – Don't get hurt

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Learning from Non-Clinical Incidents

We found….	We Acted….
A patient had attended the Warrington site for several appointments. He was in a wheelchair and on his own. As he has propelled himself up the drop down kerb, his wheelchair flipped backwards, the patient fell out of his wheelchair and landed on the floor.	The Health and Safety Department contacted the Estates Department immediately and asked that the drop down kerb be assessed. It has been highlighted that the gradient was too steep therefore this is being looked into 
A patient was walking without a zimmer or back brace. As she was getting into bed, she lost her balance and was falling. A member of staff went to her aide, took the patients weight and in doing so injured her own back. The member of staff had 63 days off sick for this incident. On her return to work, whilst escorting another patient to the toilet, the patient had a vasovagal episode, therefore the staff member guided her to the floor, aggravating her existing back condition.	The member of staff was in date for manual handling training. It was agreed that this member of staff should attend refresher training prior to attending a clinical environment and caring for patients
A patient had been dropped off in the Daresbury car park to attend an Ophthalmology appointment. She walked across the parking bays and headed towards a gap in the shrubbery. This was being used as a short cut rather than walk around to the main entrance. In doing so, she has slipped in mud and fell to the floor	 The Estates Department were contacted and asked if the Gardeners could build up the borders to prevent anyone else from using this as a short cut. An additional planter has been placed in the area which now fills in the gap until work can be carried out in the spring 

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/03/40**
SUBJECT:	Safe Staffing Report – 6 monthly review (June 2019 – Dec 2019)
DATE OF MEETING:	25th March 2020
AUTHOR(S):	Rachael Browning, Assistant Chief Nurse, Clinical Effectiveness
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO2: To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work togther to care for our patients
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	BAF2.2: Nurse Staffing BAF2.5: Right People, Right Skills in Workforce BAF2.1: Engage Staff, Adopt New Working, New Systems
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper details the six monthly review of nurse staffing in line with the commitment requested by the National Quality Board in 2016 and more recently in the Improvement Resource for Adult Inpatient Wards in Acute Hospitals January 2018. • The report provides an overview of the current nurse staffing workforce data, including numbers of staff in post, turnover of staff, and the introduction of the 8 registered nurse associate roles in January 2019 with a further 5 trainees due to qualify in March 2020. • The report represents the review of a 4 week sample of census data recorded within the SafeCare acuity and dependency system between 1st to 31st December 2019 • The data demonstrates that our budgeted nurse staffing WTE (whole time equivalent) is comparable to the safe care data requirements. Significant improvements have been made in the overall nurse staffing establishments enabling the Trust to meet the SafeCare acuity requires 697.11 WTE nurses (RN & HCA). The actual number of staff in post is currently 557.32 leaving the number of nurse vacancies across the Trust at 104 which is a reduction from the previous 6 months review of 109. • The ongoing Trust Nursing Recruitment and Retention Plan continues to be delivered. A number of new and innovative approaches have been adopted to support the recruitment campaign, which has resulted in a further 103.6 WTE RNs recruited in the last 12 months which is an increase of 20.2 WTE from the previous year. • We have 71 registered nurses who have accepted an offer to join the Trust in 2020 as a result of a series of recruitment events. • Since the development of The Trust retention plan as part of the NHS Improvement collaborative programme we have seen an improvement in turnover from 14.99% in November 2018 to

<table>
<tr><td></td><td colspan="4">12.65% in December 2019
• Care Hours per Patient Day (CHPPD) is the national reporting metric for safe staffing levels. NHS Choices has recently replaced planned versus actual staffing levels. The average CHPPD from April until December 2019 is 7.3. CHPPD continues to increase bringing us in line with the national median rate of 8.0 and peer organisations of 7.6.
The report demonstrates the progress that continues to be made across the organisation in Nursing and Midwifery staffing. There are still a number of challenges faced including recruitment to vacant posts and acknowledging the age profile of our current workforce which is a work stream initiative in the NHSI retention plan.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information</td><td>Approval</td><td>To note</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4">It is recommended that the Trust Board review the progress to date and note the contents of the report.</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="3">Quality Assurance Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="3">QAC/20/03/44</td></tr>
<tr><td>Date of meeting</td><td colspan="3">3 March 2020</td></tr>
<tr><td>Summary of Outcome</td><td colspan="3">Noted</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="4">Choose an item.</td></tr>
</table>

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REPORT TO BOARD OF DIRECTORS

SUBJECT	Safe Staffing Report – 6 monthly review (June 2019 – Dec 2019)	AGENDA REF:	BM/20/03/42

1. Introduction

This paper details the six monthly review of nurse and midwifery staffing in line with the commitment requested by the National Quality Board (NQB) document, 'Supporting NHS Providers to deliver the right staff, with the right skills, in the right place at the right time – safe and sustainable staffing ' (2016) in response to the Francis Enquiry (2013). More information on this can be found in Appendix 1. The NQB guidance has been further refreshed, broadened and re issued in January 2018 with the provision of 'An Improvement Resource for Adult In-patient Wards in Acute Hospitals' which recommends that Boards should carry out a strategic staffing review at least annually. At this Trust, the staffing review is carried out twice per year, review meetings are held with the ward managers and Chief Nurse to discuss and sign off all establishments in addition to the bi –annual staffing reviews.

The following report is presented as an expectation of the NQB guidance and represents the outcome of reviewing the acuity and dependency data recorded in the Safe Care system over a four week period from between 1st to 31st December 2019 at WHH.

All ward sisters/charge nurses, matrons, lead nurses and the associate chief nurse, clinical effectiveness participate in the acuity and dependency review process.

2. Workforce Information - Warrington and Halton Hospitals (WHH)

There is a growing body of evidence which shows that nurse staffing levels make a difference to patient outcomes (mortality and adverse events) patient experience, quality of care and the efficiency of care delivery. Short staffing compromises care and recurrent short staffing results in increased stress and reduced staff wellbeing, leading to higher sickness and a higher turnover rate as more staff leave.

2.1. Staff in post

The chart below shows the total number of budgeted registered nursing and midwifery staff in post by month from January 2019 to December 2019. Nurse recruitment remains a priority with targeted recruitment events in place locally and regionally, bespoke recruitment for areas with high number of vacancies supported by enhanced social media campaigns. A focused approach for retaining staff includes options available such as ward moves, flexible contracts and continued professional development in order to retain staff. Chart 1 indicates the number of staff in post which has shown a reduction from July 2019 to September 2019 of 16 WTE, however our proactive recruitment campaigns has recovered this position peaking at 970 in November 2019 with a slight reduction to 964 in December.

Chart 1

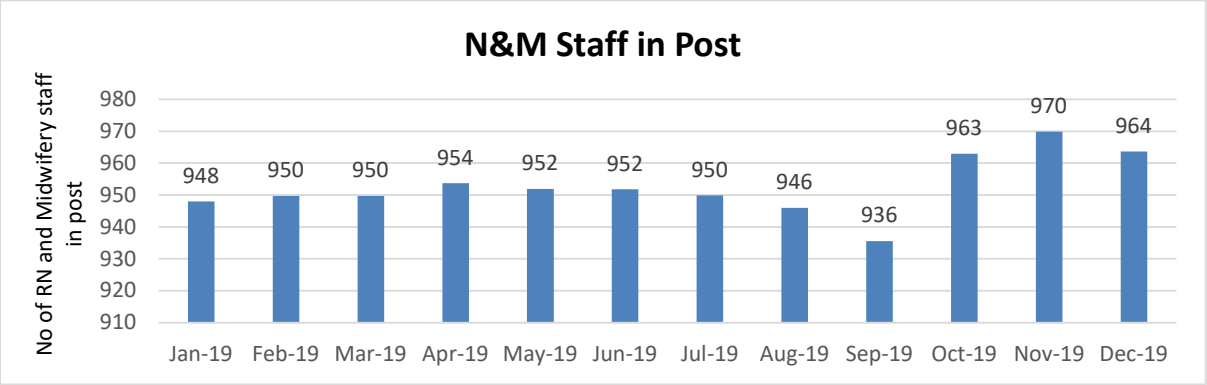
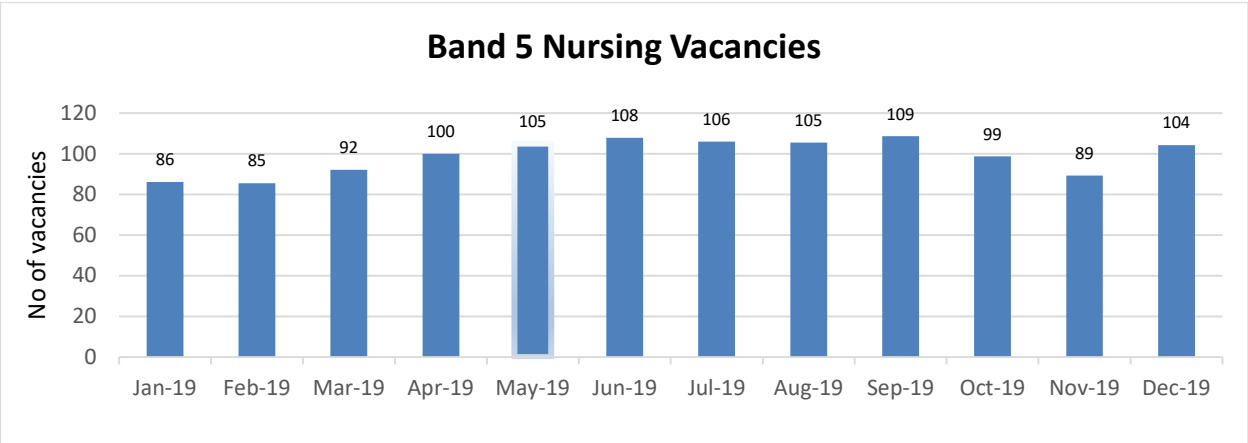


Chart 2 identifies the number of band 5 vacancies based on the funded establishments against the number of staff in post (excluding operating department practitioners in Theatres). We have seen a gradual increase in the number of RN vacancies in the Trust. This increase is associated with the investment in nurse staffing, an increase of 20 WTE RN's and with the Trust opening a number of new facilities during 2019 to ensure that our patients receive high quality care in the appropriate setting e.g. The Frailty Assessment Unit and Discharge Suite. In December 2019 the number of RN vacancies stands at 104 WTE's however 71 candidates have accepted a position at WHH and are due to commence in post over the next 8 months (September 2020) as a result of continued recruitment campaigns.

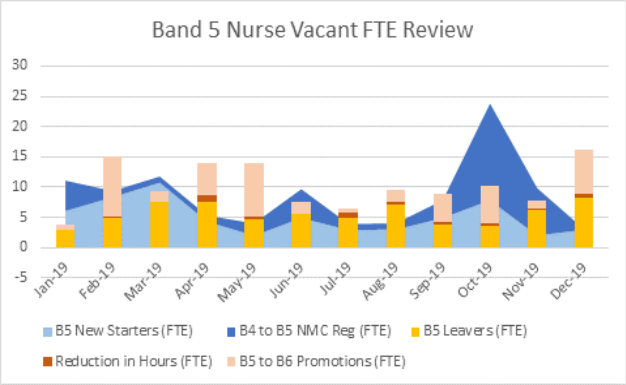
Chart 2



In this report we have included further detailed analysis on band 5 nursing vacancies. In the last 6 months the turnover rate has reduced therefore whilst we are not losing staff, as demonstrated in chart 3, we have seen a change in the workforce profile in terms of an increase in the number of internal promotions and the number of staff reducing their contracted hours, both of which would represent a vacancy at band 5.

In the context of new starters in the last 12 months the Trust has welcomed 103.6 WTE new starters into the Band 5 Nursing roles.

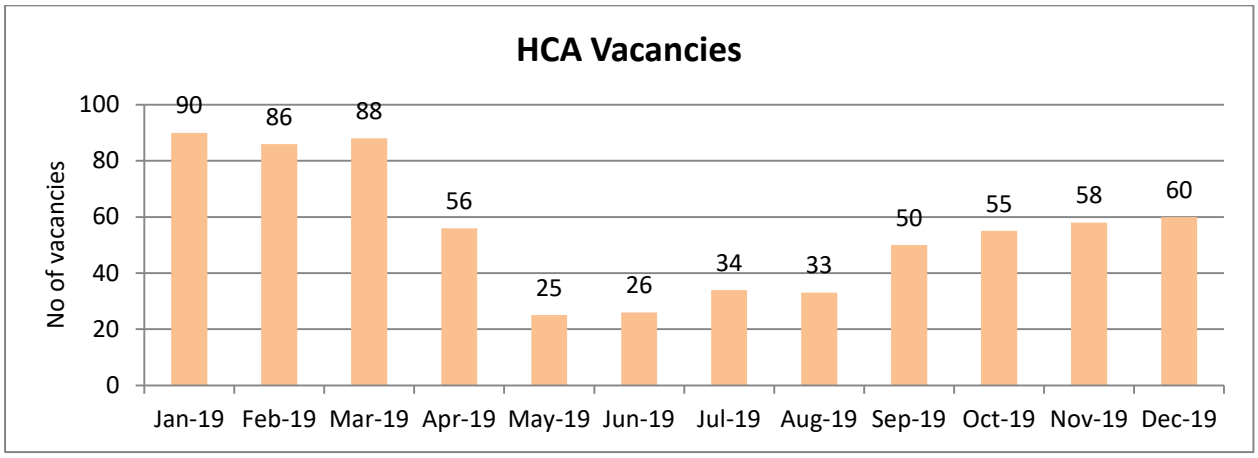
Chart 3



B5 Leavers (FTE)	Reduction in Hours (FTE)	B5 to B6 Promotions (FTE)
66.71666	4.65	51.16

Chart 4 identifies the number of HCA vacancies based on the funded establishments against the number of staff in post. Targeted recruitment campaigns in February / March 2019 resulted in a significant reduction in the number of HCA vacancies during May to August 2019. Despite our significant improvements in recruitment initiatives for HCA's we have seen a steady increase in the number of vacancies which stands at 60 in December 2019. A further focused recruitment event is scheduled for Feb 2020 for HCA staff. Turnover for HCA staff has improved for the 4th consecutive month and currently is recorded at 13.16%. A number of our HCA staff have gone on to undertake other roles within the organisation for example Trainee Nurse Associates. Reducing turnover remains a priority for this staff group particularly for those staff who have been in the Trust less than 12 months.

Chart 4



2.2. Staff Turnover

Chart 5 illustrates nursing and midwifery turnover which has seen a gradual improvement from November 2018, the current rate in December 2019 is 12.65% against the national average of 11.9%.

The Trust continue to be part of a national programme with NHS Improvement (NHSI) Retention workforce collaborative, which has enabled access to best practice and exemplar practice from other organisations as well as identifying our retention priorities and plan for 2019/20.

Initial assessment of the data, in conjunction with staff engagement, has indicated a requirement to focus on the following areas:

- Work life balance
- Continued professional development
- Recognising and Valuing Experience (RAVE)
- Developing and empowering line managers

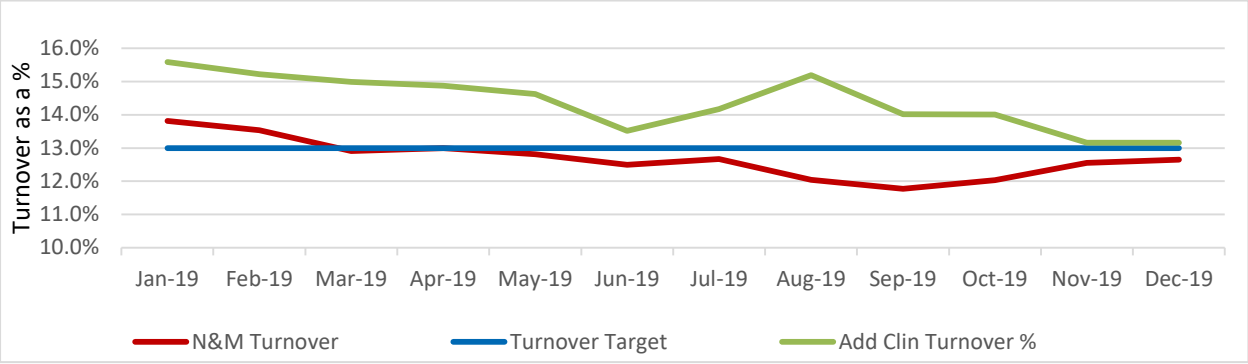
The aim of the collaborative is to reduce the turnover of our Nursing and Midwifery workforce by 1.5% over 12 months from a baseline rate of 14.99% commencing in November 2018. The turnover in December 2019 is 12.65%, which is a reduction of 2.34% which is an overachievement of the target set.

Work completed in 2 of the NHSI work streams, the *WHH career and development offer* and the *best use of data diagnostics to inform retention initiatives* has been recognised nationally at the prestigious Burdett Retention Awards in November 2019. More recently NHSI have used the WHH retention initiatives as a case study example to share as exemplar practice with other NHS organisations nationally.

The development of an *internal transfer process* for nursing and health care assistants was successfully tested in September 2019 and has supported staff to remain at WHH. This initiative has been shared regionally and is currently being considered for adoption across Cheshire and Merseyside.

Monthly progress updates on staff turnover reduction continue to be provided to the recruitment and retention group chaired by the Chief Nurse.

Chart 5

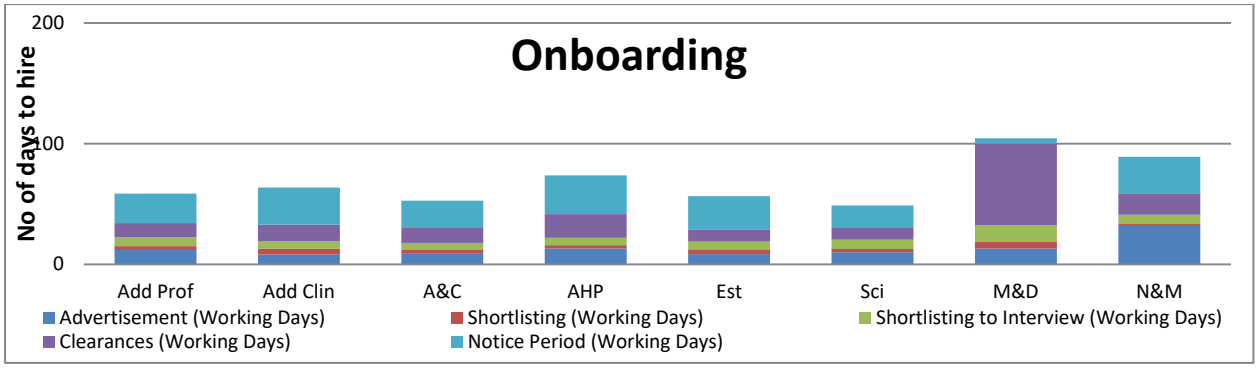


2.3. Recruitment and Retention

The Nursing Recruitment and Retention Strategy is being delivered alongside the NHSI Retention Collaborative programme. An innovative recruitment campaign continues with flexible working plans as one of the initiatives on offer. A number of new approaches have been adopted to support the recruitment campaign, including open days. In the last 12 months the Trust has welcomed 103.6 WTE new starters into the Band 5 Nursing roles and 103 HCA's. We anticipate 71 registered nurses joining the Trust in 2020 as a result of a series of recruitment events.

It should be noted that whilst we are celebrating some success over the last 12 months in managing to recruit this number of qualified nurses in a competitive market, we must be cognisant that the lead in time for some of the staff to commence in post in 2020 and continuing attrition rates must also be considered.
Chart 6 illustrates the results of the '*on boarding'* questionnaire, given to new starters on their induction. This details an overwhelming positive response. Managers are reminded about their responsibility to keep in touch with their successful candidates while the process is under continual review by the recruitment team.

Chart 6



2.4 International Nurse Recruitment

WHH have been approached by Wigan, Wrightington and Leigh to participate in a regional pilot for international nursing recruitment. The pilot is working in partnership with Health Education England (HEE) model for earn, learn and return programme. A business case is currently being developed which will be presented to the Trust executive team in February 2020. The interim NHS people plan acknowledges the need to increase the number of international recruits and empowers organisations to actively recruit overseas as part of the short to medium term workforce supply plan.

2.5. Workforce Development

Work is currently underway to evaluate the Trust's preceptorship programme. This includes engagement with staff through focus groups, 'preceptorship fortnight' and 'afternoon out' sessions. The review will also take into consideration outputs from the Cheshire and Merseyside Nursing and Midwifery Programme Preceptorship work stream.

WHH welcomed the first cohort of 8 registered nurse associates in January 2019. Our second cohort of 5 trainee nurse associates qualify in March 2020. With the introduction of this new role and in line with recommendations outlined within NHS Improvements resource "Safe, sustainable and productive staffing improvement resource for the deployment of nursing associates in secondary care," quality impact assessments have been undertaken.

From our first cohort of registered nursing associates, 4 of the cohort 1 year after qualification have gone on to undertake their apprenticeship registered nurse training at Chester University which is due to commence in February 2020.

Confirmation was received of funding from Health Education England for 5 nursing staff to commence advanced clinical practitioner (ACP) apprenticeship programmes with Manchester Metropolitan University in 2019/20:

- 2 x Acute Care Nurses
- 2 x Community respiratory nurses
- 1 x Diabetes

In addition to this, Health Education England have provided funding to support a member of staff within acute care team, to complete stand-alone modules of the ACP programme with Liverpool John Moores University both of which strengthening the development of WHH nursing workforce.

In July 2019 we received notification from NHS England and NHS Improvement that our Clinical Placement Expansion Programme expression of interest submission had been approved. The Chief Nursing Officer's funding, £50K, was provided to enable investment in infrastructure to increase the availability of clinical placements. The funding was contingent on delivery of the expansion in clinical placements which we achieved. The increase in capacity was achieved in the main through the roll out of the Collaborative Learning in Practice (CLiP). The Clinical Education Team recruited 5 Band 6 Clinical Educators (2.0 wte) and uplifting one of the Clinical Educators to a Band 7 post to project manage the roll out (all fixed term until 31st March 2020).

The CLiP programme has been introduced in 2 waves with the second wave being rolled out onto wards A7, A9, B10 and B11 in December 2019. Fifty-three members of staff from these areas completed an 'Introduction to CLiP and Coaching' training session in preparation for the roll out of the programme. Discussions have taken place with three ward managers at Halton/CMTC to roll out Wave 3 of CLiP into their wards. Training sessions for staff in the new areas commence January 2020 with an aim to have CLiP students commence their placements in February/March 2020.

A recent announcement of new resources for continuing professional development (CPD) of nursing staff, £150 million is being made available from Health Education England (HEE) in 2020/21. This will enable employers to provide a £1,000 training budget over the next three years for each NHS nurse, midwife and AHP within the Trust. This funding will support WHH nursing and midwifery staff to ensure they continue to be able to deliver high quality care for patients, adapt to the changing needs of the population and build rewarding, lifelong careers in the health service.

HEE will award funding directly to Trusts from 1 April 2020. In planning how this funding is utilised the Trust have been asked to consider the principles outlined in the guidance from HEE and will agree with employers how to track the use of the additional investment.

3. Evidence Based Strategic Workforce Planning

There must be sufficient and appropriate staffing capacity and capability on inpatient wards to provide safe, high quality care to patients at all times. Nurse staffing levels are determined by using a range of metrics. Warrington and Halton Foundation Trust use four factors as follows;

- Using systematic evidenced based acuity data utilising the Safer Nursing Care Tool (SNCT)
- Benchmarking with Peers for example Care Hours per Patient Days (CHPPD) through the Model Hospital.
- NICE Guidance and 1:8 minimum staffing: patient ratios
- Professional judgement

Each of the above methodologies are used to ensure that we have consistent evidence based approach to determining the required establishments for each ward.

3.1. Evidence Based Acuity Data

The Trust operationally utilises the SafeCare function within the Allocate e-rostering system to collect acuity and dependency data twice daily for all wards. SafeCare uses the same dependency scoring as the Safer Nursing Care Tool (SNCT). This is an evidence based tool that enables nurses to assess patient acuity and dependency, incorporating a 'staffing multiplier' to ensure that nursing establishments reflect patient needs in acuity/dependency terms. The data has previously been manually collated for a two week period twice a year; however we are now able to access the information on a daily basis from the SafeCare module in the electronic system. The data is inputted twice daily. The senior nursing team review the data twice daily to ensure appropriate escalation plans are in place to support staffing decisions to meet the needs of the operational demands so that high quality care can be provided on inpatient wards. Any potential care issues associated with staffing are also recorded here using the Red Flag system (See Appendix 2).

3.2. SafeCare Census Results

It should be noted that the SafeCare tool does not differentiate between qualified and unqualified staff staffing hours and as such requires a very good understanding of the patient groups and nursing requirements. Professional judgment is also an important and essential factor to be considered when making decisions about staffing establishments.

Overall the SafeCare results (summarised in Table 1) demonstrates the acuity of the patients at the time of the survey indicated we required 697.11 WTE against a budgeted nursing staff wte of 677.47. This represents a difference of -19.64 WTE. The survey is an average of the acuity and dependency of the patient group over the month of December 2019. It is important to note that two wards (K25 & B3 at Halton) which were open at the time of the data collection did not have a funded establishment for nursing staff. Staffing requirements for ward K25 and B3 were achieved by a combination of transferring substantive nurses from other wards as well as the use of temporary staff from NHS Professionals. Some wards are showing a positive staff position however there are a number of other considerations that impact on staffing which is detailed below.

Table 1 – SafeCare™ Census Results 1st to 31st December 2019

	SafeCare Required WTE Nurses vs Nurses in Post*					
Ward	SafeCare Required WTE	Budgeted Nursing Staff WTE	+/- Budget	Nursing Staff in Post WTE	+/- in-post	Average Daily 1:1s
A1	49.99	59.66	9.67	45.25	-4.74	1.86
A2	40.21	37.17	-3.04	25.23	-14.98	2.19
A4	40.15	38.51	-1.64	31.01	-9.14	1.00
A5	36.22	38.61	2.39	31.34	-4.88	0.00
A6	43.36	40.04	-3.32	26.92	-16.44	0.00
A7	53.84	43.47	-10.37	34.9	-18.94	1.00
A8	48.30	42.94	-5.36	31.98	-16.32	3.80
A9	37.25	47.14	9.89	39.37	2.12	1.10
HICU	34.51	26.93	-7.58	23.38	-11.13	0.00
B3	31.43	0	-31.43	14.9	-16.53	1.44
B4	17.44	23.02	5.59	14.19	-3.25	0.00
B12 FMN	33.49	47.12	13.63	35.47	1.98	1.00
B14	37.14	36.48	-0.66	28.53	-8.61	0.68
B18	31.58	37.54	5.96	33.24	1.66	0.00
B19	38.59	32.95	-5.64	28.99	-9.60	3.50
C20	12.54	19.24	6.70	15.92	3.38	0.28
ACCU	36.33	48.71	12.38	46.01	9.68	0.45
C21	31.80	26.76	-5.04	25.4	-6.40	2.10
CMTC	25.69	31.18	5.49	24.29	-1.40	0.00
K25	17.24	0	-17.24	1	-16.24	0.00
Total	697.11	677.47	-19.64	557.32	-139.79	20.40

* Nurses in post information taken from e-rostering system

3.2.1 One to One or Enhanced Care

On average during the census period we had 20.4 patients identified each day across all wards that required enhanced care (1:1s). This is not directly included in the SafeCare requirement; however the wards record the number of patients requiring the direct supervision therefore to directly supervise 20.4 patients 24 hours a day would require a significant nursing resource.

3.2.2 Medical Admissions Ward and Elective / Day Case Surgical Wards

The budgeted nursing staff for A1, CMTC A9 and B4 shows a positive position however throughout the day the daily responsive staffing planning is in line with NICE guidance and 1:8 minimum staffing: patient ratios. SNCT does not adequately quantify the care hours required on a medical admissions ward like A1, and elective day case patients. These areas have a high turnover of patients that cannot be captured in the twice daily census.

3.2.3 SafeCare Requirement Compared to Number of Staff in Post

The SafeCare WTE requirement is 697.11 with 557.32 WTE staff currently in post giving a shortfall of 139.79 WTE which represents the total number of RN and HCA vacancies at the time of the report.

4. Monthly Staffing Return

Nursing and Midwifery staffing data is published on a daily basis at entrances to WHH wards along with submission of data on a monthly basis through the Unify system to NHSE, in addition to

publication on the Trusts website and reporting to the Board of Directors. A review of the 'ward staffing boards' has been undertaken to ensure that staffing levels are displayed on all ward entrances and to support patient understanding of ward staffing.

The Trust is required to submit a monthly staffing return as part of the Strategic Data Collection Service (SDCS) detailing planned v's actual staffing fill rates. In line with recommendations from the NQB (2016) the staffing data return is presented to the Board of Directors on a monthly basis highlighting areas where fill rates fall below 90%. Although the 90% standard has not been constantly achieved during the day time there have been mitigating actions taken with senior nurse escalation, and an increase in HCA fill rates to support the ward teams. Matrons and lead nurses support the ward managers with ward risk assessments and staffing plans to ensure safety is maintained.

4.1. Comparing staffing levels with peers – Care Hours Per Patient Day (CHPPD)

Care Hours per Patient Day (CHPPD) was developed following Lord Carter's review in February 2016, it has been tested and adopted to provide a single, consistent and nationally comparable way of recording and reporting deployment of staff to provide care on inpatients wards. CHPPD monitoring and tracking can be facilitated alongside e-rostering systems and supports the daily assessment of operational staffing requirements. NHS Improvement (NHSI) Model Hospital portal now makes it possible to compare CHPPD metrics with comparable peer Trusts.

Chart 7 and 8 illustrates the reported CHPPD figures for the Trust from April 2019 to December 2019 which gives us an overall CHPPD for the current financial year of 7.3. This is in comparison to the peer median of 7.6 and the national median figure of 8.0 hours over the same period and represents an improvement from 2018 / 19 in which we saw a gradual increase in CHPPD as a result of the significant investment in nurse staffing and ended the year with a rate of 7.3.

This position will continue to improve as we make progress in the Trust wide Recruitment and Retention Strategy.

Chart 7 CHPPD - Model Hospital website

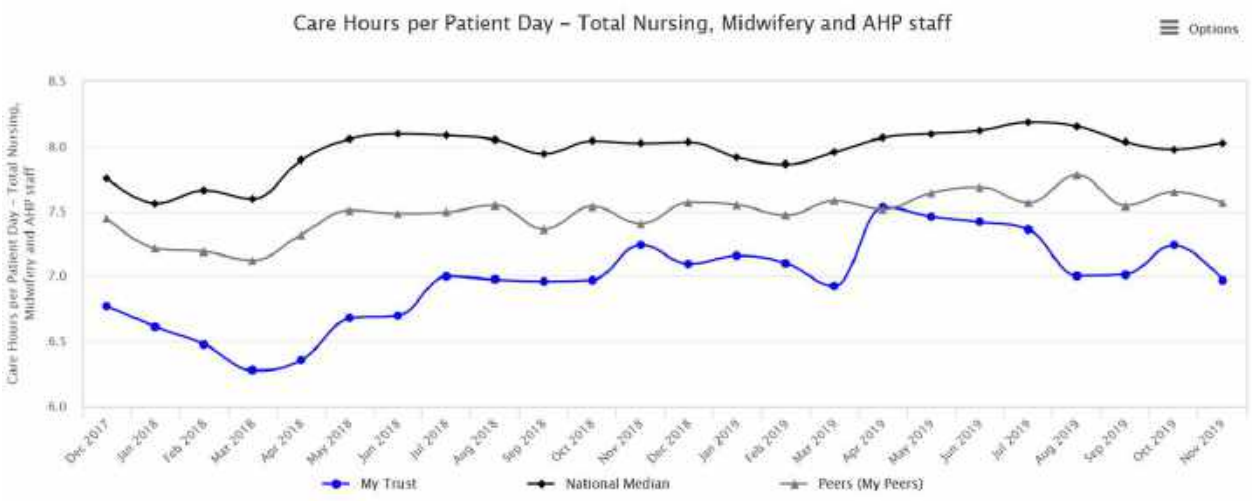


Chart 8 – CHPPD Model Hospital website

Financial year	Month	Cumulative count over the month of patients at 23:59 each day	CHPPD - Registered	CHPPD - Care Staff	CHPPD All
2019/20	Apr	14008	4.4	3.2	7.6
	May	14623	4.3	3.3	7.6
	Jun	14410	4.3	3.2	7.5
	Jul	14917	4.2	3.3	7.5
	Aug	15282	3.9	3.2	7.1
	Sep	14927	4.0	3.1	7.1
	Oct	15271	4.1	3.2	7.4
	Nov	14940	4.0	3.1	7.1
	Dec	14740	4.1	3.2	7.3
2019/20 Total		**133118**	**4.1**	**3.2**	**7.3**

Monitoring arrangements remain in place to review staffing on a daily basis. The number of staff is triangulated with staffing incidents and 'red flag' events. Further information can be found in appendices 2 and 6. This provides greater assurance and a transparency to the governance processes to ensure adequate safe staffing levels and well as indicators of safety and effectiveness across the organisation.

4.2 Escalation beds and costs

Additional bed capacity has been utilised to support the operational pressures in the Trust during July 2019 – December 2019. The general practitioner assessment unit has recently combined with the surgical assessment unit to become the combined assessment unit (16 beds) on occasions has been used as an inpatient overnight facility. The senior nursing team monitor the additional beds and associated staffing costs which are reported monthly to the board. The table below provides a summary of the costs for the period July to December 2019.

Unfunded Beds	**Year to Date**			
Ward	**No. Bed Days**	**Additional Costs £**	**Notional Bed Day Cost £**	**Total Cost £**
GPAU	1075	264,204	0	264,204
C20 / GAU	420	90,583	0	90,583
A4	174	0	41,760	41,760
A5	44	0	10,560	10,560
AMU	32	0	7,680	7,680
C21	55	17,387	0	17,387
CDU	44	0	10,560	10,560
Totals	**1844**	**372,174**	**70,560**	**442,734**

Year to Date				
Ward	**No. Bed Days**	**Additional Costs £**	**Total Cost £**	
B3	4759	1,075,780	1,075,780	Funded by Halton Borough Council / Winter Funding
K25	849	191,918	191,918	Funded by Winter Funding
Totals	**5608**	**1,267,697**	**1,267,697**	

Staffing levels are reviewed daily to determine the additional staffing required in the escalation areas to ensure patient safety as part of the daily operational staffing plans.

5. Women and Children

5.1. Paediatrics

Nurse staffing levels for Paediatrics, including Paediatric Emergency Department, are based on Royal College of Nursing (RCN) Standards from the document 'Defining Staffing Levels for Children and Young People's Services: RCN Standards for Clinical Professionals and Service Managers (July 2013)'. This supports assessing acuity with numbers of staff on shift, patient acuity and dependency needs. Paediatrics use an adapted acuity tool. Patient acuity levels are monitored at 3 different time points through a 24 hr period against staffing levels on the main ward B11. Acuity and dependency of the patients on the Paediatric wards was monitored over a 4 week period in December 2019 (appendix 6).

During the 4 week monitoring period there were a number of shortfalls of qualified nursing staff identified on the ward at the specific monitoring times. The majority of the shortfalls were noted at times when the ward had young people admitted for Child and Adolescent Mental Health Services (CAMHS) which increased acuity due to the supervision element of care required; in response to this additional HCA support was utilised. The current escalation tool does not account for HCA's which means the ward had additional resources available to them. Therefore during the monitoring period the paediatric department was safe and had appropriate escalation processes in place to manage the peaks in activity and acuity. Following a recent staffing review, the department now ensures a band 6 is allocated to each shift ensuring an appropriate skill mix. The paediatric department is currently fully established.

5.2 Neonatal Unit (NNU)

Neonatal Unit (NNU) staffing levels are defined by British Association of Perinatal Medicine (BAPM) guidance. Table 2 below demonstrates the impact of the Trust-wide staffing business case. The NNU staffing establishment ensures compliance with commissioned activity and BAPM guidance making us one of the only units in Cheshire and Merseyside to achieve this standard.

BAPM staffing recommendations are assessed at two points during a 24 hour period and recorded on the Badgernet system. This system is used across the region for all NNU's. An acuity assessment against the BAPM standards utilising the Badgernet system was undertaken over a 4 week period, 2nd-29th December 2019. A robust escalation plan is in place based on BAPM guidance in order to ensure safe quality care delivery is in place on the NNU. The unit, as part of the escalation process, remained open during this period. The findings of a staffing review which were included in the Trust-

wide staffing business case has confirmed NNU staffing establishment ensures compliance with commissioned activity and BAPM guidance.

Table 2

	% Shifts staffed to BAPM recommendations		
	2016/17	2017/18	18/19
WHH	46.03	57.48	92.16
National average	56.93	61.62	71.32

5.3 -Midwifery Workforce Position

A recent staffing benchmarking tool for maternity services has been provided by the National Quality Board (2018) - Improvement Resource for Maternity Staffing, which recommends using Birthrate Plus for measuring staffing levels in maternity services.

The Birthrate Plus Acuity Tool provides staff with a framework to assess the demands within the Labour Ward and the number of staff required to manage these demands. It uses a classification system based upon clinical indicators during labour, birth and the immediate postnatal period. WHH Midwives work flexibly between different areas of the Maternity service to ensure each setting is safe. The current Birthrate Plus assessment performed in 2018 gives a ratio of 1:28 (midwife: birth).

Staffing levels are based on assessment of clinical risk and the needs of the women and their babies during labour, delivery and the immediate postnatal period. A minimum staffing ratio of 1:1 care for women in established labour has been recommended in Safer Childbirth 2007 and is further supported by NICE, 2015. A review of a two week sample of census data recorded of staffing levels to meet acuity was performed between the 2nd to the 15th December 2019. The snapshot demonstrated a ratio of 1:30. Due to increased sickness rates within the community midwifery team the ratio of births to midwives available on duty across the maternity pathway has increased. Midwives were relocated to community from other areas, managers and the senior leadership team worked clinically to respond to the situation to ensure safety could be maintained. Sickness levels in community have improved and a further snapshot audit will be completed in January 2020.

The National Quality Board recommends a 3 month census period in maternity services for staffing and acuity measures. In order to meet the NQB recommendations a 3 month acuity assessment was undertaken in July 2019 to September 2019, which showed a ratio of 1:29 (midwife: birth). An increase in activity occurred during this time due to the collapse of One to One Midwives Company. Midwives were recruited through NHSP to provide extra staffing to meet the acuity and demand on the service. The birth rate has increased slightly since this situation occurred. It should be noted that The Royal College of Midwives (RCM) recommend a target of 85% staffing levels to meet acuity with clear protocols for escalation. . Our acuity tool does show that we escalated to meet the acuity demands on a four hourly basis to achieve 85% staffing levels. We do have a current escalation policy which has been aligned with a regional escalation policy across Cheshire and Merseyside.

5.4 Maternity Workforce Development

A workforce document produced by HEE England (2019) outlines the challenges to provide improved outcomes for women and babies through Continuity of Carer (CoC) models. To support the development of a CoC model the Trust has received funding via The Local Maternity System over a 6 month period for a midwife to lead on implementation.
Development of an integrated staffing model alongside midwifery led unit, due to open the end of March 2020, and a workforce consultation is currently taking place which incorporates a review of the requirements to provide the CoC model. Developing these types of models can lead to many workforce challenges, such as a change in staff working patterns and a review of on call payments. In return the evidence shows many benefits to women and babies, including reduction in pre-term birth and foetal loss, which would have a positive impact financially.

The document describes how the workforce for maternity will be viewed as a whole Local Maternity System, with the ageing population of midwives being identified as a specific area of concern regionally. With this in mind there is a requirement to increase student placements. As a Trust student placements in Maternity will be increased by 29% for 2019 with a further 10% the following year, above the 25% required.

Strengthening leadership and changing the culture of birth to be woman and family focused is a focus of the document. We have made huge strides at WHH to work on changing the culture using funding creatively to develop a new Midwifery Led Unit Manager and a second Matron post in order to strengthen leadership and drive change.

The Head of Midwifery is currently reviewing the maternity staffing establishments as determined by birth rate plus (BR+) to include the impact of any increased activity in 2019 / 20 as we move to implement a strengthened marketing strategy.

Ref: Health Education England (2019) Maternity Workforce Strategy. Transforming the Maternity Workforce Phase 1: Delivering the Five Year Forward View for Maternity. www.hee.nhs.uk

6. Use of Temporary Staffing

NHS Professionals (NHSP) is the agreed supplier of temporary staffing to the Trust. During periods of high demand NHSP have been unable to meet the demand for registered nurses which has resulted in the use of agency staff. (As per appendix 5).

Overall Warrington performed better than North West Acute Trusts in December 2019 across all measures and Cheshire & Mersey Acute Trusts in all but agency usage, this is an improvement in each of these areas from previous months. These metrics are reported and monitored monthly at the NHSP meetings with the Deputy Chief Nurse and Workforce Group chaired by the Chief Nurse.

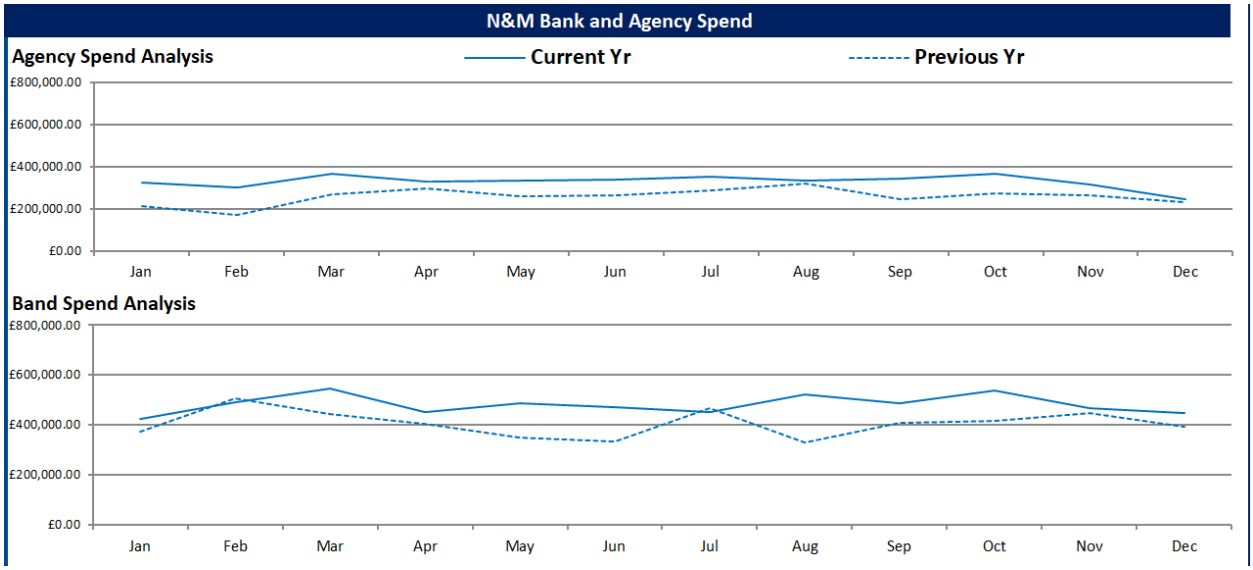
Table 3

	% Filled by NHSP	% Filled by Agency	% Hours Unfilled	% Overall Fill
North West Acute Trust Data	52.9%	14.9%	32.2%	67.8%
Cheshire & Mersey - Acute	55.8%	11.5%	32.7%	67.3%
Warrington	56.4%	14.7%	28.9%	71.1%

Mitigation against low fill rates takes place four times a day at the capacity, demand and flow meetings supported by the operational teams.

Chart 9 below shows agency use and bank spend analysis for the current financial year. Bank / agency spend remains consistent throughout 2019 which is a similar spend in 2018. Agency reduction is a priority and we have recently introduced a review panel led by the deputy chief nurse for the high spending wards. The aim is to challenge and support these areas to reduce overall spend on temporary staffing. We have a pro-active approach for any WHH staff to join the NHSP bank to enable us to reduce overall high cost agency spend. As we recruit more nurses, we would expect to see a further reduction in this spend.

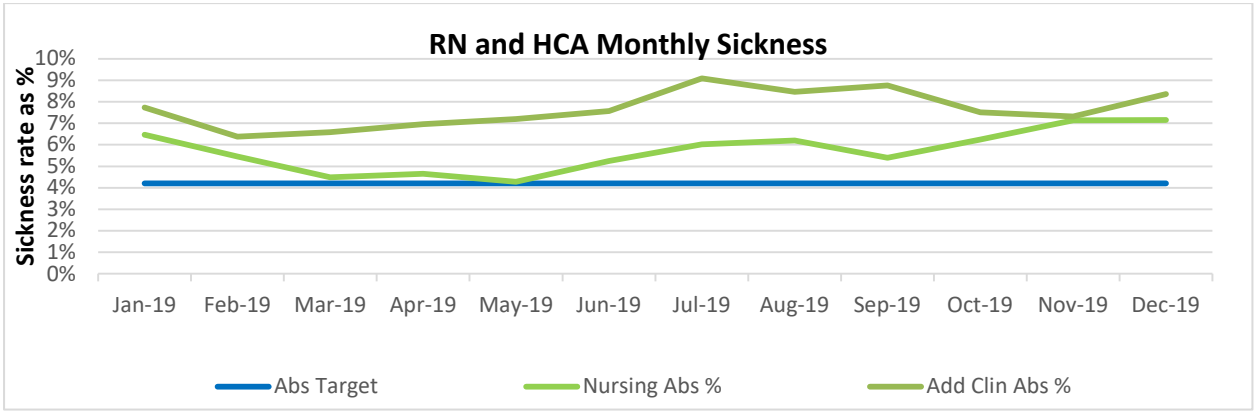
Chart 9



7. Monthly Sickness Absence

Sickness absence levels for registered nurses and health care assistants has been above the Trust target of 4.2% during the last 6 months which impacts on the overall staffing available in the Trust.

The Trust has recently established a Health and Wellbeing sub group led by Deputy Director of HR to implement plans in order to reduce overall sickness absence.



8. Overall Conclusions

The report provides an overview of the current position in the nursing workforce, including data from the evidence based staffing review (SNCT) and comparative benchmarking data from CHPPD. It is positive to report that the census data recorded within the SafeCare acuity and dependency system in December 2019 demonstrated that our budgeted nurse staffing WTE is comparable to the safe care data requirements.

The report recognises that although significant improvements have been made in the overall nurse staffing establishments enabling the Trust to meet the SafeCare acuity establishments of 697.11 WTE's, the actual number of staff in post is currently 557.32 leaving a difference of 139.97. This figure includes nursing and HCA vacancies including the additional staffing requirements for ward B3 and K25 which don't have a funded establishment.

The Nursing Recruitment and Retention Strategy is being delivered alongside the NHSI Retention Collaborative programme. An innovative recruitment campaign continues with flexible working plans and night only contracts. A number of new approaches have been adopted to support the recruitment campaign, including open days. In the last 12 months the Trust has welcomed 103.6 WTE new starters into the Band 5 Nursing roles and 103 HCA's. We anticipate 71 registered nurses joining the Trust in 2020 as a result of a series of recruitment events.

Since the development of The Trust retention plan as part of the NHSI collaborative programme we have seen an improvement in turnover from 14.99% in November 2018 to 12.65% in December 2019.

CHPPD is the national reporting metric for safe staffing levels. NHS Choices has recently replaced planned versus actual staffing levels. WHH ended 2018 / 19 with a CHPPD rate of 7.3. Since April 2019 we have maintained a rate of between 7.6 and 7.1 with a year to date position of 7.3. CHPPD continues to be monitored monthly against the national rate of 8.0 and peer organisations rate of 7.6.

The report demonstrates the progress that continues to be made across the organisation in Nursing and Midwifery staffing. There are still a number of challenges faced including recruitment to vacant posts and acknowledging the age profile of our current workforce which is a work stream initiative in the NHSI retention plan.

8. Recommendations

It is recommended that the Trust Board review the progress to date and note the contents of the report.

Appendix 1

National context and expectations of the National Quality Board

Boards of Trusts are ultimately responsible for the quality of care they provide, and for the outcomes they achieve. It is well documented that nursing, midwifery and care staff capacity impacts on the ability to deliver a quality experience to our patients and that this has an effect on patient outcomes. Multiple studies have linked low staffing levels to poorer patient experience and outcomes along with increased mortality rates.

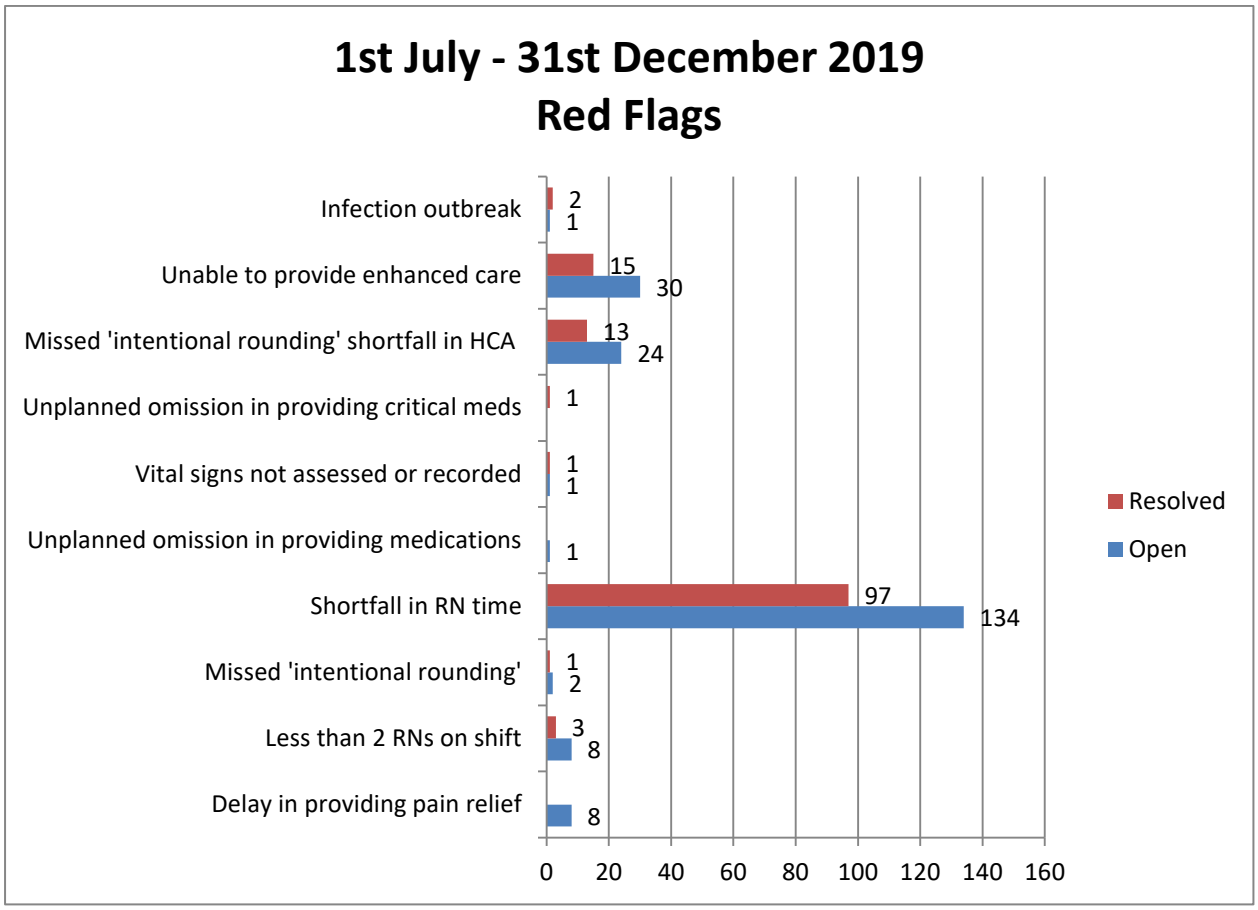
The NQB (2016) described three main expectations of NHS Provider Boards to ensure their organisation has the right culture, leadership and skills in place for safe, sustainable and productive staffing. They are also responsible for ensuring proactive, robust and consistent approaches to measurement and continuous improvement, including the use of a local quality framework for staffing that will support safe, effective, caring, responsive and well led care.

Safe, Effective, Caring, Responsive and Well-Led Care		
Measure and Improve - patient outcomes, people productivity and financial sustainability - - report investigate and act on incidents (including red flags) - - patient, carer and staff feedback -		
- Implementation Care Hours per Patient Day (CHPPD) - - develop local quality dashboard for safe sustainable staffing -		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Appendix 2

NICE Guidance Red Flags

Red flags can be defined as events that prompt immediate response by the registered nurse in charge of the ward on a given shift to ensure there is sufficient staff to meet the needs of patients on the ward. These events are recorded within the SafeCare™ system, there have been 342 raised in the 6 months between July and December 2019, these are summarised in the chart below. This is an increase on the previous report from 284 noted in the previous 6 months. Red Flags are one way for our ward staff to escalate staffing related issues to their Matron. However they can be by passed when wards verbally report the issue directly and it is resolved without cause to record within SafeCare™. A recent audit indicated staff were satisfied with the response when a red flag is raised however the senior nursing team need to ensure the process of closing the red flag on the system is undertaken on each occasion.



Following an audit of the escalation process for nurse staffing it was agreed to check the Red Flag system. The outcome of this was to adapt the Red Flag list to ensure that all staffing challenges are represented.

Maternity Red Flags

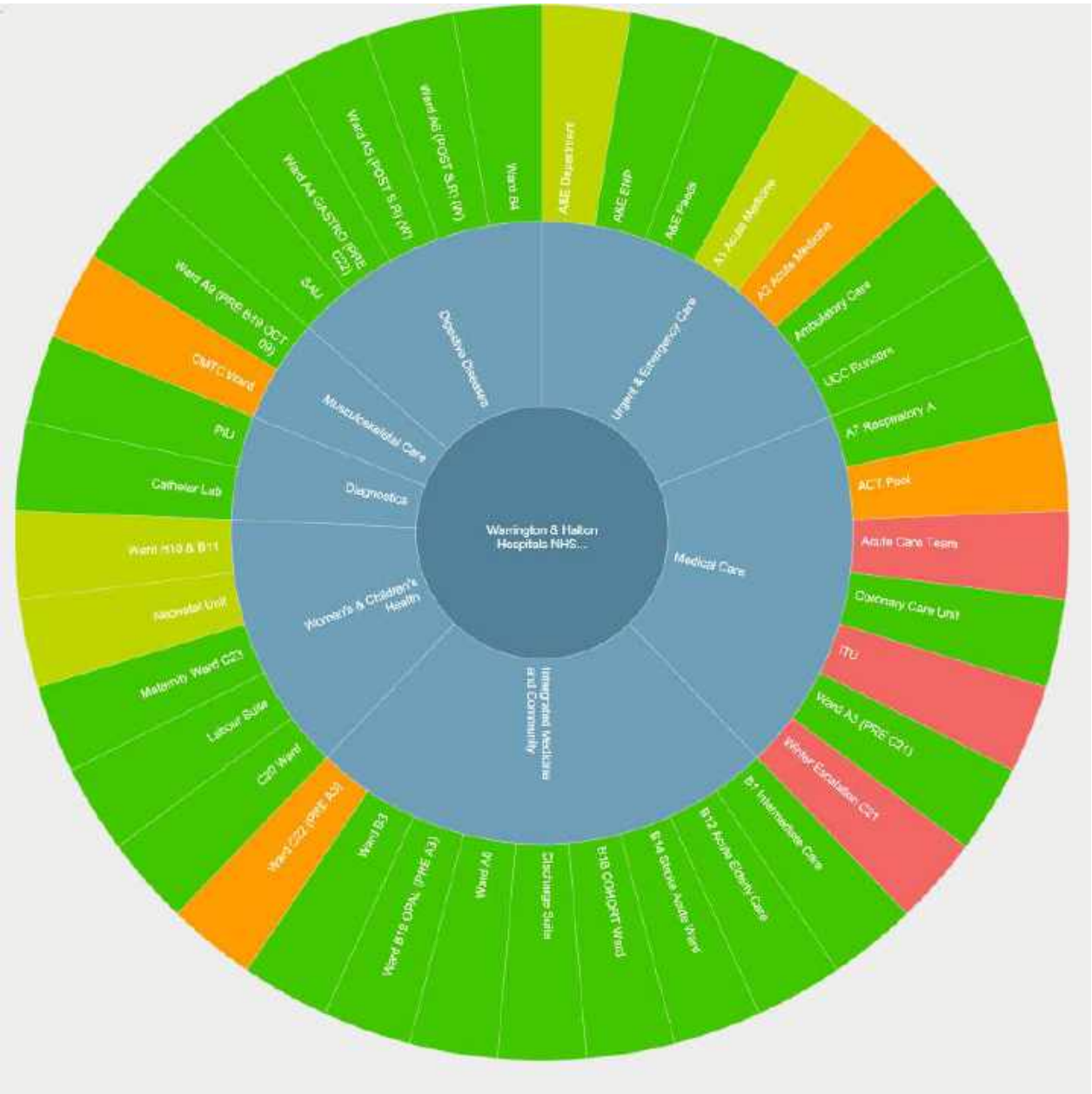
Red flags are reviewed in each area and data collected if red flag is triggered. These have been reviewed July to December 2019.

Each area has its own red flags which are detailed as follows:

Maternity Area	Red Flag
Triage / ANDU	• Delay of more than 60 minutes of review by Doctor - none • Delay of 30 minutes or more between presentation and triage - none
Labour Ward	• Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing) - none • Delay of two hours or more between admission for induction and start of the process - 1 • Any occasion when one midwife is unable to provide continuous one to one care in labour - none
Maternity Ward	• Missed medication during an admission to hospital (e.g. diabetes medication) - none • Delayed recognition and action on abnormal vital signs (e.g. sepsis or urine output) - none

Appendix 3

Allocate Safe Care "live" output



The above chart is an example of the live report that can, with one click, provide detailed information about staff and patients on all of our wards. Wards highlighted in 'Red' have either got a potential challenge (insufficient staff to provide adequate care) or have not submitted the required patient information.

This is reviewed with senior nurses on a three times daily staffing meeting that occur before patient flow meetings. Areas of concern are addressed and risks to patients and staff are minimised as a result.

Appendix 4

Establishment Uplift

There is a requirement for an agreed level of contingency for planned and unplanned leave, within the nursing establishments, (this may also referred to as headroom or uplift). Factors included currently within the organisation are long service entitlements in annual leave and alignment with Trust sickness/absence targets along with both mandatory and specific training leave for development. The requirement for this will be greater if there is a higher proportion of part time staff.

It is important that the level of uplift is realistic and reviewed at least annually. In conjunction with the finance team a review has taken place to understand the WHH position against peer organisations in more detail to ensure alignment and parity, particularly with regard to the management of maternity leave which currently does not align with the uplift in establishment. The outcome of the review noted WHH to be both a local and national outlier in regards 'uplift' based at 20% with national recommendations between 22.5% and 25%. As part of the recent financial injection into the nursing staffing budget the establishment uplift, the 23 wards included in the staffing business case have now had their uplift to 23%. The table below illustrated how the 23% uplift has been broken down

	RCN recommended	Current WHH funded uplift	Evidenced WHH actual position	Recommended WHH funded uplift	Comments
Annual Leave	17.0%	15.5%	17.0%	17.0%	17% is sufficient to cover an average of 30 days + 8 bank hol per person.
Sickness / absence	4.5%	3.5%	6.4%	4.2%	Sickness cover should be aligned to the organisational sickness absence target.
Study leave	2.0%	1.0%	1.8%	1.8%	The requirement for study leave cover is 1.8% based upon the current mandatory & essential training demands
Parenting leave	1.0%	0.0%	2.5%	0.0%	On average 18 wte are on parenting leave at any one time, equating to 2.5%. It is proposed that parenting leave is managed within baseline
Other leave	0.5%	0.0%	0.5%	0.0%	4,900 hours lost to special leave during 16/17 across all wards areas, this equates to 0.5%. It is proposed that special leave is managed within baseline.
Total	**25.0%**	**20.0%**	**28.2%**	**23.0%**	

Appendix 5

Bank and Agency demand and fill rates from July 2019 to December 2019.

Clinical Business Unit	Agency Filled	Bank Filled	Unfilled	Grand Total
Acute Care Services	57	34	15	106
Airway Breathing & Circulation	512	1235	600	2347
Child Health		21		21
Corporate		52		52
Corporate Nursing		17		17
Diagnostics	191	168	152	511
Digestive Diseases	1629	2041	725	4395
Discharge/Patient Flow		47		47
Medical Care	145	330	218	693
Musculoskeletal Care	176	231	239	646
Outpatients	45	142	95	282
Specialist Medicine	940	1285	969	3194
Specialist Surgery		5	4	9
Unscheduled Care		48	44	92
Urgent & Emergency Care	2225	1700	1193	5118
Women's & Children's Heal	246	1628	450	2324
Grand Total	6166	8984	4704	19854

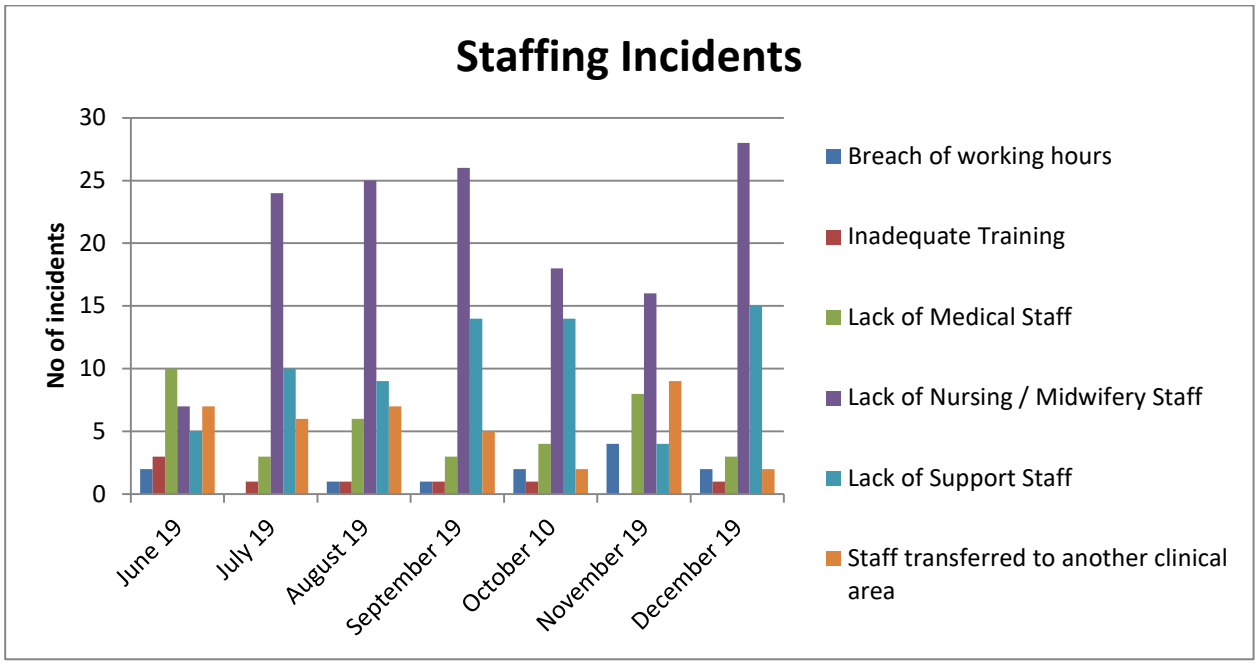
Appendix 6

Reported Staffing Incidents

In order to ensure effective triangulation of data the following information was gathered from the Trust Datix system to understand staff reporting rationales under the heading of staffing incidents.

'Lack of Nursing / Midwifery Staff and 'lack of support staff' are highlighted as the largest reason for completing a Datix within this criterion. This does not distinguish between members of the multi-disciplinary team. All incidents are monitored and actioned within the relevant CBU with detail provided in monthly governance reports. Monitoring of staffing incidents takes place on a monthly basis by the senior nursing team.

Number of staffing incidents from June 2019 to December 2019.



This illustrates a similar number of incidents being reported in the previous 6 months however we have seen a slight rise in the number of incidents relating to lack of nursing staff reported each month. This is reflective of the staffing challenges the Trust has faced over the last 6 months with the vacancy rates, additional beds in operation and sickness. Staffing incidents continue to be monitored monthly within the CBU's and in the safe staffing group with the senior nursing team.

Appendix 7

Acuity and dependency levels on the Paediatric wards over a 4 week period December 2019.

December 2019	0700	1400	2200	Mitigation
Mon 2nd				
Tues 3rd				
Wed 4th		-0.8 wte		Ward manager on duty and 2 HCA's
Thurs 5th	-0.6 wte			Ward manager on duty and 2 HCA's
Fri 6th	-1 wte	-0.8 wte		Sickness of RN but safe as 2 HCA's on duty and nurse for PAU
Sat 7th	-0.7 wte	-0.7 wte		2 HCA's and nurse on duty for PAU.
Sun 8th				
Mon 9th				
Tues 10th			-0.2wte	HCA Night duty
Wed 11th	-0.2 wte	-0.9 wte	-0.3 wte	Ward manager on duty during the day and 2 HCA's. HCA night duty.
Thurs 12th			-0.4 wte	HCA Night duty
Fri 13th				
Sat 14th			-0.3 wte	HCA Night Duty
Sun 15th			-0.2 wte	HCA Night duty
Mon 16th				
Tues 17th				
Wed 18th	-1.3 wte			High acuity and staff sickness. Ward manager acted as co-ordinator.2CAMHS patients but 2 HCA's on duty. Therefore safe.
Thurs 19th				
Fri 20th				
Sat 21st				
Sun 22nd			-0.8 wte	HCA Night duty
Mon 23rd				
Tues 24th				
Wed 25th				
Thurs 26th				
Fri 27th				
Sat 28th				
Sun 29th				

To: Chief Executive Officer
Chief Nursing Officer / Director of Nursing
Chief People Officer / Director of Workforce

CC: Regional Director of HEE, NHS England and Improvement

Warrington and Halton Hospitals NHS Foundation Trust

North West
RWW

Dear colleague,

We are writing to provide final confirmation of the allocations your Trusts will receive in line with the announcement of £150m increased investment in continuing professional development (CPD) for nurses, midwives and allied health professionals (AHPs). These allocations replace the indicative range provided in our letter of 5th November 2019. In addition to this, we also include allocations for Primary Care which will be managed through by Primary Care Training Hubs.

Your Organisations Final CPD allocation for 20/21 is : £ 472333

As you know, this funding enables employers to provide a £1,000 training budget over the next three years for each nurse, midwife and AHP in your organisations in addition to your investments made locally by your organisation. This is important funding to support our staff to ensure they continue to be able to develop the skills to deliver high quality care for patients. Combined with the recently announced support for nursing, midwifery and AHP degree students, this underlines our determination to secure the workforce we need to deliver the ambitions of the long-term plan.

It is important that this funding is deployed rapidly and, following interim communications in November 2019, your teams will have already been considering their personal and collective training needs. To support this, we have provided some further detail on the onward process of this policy.

Focus of the policy

This policy is aimed to support CPD requirements of nurses, midwives and AHPs in NHS provided services. CPD is ostensibly a professional requirement via NMC and other regulators but also links to the needs of the individual aligned to the service and organization that they work in. This additional funding is to support employers as part of yearly appraisal in delivery of an employees CPD alongside service requirements to develop skills and expertise at point of care.

From April 2020, it is for providers to allocate this in line with the policy that employees have access to the £1000 funding over three years. For some employees, this may be in one sum during this time or in multiple amounts over the 3 years. Providers will be required to ensure in their practical and financial planning that access to the funding is equitable. This will require quarterly reporting to the public part of the board including areas of spend, uptake and benefits alongside other people performance data.

This fund is to support the NHS as a whole, and the skills and expertise of our people vital to services and communities. Staff will move between organizations and take those skills to new roles in the NHS. We expect Trusts and Hubs as part of STPs to work to this principle and ensure that there are processes to monitor this between Trusts but not introduce any processes or policies that places any restrictions on staff (Practical or Financial).

Allocation process

Allocations have been set against NHS Digital's April 2019 workforce data and will be issued through the Learning Development Agreement process in two stages:

- Organisations will initially receive 50% of their confirmed allocation in Quarter 1 2020/21 as part of the LDA. You will then be required to submit investment plans to HEE by end of August 2020. A template to support completion will be provided by HEE in July 2020.
- Subject to the submission and acceptance of plans the remaining allocation will be issued in Quarter 3 of 2020/21.

This is designed to ensure that the principles of the policy are being adhered to and other data from the baseline financial assessment have been assessed ***in line with no reduction in existing funding and backfill have been identified and achieved***.

In line with ministerial announcement, the funding will go direct to Provider organisations and primary care training hubs. Regional systems of HEE and NHS E and I will not need to transact this additional money.

This funding is a one year settlement and future allocations for years 2021/22 and 2022/23 will be reviewed in line with the Spending review process and providers informed in the Autumn of 2020.

Workforce Development Funding

HEE continues to fund workforce development over and above the CPD allocation, to be used in line with our workforce transformation 'menu' that was used last year and is being updated for 2020/21, based on stakeholder feedback.

This year, part of the allocation will be notified to STP/ICS workforce boards, to support system wide priorities.

Further detail will be circulated by HEE Regional Directors towards the end of February

Requirements on organisations

In addition to the provision of an investment plan to HEE as set out above, organisations will also be required to ensure that this funding is utilised ***in addition*** to current CPD investment levels on both courses and infrastructure.

The NHS Financial Planning Guidance includes information on setting a baseline position for CPD using data collected in the financial planning returns for 2019/20 forecast outturn. The planning guidance will also include a planned spend for 2020/21 which should reflect the additional investment.

Organisations will also need to support this new CPD investment ***through backfilling staff time during training*** to ensure staff are able to take up education and training opportunities.

All these requirements will be monitored for their impact to ensure the policy is delivered as set out.

Next steps

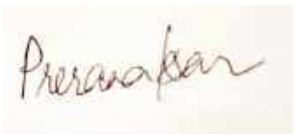
As indicated in the recent planning guidance Trust will received 50% of the allocation in April. Following return of their plans and assurance on current CPD spend and backfill in place then further tranche will be released in September. Additionally, Health Education England will track use of the additional investment to enable collective understanding of the benefits of the additional investment to be seen.

I would be grateful if you could keep your teams updated on these arrangements.

Yours sincerely,

Ian Cumming
Chief Executive, HEE

Ruth May
Chief Nursing Officer



Prerana Issar
Chief People Officer

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/03/42 a**			
SUBJECT:	**Staff Survey Report 2019 – Trust Results**			
DATE OF MEETING:	25 March 2020			
AUTHOR(S):	Deborah Smith, Deputy HRD+ OD			
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Director of HR & OD			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#145 (a) Failure to deliver our strategic vision.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper provides an overview of the 2019 staff survey results which were published on the 18th February 2020. The paper highlights the organisation's response rate of 53% which was 6% better than the national acute trust score. The thematic results demonstrate how the organisation has improved from the 2018 results in 9 areas, remained the same as the 2018 results in 1 area which related to bullying and harassment and has decreased in 1 area relating to violence. The paper also provides a detailed analysis in relation to the 11 national staff survey themes and against the national Workforce Race Equality standard (WRES) and Workforce Disability Equality Standard (WDES). In addition to the results, the paper describes the next steps from an organisational and department perspective. From an organisational perspective, the staff engagement team will share the results across the organisation utilising existing staff engagement mechanisms. As part of this approach, staff will be reminded of the workstreams that are already in place in order to address the staff survey results and will be invited to be involved in building up workstreams on the areas that require further improvement. From a departmental perspective, results will be shared to managers via HR Business Partners and the approach will be to work alongside staff to develop and agree three priorities of focus according to their localised feedback.			
PURPOSE: *(please select as appropriate)*	Information	Approval	To note ✓	Decision
RECOMMENDATION:	Trust Board are asked to note: 1. The results have been reviewed and discussed at Strategic People Committee and have approved the proposed next steps and CBU Priority workstreams 2. The staff survey organisational thematic results			

PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee
	Agenda Ref.	SPC/20/03/29
	Date of meeting	18 March 2020
	Summary of Outcome	This report was presented to Strategic People Committee under the title: Engagement and Recognition Annual Report
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Staff Survey Report 2019 – Trust Results	AGENDA REF:	BM/20/03/42 a

1. BACKGROUND/CONTEXT

The NHS Staff survey is a nationally mandated survey across all organisations to inform local improvement in staff experience and wellbeing. It is a national measure against the pledges set out in the NHS Constitution and provides useful intelligence to the Care Quality Commission and local commissioners.

The 2019 staff survey took place between September and November 2019 via Quality Health, who are an approved NHS staff survey provider. The organisation undertook a mixed mode approach to the survey providing paper copies as well as an online option for all members of staff.

The staff survey is made up of a number of questions, which equate to the following themes:

- Equality, Diversity and Inclusion
- Health and Wellbeing
- Immediate Managers
- Morale
- Quality of Appraisals
- Quality of Care
- Safe Environment – Bullying and Harassment
- Safe Environment – Violence
- Safety Culture
- Staff Engagement
- Team Working

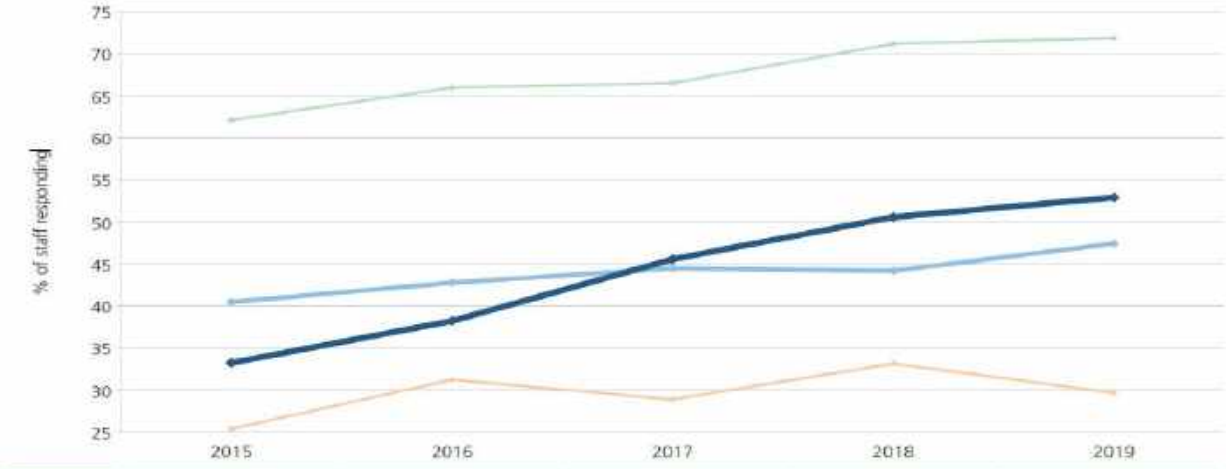
The results from the survey provide the organisation with the opportunity to understand staff experience in terms of what is going well and the areas that may require further improvement.

In addition to the publication of results, organisations are required to develop local priority workstreams to address the results from both an organisation and directorate (Clinical Business Unit) perspective to demonstrate to staff how the organisation is responding to staff feedback.

2. THEMATIC RESULTS

In the 2019 staff survey, the organisation's response rate was 53% which is an increase of 2.4% from the 2018 staff survey figures, **diagram one** identifies our organisational position in comparison with the best, average and worse acute trust scores. 2,136 member of staff completed their survey and the organisation's response rate was 6% above the national score when compared with other acute trusts nationally. The thematic results demonstrate how the organisation have made great strides in increasing participation in the survey and most importantly how there have been initiatives and interventions throughout the year which have contributed to a cycle of continuous improvement from our staff and the services that we provide.

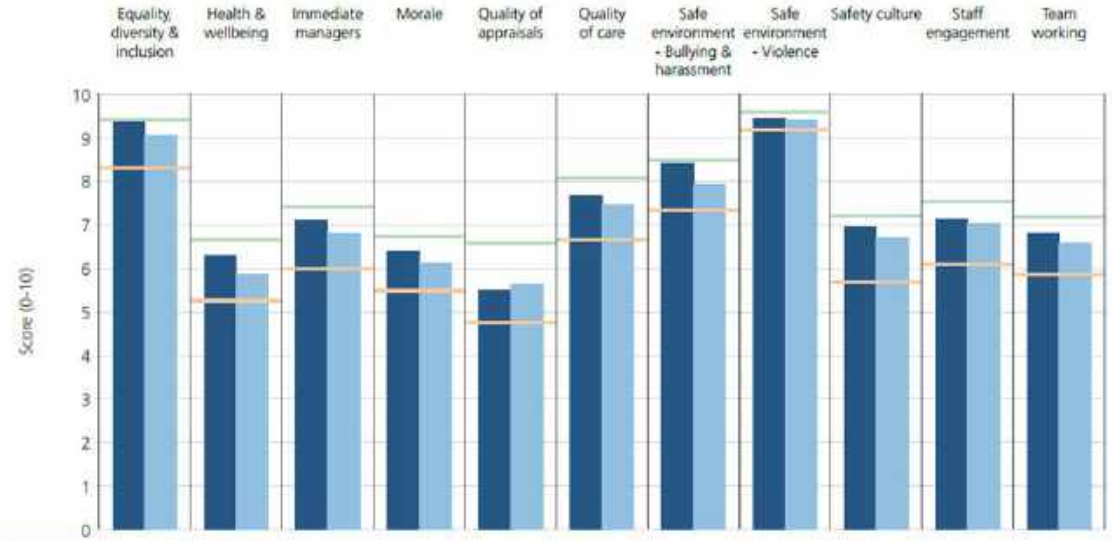
Diagram One: Response Rates



	2015	2016	2017	2018	2019
Best	62.2%	66.0%	66.6%	71.3%	71.9%
Your org	33.3%	38.3%	45.6%	50.6%	53.0%
Median	40.5%	42.8%	44.5%	44.2%	47.5%
Worst	25.4%	31.3%	28.9%	33.2%	29.7%

Table one highlights the thematic results from the 2019 staff survey including best and average scores. The results illustrated that the organisation is better than the average score in 9 areas, the same as the average score in one area in relation to a safe environment from violence and slightly below average in the quality of appraisals. Although the quality of appraisals thematic score is lower than the national average for acute specialist trusts, the organisation has improved on last year's score which demonstrates the impact of some of the initial work undertaken in relation to refreshing and developing the PDR and appraisal process for the organisation.

Table one: Staff Survey Thematic Results



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.4	6.7	7.4	6.7	6.6	8.1	8.5	9.6	7.2	7.5	7.2
Your org	9.4	6.3	7.1	6.4	5.5	7.7	8.4	9.4	6.9	7.1	6.8
Average	9.0	5.9	6.8	6.1	5.6	7.5	7.9	9.4	6.7	7.0	6.6
Worst	8.3	5.3	6.0	5.5	4.8	6.7	7.3	9.2	5.7	6.1	5.9
Responses	2,103	2,108	2,121	2,090	1,801	1,758	2,099	2,100	2,101	2,127	2,104

In comparison with the 2018 data, which is shown in **table two**, the organisation has improved in nine thematic areas, remained the same in one area which focuses on bullying and harassment and has decreased in providing a safe environment in relation to violence.

Table two: Comparison of thematic results

Theme	2018 score	2019 score	Comparison between years	Comparison with national acute trust average score
Equality, Diversity and Inclusion	9.3	9.4	↑	↑
Health and Wellbeing	6.2	6.3	↑	↑
Immediate Managers	7.0	7.1	↑	↑
Morale	6.2	6.4	↑*	↑
Quality of Appraisals	5.3	5.5	↑*	↓
Quality of Care	7.5	7.7	↑	
Safe Environment – Bullying and Harassment	8.4	8.4	–	↑
Safe Environment – Violence	9.5	9.4	↓	–
Safety Culture	6.7	6.9	↑*	↑
Staff Engagement	7.0	7.1	↑*	↑
Team Working	6.6	6.8	↑*	↑

* Refers to scores that are statistically significant according to Quality Health's significance testing. Quality Health are the organisation's NHS staff survey provider.

The thematic results demonstrate that the organisation is doing well in comparison with other acute trusts nationally, and there is demonstrably improvements in most areas as identified in table two. The thematic results identify the areas for further work as quality of appraisals, bullying and harassment and violence.

3. DETAILED THEMATIC ANALYSIS

Overall, the organisation fares very well in terms of its thematic results and individual question breakdowns, a summary of the full results can be found in **appendix one.**

The staff survey contains 104 questions in total and 85 of these questions scored better than last year from an organisational perspective with two remaining the same and seventeen scoring lower than last year. In comparison with the average scores for acute trusts nationally, the organisation has fared better than the average score in 89 questions and slightly worse than the average score in 15 questions.

a. Equality, Diversity and Inclusion

- The organisation has the best score of 9.4 for equality, diversity and inclusion when compared with other acute trusts nationally
- Staff feel that the organisation acts fairly in relation to career progression or development irrespective of protected characteristic with a 1% increase from 2018
- Individuals experiencing discrimination on the basis of ethnicity has decreased by 3.6% and is 17% better than the average acute trust score nationally
- There has been an increase in discrimination on the grounds of gender, disability and age which is an area for development.

b. Health and Wellbeing

- Staff feel that the organisation takes positive action on health and wellbeing with an increase of 2.9% from 2018
- There has been an improvement in the number of staff feeling unwell as a result of work related stress
- Staff experiencing musculoskeletal issues as a result of work activities has increased by 2%
- Whilst the trust results are overall positive, MSK interventions will be an area to focus on over the next year.

c. Immediate Managers

- 5.6% increase in the numbers of staff feeling that senior managers act on staff feedback and involve staff in important decisions
- Increase by 2.3% in the workforce feeling that their immediate managers are supportive in terms of helping with difficult tasks
- There are improvements to be made in relation to staff feeling that clear feedback is given on their work as the score has decreased by 0.2%.

d. Staff Morale

- All questions relating to staff morale show a positive improvement above the national average for acute trusts
- There has been a 3.2% increase in individuals feeling that they have a choice in deciding how to do their work
- The workforce's intentions to leave the organisation have dropped by 2.4% which is positive news.

e. Quality of Appraisals

- The workforce feel that the appraisal process has helped to agree clear objectives which has increased by 2.3% since 2018
- There has been a 5% increase in staff feeling that the organisation's values were discussed as part of the appraisal
- The number of people having an annual appraisal has dropped by 3.3% but the organisation score is better than the national average for acute trusts
- An area identified for improvement is how the appraisal has helped individuals to improve how they do their job as the organisational score is 1.10% lower than the national acute trust average

f. Quality of Care

- Staff feel satisfied with the quality of care that they give which has increased by 1.3% from 2018
- Staff also feel able to deliver the care they aspire to which has increased by 4.6%
- However, there are issues with some of the workforce feeling that their role makes a difference to patients which has decreased by 1.2% and is less than the national average score for acute trusts.

g. Safe Environment – Bullying and Harassment

- In the last 12 months, there has been a decrease in harassment, bullying or abuse at work from patients, service users and managers
- In the last 12 months there has been an increase of 0.3% in staff experiencing bullying, harassment or abuse from other colleagues.

h. Safe Environment – Violence

- The organisation has a better score than the national average for acute trusts in the questions relating to experiences of violence
- In the last 12 months, there has been a reduction in staff experiencing physical violence from managers or work colleagues
- In the last 12 months, there has been an increase of 1% of the workforce experiencing physical violence from patients, carers or relatives at work.

i. Safety Culture

- All questions that fall under the safety culture theme have improved results since 2018
- The organisation has scored higher than the national average score for acute trusts
- 6% increase in staff feeling that they are given feedback about the changes made as a result of an error, near miss or incident
- 6% increase in staff feeling that the organisation responds to concerns raised by patients.

j. Staff Engagement

- All questions that fall under the staff engagement theme have improved since the 2018
- The organisation has scored higher than the national average score for acute trusts
- Staff look forward to coming to work and are enthusiastic about their job
- 6% increase in staff recommending the organisation as a place to work

k. Team working

- All questions that fall under the team working theme have improved since the 2018 survey
- The organisation has scored higher than the national average score for acute trusts
- There has been a 1.6% increase in staff feeling part of an effective team with shared objectives
- Increase of 2% for our staff feeling that there are opportunities to meet regularly as a team.

3.1 Protected Characteristics Analysis

In addition to the detailed thematic results, **table three** illustrates some of the results that are used for the national Workforce Race Equality Standard (WRES) and **table four** illustrates the national Workforce Disability Equality Standard (WDES).

To provide some context to these results, 18.5% of respondents to the staff survey declared that they have physical or mental health conditions which are expected to last 12 months or more. In relation to ethnicity, 91.8% of respondents declared themselves to be white with other ethnicities declaring as follows:

- Mixed 0.9%
- Asian / Asian British – 5.5%
- Black / Black British – 0.7%
- Chinese – 0.4%
- Other – 0.7%

Although the organisation has the best score in relation to equality, diversity and inclusion, there is still work to be undertaken in relation to tackling bullying and harassment and also the perception of our BAME and disabled members of staff who feel that the organisation does not provide equal opportunities for career progression or promotion.

Table three: Protected Characteristic Analysis – Workforce Race Equality Standard

Question	BAME members of Staff	White Members of Staff	Narrative
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives of the public in last 12 months	25.0%	21.6%	BAME members of staff are experiencing more harassment, bullying or abuse from the public in the last 12 months than white staff.
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	26.0%	19.0%	BAME members of staff are experience more harassment or bullying from other members of staff than white staff.
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	82.3%	91.4%	More white members of staff than BAME members of staff believe that there are equal opportunities for career progression or promotion.
Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months	10.7%	4.5%	More BAME members of staff than white members of staff have experienced discrimination at work from a manager, team leader or other colleague in the last 12 months.

Table Four: Protected Characteristic Analysis – Workforce Disability Equality Standard

Question	Disabled members of Staff	Non-disabled members of staff	Narrative
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	25.7%	20.9%	Disabled staff have reported experiencing slightly more harassment, bullying or abuse from patients, relatives or the public in the last 12 months.
Percentage of staff experiencing harassment,	13.1%	8.4%	More disabled staff than non-disabled staff have reported experiencing

bullying or abuse from manager in last 12 months			harassment, bullying or abuse from manager in last 12 months.
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	21.1%	13.2%	More disabled staff than non-disabled staff have reported experiencing harassment, bullying or abuse from other staff in the last 12 months.
Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	48.0%	51.1%	Non-disabled staff are more likely to report their experiences of harassment, bullying or abuse than disabled members of staff.
Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion	85.8%	91.5%	Non-disabled staff believe that the organisation provides equal opportunities for career progression or promotion than disabled staff.
Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	27.9%	19.3%	More disabled staff have felt pressure to come to work despite not feeling well enough to perform their duties than non-disabled staff.
Percentage of staff satisfied with the extent to which their organisation values their work	39.2%	54.6%	Disabled staff do not feel as satisfied as non-disabled staff that the organisation values their work
Percentage of disabled staff saying their employer has made adequate adjustment (s) to enable them to carry out their work	75.0%	N/A	In comparison with the average score for national acute trusts, our organisational score is 1.7% higher.
Staff engagement score	6.7	7.2	Non-disabled staff have scored the organisation higher than disabled members of staff in relation to intentions to stay and involvement in the organisation.

4. ASSURANCE COMMITTEE

Strategic People Committee

5. NEXT STEPS: TRUST WIDE

The staff survey results provide the organisation with the opportunity to directly respond to staff feedback through robust assurance and priority setting. There will be a three step process which involve the following stages:

1) Sharing the results
2) Emphasising existing work to remind staff how we are responding to staff feedback

3) Involving staff in building organisational workstreams together.

The organisational staff survey results will be shared in a variety of methods that are accessible and that capture all staff by utilising some of our existing communication mechanisms and partnerships such as with our Union networks. In addition there will be opportunities for staff to hear and understand what the organisation has undertaken or will be doing to address the results. Examples of new and existing work to address the results include the new BAME staff network, launch of the new PDR appraisal paperwork and the development of Freedom To Speak Up Champions across the organisation.

Sharing the organisational results will take place at both Warrington and Halton sites by utilising existing staff mechanisms and meetings as well as marketplace stalls within communal areas.

The approach of disseminating the results will form part of a wider staff engagement piece of work. Through various mechanisms staff will have the opportunity to be reminded of what is already in place within the organisation in order to address the staff survey results and what work is currently in progress. There will also be an opportunity for staff to directly influence some of the workstreams that we need to undertake in order to respond to the results so that we can continually improve as an organisation.

6. NEXT STEPS: LOCAL OWNERSHIP

In addition to the organisational results and subsequent development of workstreams, Clinical Business Units / Departments will also be required to develop priority workstreams responding to the results of their localised staff feedback. It is really important to have local ownership as it will demonstrate to staff at a team level how their concerns and voice has been included in order to make improvements for the benefit of all staff within their local areas.

The results have been shared with management teams. The CBU/Department teams will be supported by the HR, OD and Engagement teams to engage with staff to work on the three priorities.

Assurances on progress will be gained via local governance meetings, via Trust Operational Board as part of exception reporting and via the Operational People Committee.

Both proposed governance approaches from an organisational and CBU perspective provides assurances to staff that their feedback is important and that the organisation is taking action on a local and organisational level to continue to improve staff experience within the organisation.

7. RECOMMENDATION

Trust Board are asked to note:

- The results have been reviewed and discussed at Strategic People Committee and have approved the proposed next steps and CBU Priority workstreams
- The staff survey thematic results

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Survey Coordination Centre

NHS England

Warrington and Halton Hospitals NHS Foundation Trust

2019 NHS Staff Survey

Benchmark Report

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Introduction

This benchmark report for Warrington and Halton Hospitals NHS Foundation Trust contains results for themes and questions from the 2019 NHS Staff Survey, and historical results back to 2015 where possible. These results are presented in the context of the best, average and worst results for similar organisations where appropriate. Data in this report is weighted to allow for fair comparisons between organisations.

Please note: q1, q10a, q19f, q23d-q28a and q29-q31b are not weighted or benchmarked because these questions ask for demographic or factual information.

Full details of how the data are calculated and weighted are included in the Technical Document, available to download from our results website.

The structure of this report

Introduction

- Introduction
- Using the report
- Organisation details

Provides a brief introduction to the report, including the graphs used throughout.

The '**Organisation details** ' page contains key information about the organisation's survey and its benchmarking group.

Theme results

- Overview
- Trends
- Detailed information

The eleven themes provide a high level overview of the results for an organisation.

The '**Detailed information**' sub-section contains the question results that feed into each theme.

Question results

- Your job
- Your managers
- Your health, well-being and safety at work
- Your personal development
- Your organisation
- Background details

Results from all questions, structured by the questionnaire sections.

Workforce Equality Standards

- Introduction
- Workforce Race Equality Standard (WRES)
- Workforce Disability Equality Standard (WDES)

Shows data required for the NHS Staff Survey indicators used in the Workforce Equality Standards.

Appendices

- Response rate trends
- Significance testing of themes
- Tips on action planning and interpreting results
- Additional reporting outputs

'**Significance testing of themes**' contains comparisons for the 2019 and 2018 theme scores.

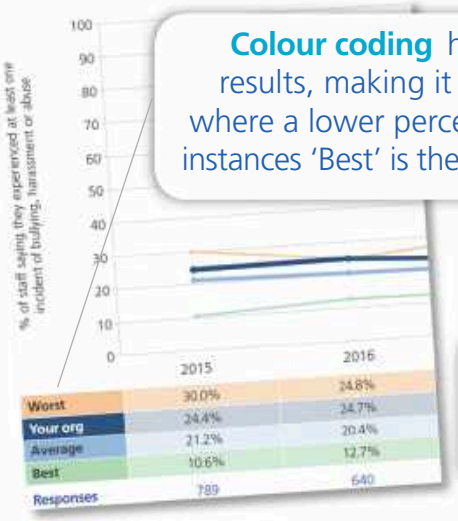
Using the report

Key features

Question number and text (or the theme) specified at the top of each slide

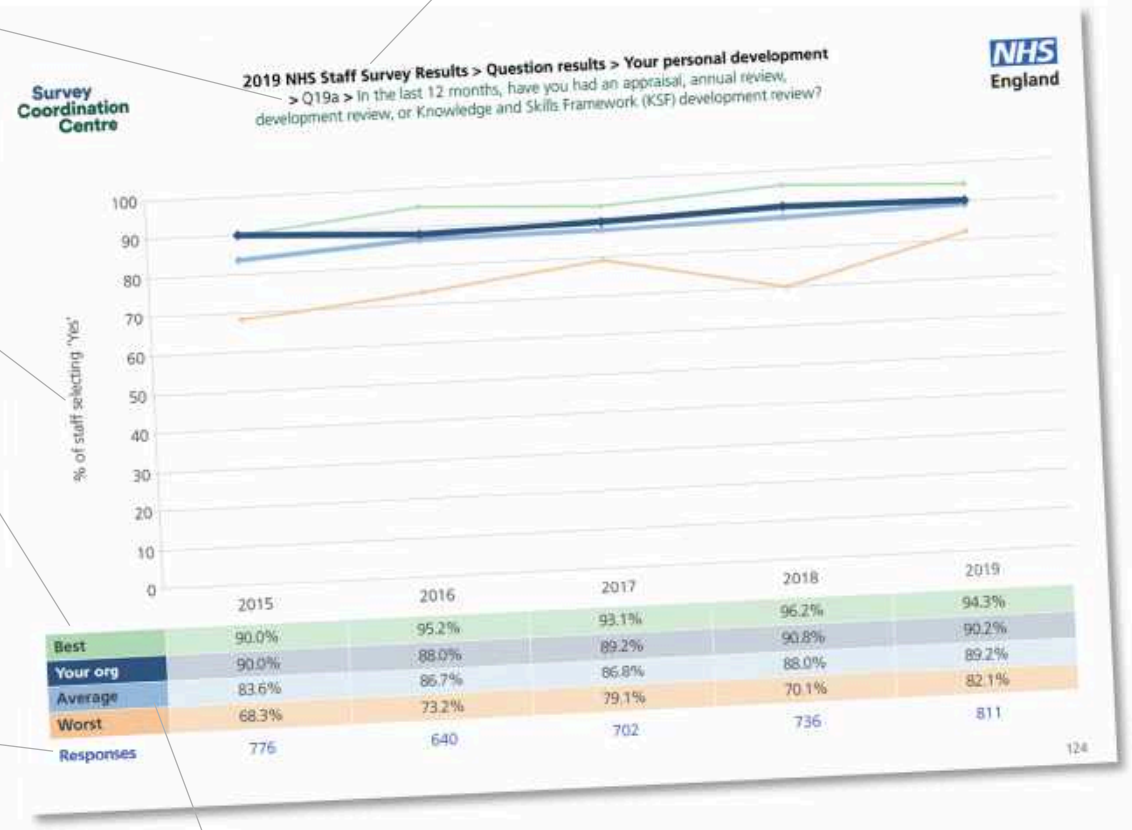
Slide headers are **hyperlinked** throughout the document. '2019 NHS Staff Survey Results' takes you back to the contents page (which is also hyperlinked to each section), while the rest of the text highlighted in bold can be used to navigate to sections and sub-sections

Question-level results are always reported as percentages; the **meaning of the value** is outlined along the axis. Themes are always on a 0-10pt scale where 10 is the best score attainable



Colour coding highlights best / worst results, making it easy to spot questions where a lower percentage is better – in such instances 'Best' is the bottom line in the table

Keep an eye out!



Number of responses for the organisation for the given question

'Best', 'Average', and 'Worst' refer to the **benchmarking group's** best, average and worst **results**

Tips on how to read, interpret and use the data are included in the Appendices

Organisation details

Warrington and Halton Hospitals NHS Foundation Trust

2019 NHS Staff Survey

Organisation details

Completed questionnaires **2,136**

2019 response rate **53%**

See response rate trend for the last 5 years

Survey details

Survey mode **Mixed**

Sample type **Census**

This organisation is benchmarked against:

Acute Trusts

2019 benchmarking group details

Organisations in group: **85**

Median response rate: **47%**

No. of completed questionnaires: **259,296**

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Survey Coordination Centre

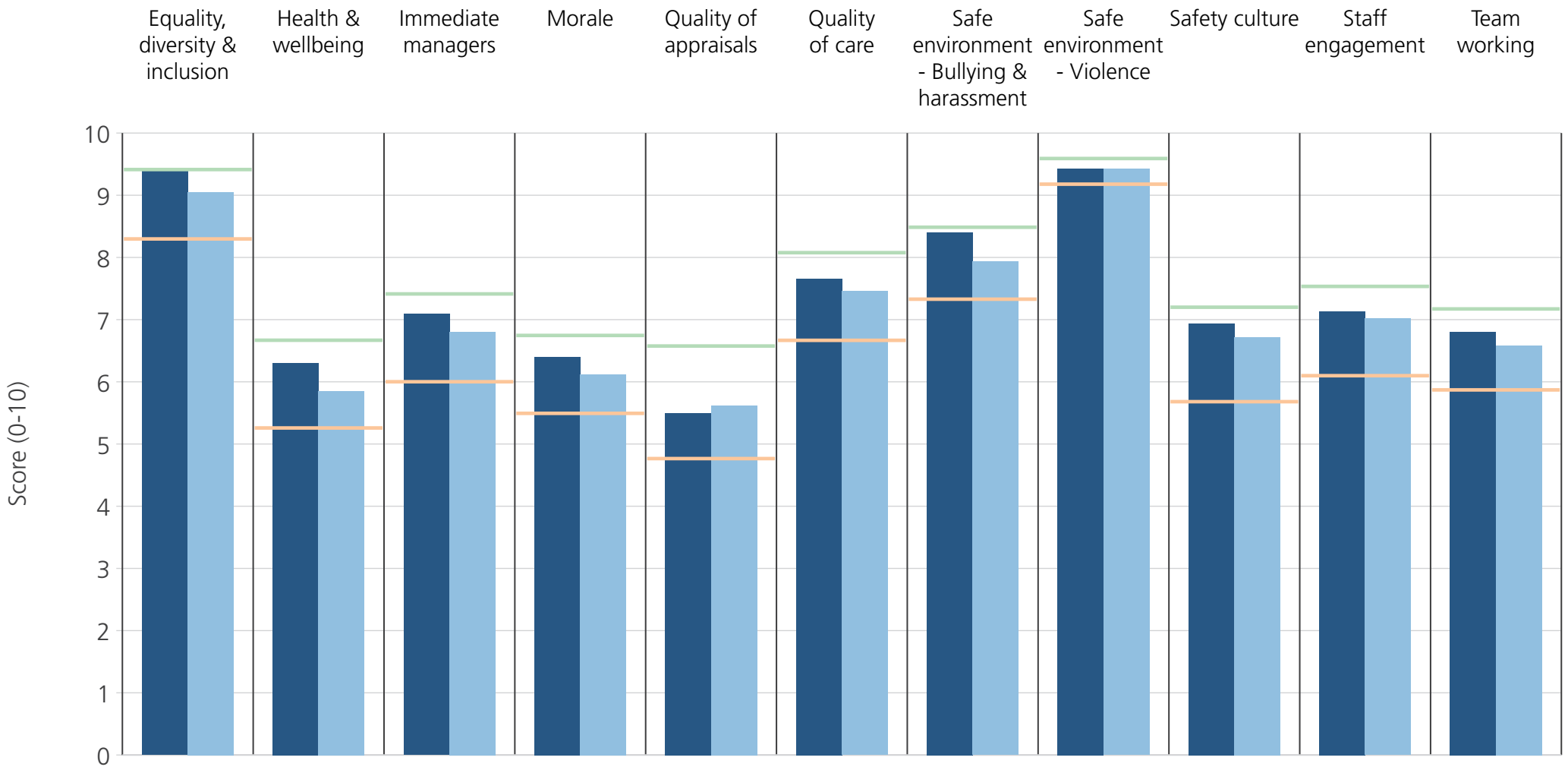
NHS England

Theme results

Warrington and Halton Hospitals NHS Foundation Trust

2019 NHS Staff Survey Results

2019 NHS Staff Survey Results > Theme results > Overview



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.4	6.7	7.4	6.7	6.6	8.1	8.5	9.6	7.2	7.5	7.2
Your org	9.4	6.3	7.1	6.4	5.5	7.7	8.4	9.4	6.9	7.1	6.8
Average	9.0	5.9	6.8	6.1	5.6	7.5	7.9	9.4	6.7	7.0	6.6
Worst	8.3	5.3	6.0	5.5	4.8	6.7	7.3	9.2	5.7	6.1	5.9
Responses	2,103	2,108	2,121	2,090	1,801	1,758	2,099	2,100	2,101	2,127	2,104

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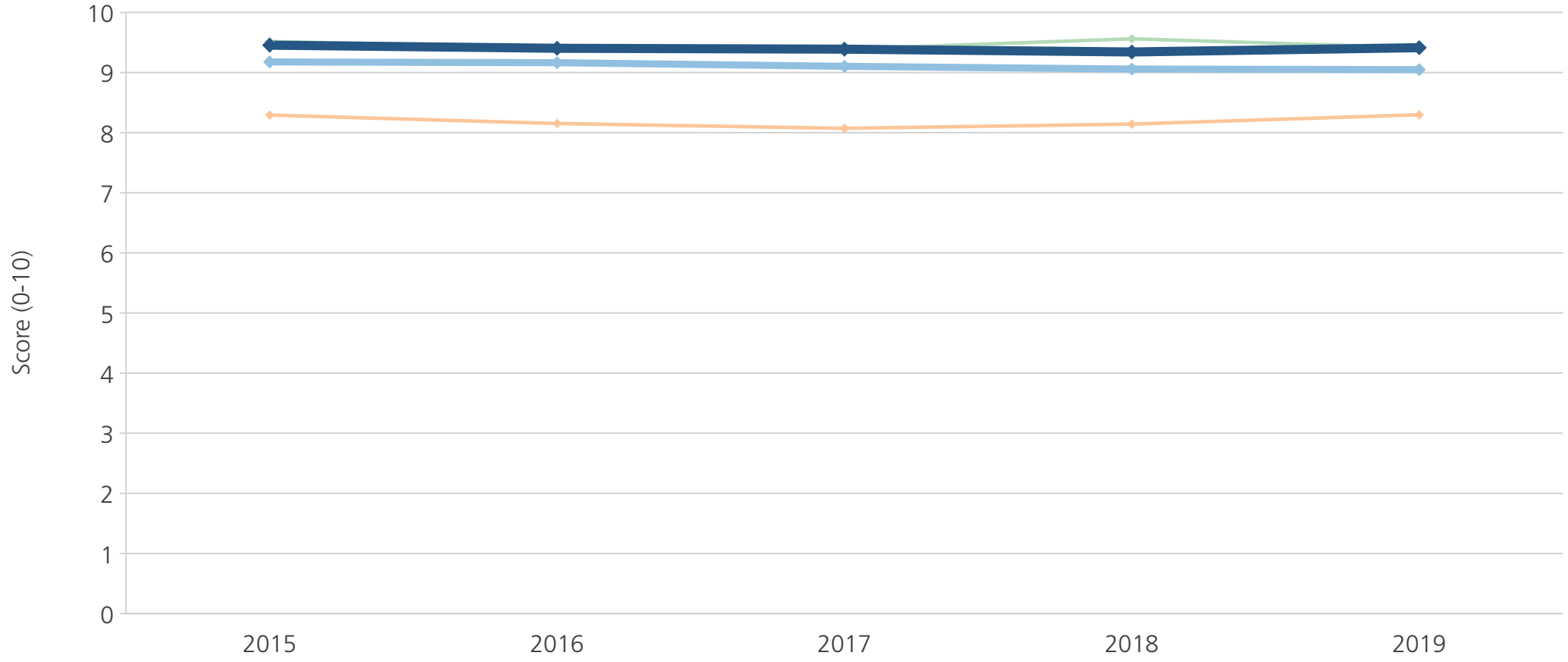
Survey Coordination Centre

NHS England

Theme results – Trends

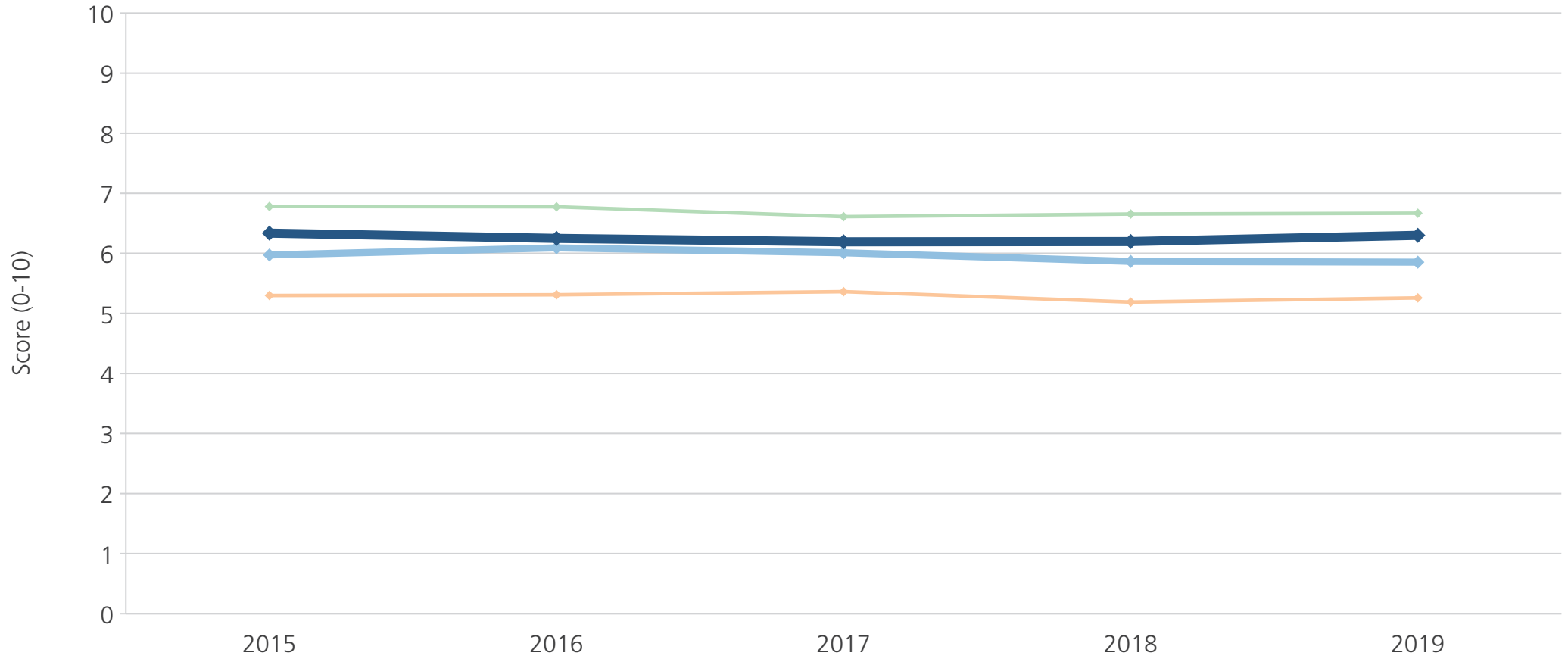
Warrington and Halton Hospitals NHS Foundation Trust

2019 NHS Staff Survey Results

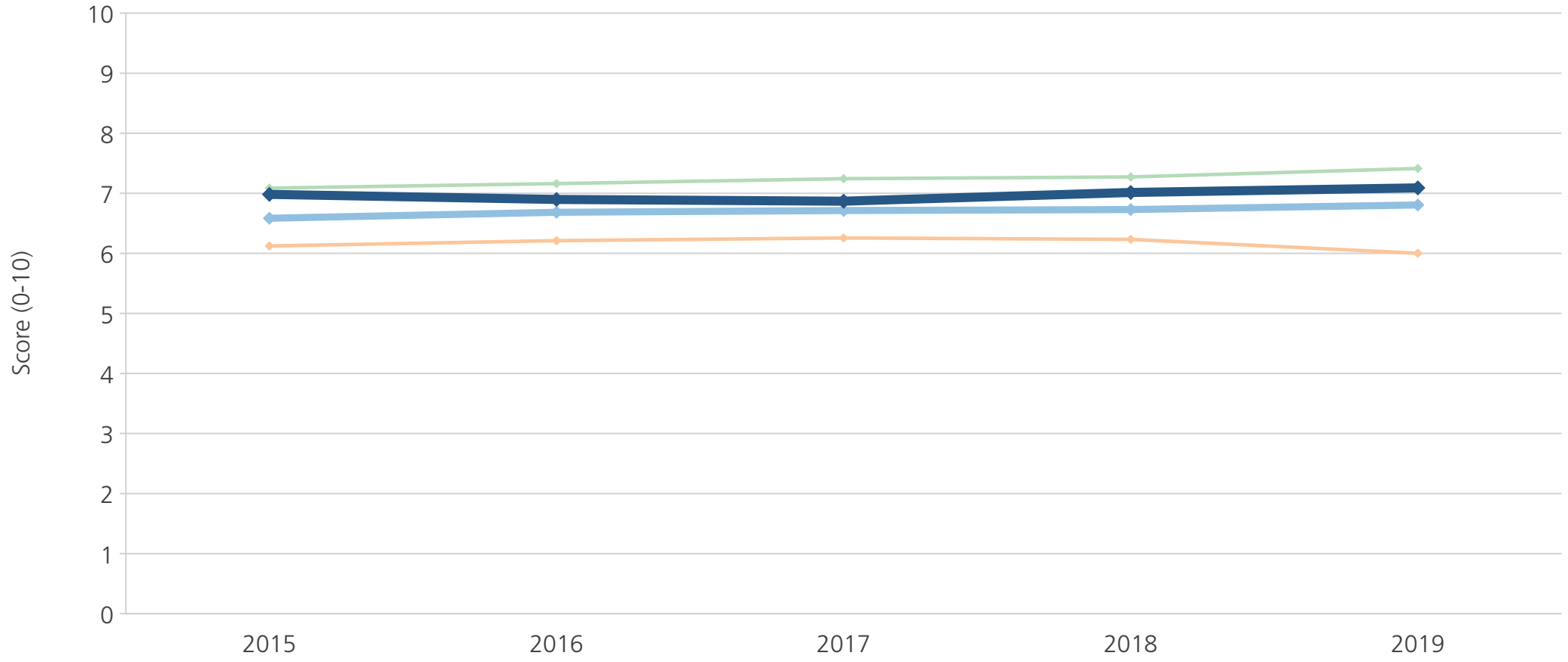


	2015	2016	2017	2018	2019
Best	9.5	9.4	9.4	9.6	9.4
Your org	9.5	9.4	9.4	9.3	9.4
Average	9.2	9.2	9.1	9.1	9.0
Worst	8.3	8.2	8.1	8.1	8.3
Responses	272	1,453	1,771	1,957	2,103

2019 NHS Staff Survey Results > Theme results > Trends > Health & wellbeing

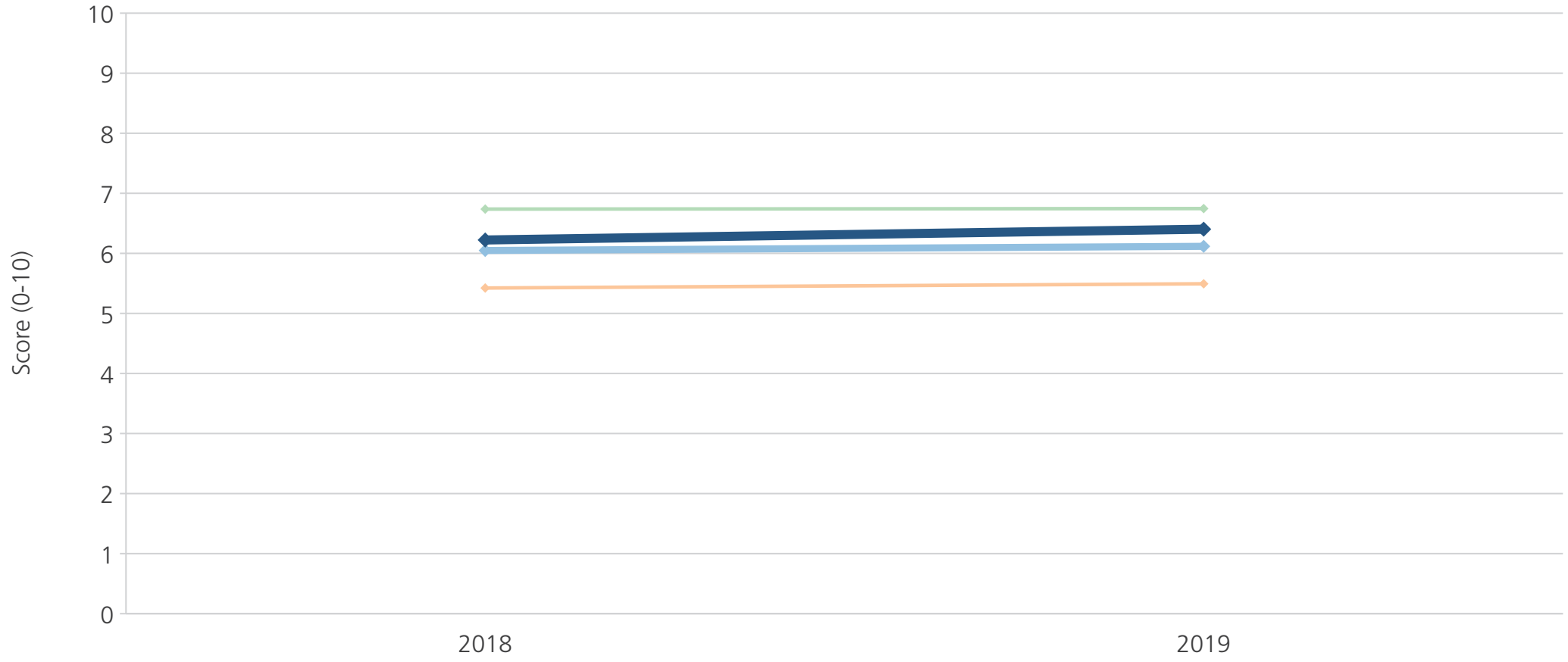


	2015	2016	2017	2018	2019
Best	6.8	6.8	6.6	6.7	6.7
Your org	6.3	6.2	6.2	6.2	6.3
Average	6.0	6.1	6.0	5.9	5.9
Worst	5.3	5.3	5.4	5.2	5.3
Responses	274	1,463	1,787	1,968	2,108

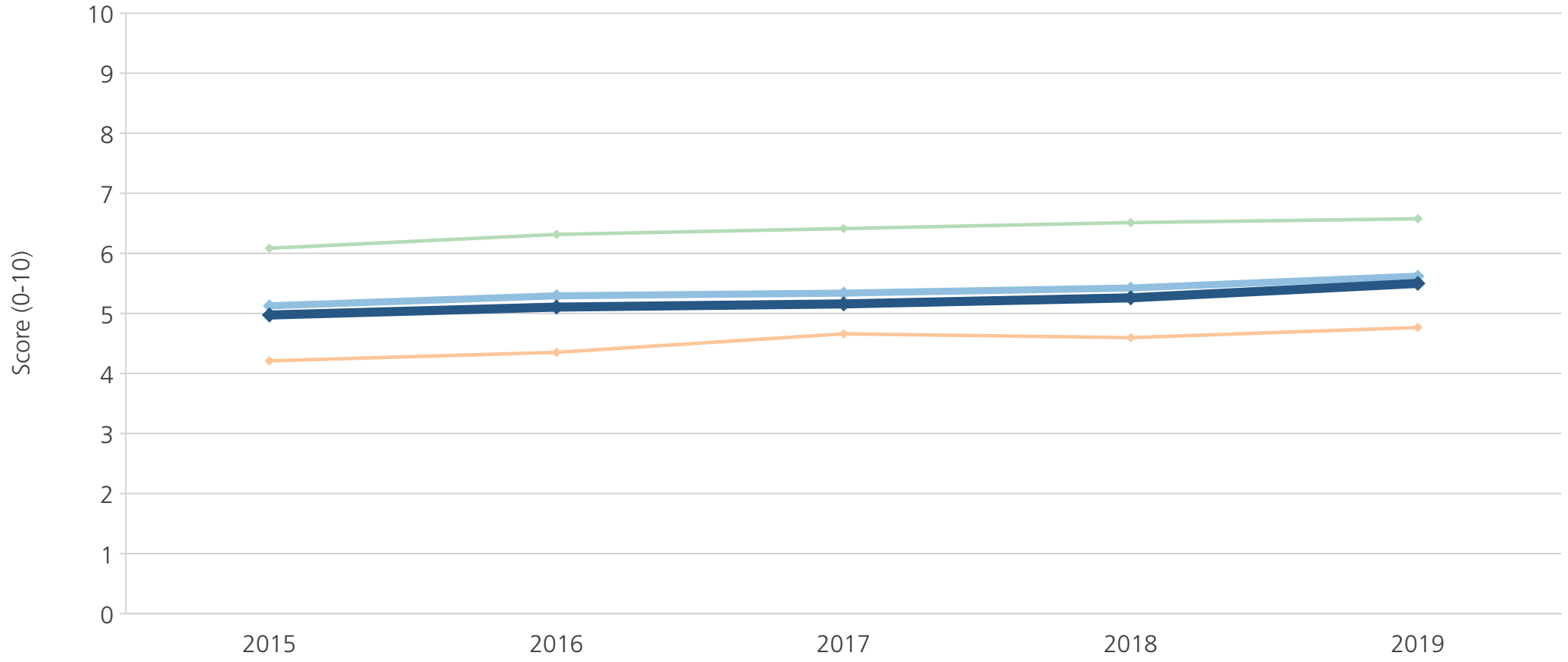


	2015	2016	2017	2018	2019
Best	7.1	7.2	7.2	7.3	7.4
Your org	7.0	6.9	6.9	7.0	7.1
Average	6.6	6.7	6.7	6.7	6.8
Worst	6.1	6.2	6.3	6.2	6.0
Responses	273	1,460	1,790	1,979	2,121

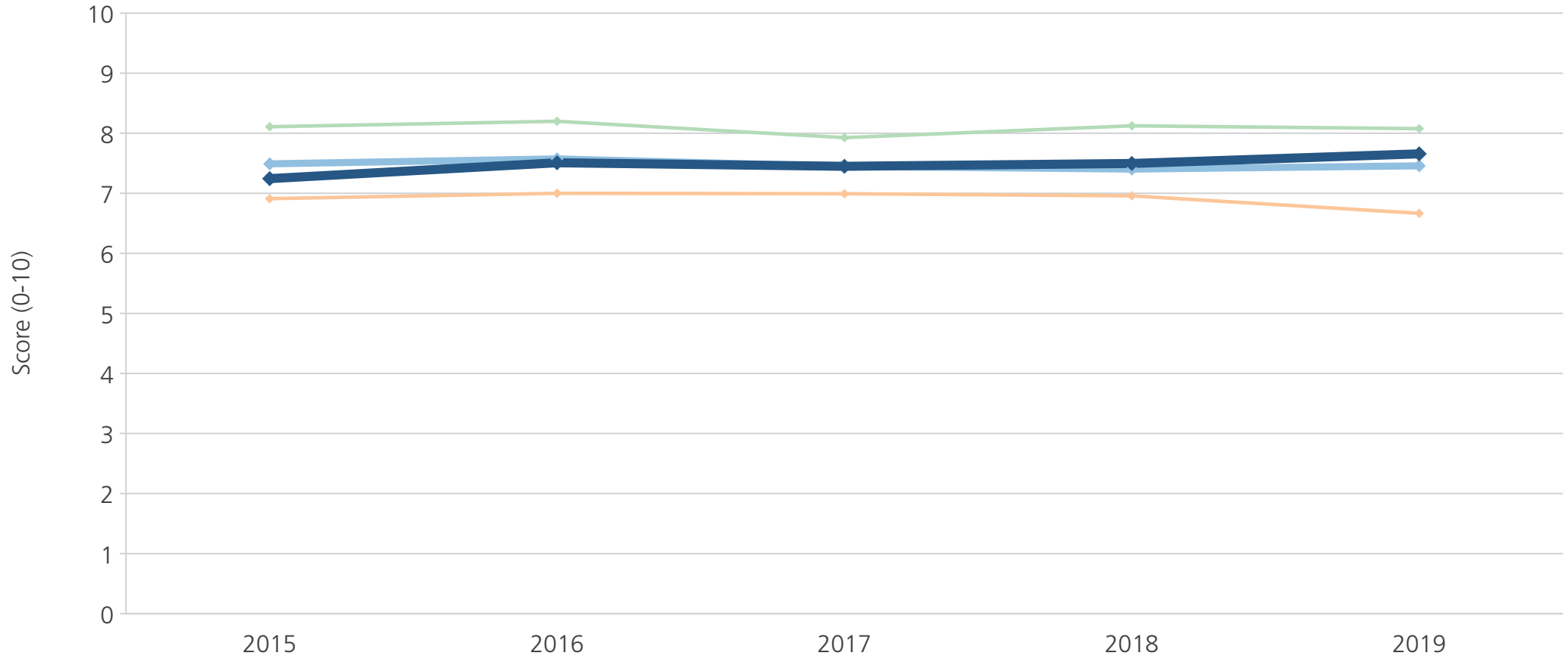
2019 NHS Staff Survey Results > Theme results > Trends > Morale



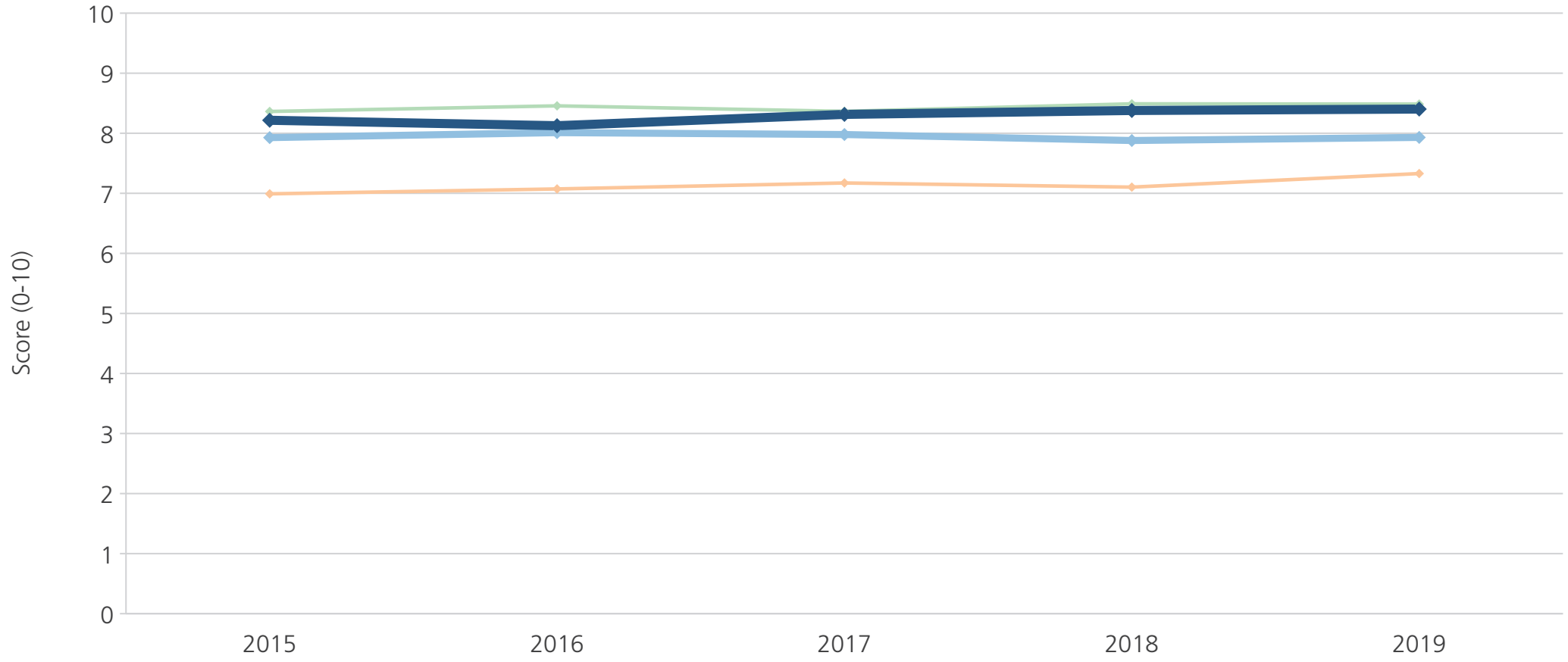
	2018	2019
Best	6.7	6.7
Your org	6.2	6.4
Average	6.0	6.1
Worst	5.4	5.5
Responses	1,943	2,090



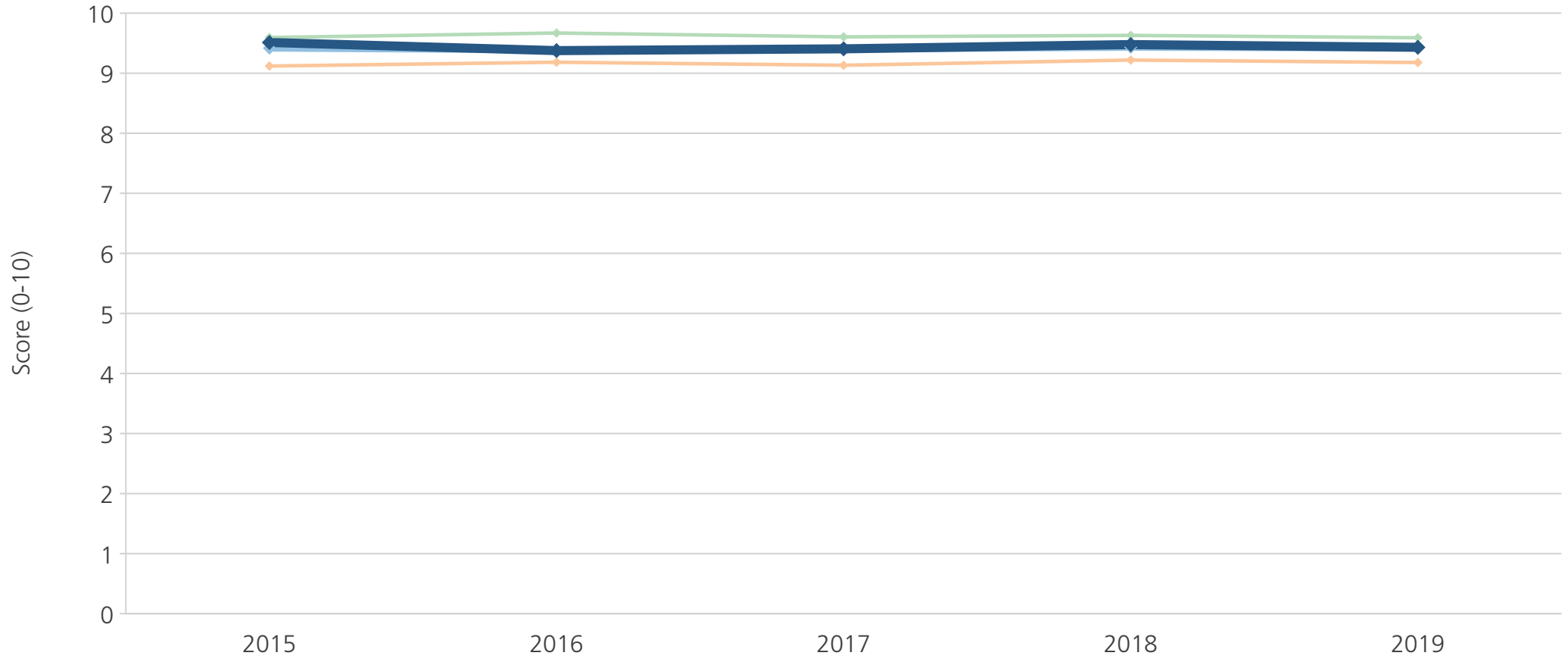
	2015	2016	2017	2018	2019
Best	6.1	6.3	6.4	6.5	6.6
Your org	5.0	5.1	5.2	5.3	5.5
Average	5.1	5.3	5.3	5.4	5.6
Worst	4.2	4.4	4.7	4.6	4.8
Responses	227	1,235	1,493	1,752	1,801



	2015	2016	2017	2018	2019
Best	8.1	8.2	7.9	8.1	8.1
Your org	7.2	7.5	7.4	7.5	7.7
Average	7.5	7.6	7.4	7.4	7.5
Worst	6.9	7.0	7.0	7.0	6.7
Responses	219	1,191	1,447	1,634	1,758

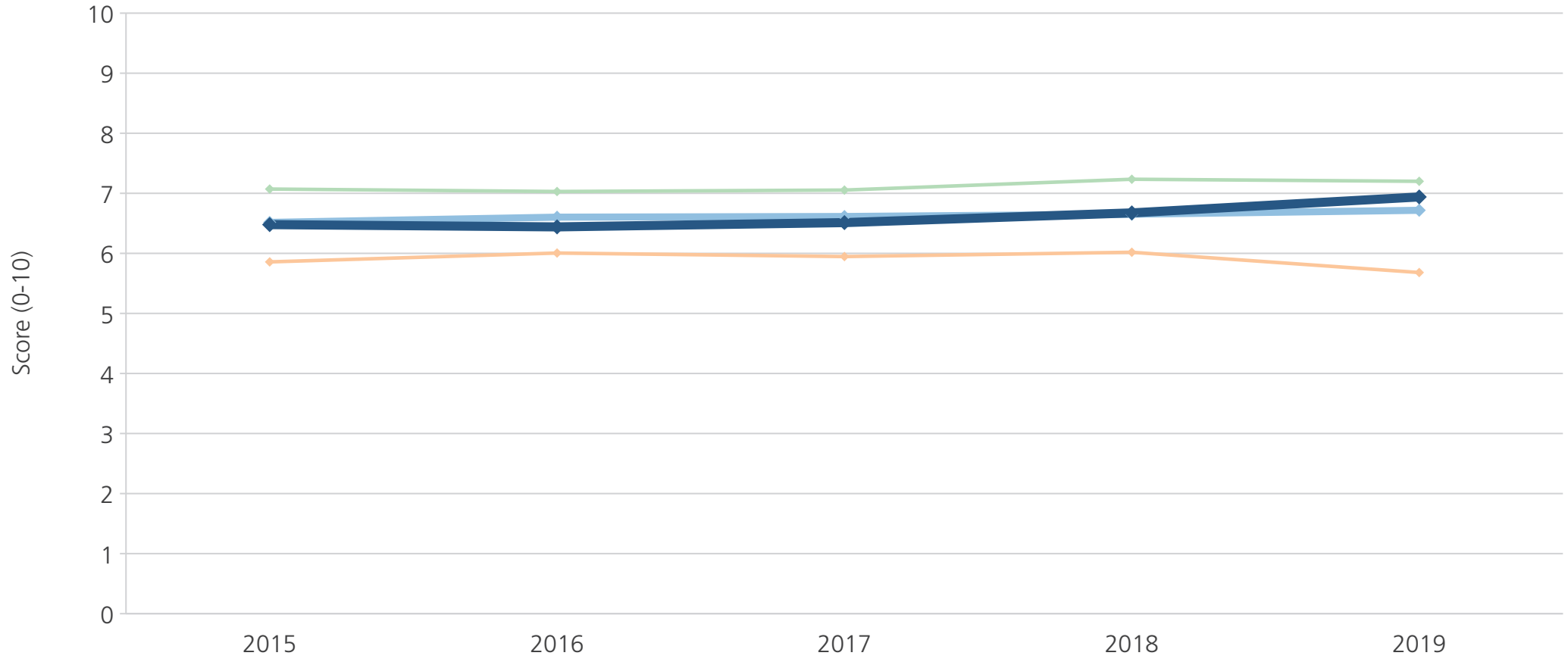


	2015	2016	2017	2018	2019
Best	8.4	8.5	8.4	8.5	8.5
Your org	8.2	8.1	8.3	8.4	8.4
Average	7.9	8.0	8.0	7.9	7.9
Worst	7.0	7.1	7.2	7.1	7.3
Responses	272	1,435	1,763	1,946	2,099

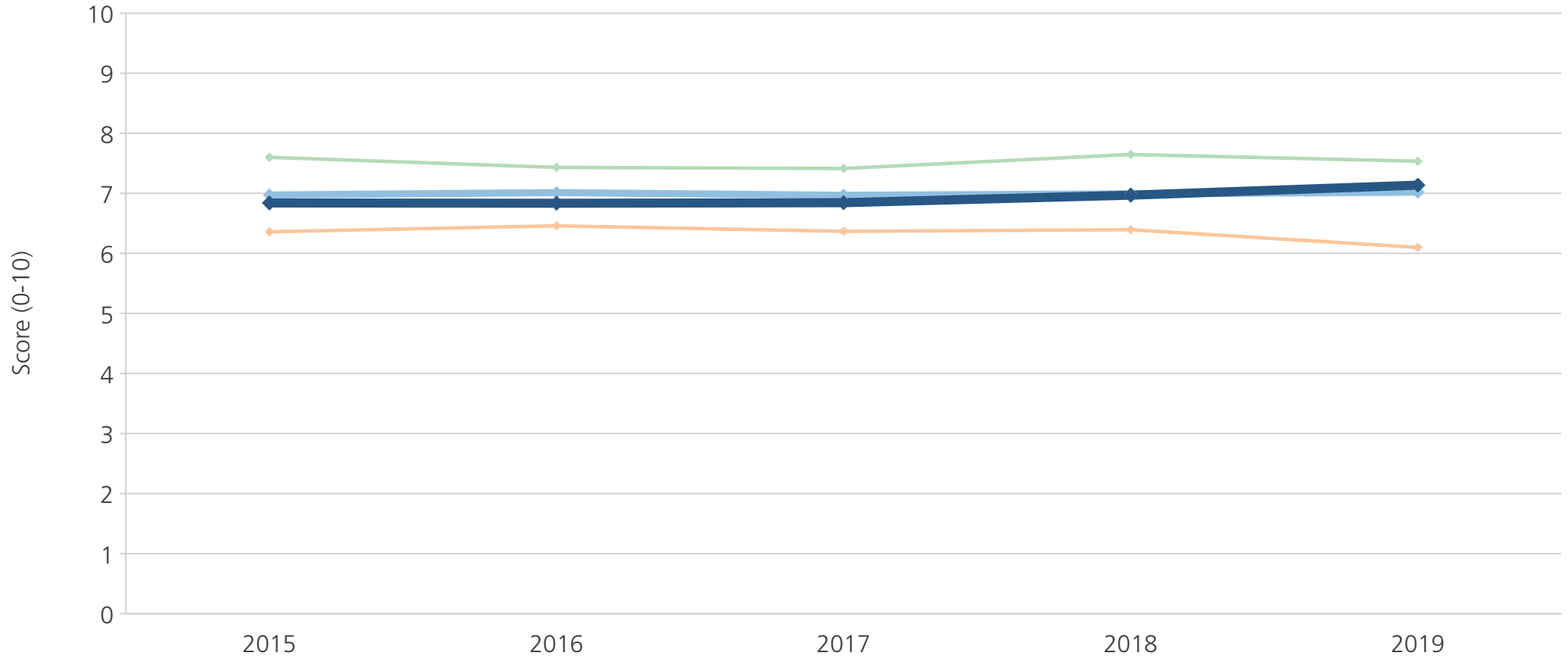


	2015	2016	2017	2018	2019
Best	9.6	9.7	9.6	9.6	9.6
Your org	9.5	9.4	9.4	9.5	9.4
Average	9.4	9.4	9.4	9.4	9.4
Worst	9.1	9.2	9.1	9.2	9.2
Responses	273	1,434	1,760	1,946	2,100

2019 NHS Staff Survey Results > Theme results > Trends > Safety culture

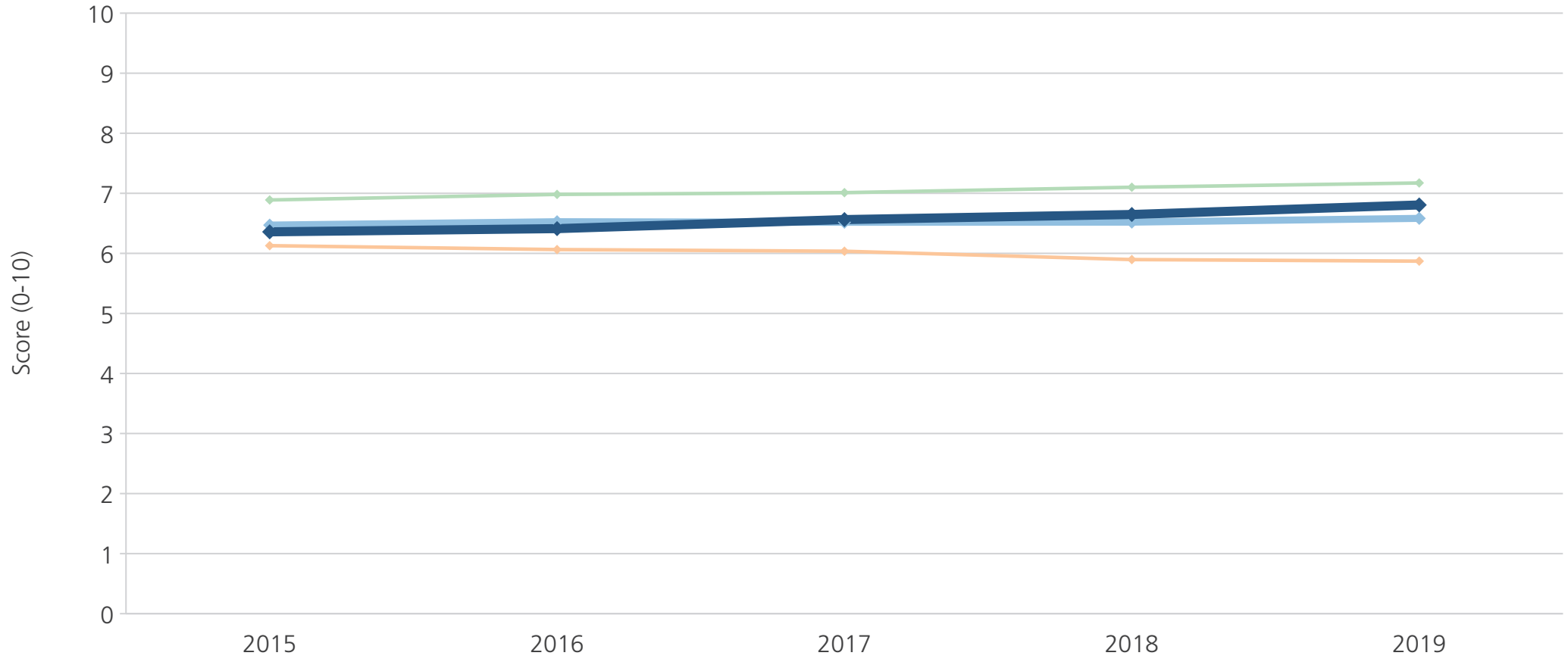


	2015	2016	2017	2018	2019
Best	7.1	7.0	7.1	7.2	7.2
Your org	6.5	6.4	6.5	6.7	6.9
Average	6.5	6.6	6.6	6.7	6.7
Worst	5.9	6.0	5.9	6.0	5.7
Responses	273	1,460	1,776	1,969	2,101



	2015	2016	2017	2018	2019
Best	7.6	7.4	7.4	7.6	7.5
Your org	6.8	6.8	6.8	7.0	7.1
Average	7.0	7.0	7.0	7.0	7.0
Worst	6.4	6.5	6.4	6.4	6.1
Responses	275	1,470	1,797	1,979	2,127

2019 NHS Staff Survey Results > Theme results > Trends > Team working



	2015	2016	2017	2018	2019
Best	6.9	7.0	7.0	7.1	7.2
Your org	6.4	6.4	6.6	6.6	6.8
Average	6.5	6.5	6.5	6.5	6.6
Worst	6.1	6.1	6.0	5.9	5.9
Responses	269	1,453	1,763	1,958	2,104

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Survey Coordination Centre

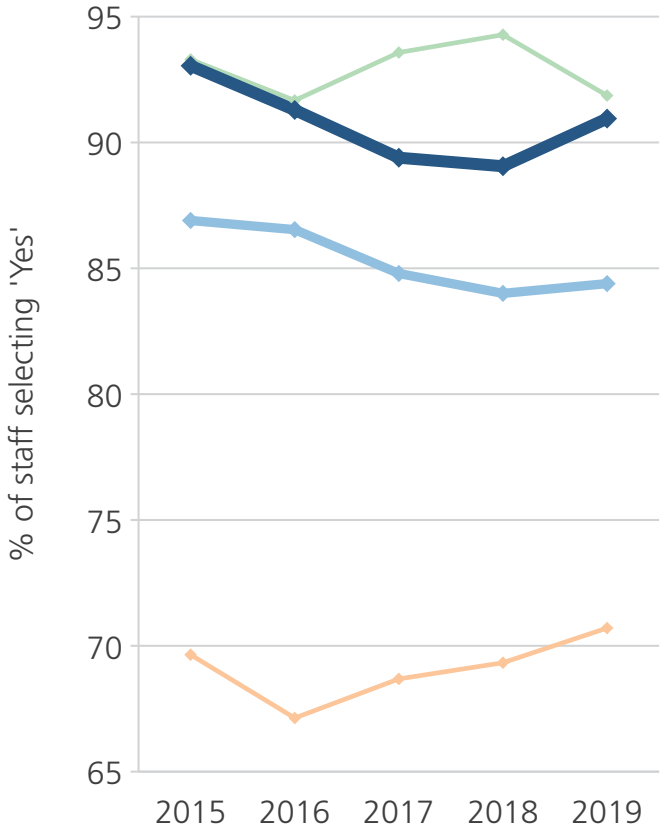
NHS England

Theme results – Detailed information

Warrington and Halton Hospitals NHS Foundation Trust

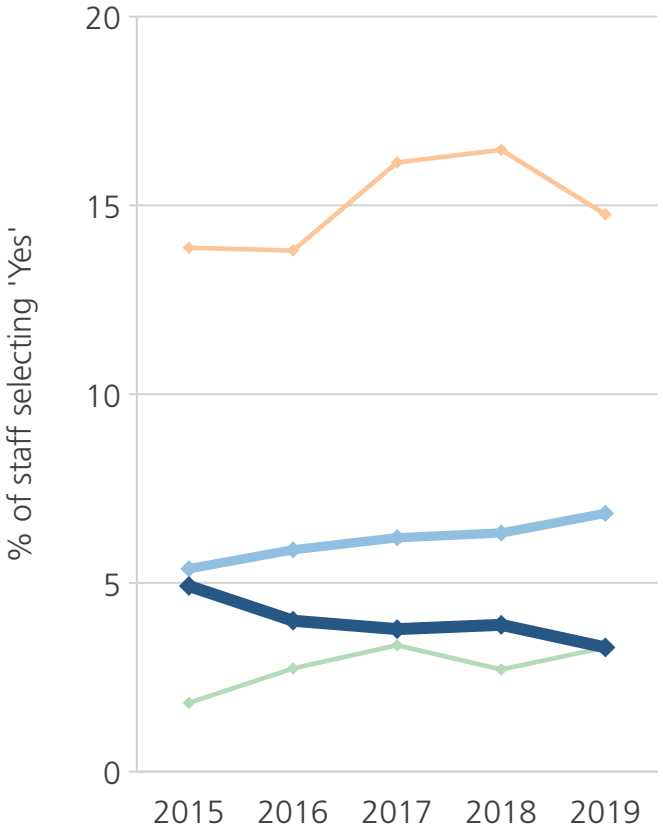
2019 NHS Staff Survey Results

Q14
Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?



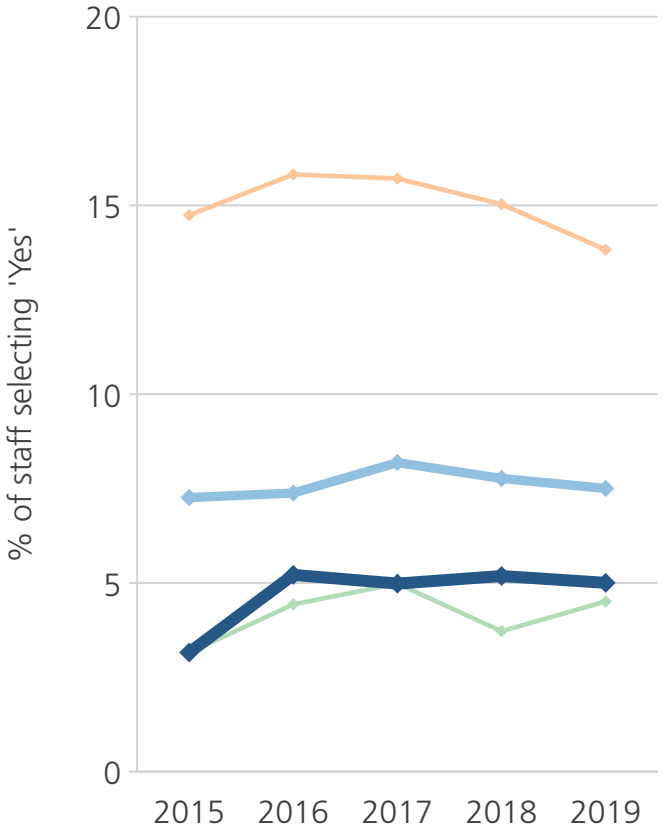
	2015	2016	2017	2018	2019
Best	93.3%	91.7%	93.6%	94.3%	91.9%
Your org	93.0%	91.3%	89.4%	89.1%	90.9%
Average	86.9%	86.5%	84.8%	84.0%	84.4%
Worst	69.6%	67.1%	68.7%	69.3%	70.7%

Q15a
In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?



	2015	2016	2017	2018	2019
Worst	13.9%	13.8%	16.1%	16.5%	14.8%
Your org	4.9%	4.0%	3.8%	3.9%	3.3%
Average	5.4%	5.9%	6.2%	6.3%	6.8%
Best	1.8%	2.7%	3.3%	2.7%	3.3%

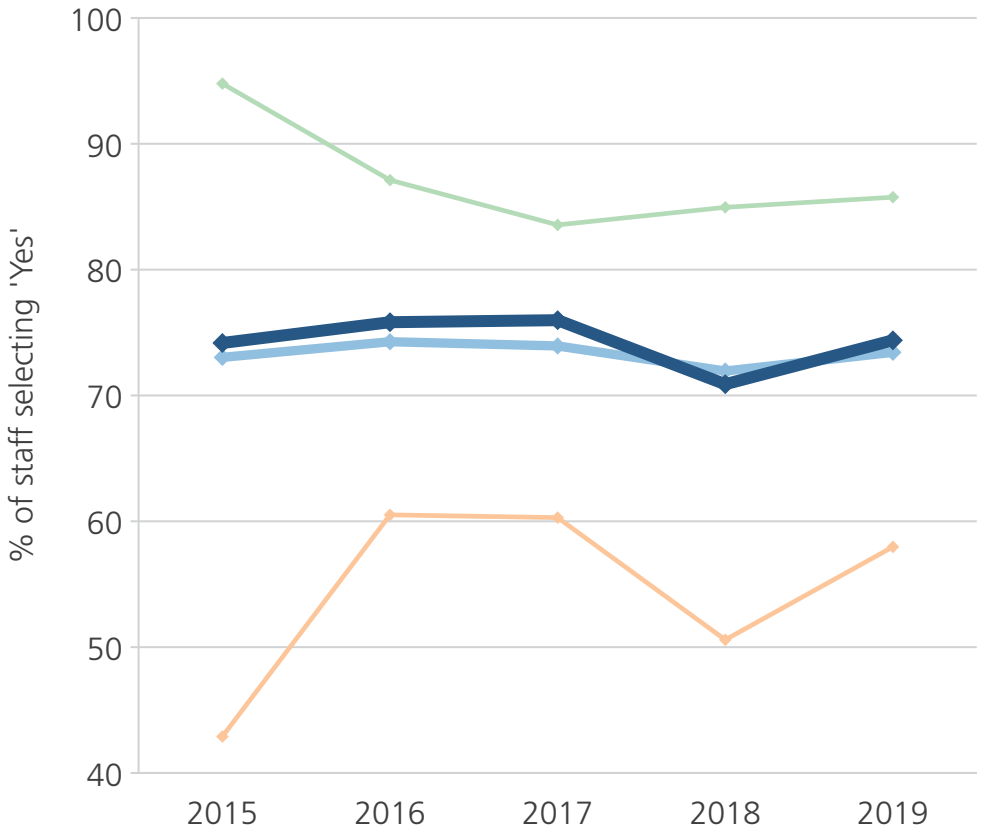
Q15b
In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?



	2015	2016	2017	2018	2019
Worst	14.7%	15.8%	15.7%	15.0%	13.8%
Your org	3.2%	5.2%	5.0%	5.2%	5.0%
Average	7.3%	7.4%	8.2%	7.8%	7.5%
Best	3.2%	4.4%	5.0%	3.7%	4.5%

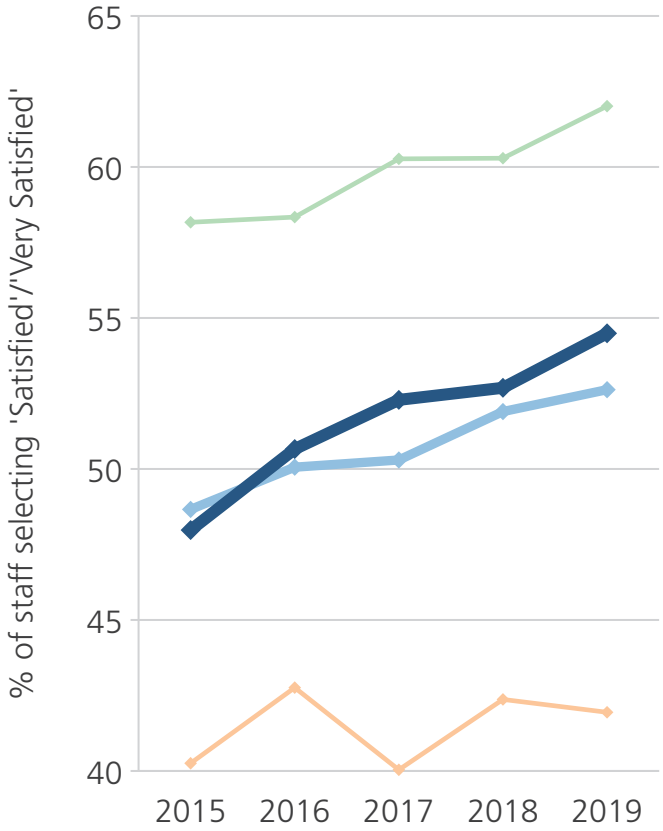
Q28b

Has your employer made adequate adjustment(s) to enable you to carry out your work?



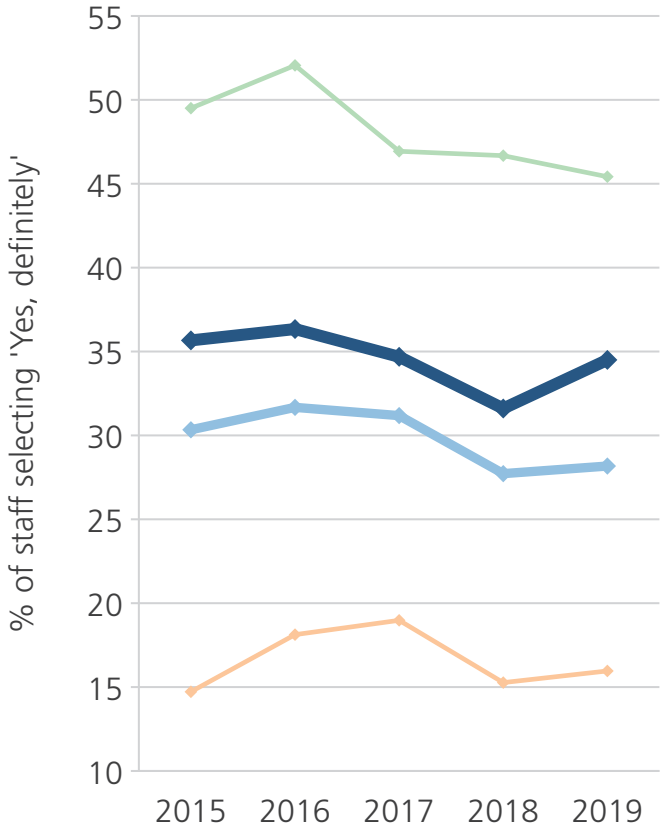
	2015	2016	2017	2018	2019
Best	94.8%	87.1%	83.6%	85.0%	85.8%
Your org	74.2%	75.8%	76.0%	70.9%	74.4%
Average	73.0%	74.3%	73.9%	71.9%	73.4%
Worst	42.9%	60.5%	60.3%	50.6%	58.0%

Q5h
The opportunities for flexible working patterns



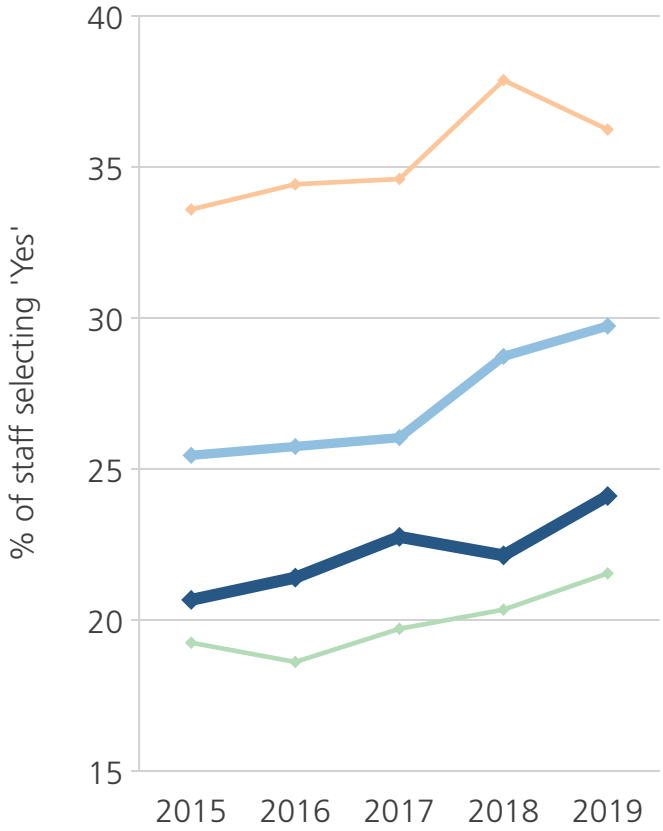
	2015	2016	2017	2018	2019
Best	58.2%	58.3%	60.3%	60.3%	62.0%
Your org	48.0%	50.7%	52.3%	52.7%	54.5%
Average	48.7%	50.1%	50.3%	51.9%	52.6%
Worst	40.3%	42.8%	40.0%	42.4%	41.9%

Q11a
Does your organisation take positive action on health and well-being?



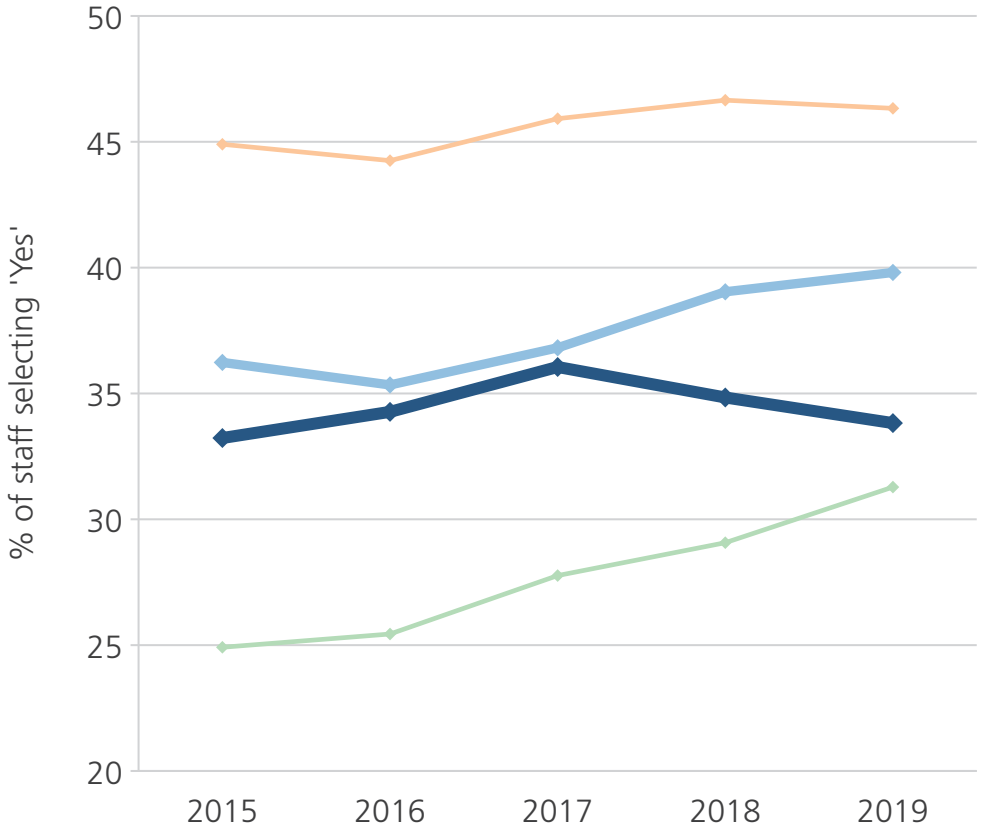
	2015	2016	2017	2018	2019
Best	49.5%	52.1%	46.9%	46.7%	45.4%
Your org	35.7%	36.3%	34.7%	31.6%	34.5%
Average	30.3%	31.7%	31.2%	27.7%	28.2%
Worst	14.7%	18.1%	19.0%	15.3%	16.0%

Q11b
In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?



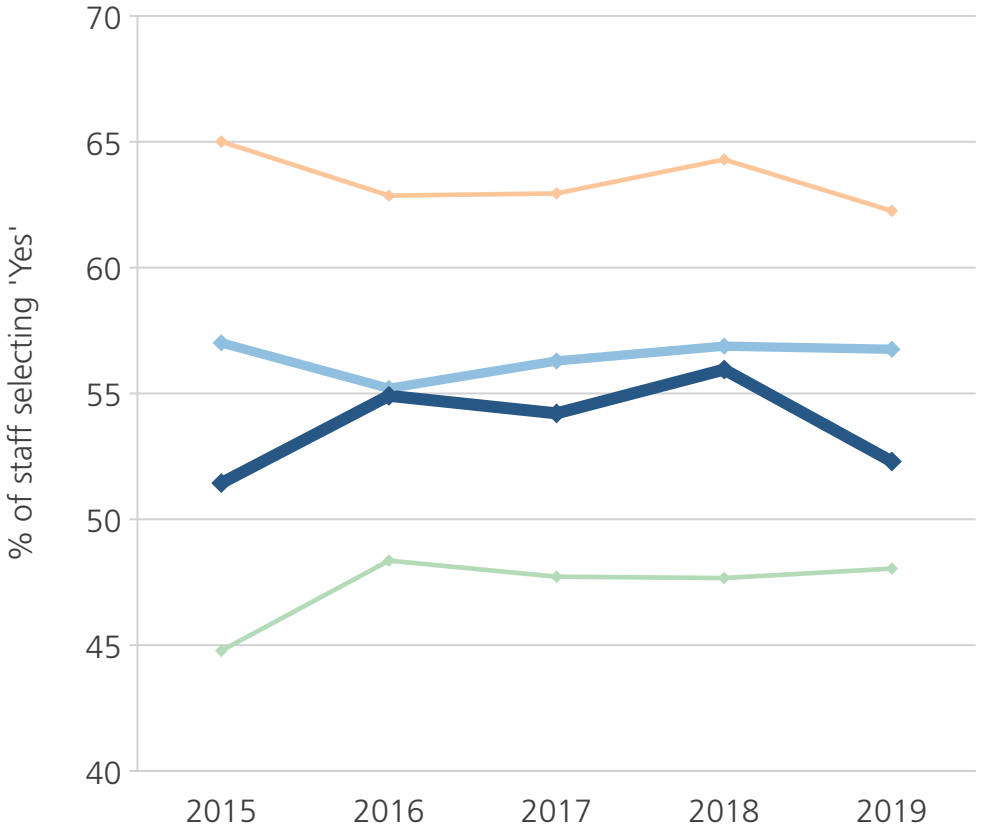
	2015	2016	2017	2018	2019
Worst	33.6%	34.4%	34.6%	37.9%	36.2%
Your org	20.7%	21.4%	22.8%	22.1%	24.1%
Average	25.5%	25.7%	26.0%	28.7%	29.7%
Best	19.2%	18.6%	19.7%	20.3%	21.5%

Q11c
During the last 12 months have you felt unwell as a result of work related stress?



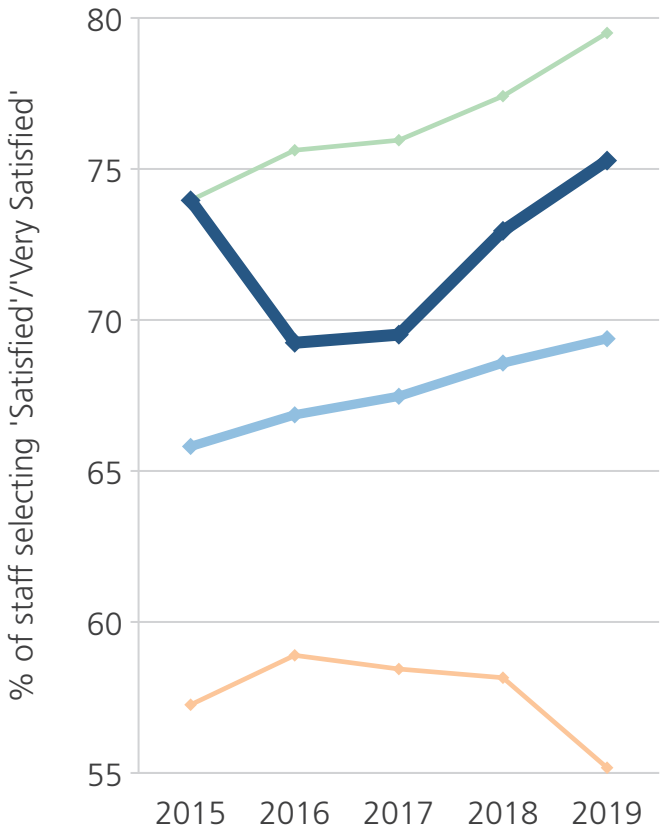
	2015	2016	2017	2018	2019
Worst	44.9%	44.3%	45.9%	46.7%	46.3%
Your org	33.2%	34.3%	36.1%	34.8%	33.8%
Average	36.2%	35.3%	36.8%	39.0%	39.8%
Best	24.9%	25.4%	27.8%	29.1%	31.3%

Q11d
In the last three months have you ever come to work despite not feeling well enough to perform your duties?



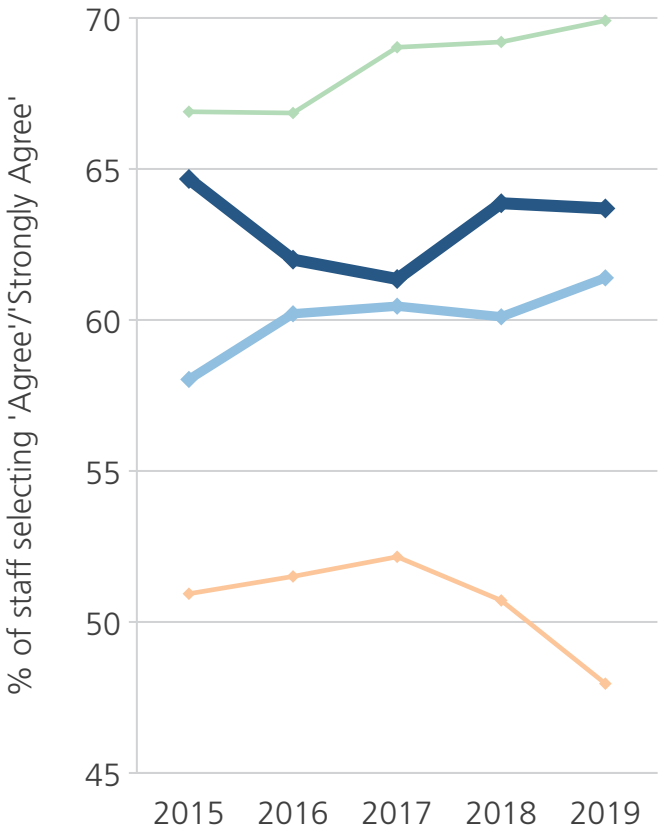
	2015	2016	2017	2018	2019
Worst	65.0%	62.9%	62.9%	64.3%	62.3%
Your org	51.4%	54.9%	54.2%	55.9%	52.3%
Average	57.0%	55.2%	56.3%	56.9%	56.8%
Best	44.8%	48.4%	47.7%	47.7%	48.0%

Q5b
The support I get from my immediate manager



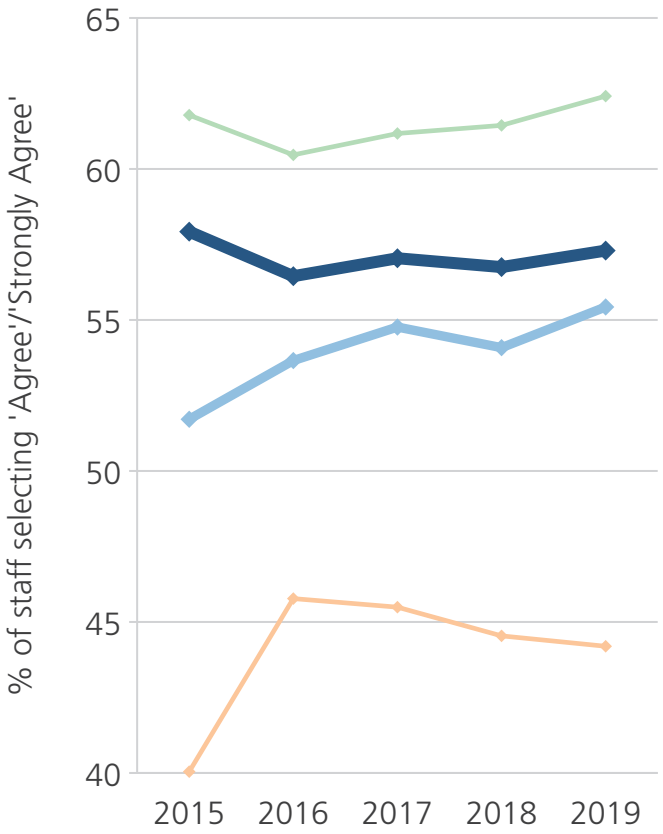
	2015	2016	2017	2018	2019
Best	74.0%	75.6%	76.0%	77.4%	79.5%
Your org	74.0%	69.2%	69.5%	73.0%	75.3%
Average	65.8%	66.9%	67.5%	68.6%	69.4%
Worst	57.3%	58.9%	58.4%	58.2%	55.2%

Q8c
My immediate manager gives me clear feedback on my work



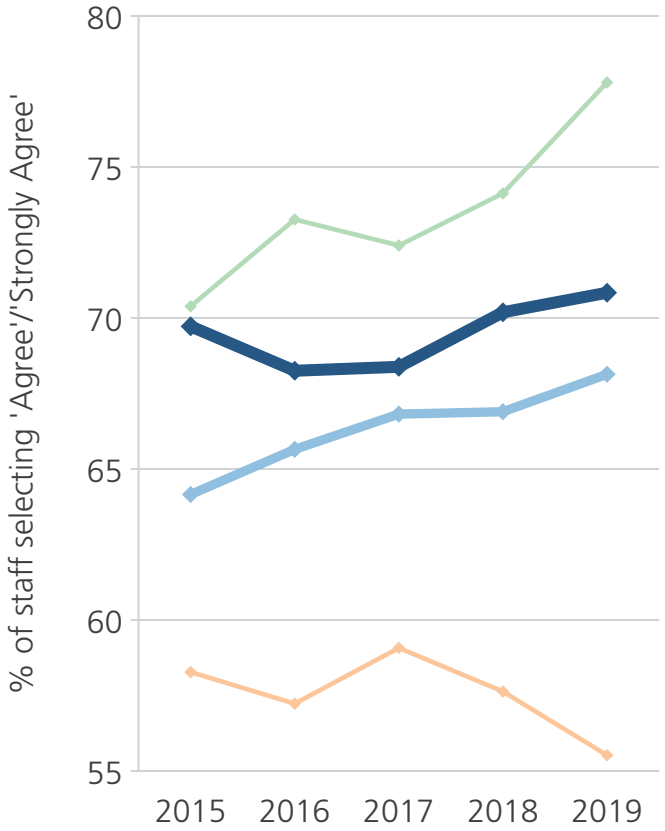
	2015	2016	2017	2018	2019
Best	66.9%	66.9%	69.0%	69.2%	69.9%
Your org	64.7%	62.0%	61.4%	63.9%	63.7%
Average	58.0%	60.2%	60.5%	60.1%	61.4%
Worst	50.9%	51.5%	52.2%	50.7%	48.0%

Q8d
My immediate manager asks for my opinion before making decisions that affect my work



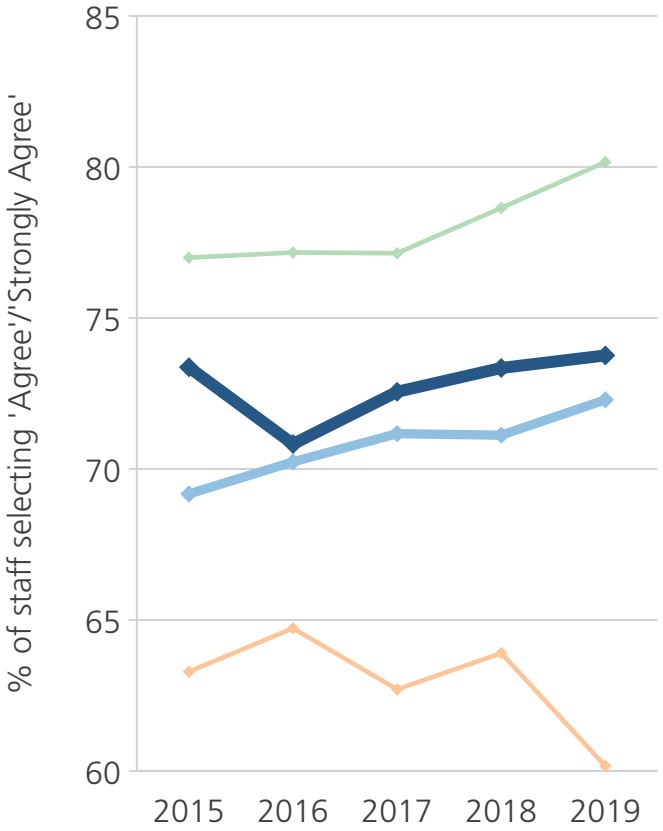
	2015	2016	2017	2018	2019
Best	61.8%	60.5%	61.2%	61.4%	62.4%
Your org	57.9%	56.4%	57.0%	56.8%	57.3%
Average	51.7%	53.7%	54.8%	54.1%	55.4%
Worst	40.0%	45.8%	45.5%	44.5%	44.2%

Q8f
My immediate manager takes a positive interest in my health and well-being



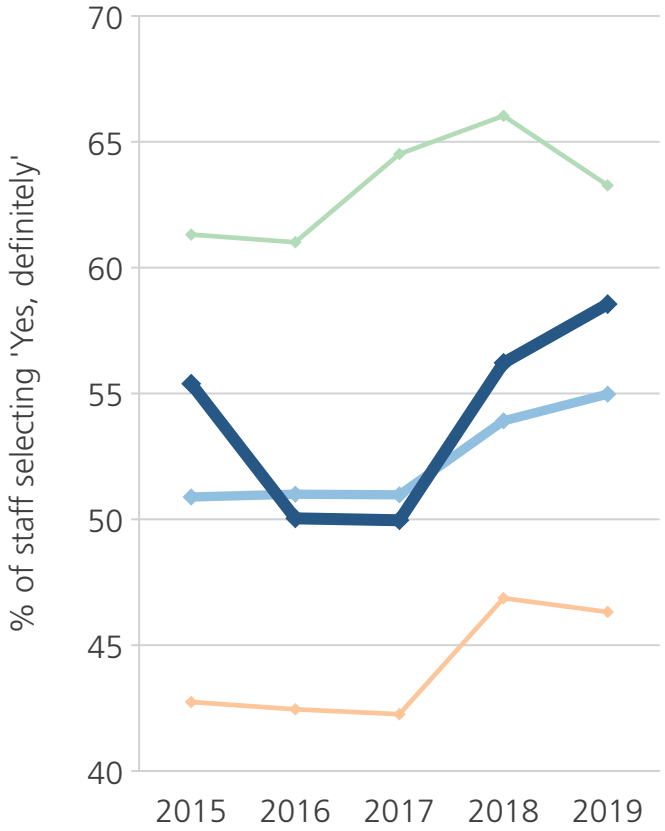
	2015	2016	2017	2018	2019
Best	70.4%	73.3%	72.4%	74.1%	77.8%
Your org	69.7%	68.3%	68.4%	70.2%	70.8%
Average	64.2%	65.6%	66.8%	66.9%	68.1%
Worst	58.3%	57.2%	59.1%	57.6%	55.5%

Q8g
My immediate manager values my work



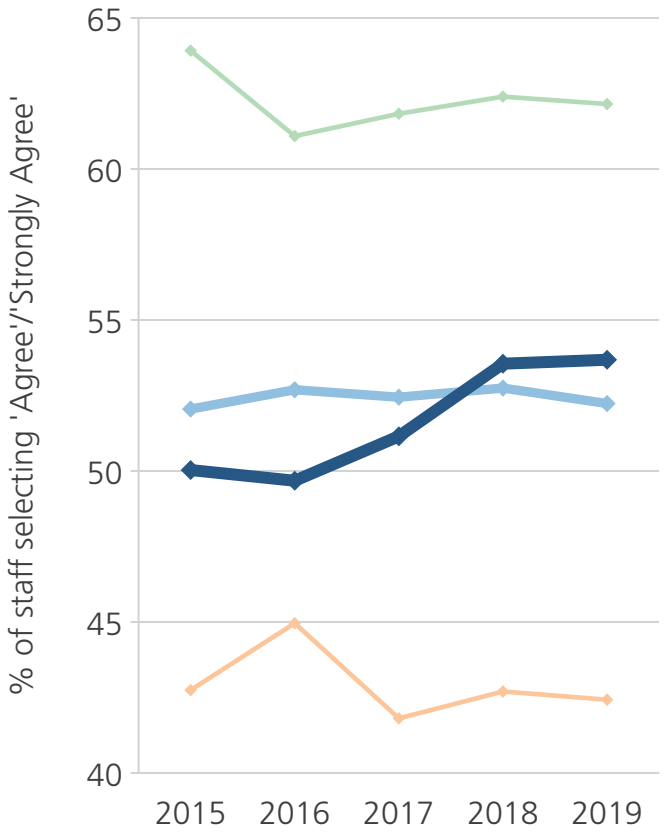
	2015	2016	2017	2018	2019
Best	77.0%	77.2%	77.1%	78.6%	80.2%
Your org	73.4%	70.8%	72.6%	73.3%	73.8%
Average	69.2%	70.2%	71.2%	71.1%	72.3%
Worst	63.3%	64.7%	62.7%	63.9%	60.2%

Q19g
My manager supported me to receive this training, learning or development



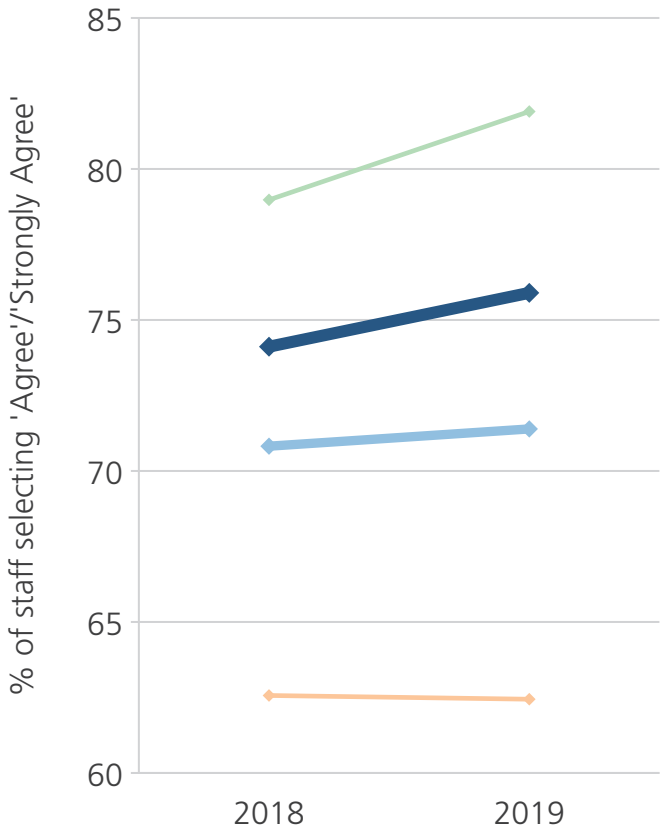
	2015	2016	2017	2018	2019
Best	61.3%	61.0%	64.5%	66.0%	63.3%
Your org	55.4%	50.0%	50.0%	56.2%	58.6%
Average	50.9%	51.0%	51.0%	53.9%	55.0%
Worst	42.7%	42.5%	42.3%	46.9%	46.3%

Q4c
I am involved in deciding on changes introduced that affect my work area / team / department



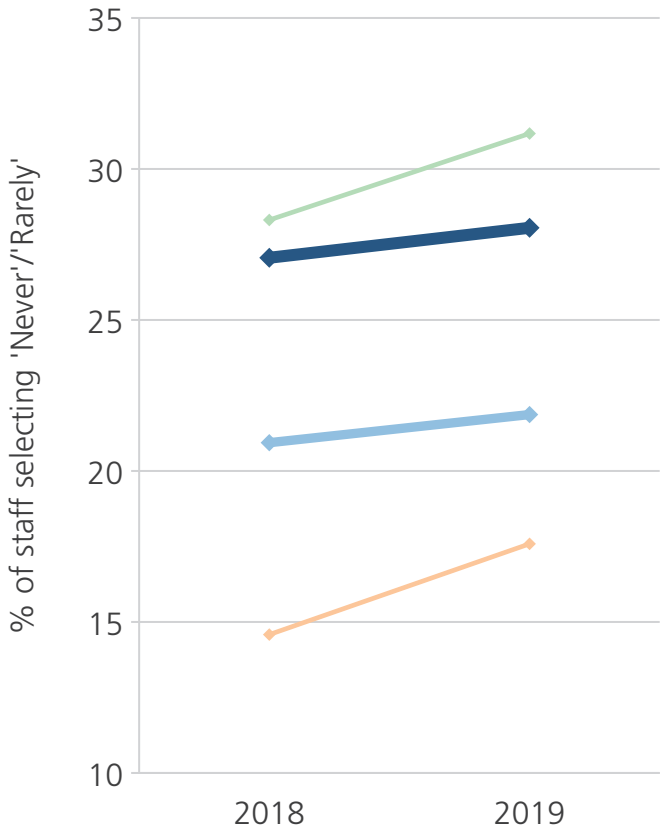
	2015	2016	2017	2018	2019
Best	63.9%	61.1%	61.8%	62.4%	62.1%
Your org	50.0%	49.7%	51.1%	53.6%	53.7%
Average	52.1%	52.7%	52.4%	52.7%	52.2%
Worst	42.7%	45.0%	41.8%	42.7%	42.4%

Q4j
I receive the respect I deserve from my colleagues at work



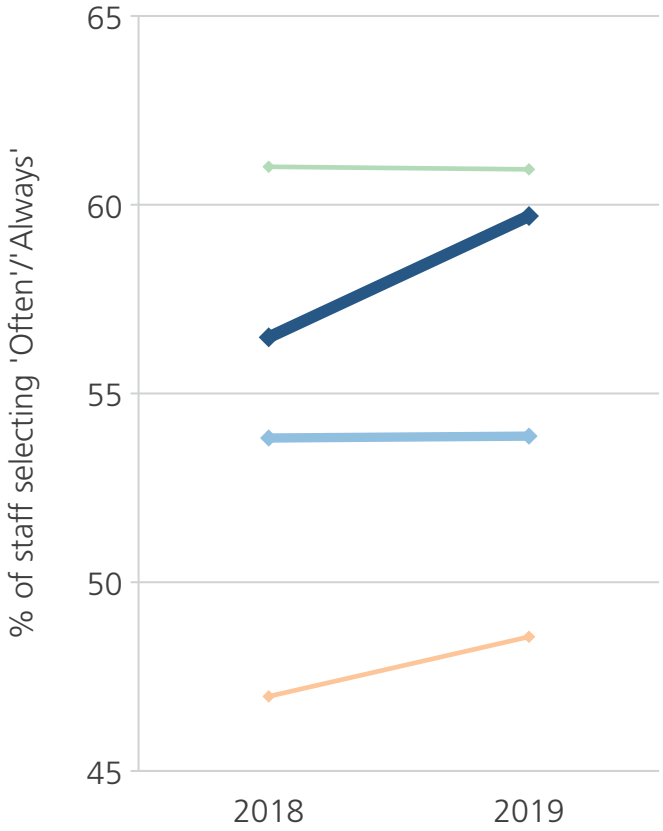
	2018	2019
Best	79.0%	81.9%
Your org	74.1%	75.9%
Average	70.8%	71.4%
Worst	62.6%	62.4%

Q6a
I have unrealistic time pressures



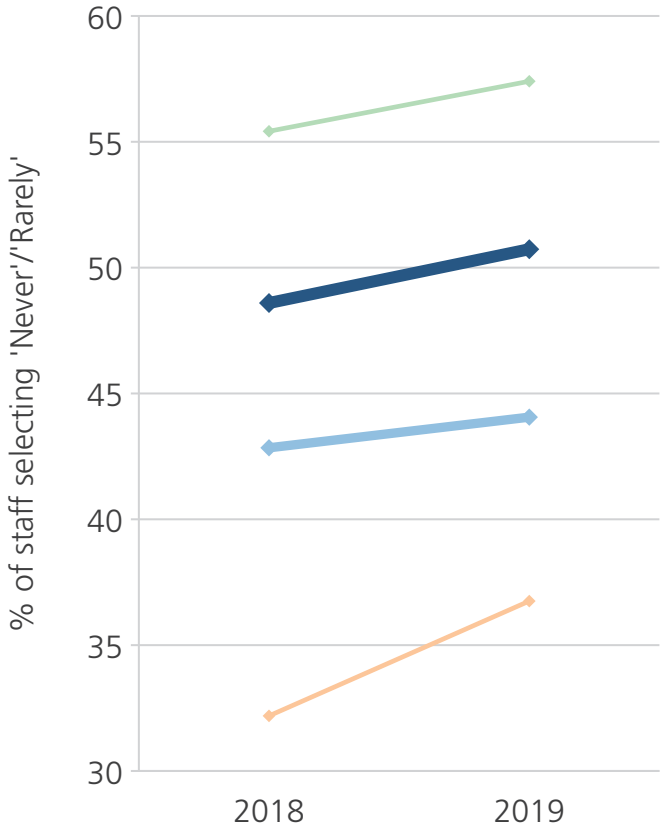
	2018	2019
Best	28.3%	31.2%
Your org	27.1%	28.1%
Average	20.9%	21.9%
Worst	14.6%	17.6%

Q6b
I have a choice in deciding how to do my work



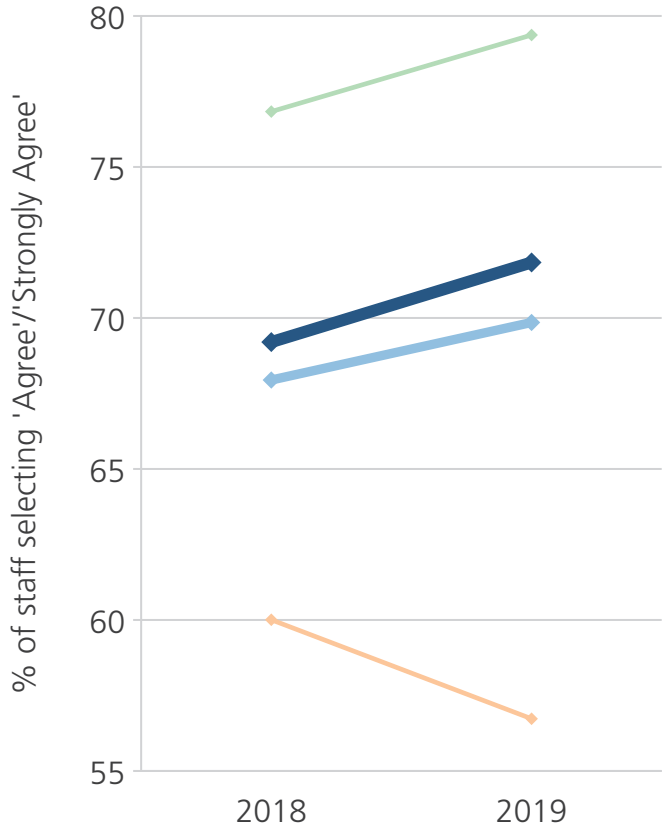
Best	61.0%	60.9%
Your org	56.5%	59.7%
Average	53.8%	53.9%
Worst	47.0%	48.6%

Q6c
Relationships at work are strained



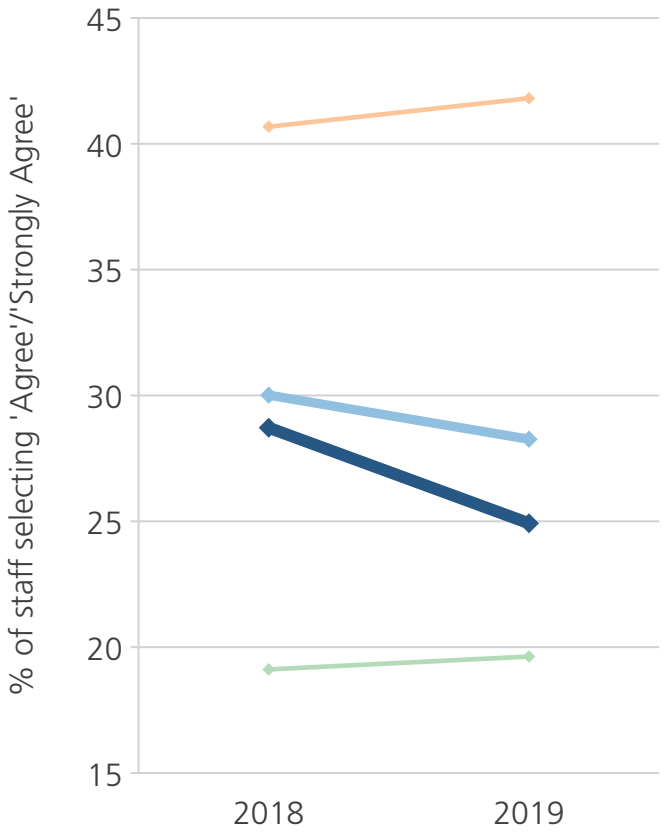
Best	55.4%	57.4%
Your org	48.6%	50.7%
Average	42.8%	44.1%
Worst	32.2%	36.8%

Q8a
My immediate manager encourages me at work



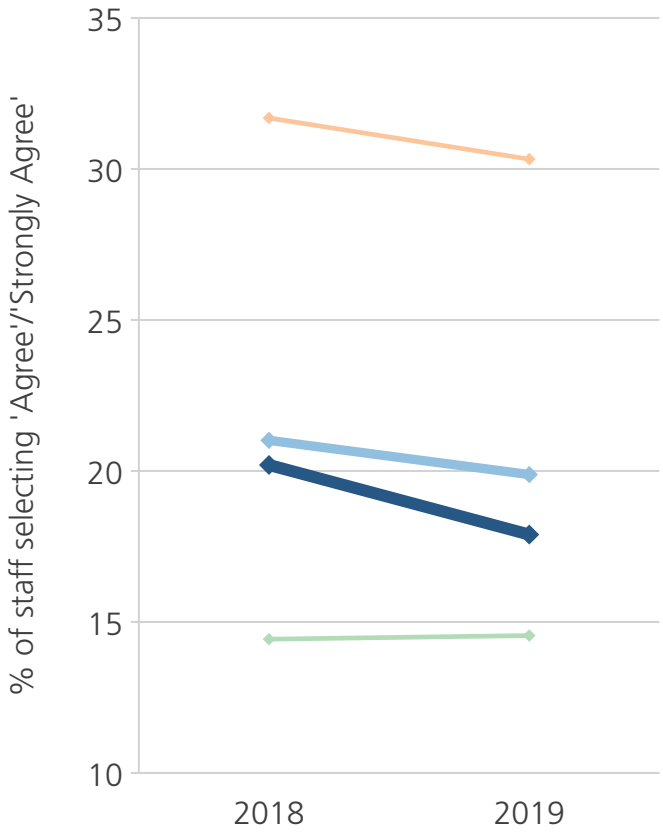
Best	76.8%	79.4%
Your org	69.2%	71.8%
Average	67.9%	69.9%
Worst	60.0%	56.7%

Q23a
I often think about leaving this organisation



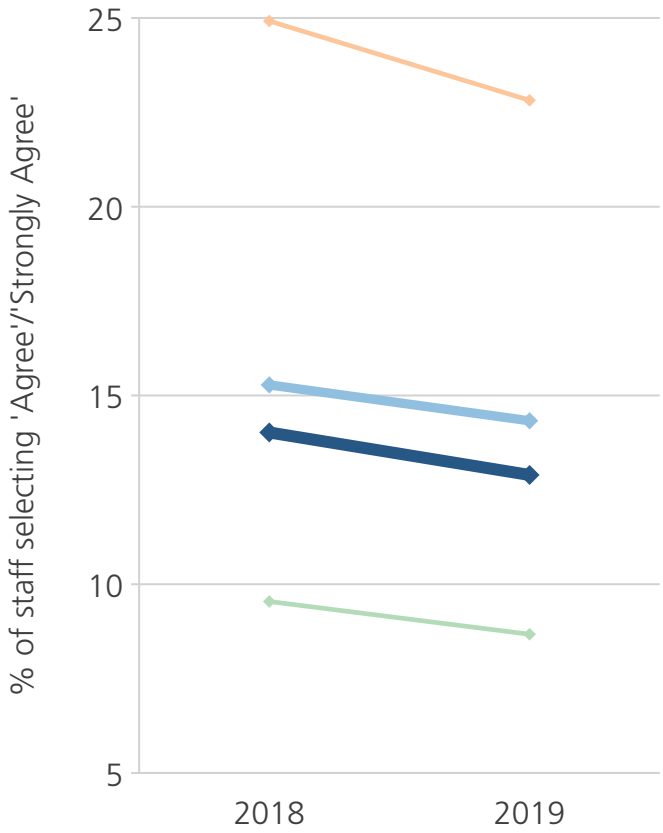
Worst	40.7%	41.8%
Your org	28.7%	24.9%
Average	30.0%	28.3%
Best	19.1%	19.6%

Q23b
I will probably look for a job at a new organisation in the next 12 months



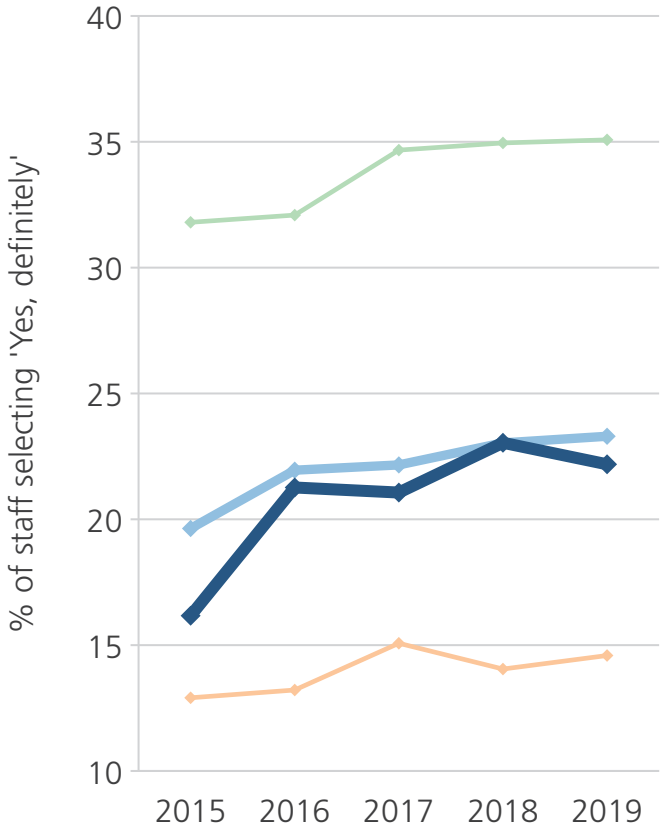
Worst	31.7%	30.3%
Your org	20.2%	17.9%
Average	21.0%	19.9%
Best	14.4%	14.5%

Q23c
As soon as I can find another job, I will leave this organisation



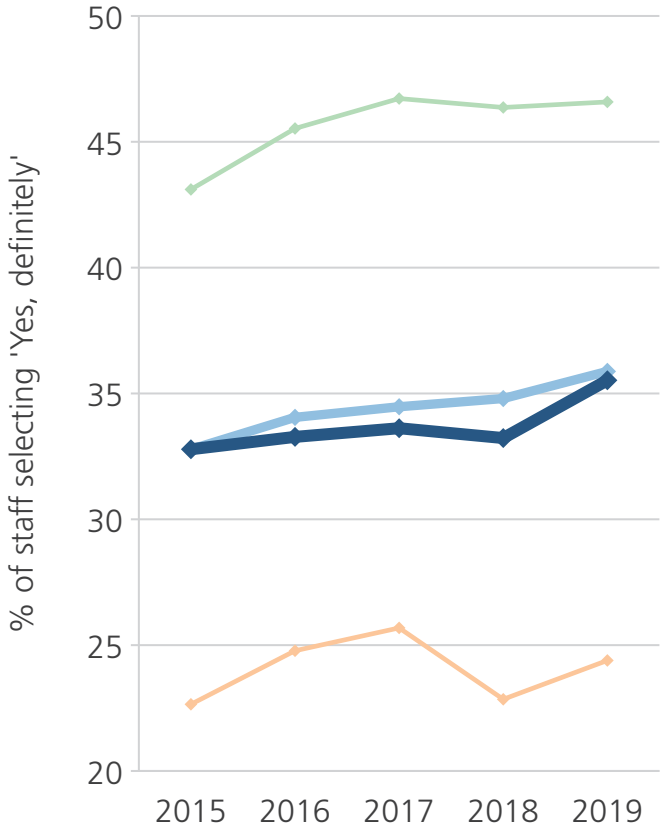
Worst	24.9%	22.8%
Your org	14.0%	12.9%
Average	15.3%	14.3%
Best	9.5%	8.7%

Q19b
It helped me to improve how I do my job



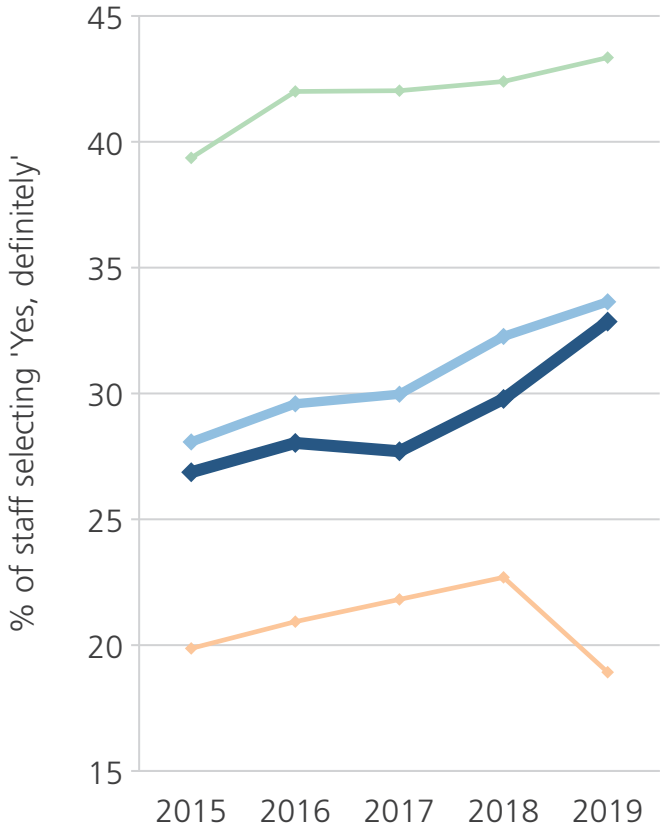
	2015	2016	2017	2018	2019
Best	31.8%	32.1%	34.7%	35.0%	35.1%
Your org	16.2%	21.3%	21.1%	23.0%	22.2%
Average	19.6%	22.0%	22.2%	23.0%	23.3%
Worst	12.9%	13.2%	15.1%	14.1%	14.6%

Q19c
It helped me agree clear objectives for my work



	2015	2016	2017	2018	2019
Best	43.1%	45.5%	46.7%	46.4%	46.6%
Your org	32.8%	33.3%	33.6%	33.2%	35.5%
Average	32.8%	34.1%	34.5%	34.8%	35.9%
Worst	22.6%	24.8%	25.7%	22.8%	24.4%

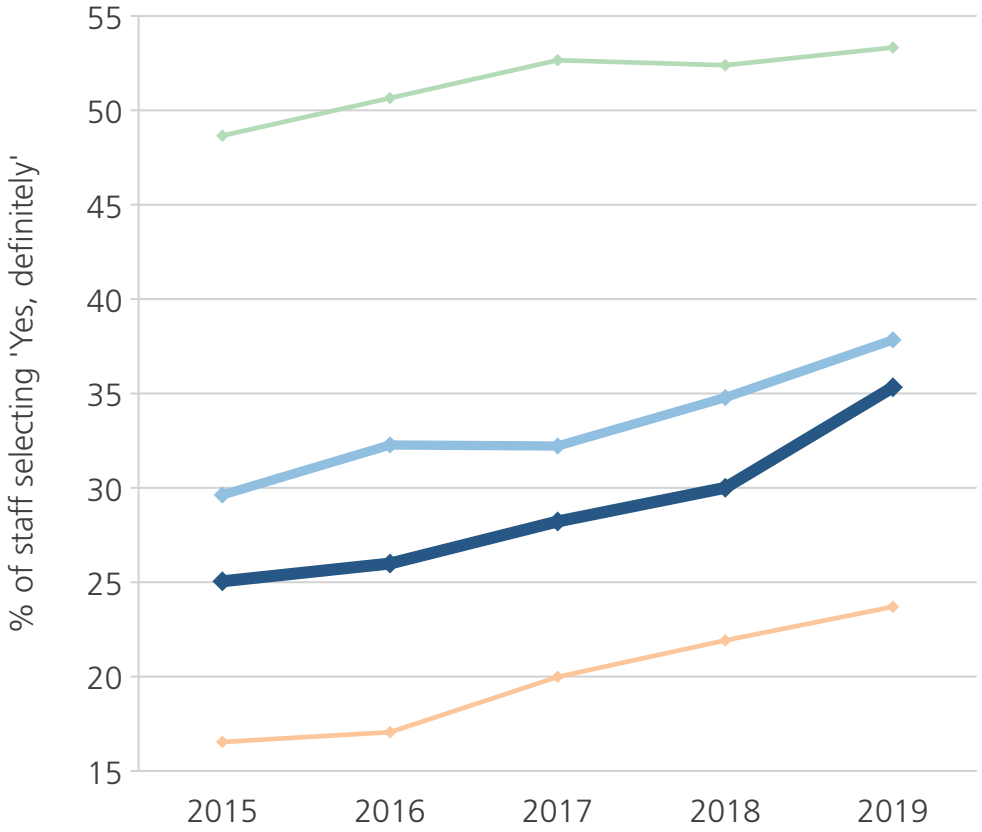
Q19d
It left me feeling that my work is valued by my organisation



	2015	2016	2017	2018	2019
Best	39.4%	42.0%	42.0%	42.4%	43.3%
Your org	26.9%	28.0%	27.7%	29.8%	32.9%
Average	28.1%	29.6%	30.0%	32.3%	33.6%
Worst	19.9%	20.9%	21.8%	22.7%	18.9%

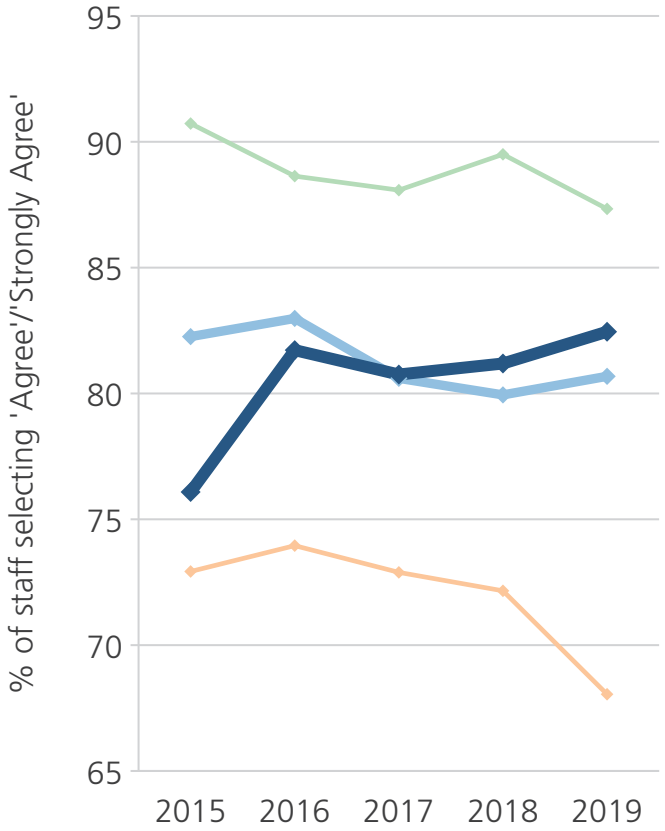
Q19e

The values of my organisation were discussed as part of the appraisal process



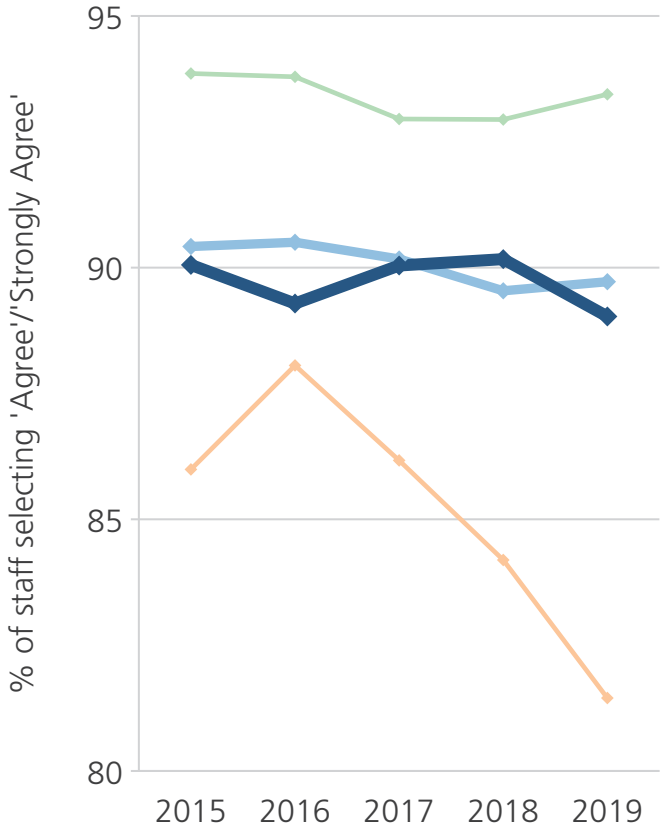
	2015	2016	2017	2018	2019
Best	48.7%	50.7%	52.7%	52.4%	53.3%
Your org	25.0%	26.0%	28.2%	30.0%	35.3%
Average	29.6%	32.3%	32.2%	34.8%	37.8%
Worst	16.5%	17.1%	20.0%	21.9%	23.7%

Q7a
I am satisfied with the quality of care I give to patients / service users



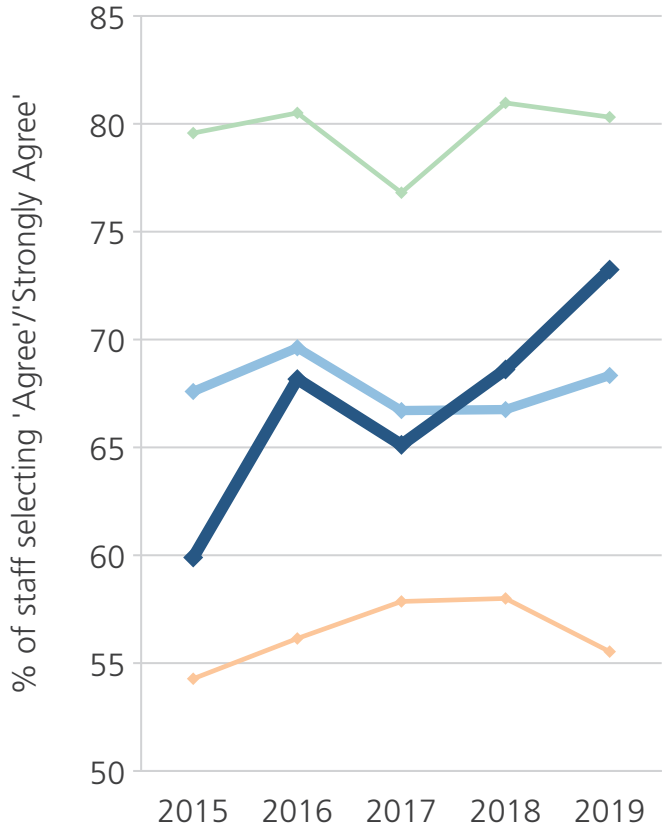
	2015	2016	2017	2018	2019
Best	90.7%	88.6%	88.1%	89.5%	87.3%
Your org	76.1%	81.7%	80.8%	81.2%	82.5%
Average	82.3%	83.0%	80.6%	79.9%	80.7%
Worst	72.9%	74.0%	72.9%	72.2%	68.0%

Q7b
I feel that my role makes a difference to patients / service users



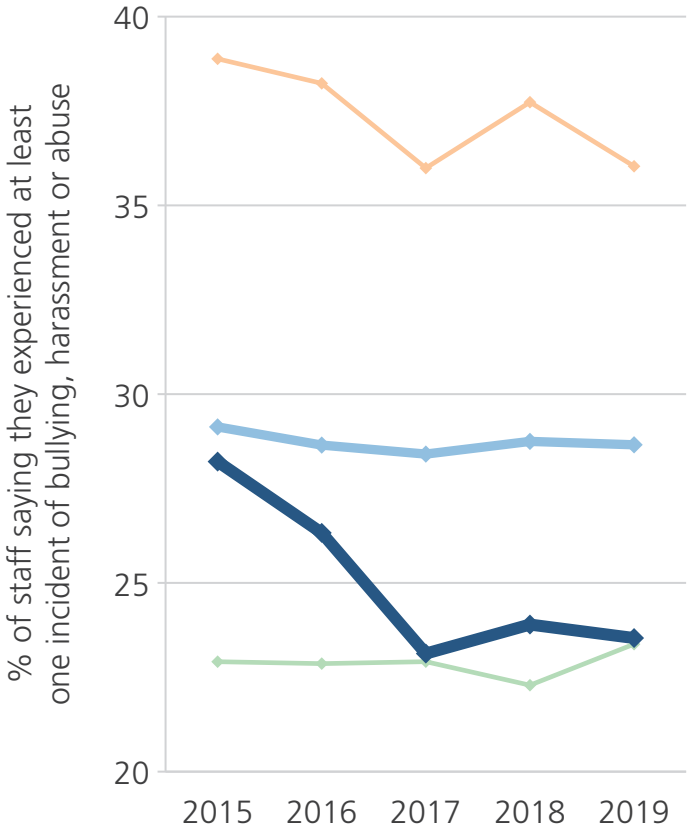
	2015	2016	2017	2018	2019
Best	93.9%	93.8%	93.0%	92.9%	93.4%
Your org	90.1%	89.3%	90.0%	90.2%	89.0%
Average	90.4%	90.5%	90.2%	89.5%	89.7%
Worst	86.0%	88.1%	86.2%	84.2%	81.4%

Q7c
I am able to deliver the care I aspire to



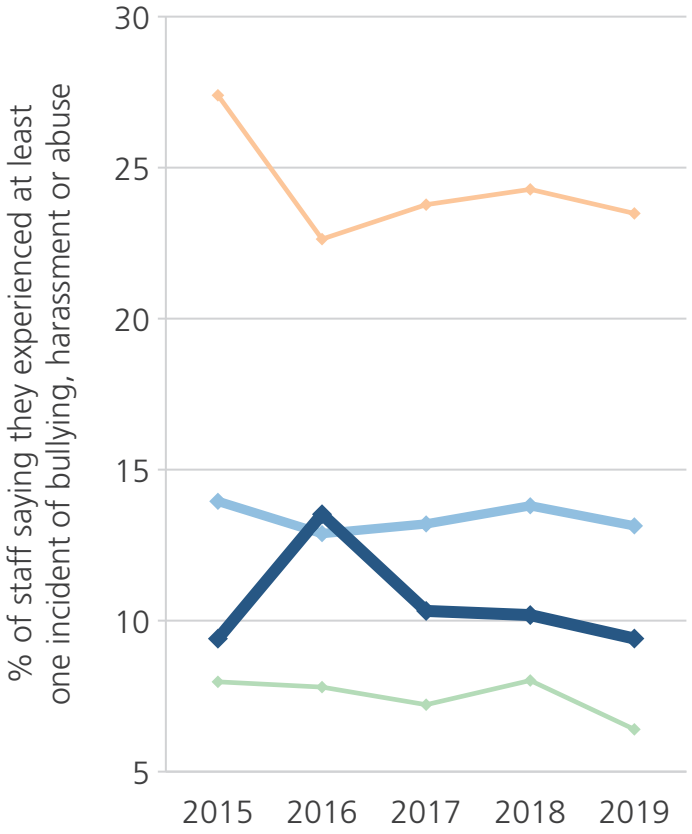
	2015	2016	2017	2018	2019
Best	79.6%	80.5%	76.8%	81.0%	80.3%
Your org	59.9%	68.2%	65.1%	68.6%	73.2%
Average	67.6%	69.6%	66.7%	66.8%	68.3%
Worst	54.3%	56.1%	57.9%	58.0%	55.5%

Q13a
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?



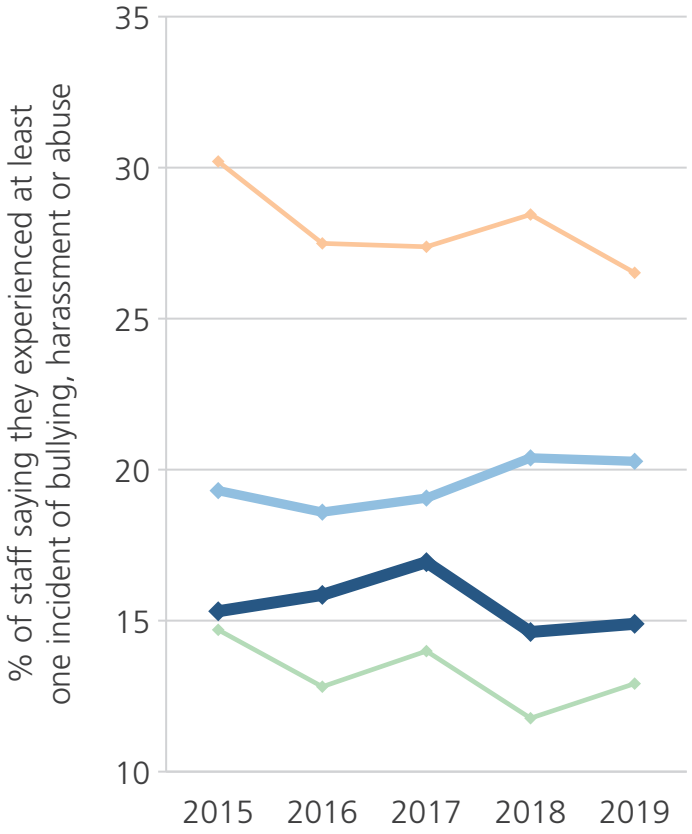
	2015	2016	2017	2018	2019
Worst	38.9%	38.2%	36.0%	37.7%	36.0%
Your org	28.2%	26.3%	23.1%	23.9%	23.5%
Average	29.1%	28.7%	28.4%	28.7%	28.7%
Best	22.9%	22.9%	22.9%	22.3%	23.4%

Q13b
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?



	2015	2016	2017	2018	2019
Worst	27.4%	22.6%	23.8%	24.3%	23.5%
Your org	9.4%	13.5%	10.3%	10.2%	9.4%
Average	14.0%	12.9%	13.2%	13.8%	13.1%
Best	8.0%	7.8%	7.2%	8.0%	6.4%

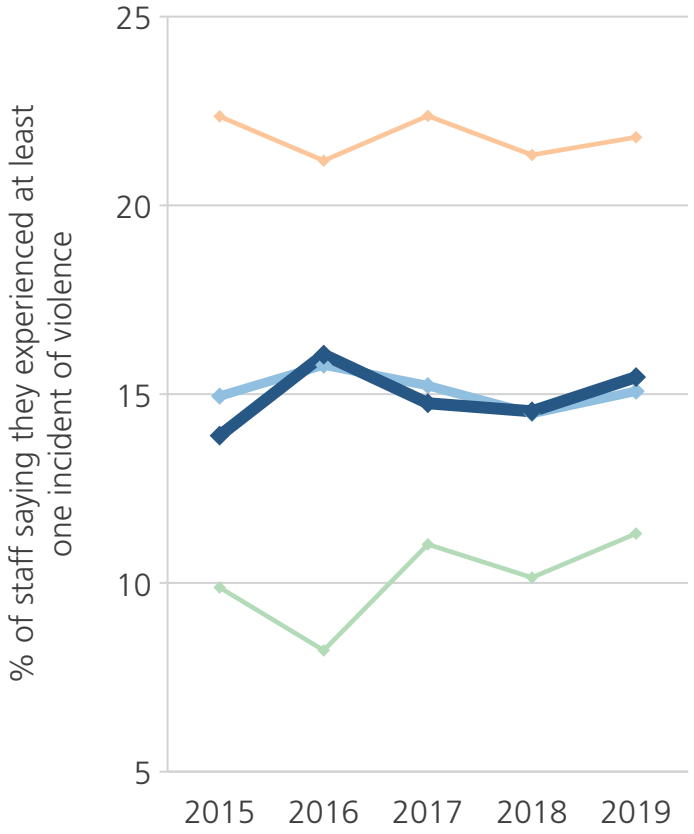
Q13c
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?



	2015	2016	2017	2018	2019
Worst	30.2%	27.5%	27.4%	28.4%	26.5%
Your org	15.3%	15.9%	16.9%	14.6%	14.9%
Average	19.3%	18.6%	19.1%	20.4%	20.3%
Best	14.7%	12.8%	14.0%	11.8%	12.9%

Q12a

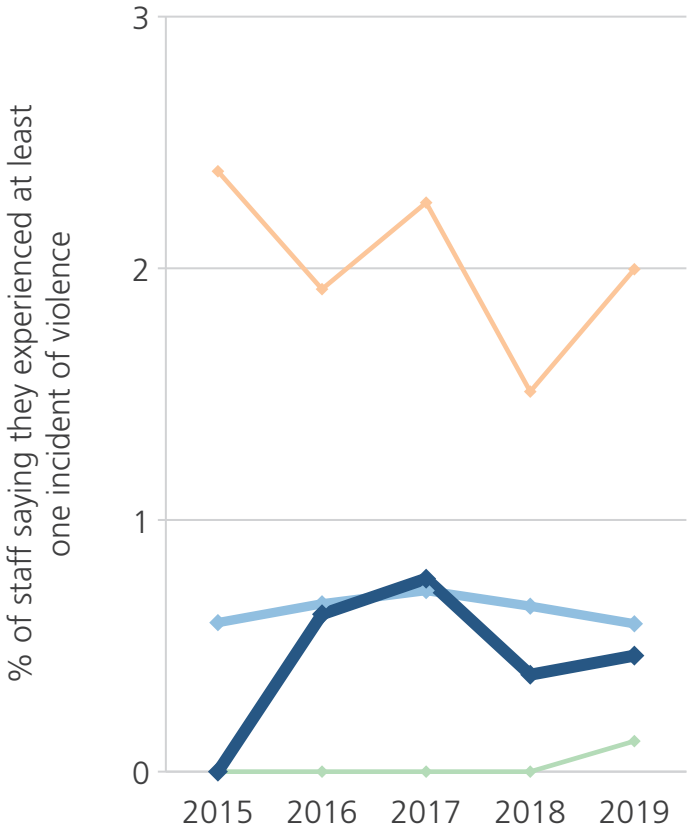
In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?



	2015	2016	2017	2018	2019
Worst	22.4%	21.2%	22.4%	21.3%	21.8%
Your org	13.9%	16.0%	14.8%	14.5%	15.5%
Average	14.9%	15.8%	15.2%	14.5%	15.1%
Best	9.9%	8.2%	11.0%	10.1%	11.3%

Q12b

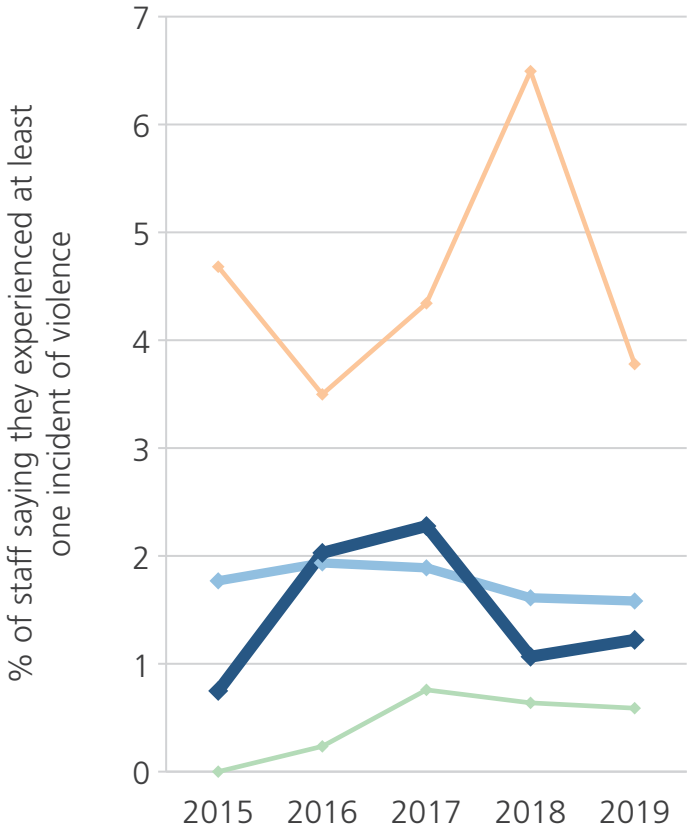
In the last 12 months how many times have you personally experienced physical violence at work from managers?



	2015	2016	2017	2018	2019
Worst	2.4%	1.9%	2.3%	1.5%	2.0%
Your org	0.0%	0.6%	0.8%	0.4%	0.5%
Average	0.6%	0.7%	0.7%	0.7%	0.6%
Best	0.0%	0.0%	0.0%	0.0%	0.1%

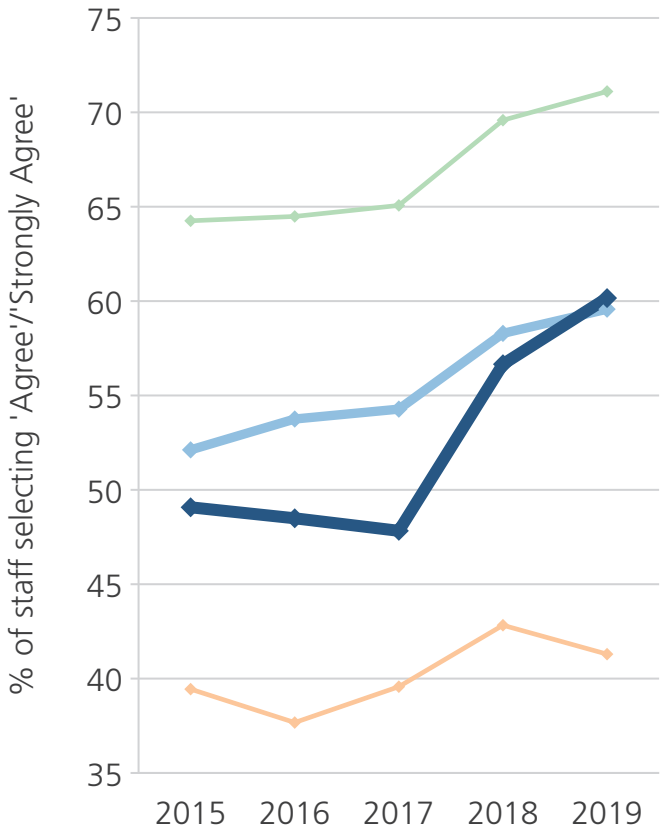
Q12c

In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?



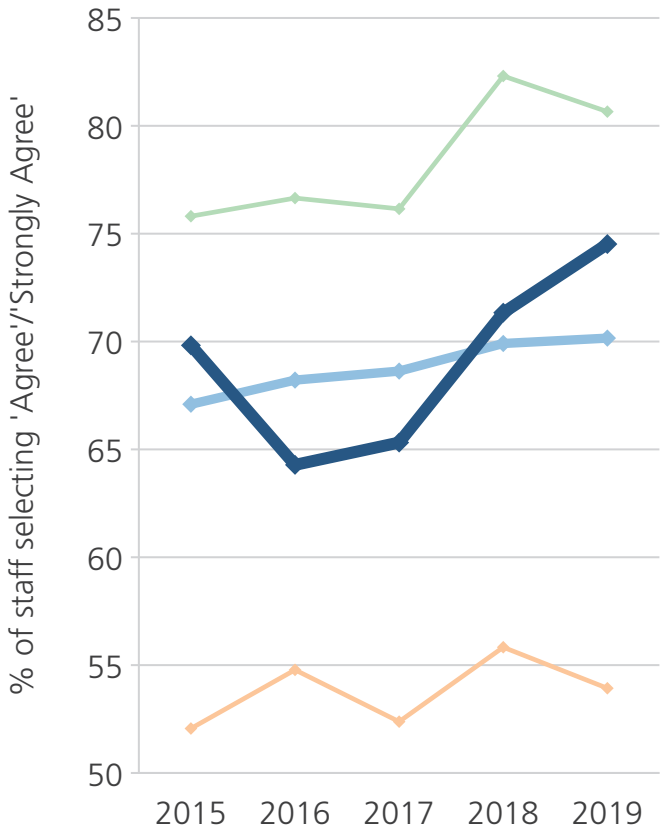
	2015	2016	2017	2018	2019
Worst	4.7%	3.5%	4.3%	6.5%	3.8%
Your org	0.7%	2.0%	2.3%	1.1%	1.2%
Average	1.8%	1.9%	1.9%	1.6%	1.6%
Best	0.0%	0.2%	0.8%	0.6%	0.6%

Q17a
My organisation treats staff who are involved in an error, near miss or incident fairly



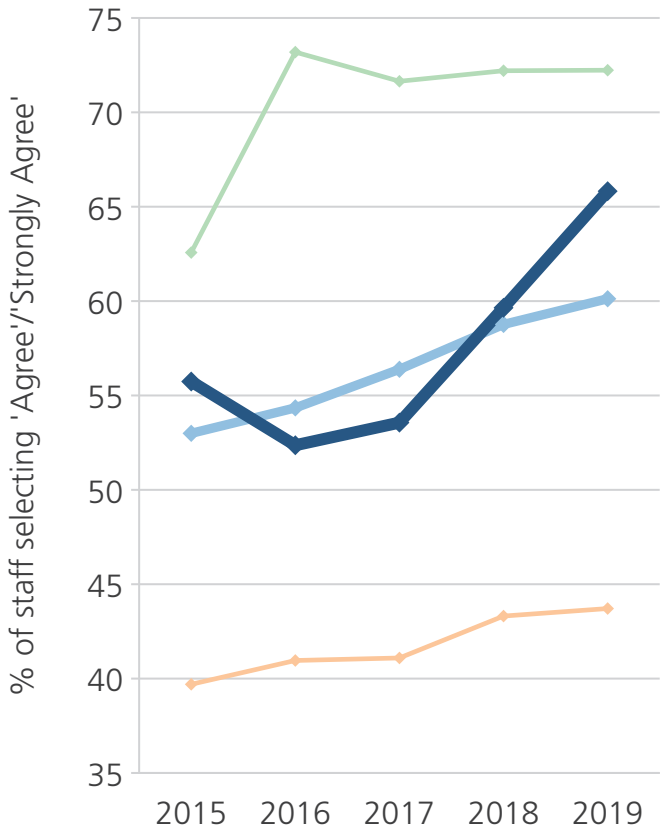
	2015	2016	2017	2018	2019
Best	64.3%	64.5%	65.1%	69.6%	71.1%
Your org	49.1%	48.5%	47.8%	56.7%	60.2%
Average	52.1%	53.8%	54.3%	58.3%	59.6%
Worst	39.4%	37.7%	39.6%	42.8%	41.3%

Q17c
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again



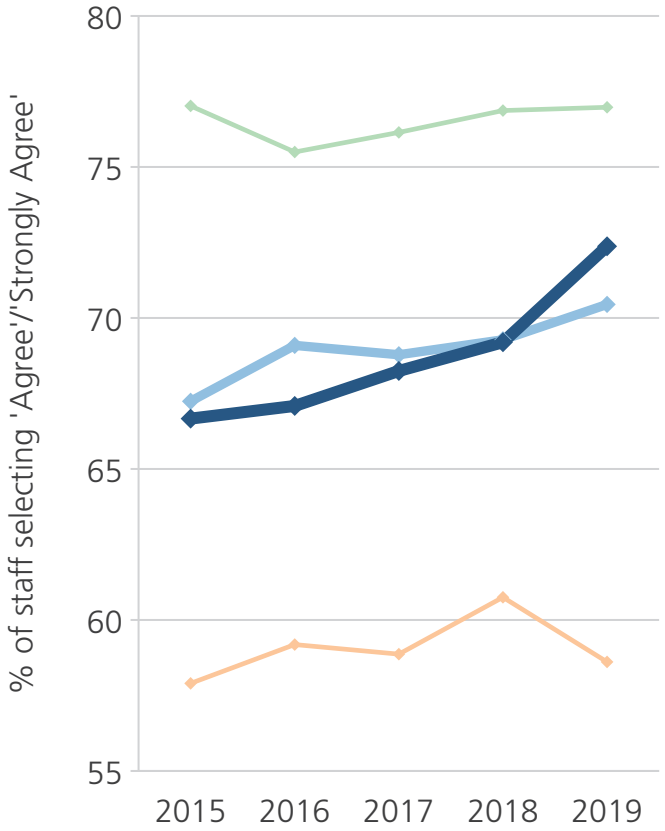
	2015	2016	2017	2018	2019
Best	75.8%	76.7%	76.2%	82.3%	80.7%
Your org	69.8%	64.3%	65.3%	71.3%	74.5%
Average	67.1%	68.2%	68.6%	69.9%	70.2%
Worst	52.1%	54.8%	52.4%	55.8%	53.9%

Q17d
We are given feedback about changes made in response to reported errors, near misses and incidents



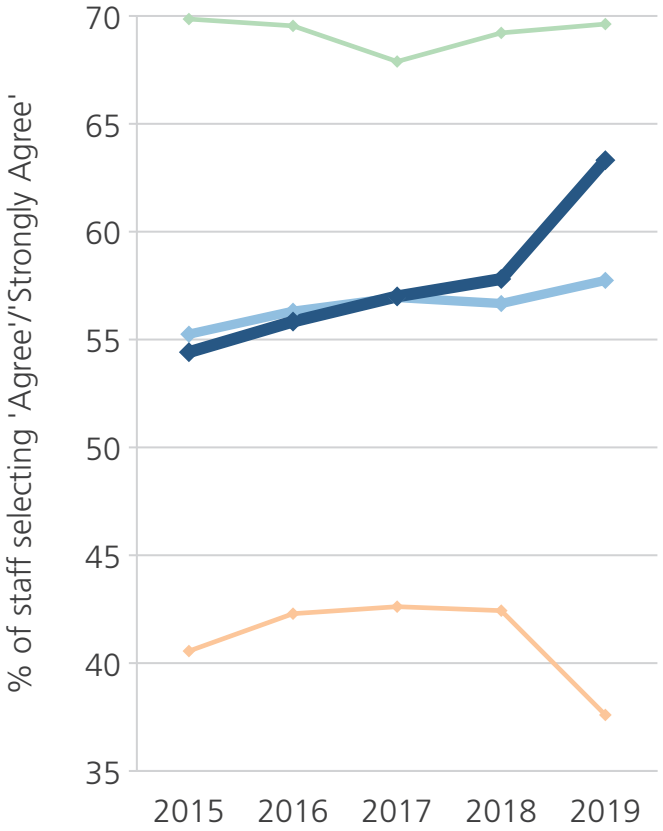
	2015	2016	2017	2018	2019
Best	62.6%	73.2%	71.6%	72.2%	72.2%
Your org	55.7%	52.4%	53.6%	59.6%	65.8%
Average	53.0%	54.3%	56.4%	58.8%	60.1%
Worst	39.7%	41.0%	41.1%	43.3%	43.7%

Q18b
I would feel secure raising concerns about unsafe clinical practice



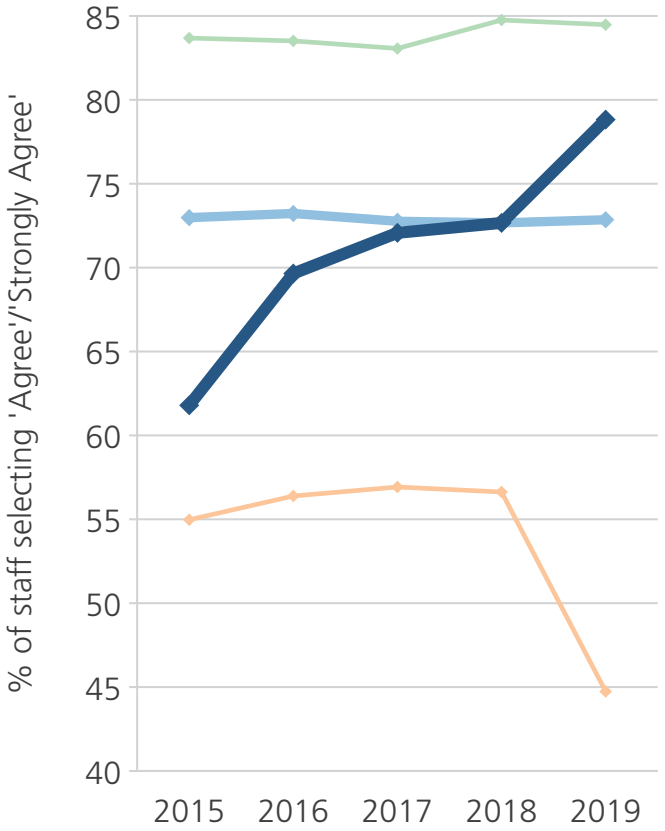
	2015	2016	2017	2018	2019
Best	77.0%	75.5%	76.1%	76.9%	77.0%
Your org	66.7%	67.1%	68.2%	69.2%	72.4%
Average	67.2%	69.1%	68.8%	69.3%	70.4%
Worst	57.9%	59.2%	58.9%	60.8%	58.6%

Q18c
I am confident that my organisation would address my concern



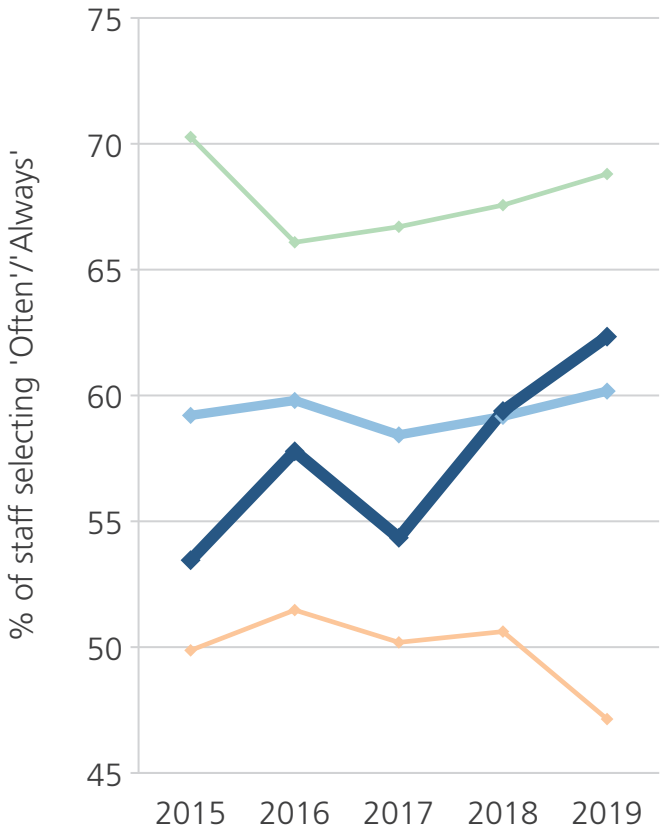
	2015	2016	2017	2018	2019
Best	69.9%	69.5%	67.9%	69.2%	69.6%
Your org	54.4%	55.8%	57.0%	57.8%	63.3%
Average	55.2%	56.3%	56.9%	56.7%	57.7%
Worst	40.6%	42.3%	42.6%	42.4%	37.6%

Q21b
My organisation acts on concerns raised by patients / service users



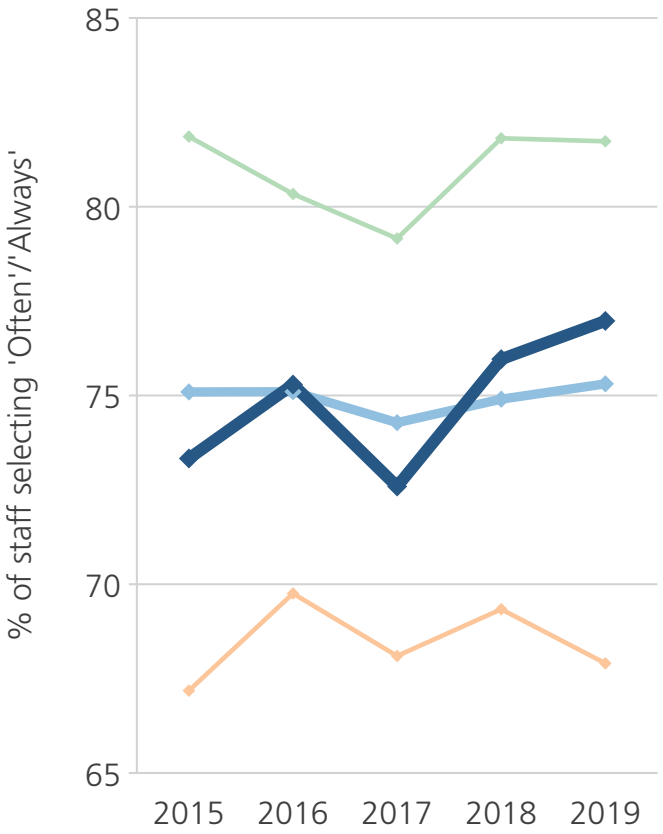
	2015	2016	2017	2018	2019
Best	83.7%	83.5%	83.1%	84.8%	84.5%
Your org	61.8%	69.6%	72.1%	72.7%	78.8%
Average	73.0%	73.2%	72.8%	72.7%	72.9%
Worst	55.0%	56.4%	56.9%	56.6%	44.7%

Q2a
I look forward to going to work



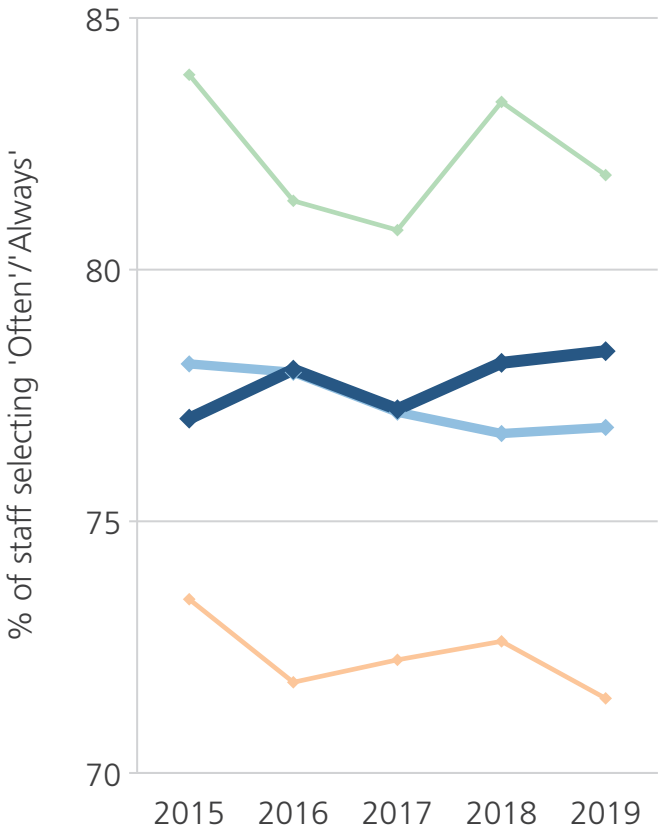
	2015	2016	2017	2018	2019
Best	70.3%	66.1%	66.7%	67.6%	68.8%
Your org	53.5%	57.8%	54.3%	59.4%	62.3%
Average	59.2%	59.8%	58.4%	59.2%	60.2%
Worst	49.9%	51.5%	50.2%	50.6%	47.1%

Q2b
I am enthusiastic about my job



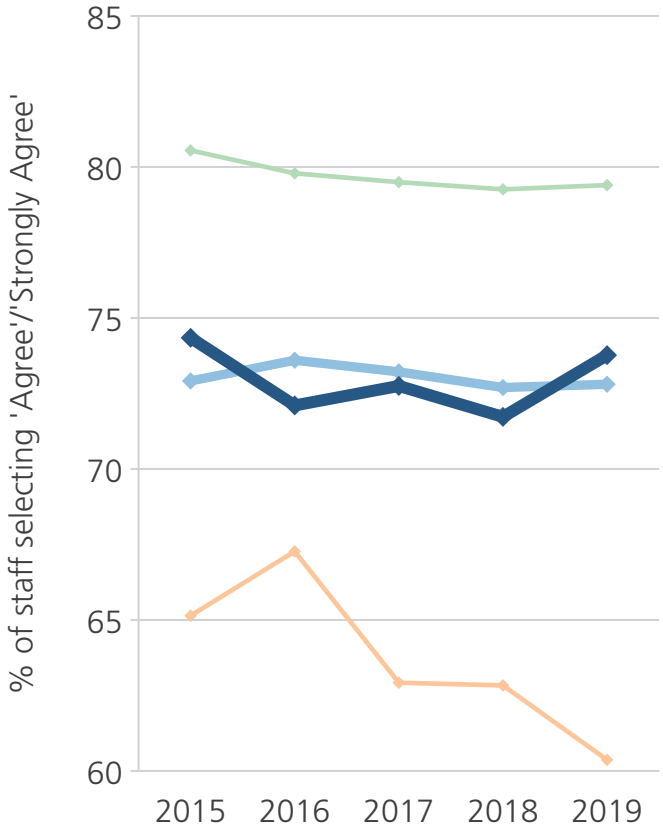
	2015	2016	2017	2018	2019
Best	81.9%	80.3%	79.2%	81.8%	81.7%
Your org	73.3%	75.3%	72.6%	76.0%	77.0%
Average	75.1%	75.1%	74.3%	74.9%	75.3%
Worst	67.2%	69.8%	68.1%	69.3%	67.9%

Q2c
Time passes quickly when I am working



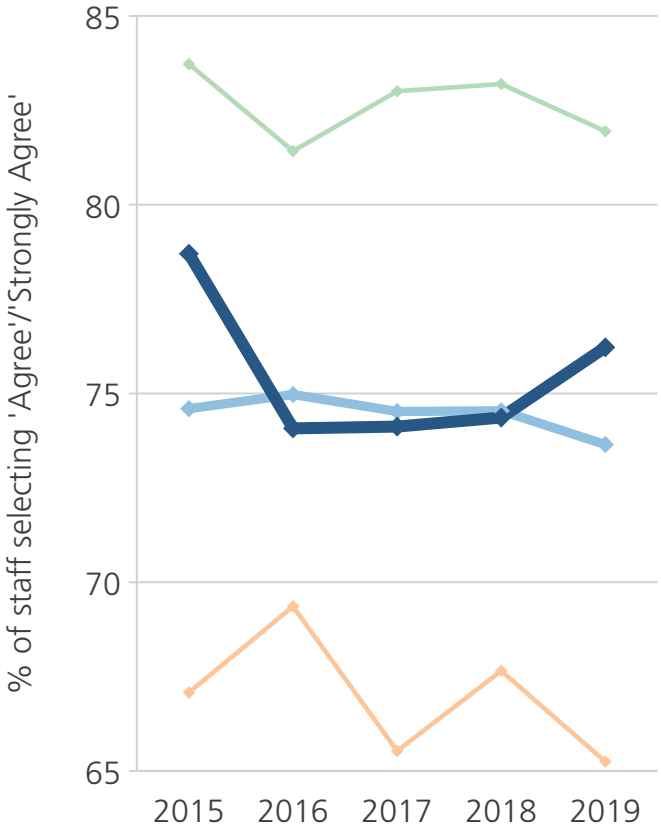
	2015	2016	2017	2018	2019
Best	83.9%	81.4%	80.8%	83.3%	81.9%
Your org	77.0%	78.0%	77.2%	78.1%	78.4%
Average	78.1%	78.0%	77.2%	76.7%	76.9%
Worst	73.5%	71.8%	72.2%	72.6%	71.5%

Q4a
There are frequent opportunities for me to show initiative in my role



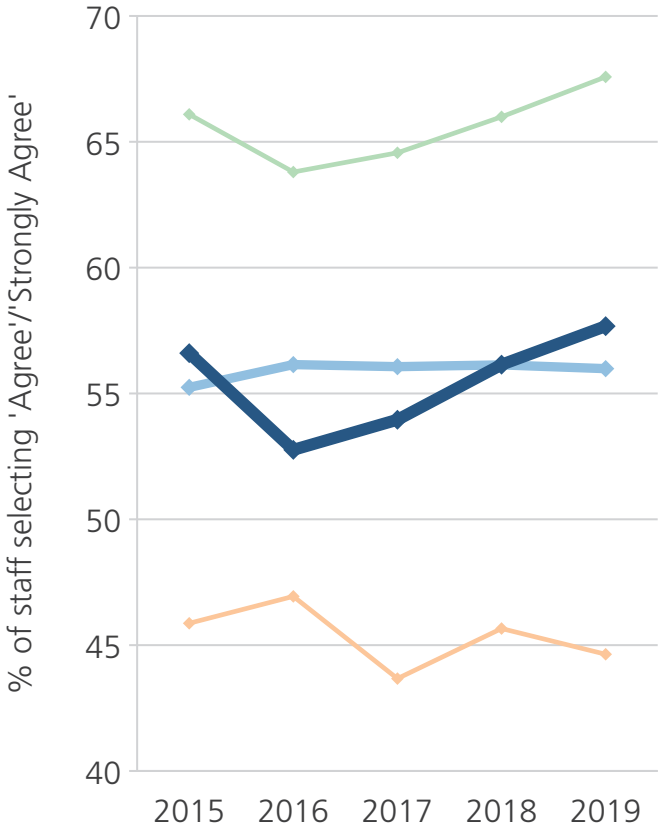
	2015	2016	2017	2018	2019
Best	80.5%	79.8%	79.5%	79.3%	79.4%
Your org	74.3%	72.1%	72.7%	71.7%	73.8%
Average	72.9%	73.6%	73.2%	72.7%	72.8%
Worst	65.1%	67.3%	62.9%	62.8%	60.4%

Q4b
I am able to make suggestions to improve the work of my team / department



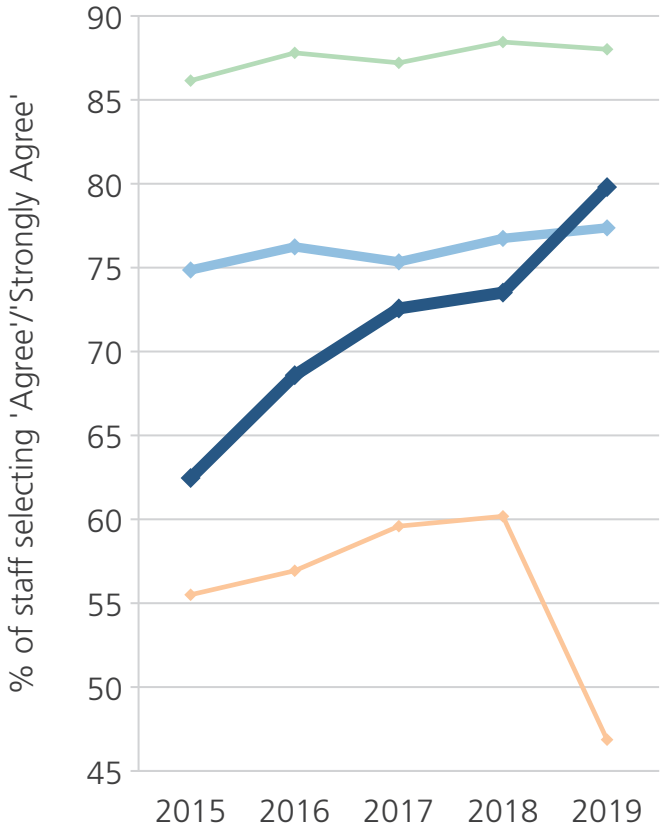
	2015	2016	2017	2018	2019
Best	83.7%	81.4%	83.0%	83.2%	81.9%
Your org	78.7%	74.1%	74.1%	74.4%	76.2%
Average	74.6%	75.0%	74.5%	74.5%	73.6%
Worst	67.1%	69.4%	65.5%	67.7%	65.2%

Q4d
I am able to make improvements happen in my area of work



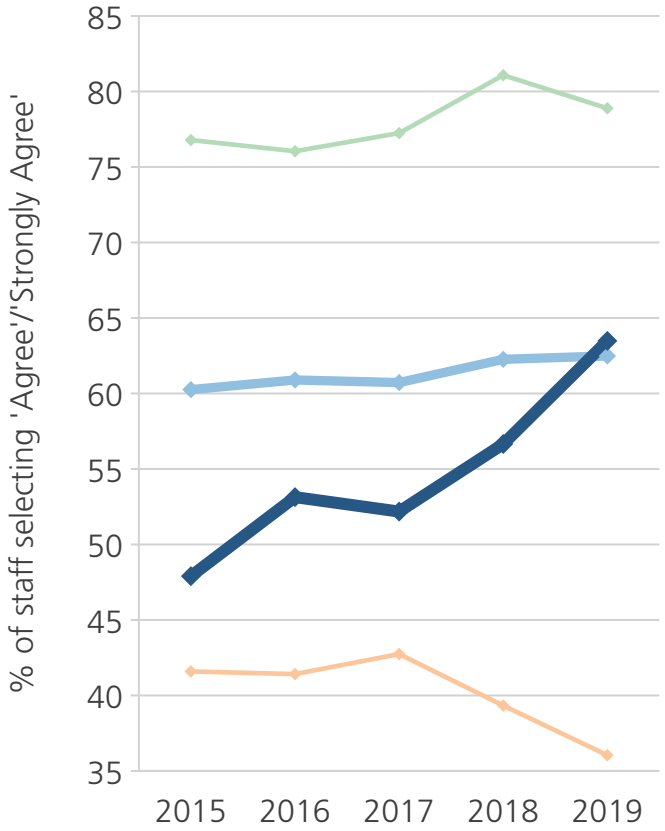
	2015	2016	2017	2018	2019
Best	66.1%	63.8%	64.6%	66.0%	67.6%
Your org	56.6%	52.8%	54.0%	56.1%	57.7%
Average	55.2%	56.1%	56.1%	56.1%	56.0%
Worst	45.9%	46.9%	43.7%	45.7%	44.6%

Q21a
Care of patients / service users is my organisation's top priority



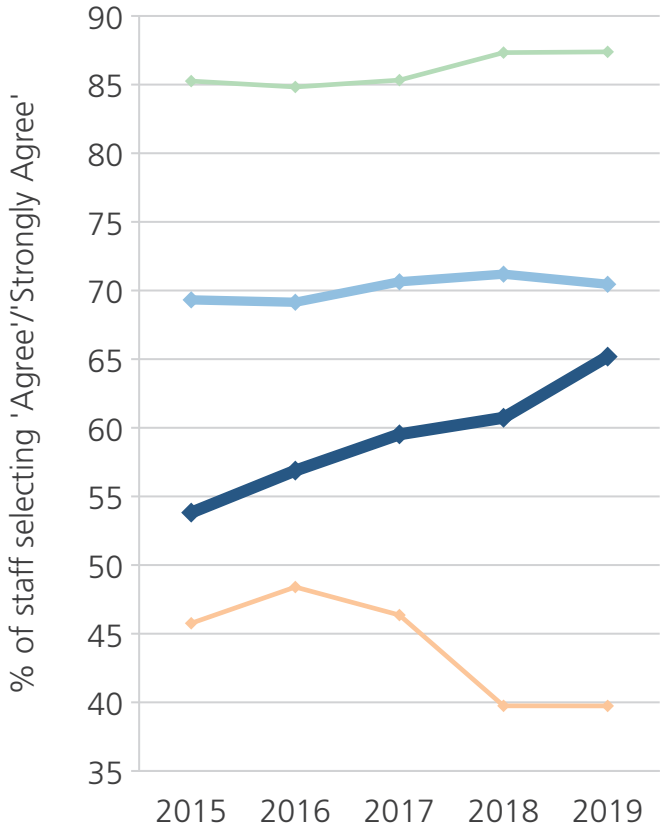
	2015	2016	2017	2018	2019
Best	86.1%	87.8%	87.2%	88.4%	88.0%
Your org	62.5%	68.6%	72.6%	73.5%	79.8%
Average	74.9%	76.2%	75.3%	76.7%	77.4%
Worst	55.5%	56.9%	59.6%	60.2%	46.9%

Q21c
I would recommend my organisation as a place to work



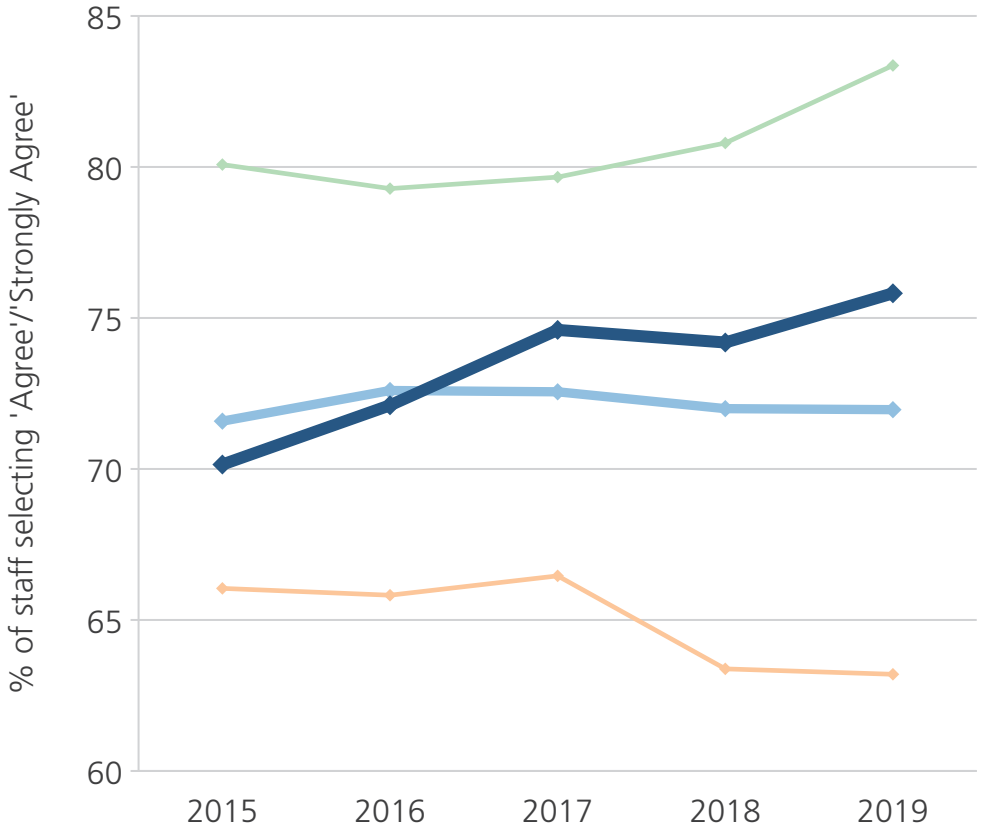
	2015	2016	2017	2018	2019
Best	76.8%	76.0%	77.2%	81.1%	78.9%
Your org	47.9%	53.1%	52.2%	56.7%	63.5%
Average	60.3%	60.9%	60.7%	62.3%	62.5%
Worst	41.6%	41.4%	42.7%	39.3%	36.0%

Q21d
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation



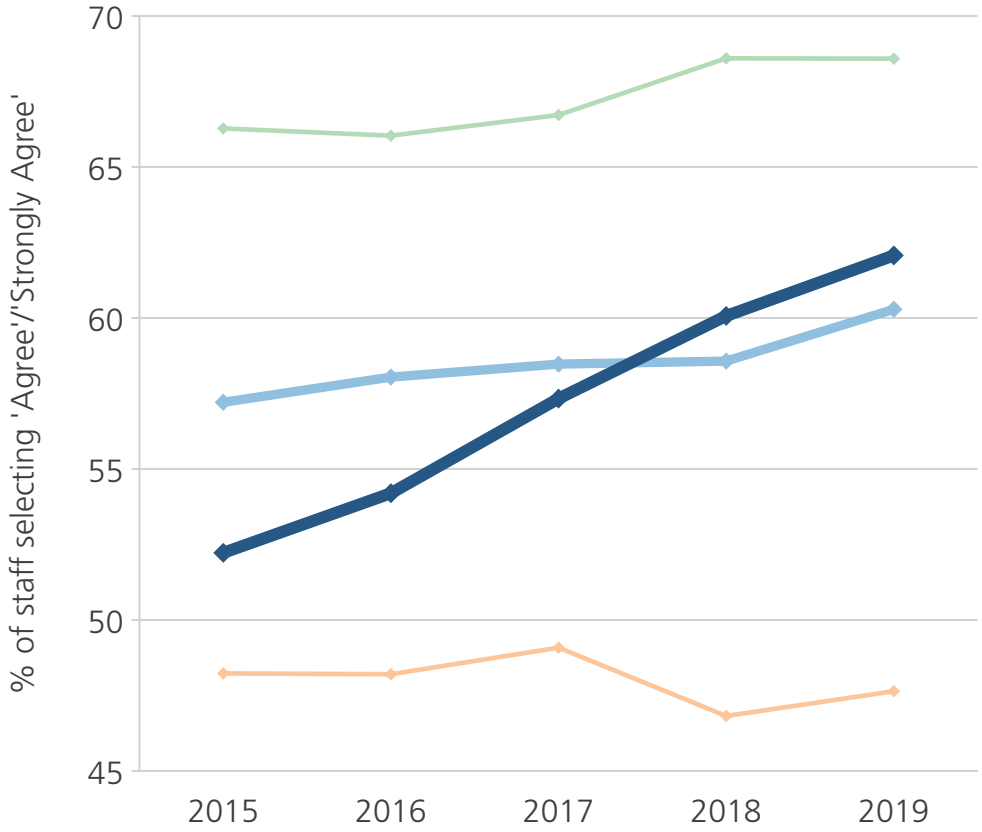
	2015	2016	2017	2018	2019
Best	85.3%	84.8%	85.3%	87.3%	87.4%
Your org	53.8%	56.9%	59.5%	60.7%	65.2%
Average	69.3%	69.1%	70.6%	71.2%	70.5%
Worst	45.8%	48.4%	46.4%	39.7%	39.7%

Q4h
The team I work in has a set of shared objectives



	2015	2016	2017	2018	2019
Best	80.1%	79.3%	79.7%	80.8%	83.4%
Your org	70.1%	72.1%	74.6%	74.2%	75.8%
Average	71.6%	72.6%	72.6%	72.0%	72.0%
Worst	66.0%	65.8%	66.5%	63.4%	63.2%

Q4i
The team I work in often meets to discuss the team's effectiveness



	2015	2016	2017	2018	2019
Best	66.3%	66.0%	66.7%	68.6%	68.6%
Your org	52.2%	54.2%	57.3%	60.1%	62.1%
Average	57.2%	58.0%	58.5%	58.6%	60.3%
Worst	48.2%	48.2%	49.1%	46.8%	47.6%

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Survey Coordination Centre

NHS England

Question results

Warrington and Halton Hospitals NHS Foundation Trust

2019 NHS Staff Survey Results

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Survey Coordination Centre

NHS England

Question results – Your job

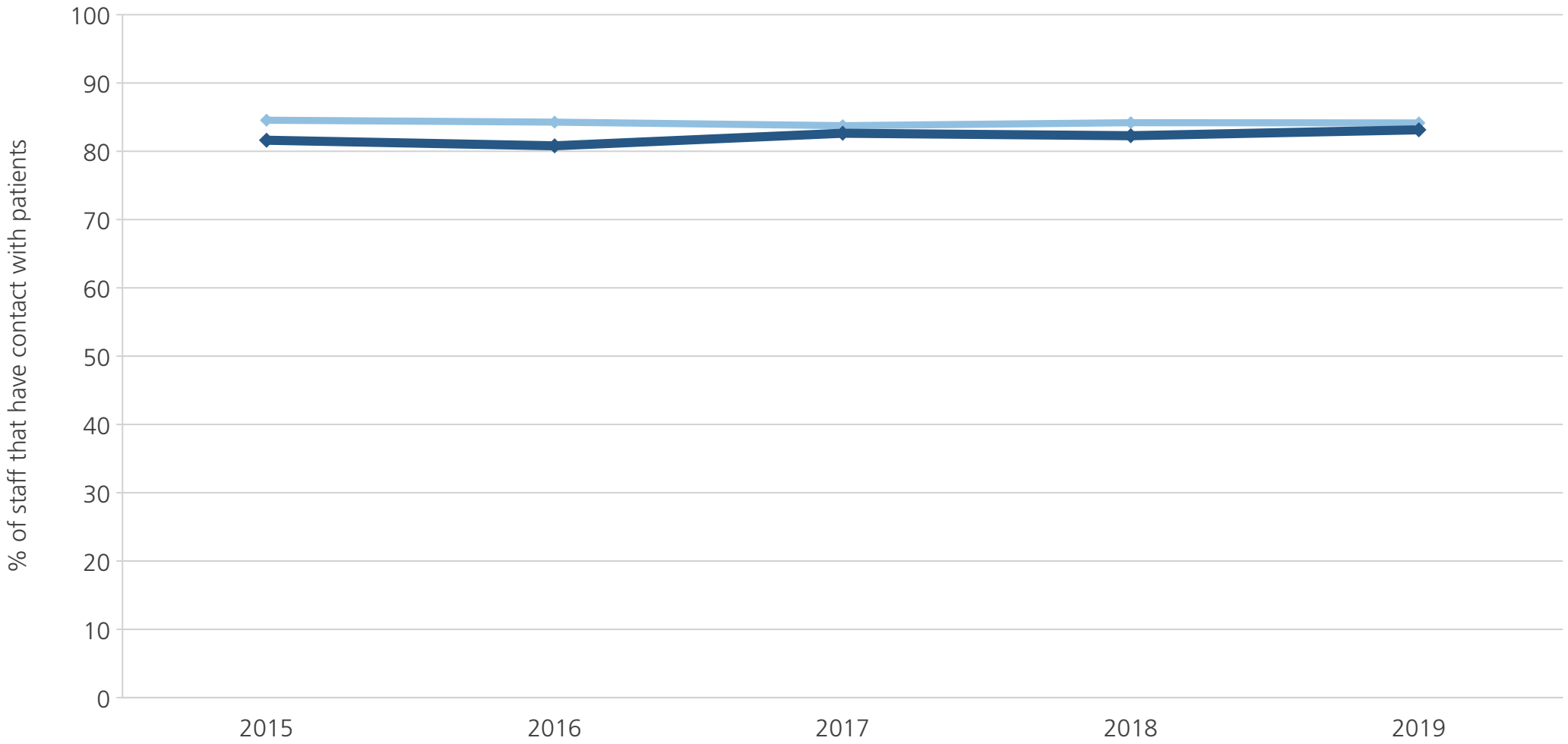
Warrington and Halton Hospitals NHS Foundation Trust

2019 NHS Staff Survey Results

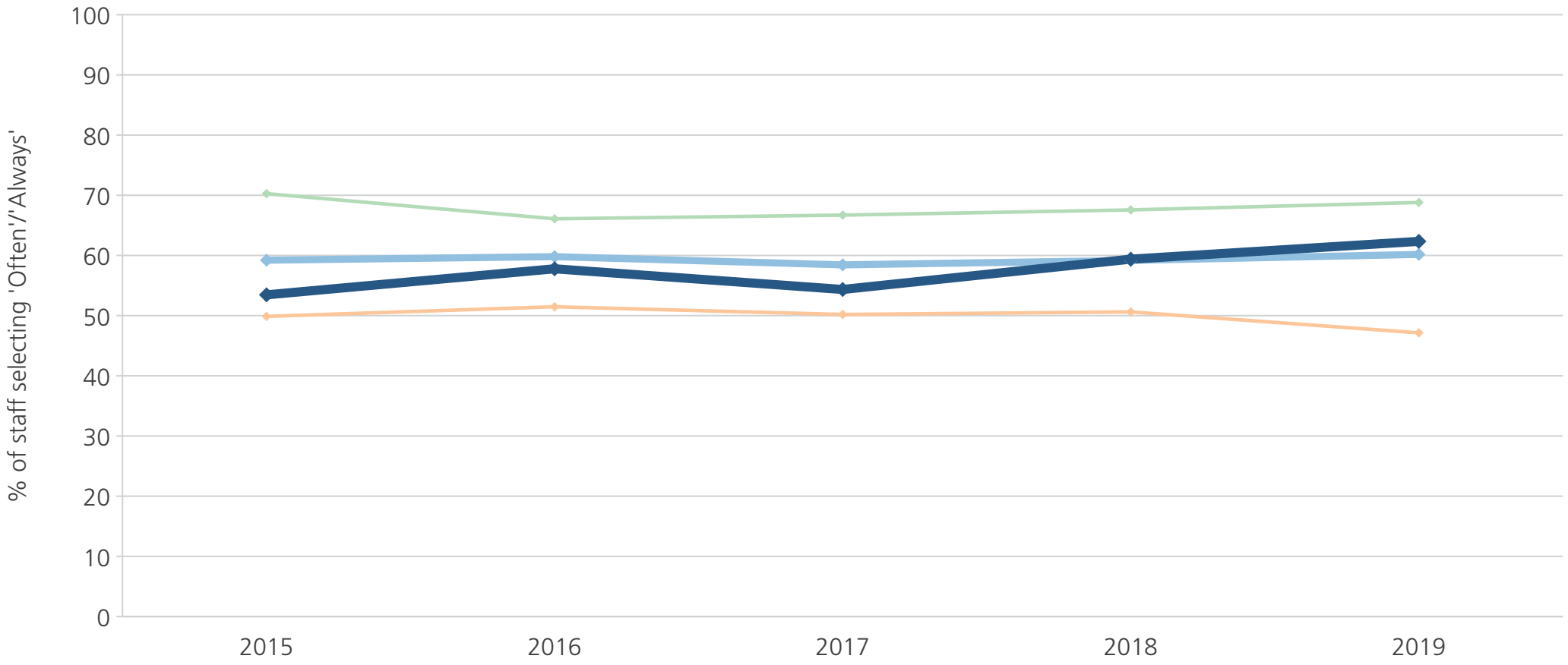
Survey Coordination Centre

2019 NHS Staff Survey Results > Question results > Your job > Q1 **>** Do you have face-to-face contact with patients / service users as part of your job?

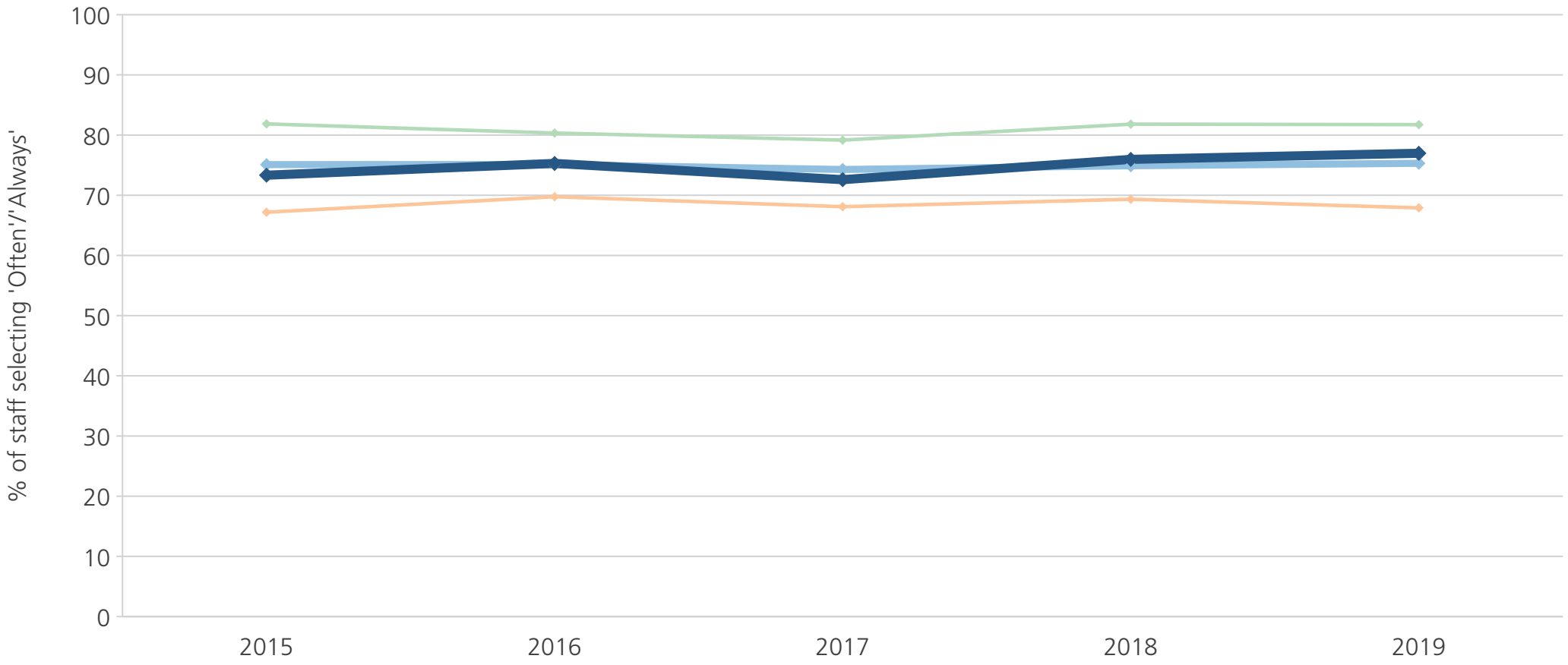
NHS England



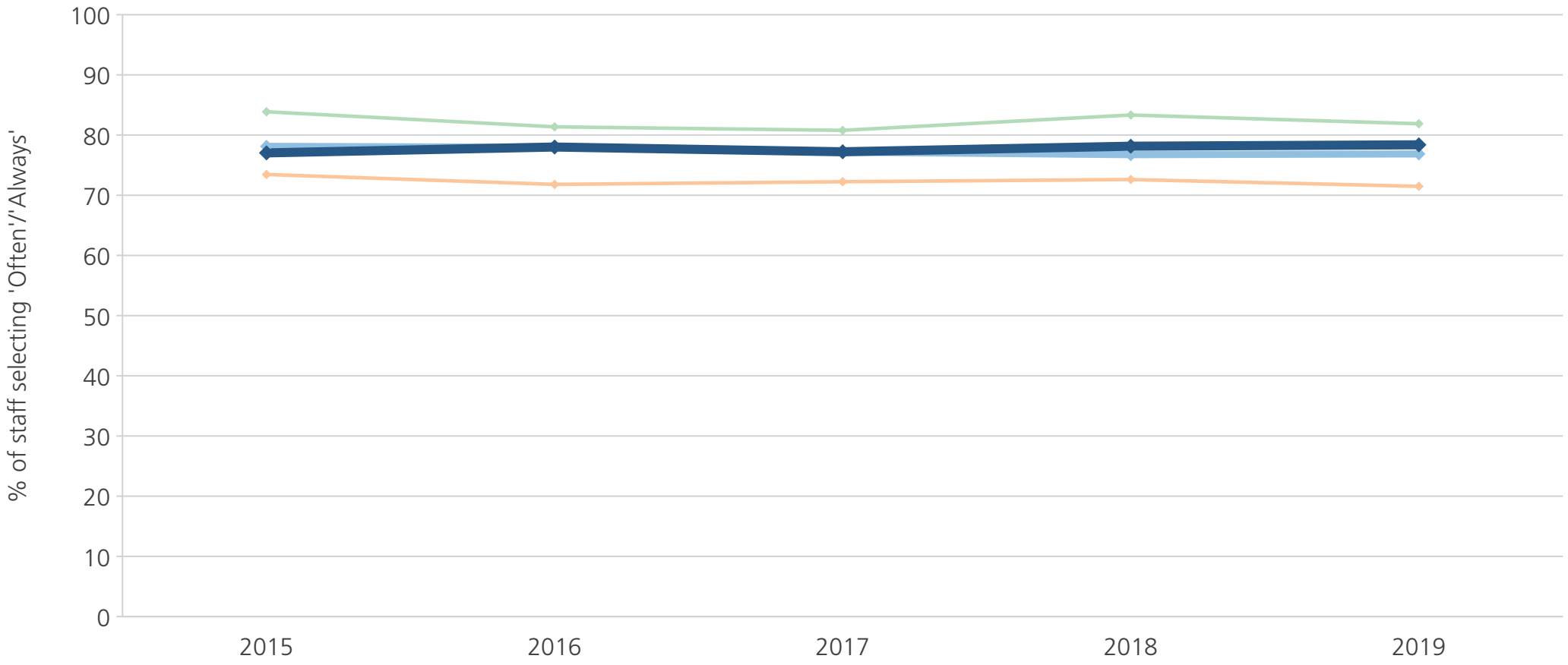
	2015	2016	2017	2018	2019
Your org	81.6%	80.8%	82.6%	82.3%	83.1%
Average	84.5%	84.3%	83.7%	84.2%	84.2%
Responses	272	1,453	1,780	1,958	2,100



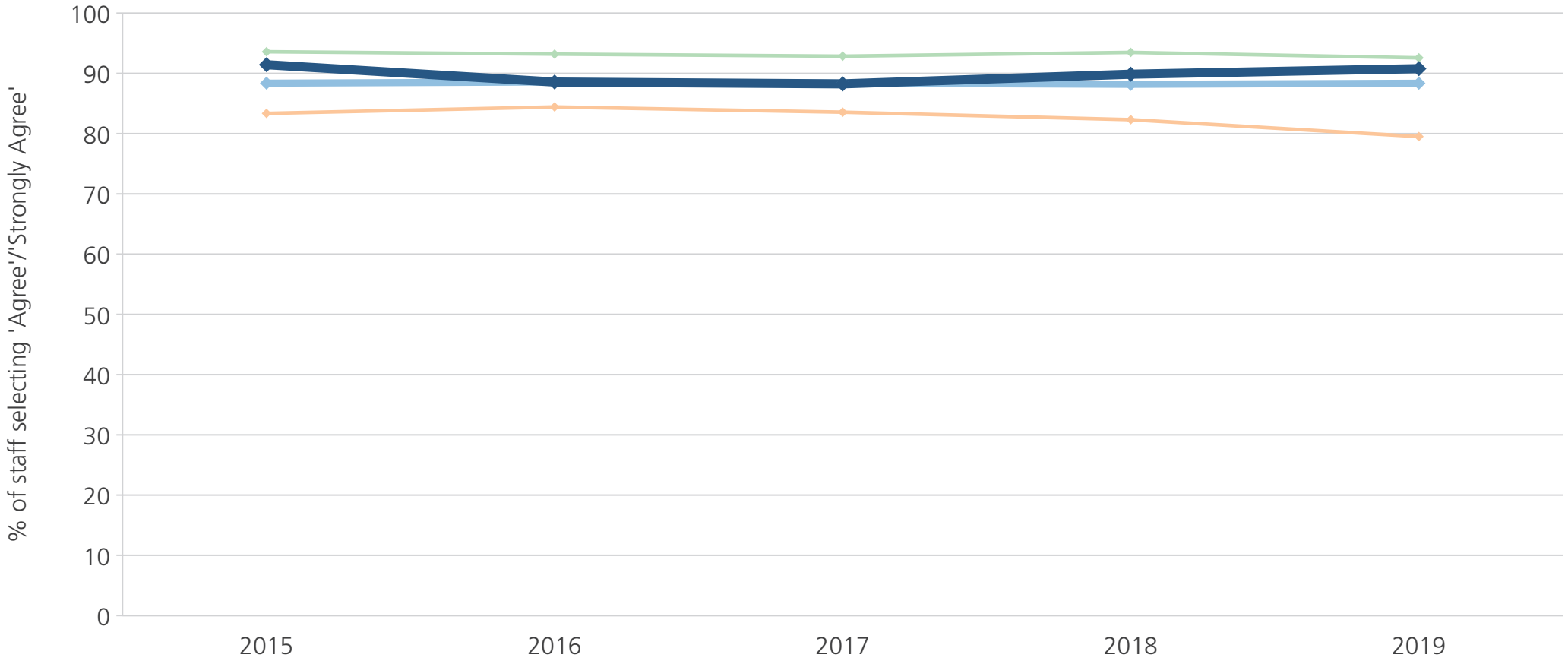
	2015	2016	2017	2018	2019
Best	70.3%	66.1%	66.7%	67.6%	68.8%
Your org	53.5%	57.8%	54.3%	59.4%	62.3%
Average	59.2%	59.8%	58.4%	59.2%	60.2%
Worst	49.9%	51.5%	50.2%	50.6%	47.1%
Responses	274	1,460	1,791	1,970	2,120



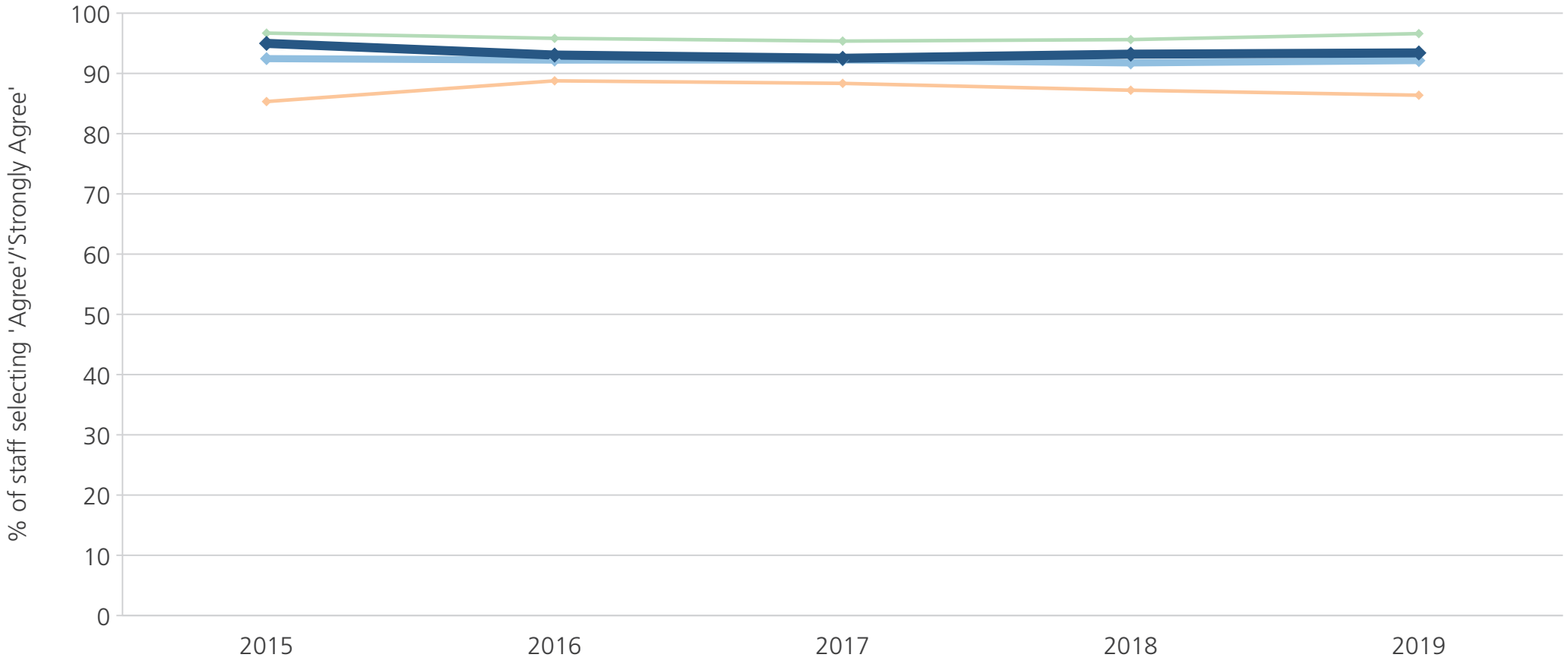
	2015	2016	2017	2018	2019
Best	81.9%	80.3%	79.2%	81.8%	81.7%
Your org	73.3%	75.3%	72.6%	76.0%	77.0%
Average	75.1%	75.1%	74.3%	74.9%	75.3%
Worst	67.2%	69.8%	68.1%	69.3%	67.9%
Responses	274	1,455	1,780	1,953	2,106



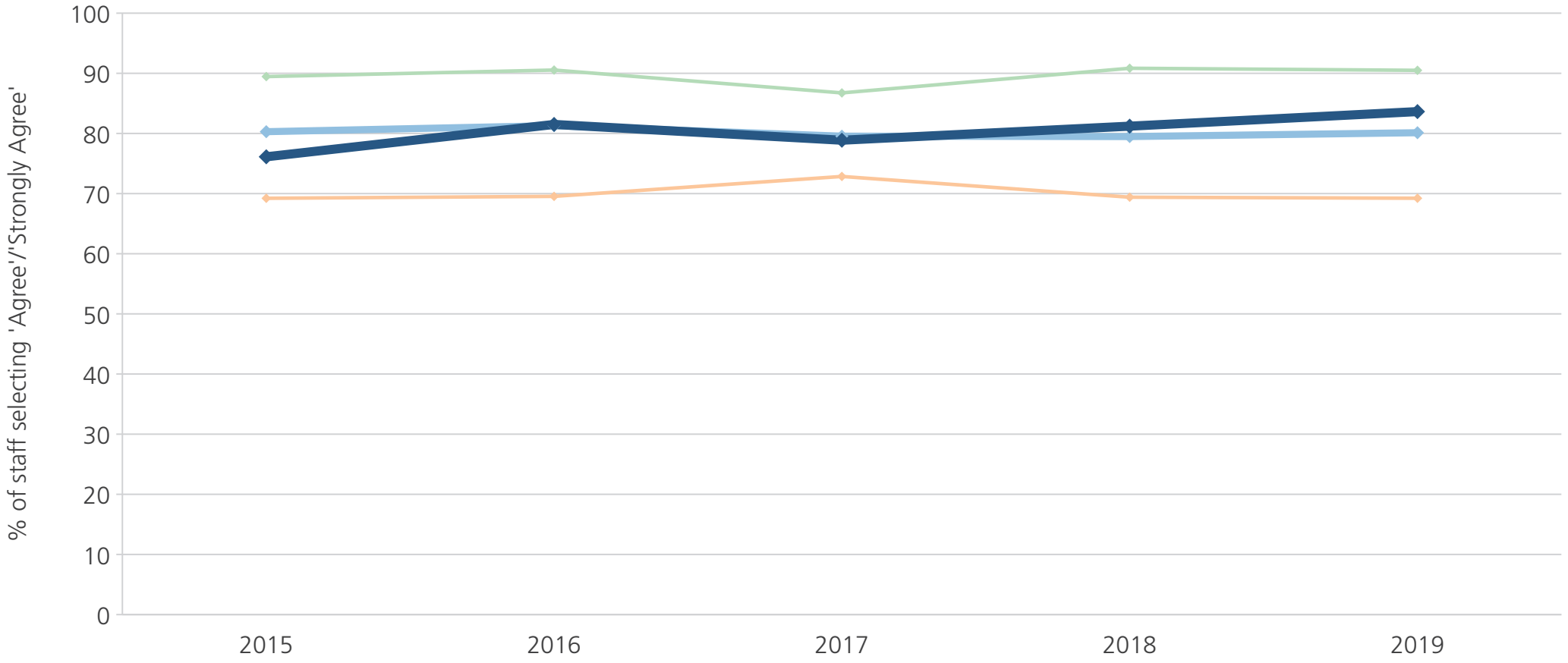
	2015	2016	2017	2018	2019
Best	83.9%	81.4%	80.8%	83.3%	81.9%
Your org	77.0%	78.0%	77.2%	78.1%	78.4%
Average	78.1%	78.0%	77.2%	76.7%	76.9%
Worst	73.5%	71.8%	72.2%	72.6%	71.5%
Responses	272	1,454	1,781	1,950	2,107



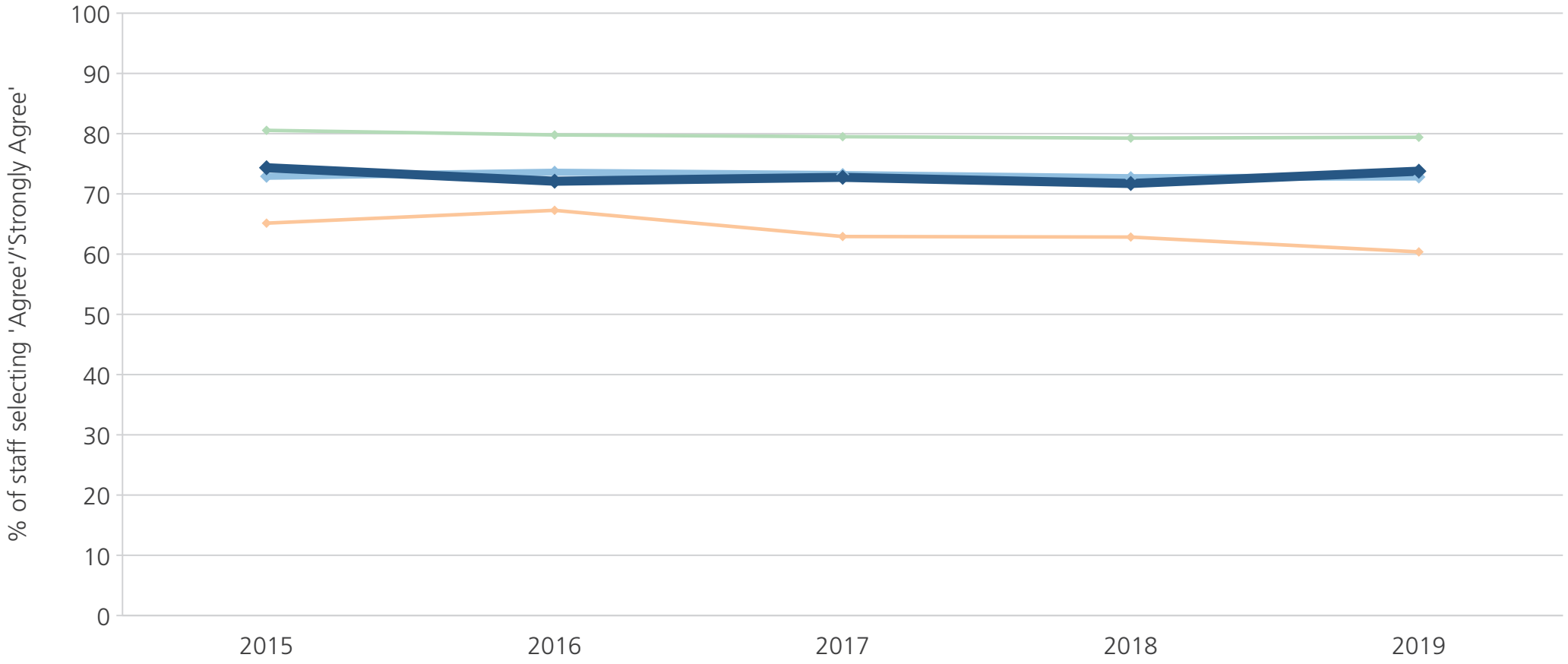
	2015	2016	2017	2018	2019
Best	93.6%	93.2%	92.9%	93.5%	92.6%
Your org	91.4%	88.6%	88.3%	89.9%	90.8%
Average	88.4%	88.6%	88.4%	88.2%	88.4%
Worst	83.4%	84.4%	83.6%	82.3%	79.5%
Responses	274	1,461	1,784	1,975	2,115



	2015	2016	2017	2018	2019
Best	96.7%	95.8%	95.4%	95.6%	96.6%
Your org	95.0%	93.0%	92.5%	93.2%	93.4%
Average	92.5%	92.2%	92.2%	91.7%	92.1%
Worst	85.3%	88.8%	88.3%	87.2%	86.4%
Responses	274	1,463	1,781	1,965	2,107

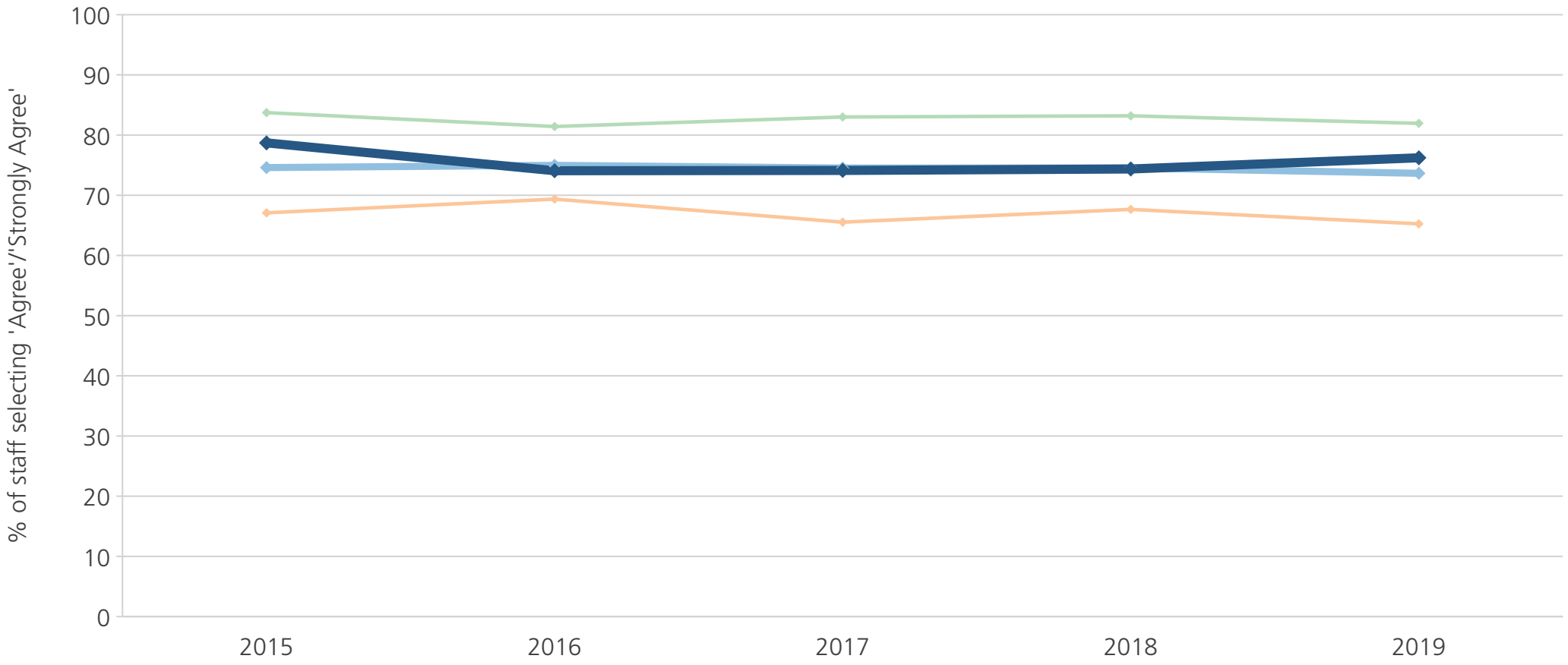


	2015	2016	2017	2018	2019
Best	89.5%	90.5%	86.7%	90.8%	90.5%
Your org	76.1%	81.5%	78.9%	81.2%	83.6%
Average	80.3%	81.3%	79.5%	79.5%	80.1%
Worst	69.2%	69.5%	72.9%	69.4%	69.2%
Responses	273	1,457	1,773	1,964	2,103



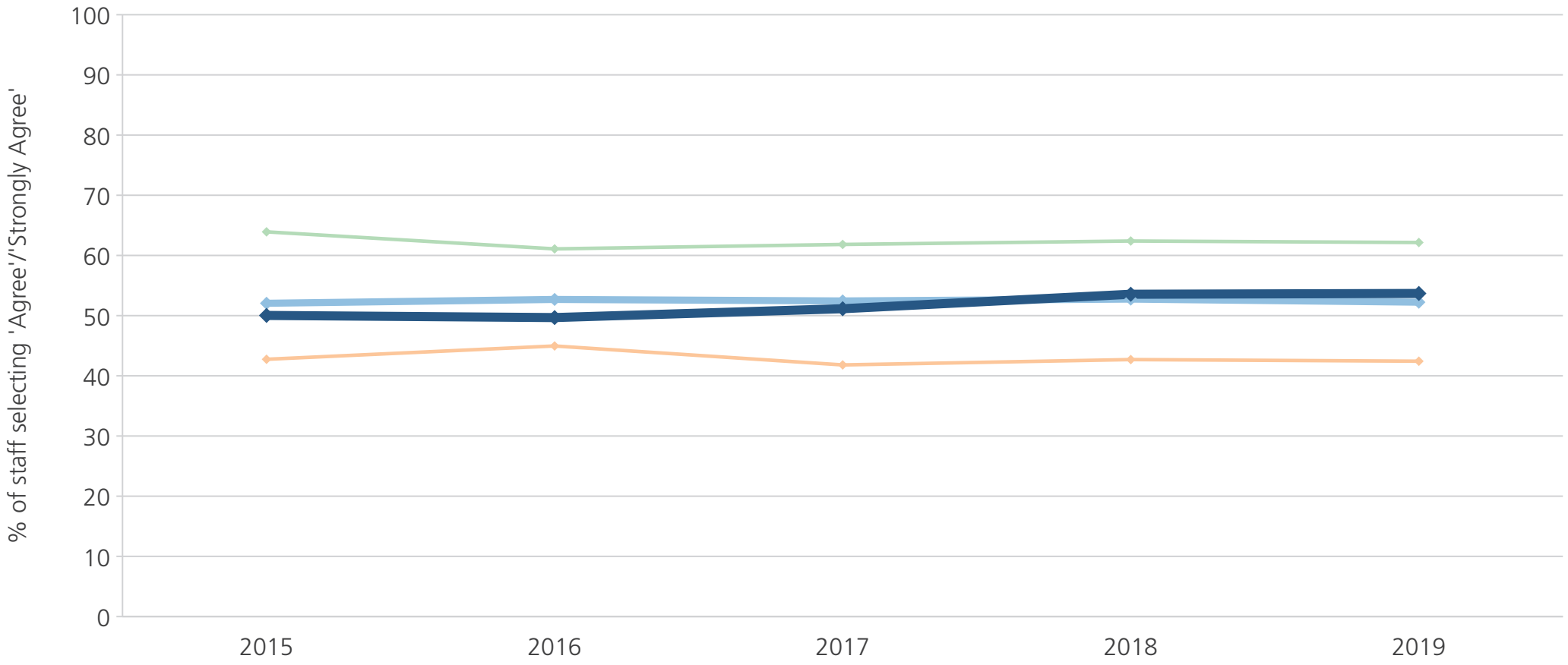
	2015	2016	2017	2018	2019
Best	80.5%	79.8%	79.5%	79.3%	79.4%
Your org	74.3%	72.1%	72.7%	71.7%	73.8%
Average	72.9%	73.6%	73.2%	72.7%	72.8%
Worst	65.1%	67.3%	62.9%	62.8%	60.4%
Responses	275	1,468	1,794	1,978	2,122

2019 NHS Staff Survey Results > Question results > Your job > Q4b **>** I am able to make suggestions to improve the work of my team / department

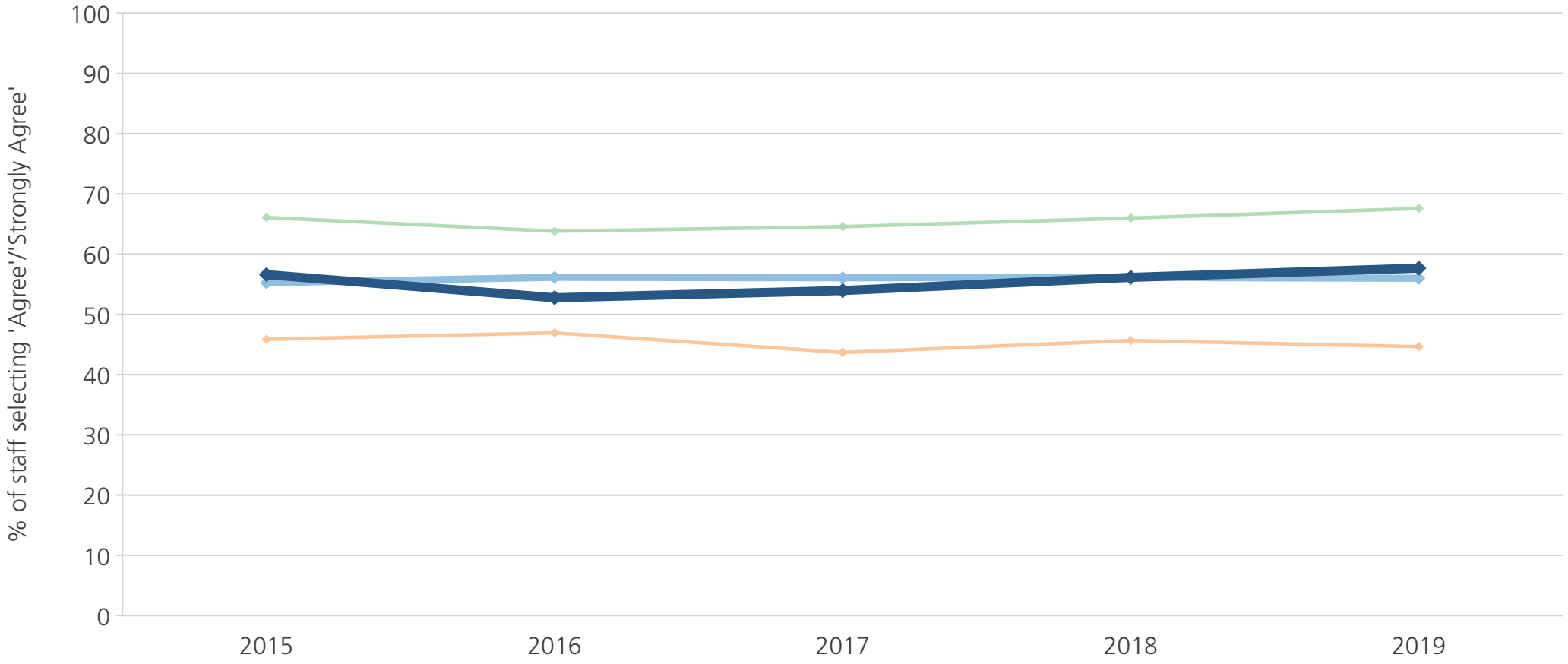


	2015	2016	2017	2018	2019
Best	83.7%	81.4%	83.0%	83.2%	81.9%
Your org	78.7%	74.1%	74.1%	74.4%	76.2%
Average	74.6%	75.0%	74.5%	74.5%	73.6%
Worst	67.1%	69.4%	65.5%	67.7%	65.2%
Responses	274	1,471	1,791	1,975	2,122

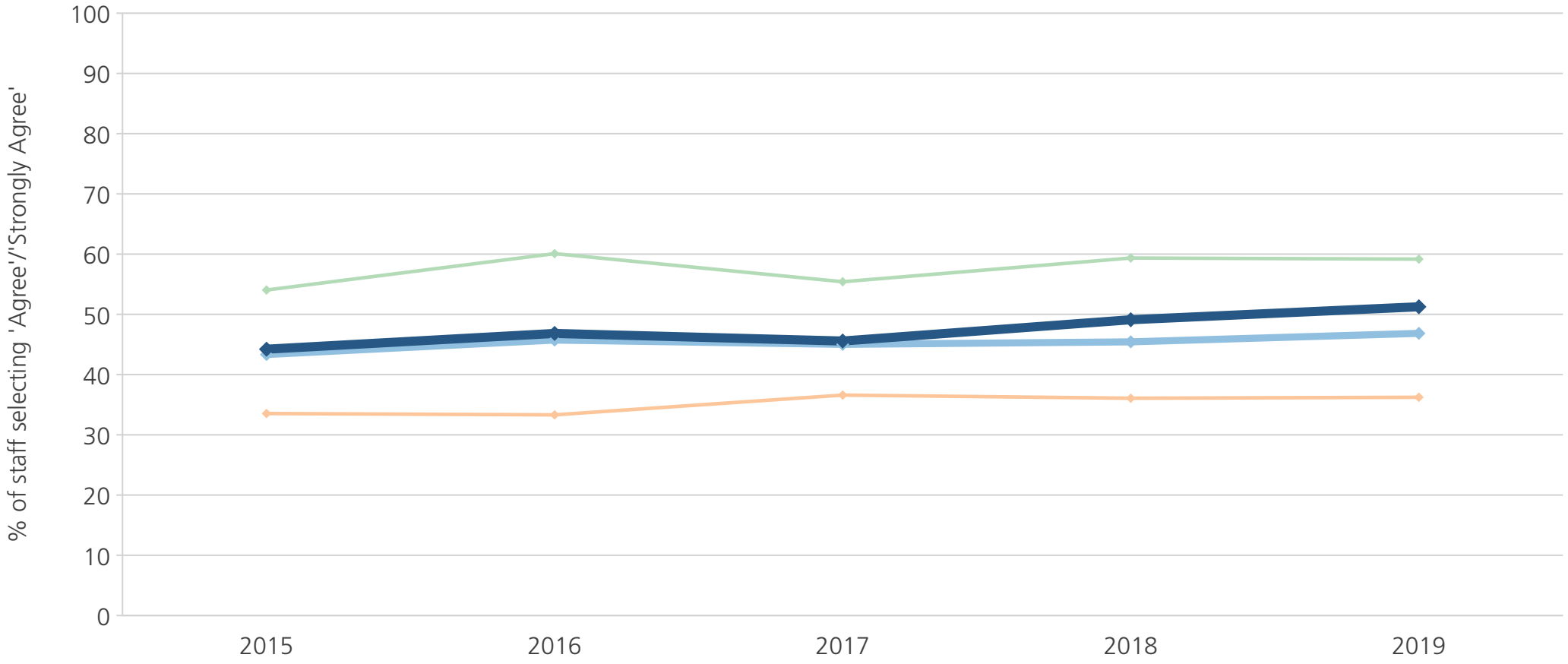
2019 NHS Staff Survey Results > Question results > Your job > Q4c > I am involved in deciding on changes introduced that affect my work area / team / department



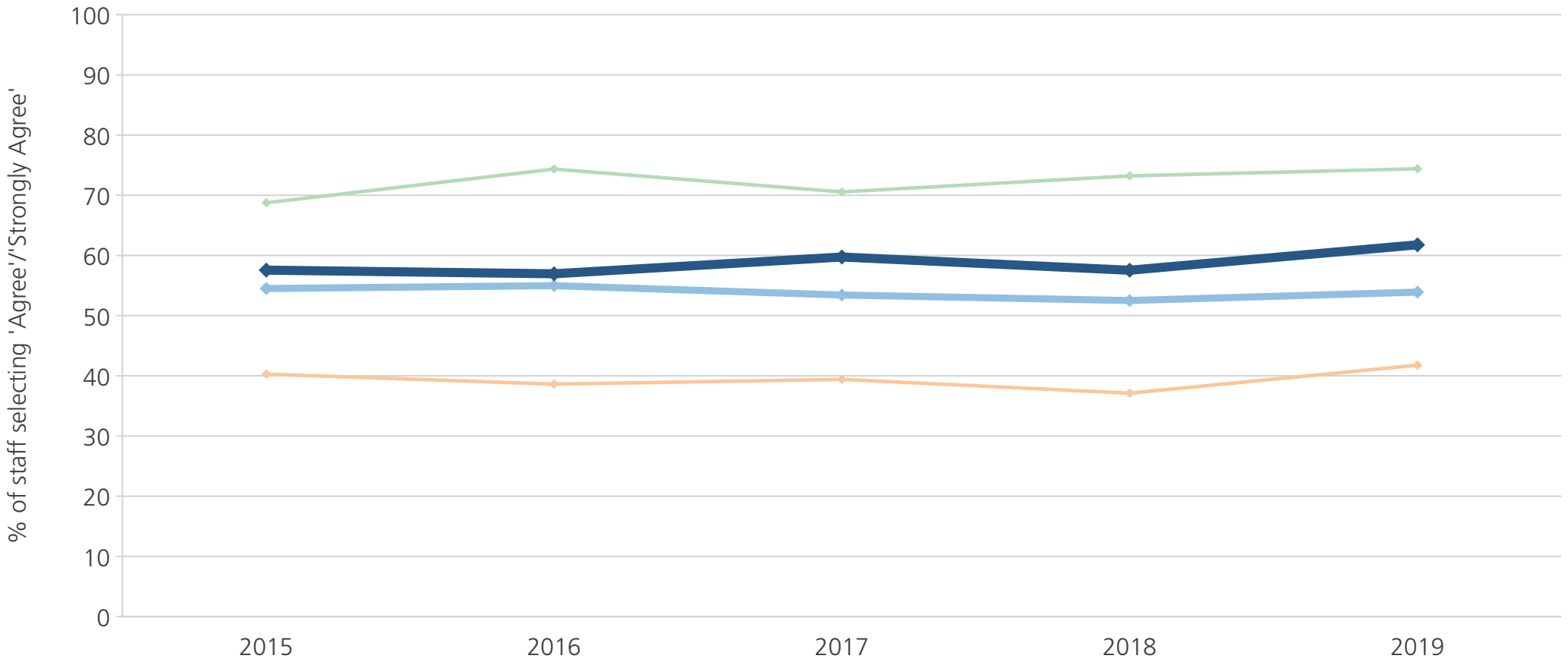
	2015	2016	2017	2018	2019
Best	63.9%	61.1%	61.8%	62.4%	62.1%
Your org	50.0%	49.7%	51.1%	53.6%	53.7%
Average	52.1%	52.7%	52.4%	52.7%	52.2%
Worst	42.7%	45.0%	41.8%	42.7%	42.4%
Responses	274	1,464	1,785	1,973	2,119



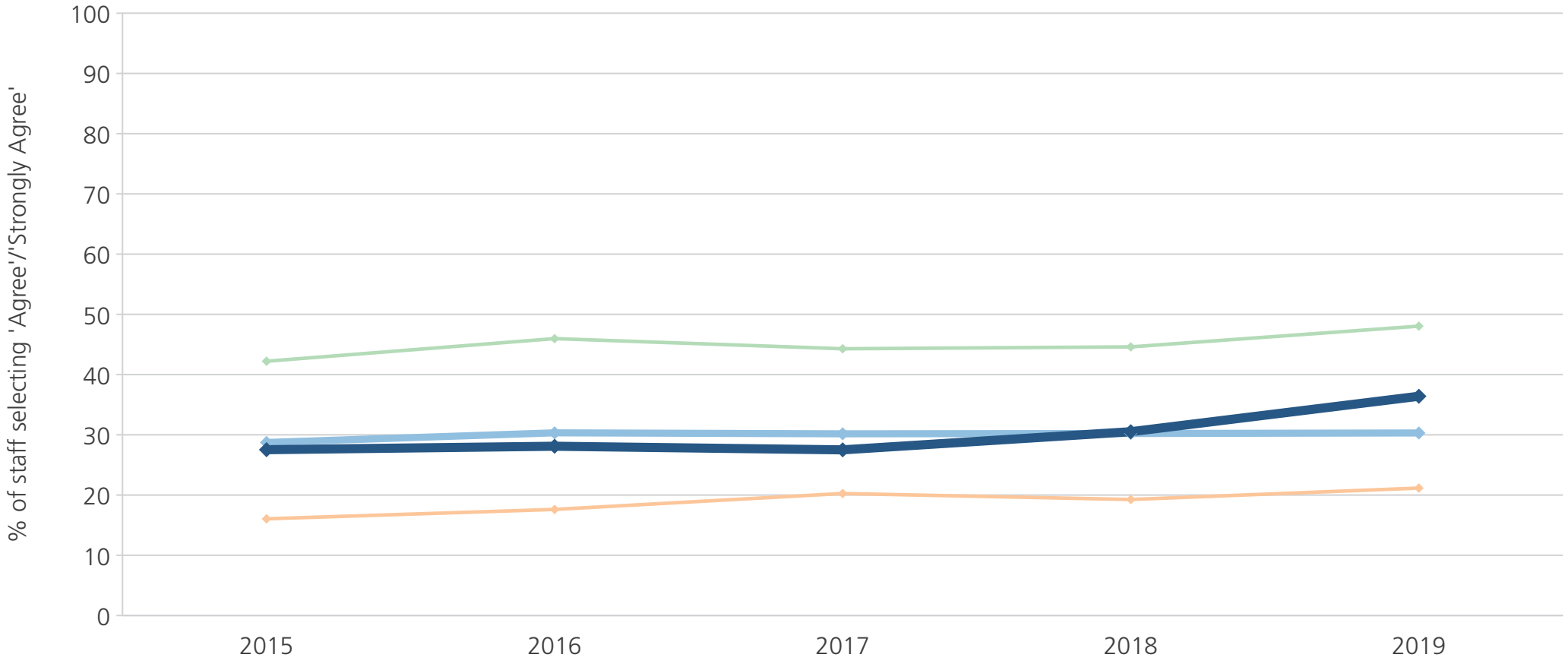
	2015	2016	2017	2018	2019
Best	66.1%	63.8%	64.6%	66.0%	67.6%
Your org	56.6%	52.8%	54.0%	56.1%	57.7%
Average	55.2%	56.1%	56.1%	56.1%	56.0%
Worst	45.9%	46.9%	43.7%	45.7%	44.6%
Responses	274	1,457	1,785	1,965	2,119



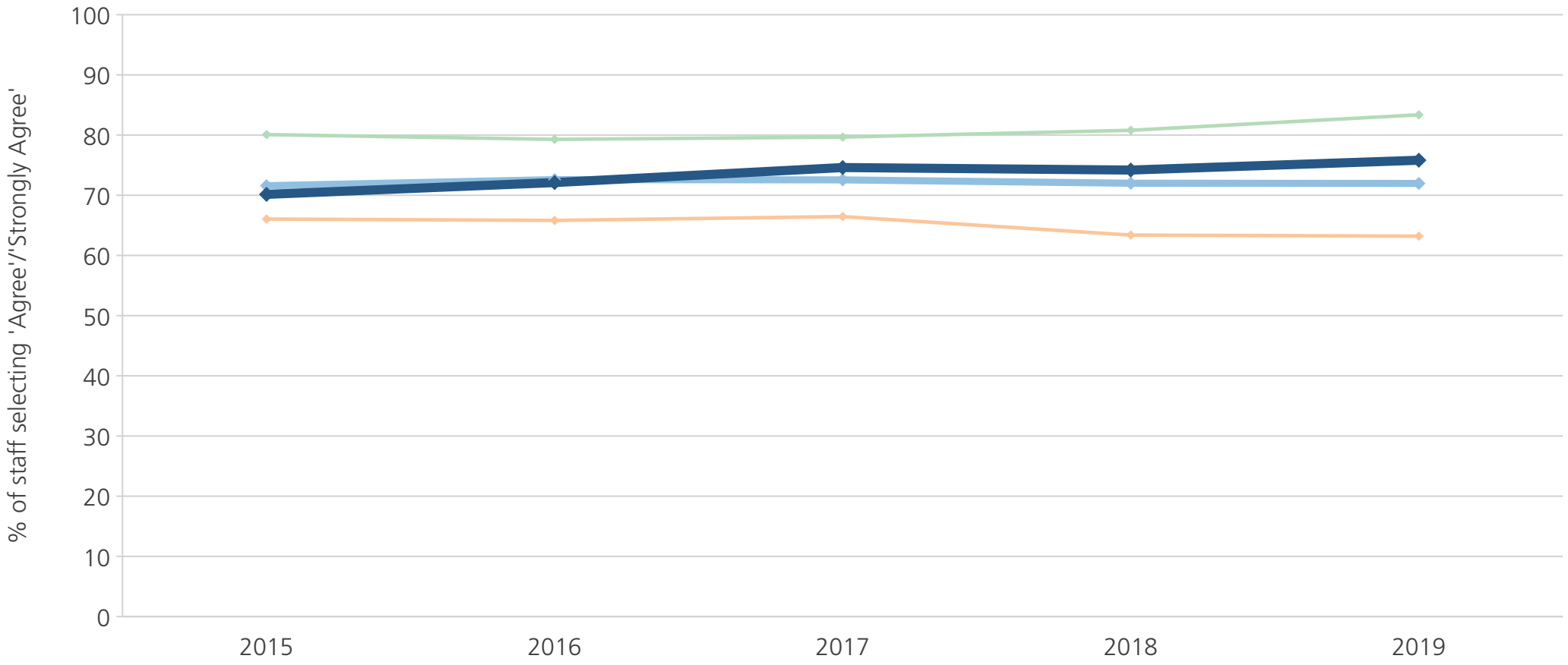
	2015	2016	2017	2018	2019
Best	54.0%	60.1%	55.4%	59.4%	59.2%
Your org	44.2%	46.8%	45.6%	49.1%	51.3%
Average	43.3%	45.7%	45.0%	45.4%	46.8%
Worst	33.5%	33.3%	36.6%	36.1%	36.2%
Responses	271	1,462	1,786	1,964	2,114



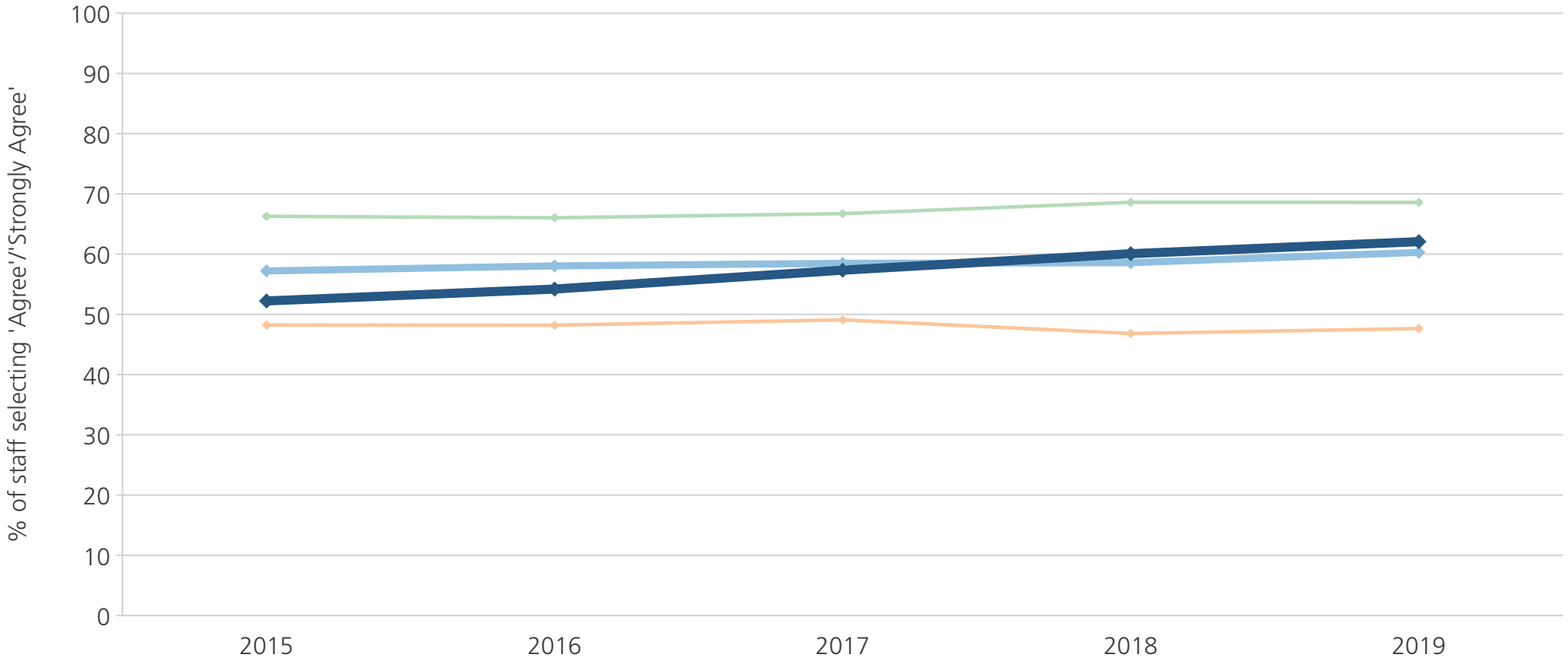
	2015	2016	2017	2018	2019
Best	68.7%	74.3%	70.6%	73.2%	74.4%
Your org	57.6%	57.0%	59.7%	57.5%	61.8%
Average	54.5%	55.0%	53.4%	52.5%	53.9%
Worst	40.3%	38.6%	39.4%	37.1%	41.8%
Responses	274	1,467	1,784	1,970	2,118



	2015	2016	2017	2018	2019
Best	42.2%	46.0%	44.3%	44.6%	48.0%
Your org	27.5%	28.1%	27.5%	30.5%	36.4%
Average	28.7%	30.3%	30.2%	30.2%	30.3%
Worst	16.1%	17.6%	20.3%	19.3%	21.2%
Responses	273	1,466	1,784	1,972	2,116



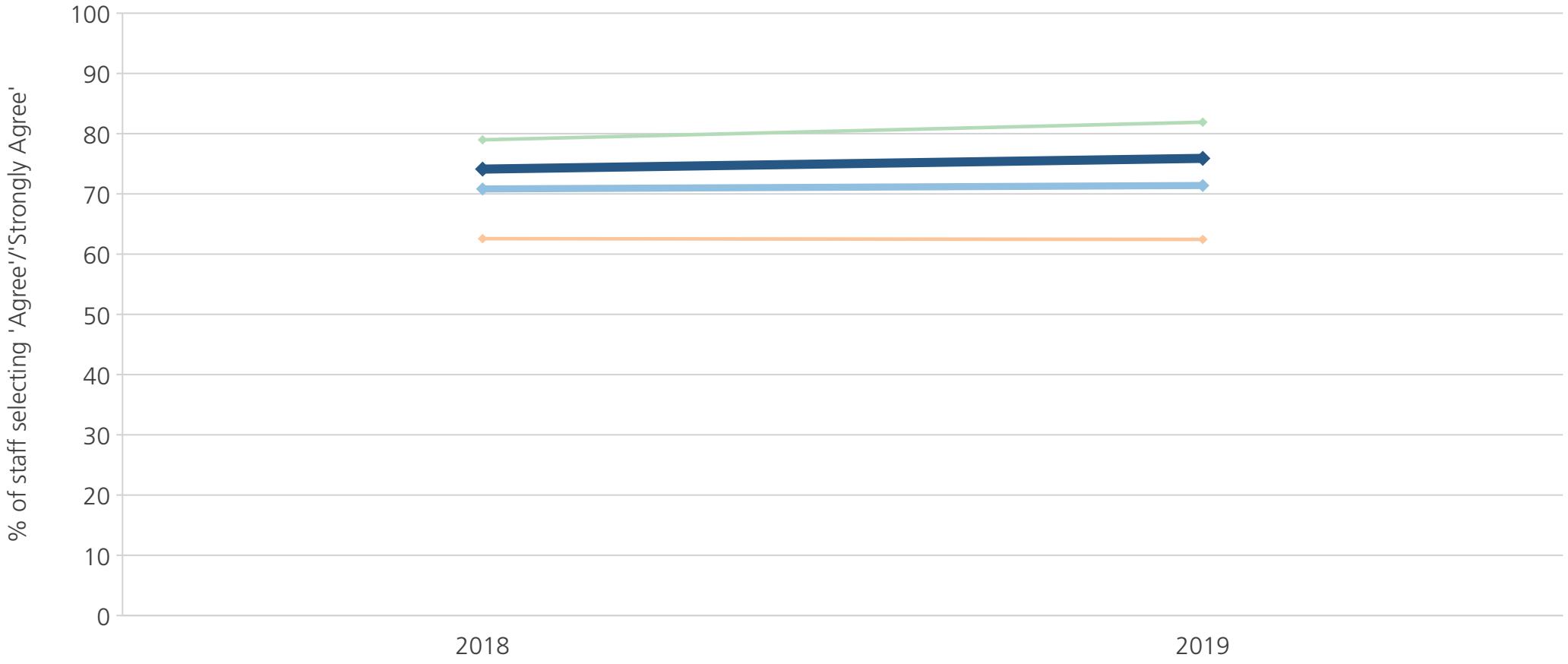
	2015	2016	2017	2018	2019
Best	80.1%	79.3%	79.7%	80.8%	83.4%
Your org	70.1%	72.1%	74.6%	74.2%	75.8%
Average	71.6%	72.6%	72.6%	72.0%	72.0%
Worst	66.0%	65.8%	66.5%	63.4%	63.2%
Responses	270	1,458	1,772	1,966	2,112



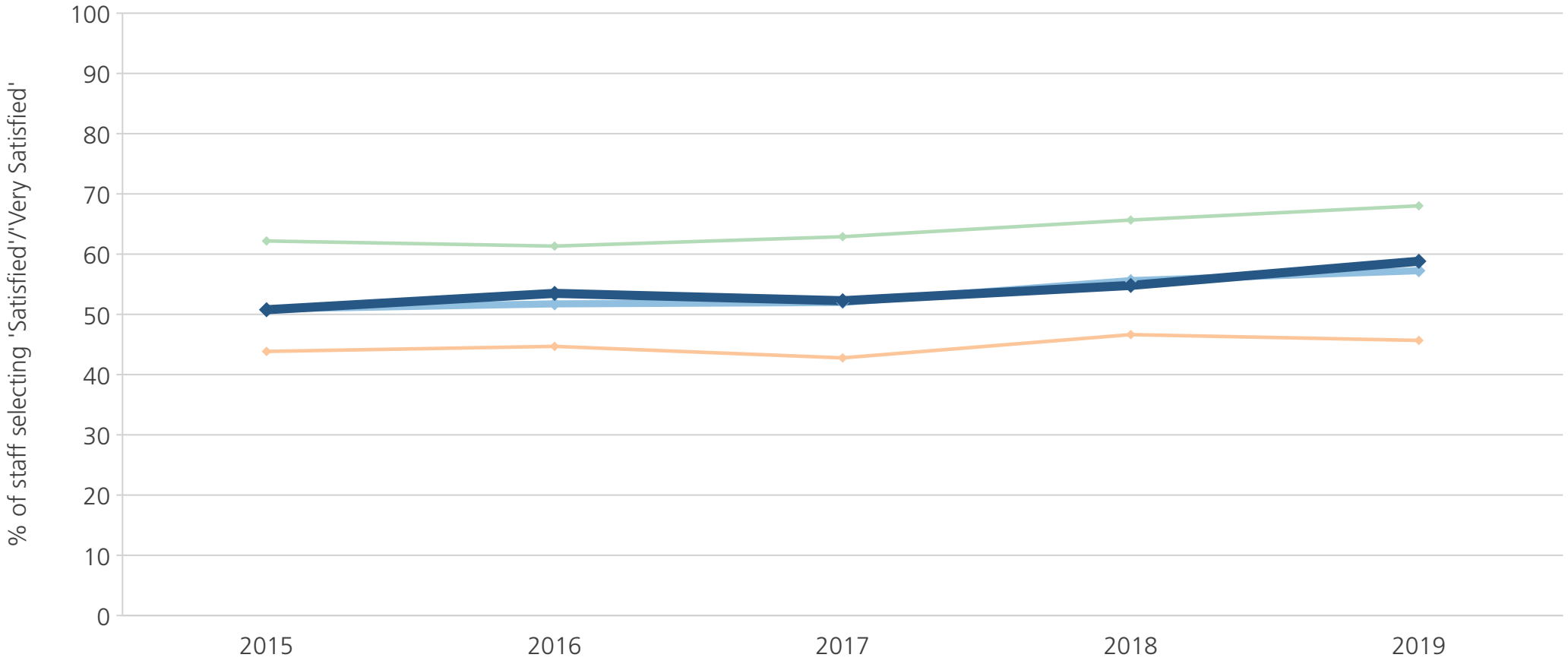
	2015	2016	2017	2018	2019
Best	66.3%	66.0%	66.7%	68.6%	68.6%
Your org	52.2%	54.2%	57.3%	60.1%	62.1%
Average	57.2%	58.0%	58.5%	58.6%	60.3%
Worst	48.2%	48.2%	49.1%	46.8%	47.6%
Responses	274	1,463	1,781	1,970	2,118

2019 NHS Staff Survey Results > Question results > Your job

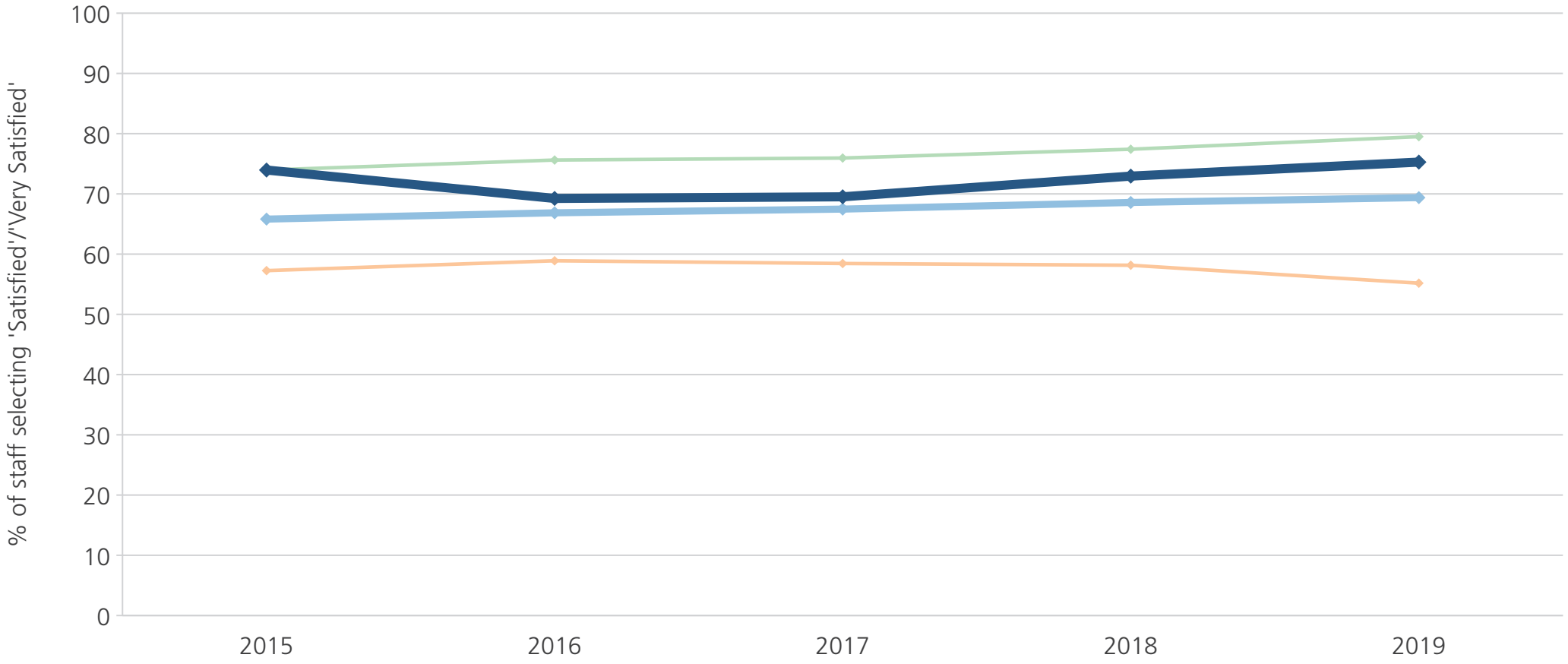
> Q4j > I receive the respect I deserve from my colleagues at work



	2018	2019
Best	79.0%	81.9%
Your org	74.1%	75.9%
Average	70.8%	71.4%
Worst	62.6%	62.4%
Responses	1,976	2,115

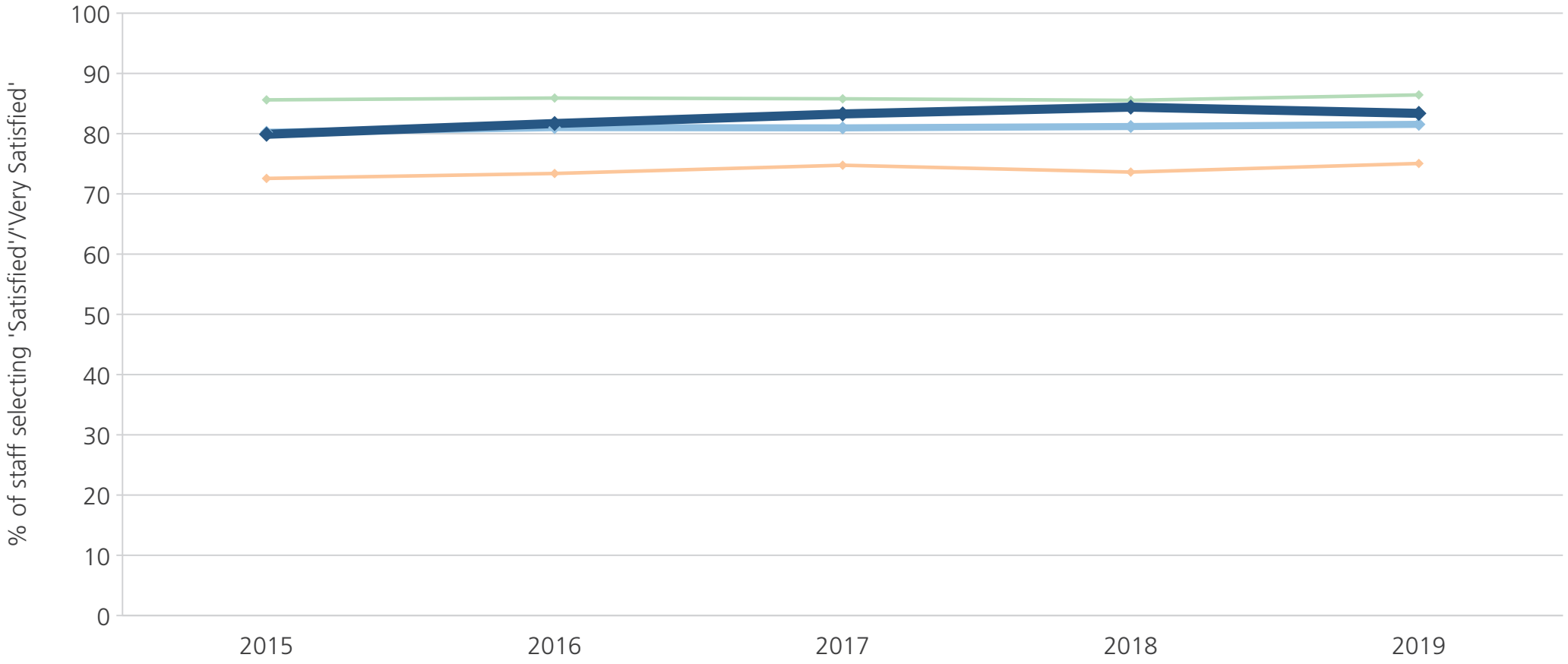


	2015	2016	2017	2018	2019
Best	62.2%	61.3%	62.9%	65.7%	68.0%
Your org	50.8%	53.5%	52.3%	54.8%	58.8%
Average	50.9%	51.7%	52.0%	55.6%	57.2%
Worst	43.8%	44.7%	42.8%	46.6%	45.7%
Responses	274	1,464	1,790	1,976	2,123

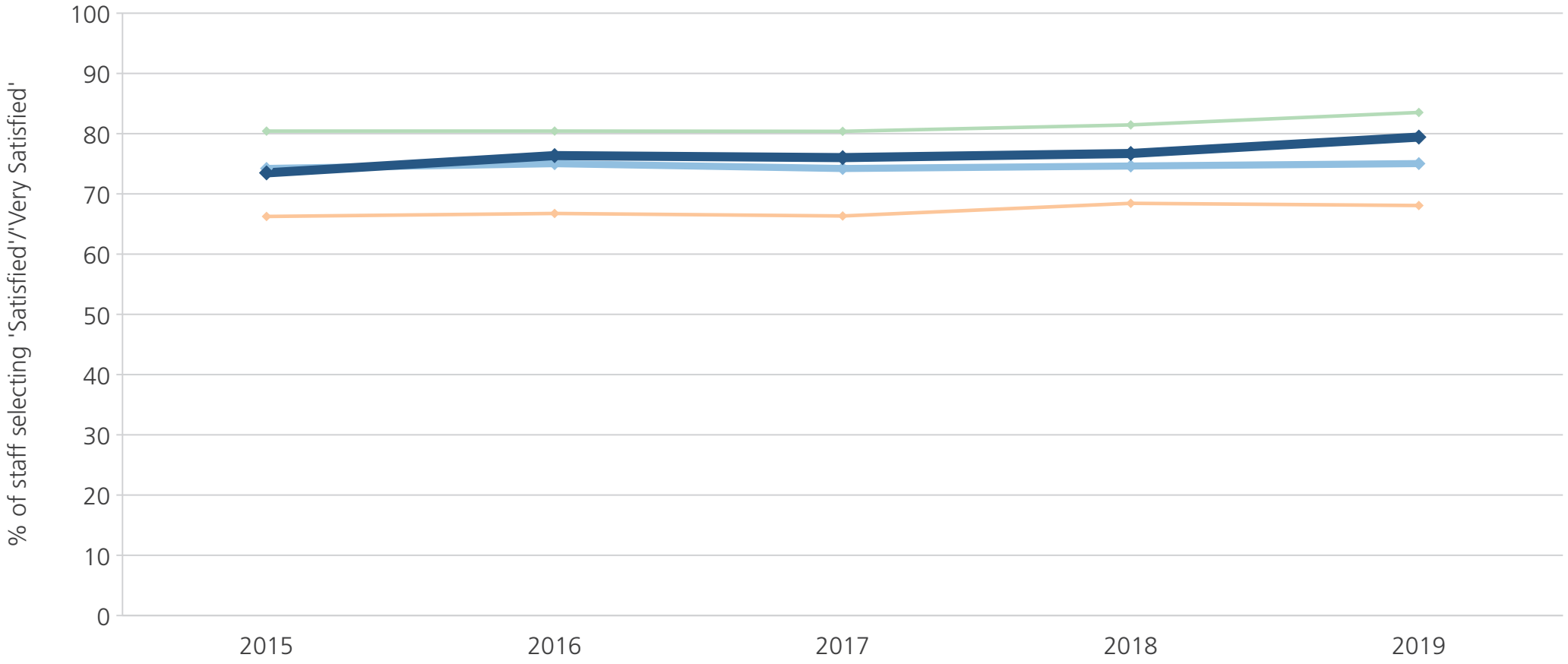


	2015	2016	2017	2018	2019
Best	74.0%	75.6%	76.0%	77.4%	79.5%
Your org	74.0%	69.2%	69.5%	73.0%	75.3%
Average	65.8%	66.9%	67.5%	68.6%	69.4%
Worst	57.3%	58.9%	58.4%	58.2%	55.2%
Responses	274	1,463	1,788	1,975	2,120

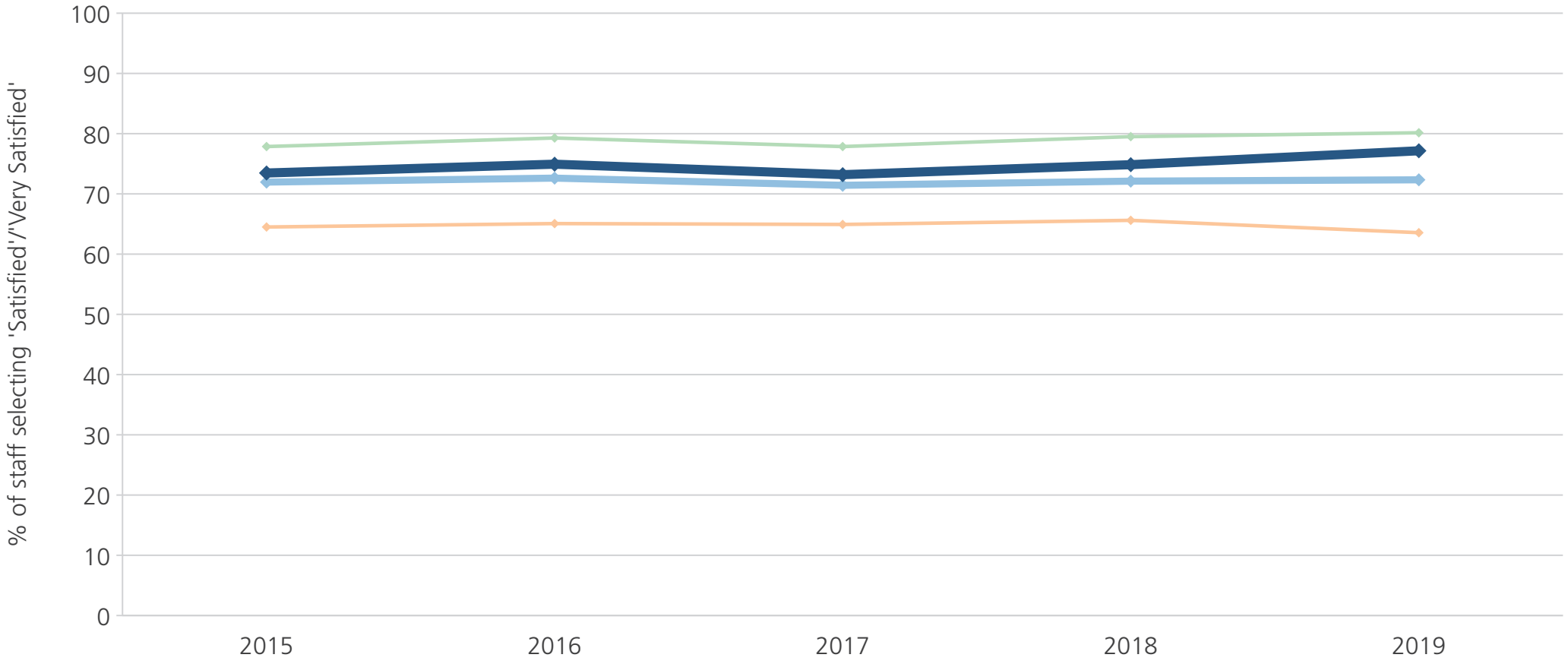
2019 NHS Staff Survey Results > Question results > Your job > Q5c > The support I get from my work colleagues



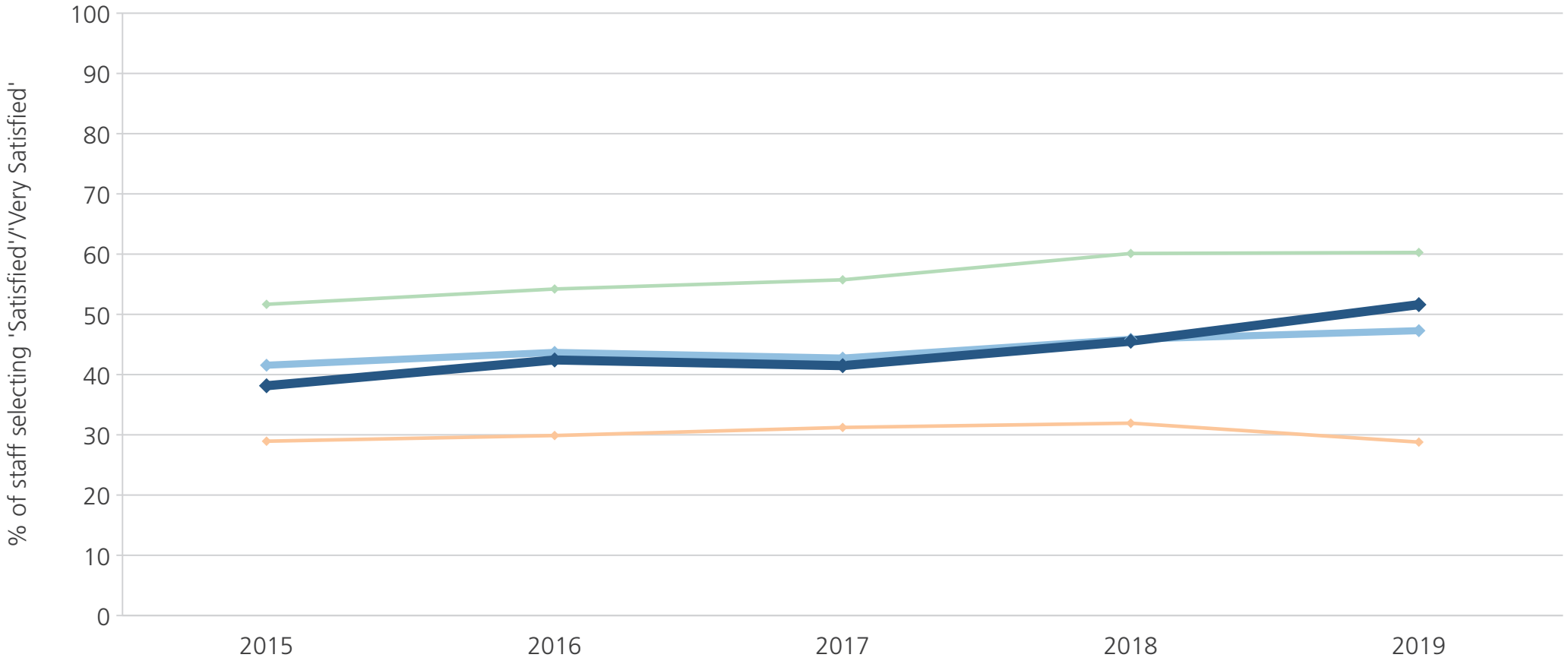
	2015	2016	2017	2018	2019
Best	85.6%	85.9%	85.8%	85.5%	86.4%
Your org	79.9%	81.7%	83.3%	84.4%	83.4%
Average	80.2%	81.0%	81.0%	81.2%	81.5%
Worst	72.6%	73.4%	74.8%	73.6%	75.0%
Responses	273	1,464	1,792	1,972	2,119



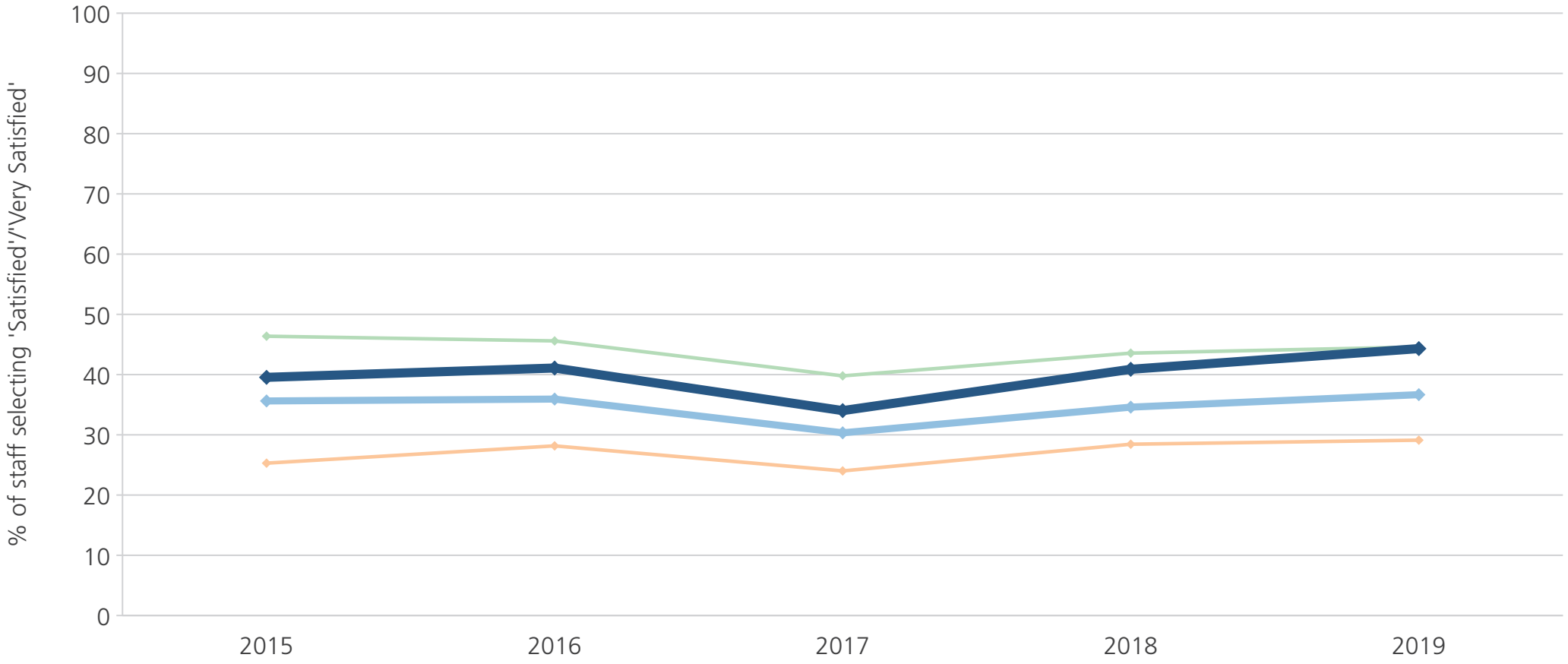
	2015	2016	2017	2018	2019
Best	80.4%	80.4%	80.4%	81.5%	83.5%
Your org	73.5%	76.4%	76.0%	76.7%	79.4%
Average	74.2%	75.0%	74.2%	74.6%	75.0%
Worst	66.3%	66.8%	66.3%	68.4%	68.1%
Responses	272	1,464	1,791	1,976	2,120



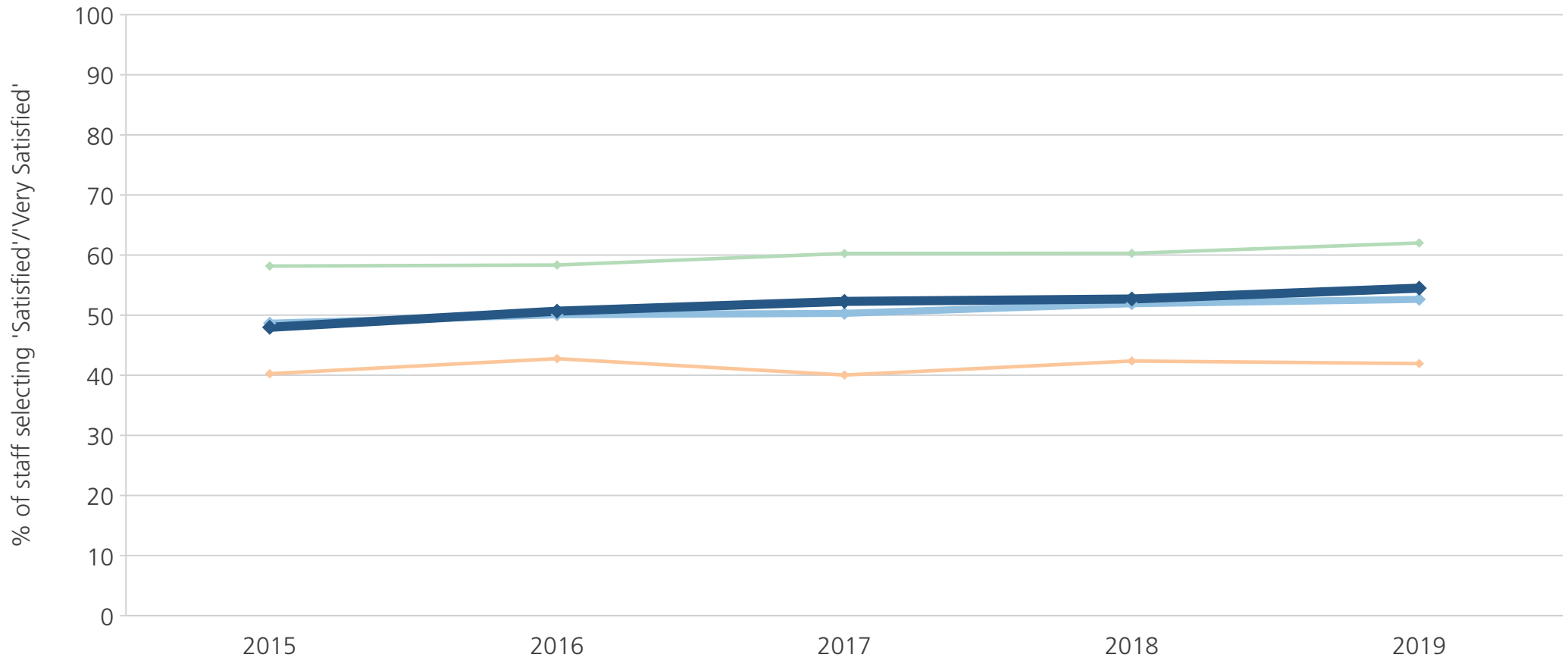
	2015	2016	2017	2018	2019
Best	77.9%	79.3%	77.9%	79.5%	80.1%
Your org	73.5%	74.9%	73.2%	74.8%	77.2%
Average	72.0%	72.6%	71.4%	72.1%	72.3%
Worst	64.5%	65.1%	64.9%	65.6%	63.6%
Responses	275	1,462	1,784	1,963	2,114



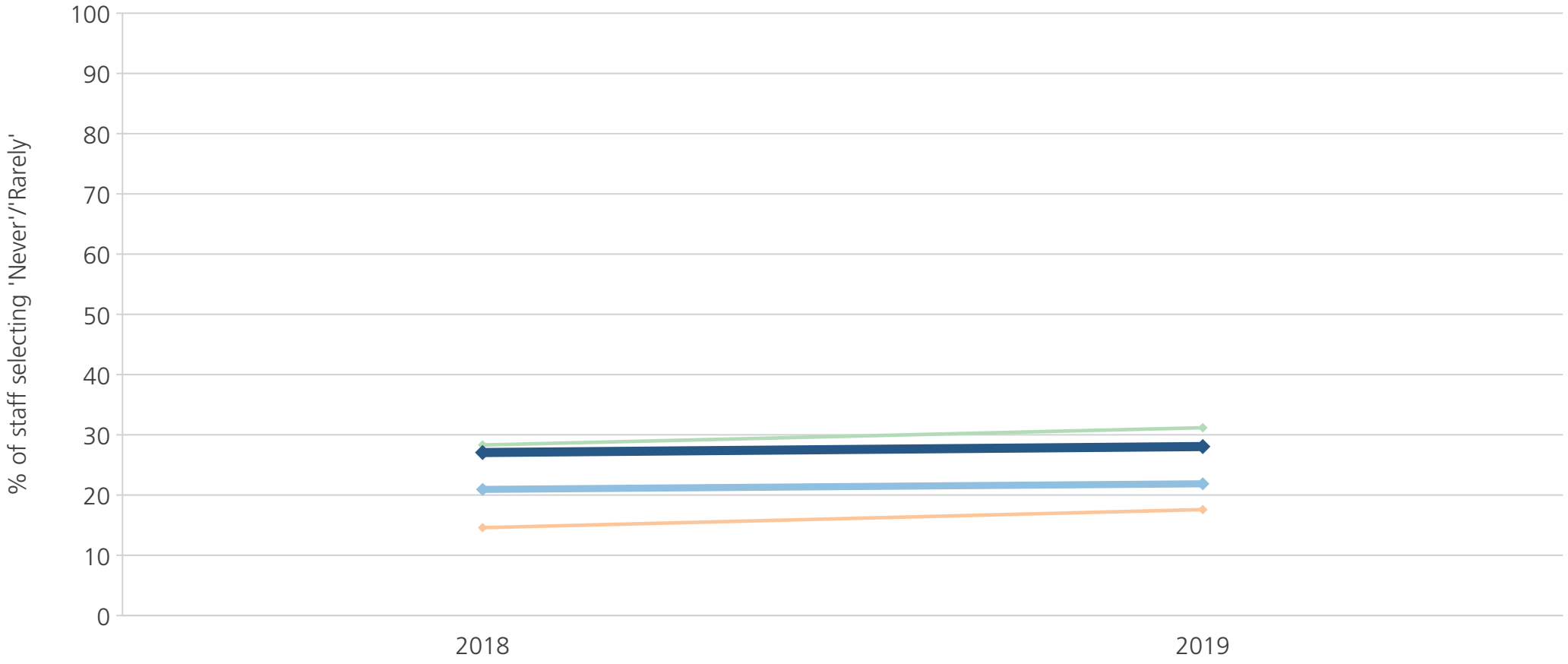
	2015	2016	2017	2018	2019
Best	51.7%	54.2%	55.7%	60.1%	60.3%
Your org	38.1%	42.4%	41.5%	45.5%	51.6%
Average	41.6%	43.7%	42.7%	45.9%	47.3%
Worst	28.9%	29.9%	31.2%	31.9%	28.8%
Responses	272	1,455	1,781	1,969	2,115



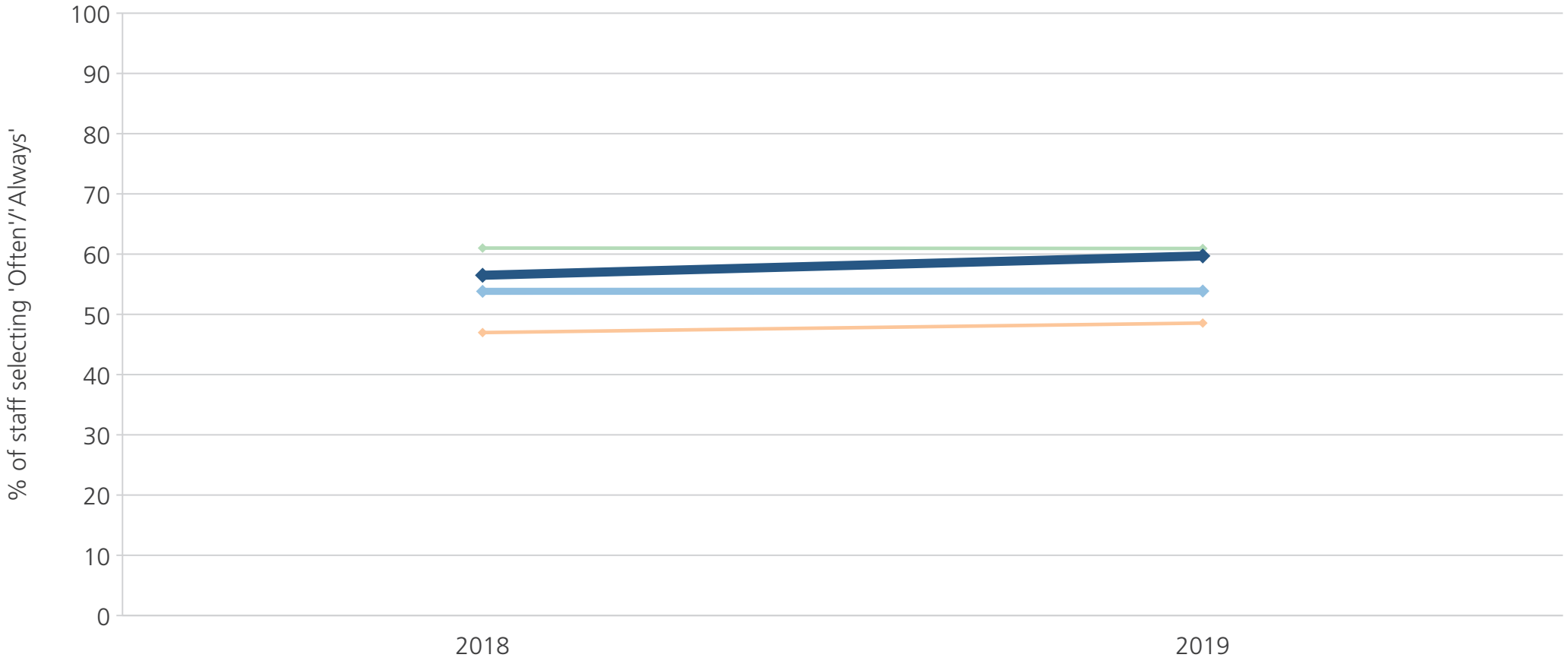
	2015	2016	2017	2018	2019
Best	46.4%	45.6%	39.8%	43.6%	44.6%
Your org	39.5%	41.1%	34.0%	40.9%	44.3%
Average	35.6%	35.9%	30.3%	34.6%	36.7%
Worst	25.3%	28.2%	24.0%	28.4%	29.1%
Responses	272	1,458	1,785	1,971	2,114



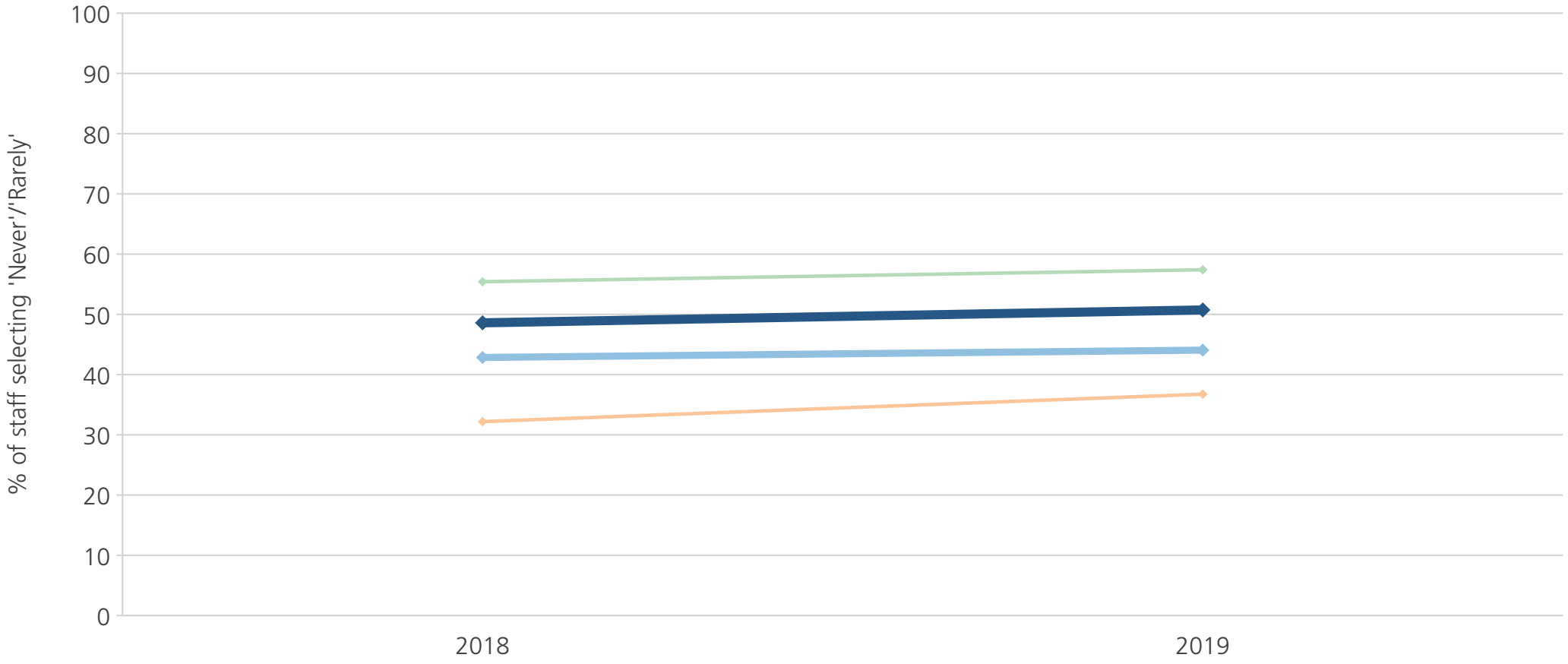
	2015	2016	2017	2018	2019
Best	58.2%	58.3%	60.3%	60.3%	62.0%
Your org	48.0%	50.7%	52.3%	52.7%	54.5%
Average	48.7%	50.1%	50.3%	51.9%	52.6%
Worst	40.3%	42.8%	40.0%	42.4%	41.9%
Responses	274	1,457	1,785	1,978	2,110



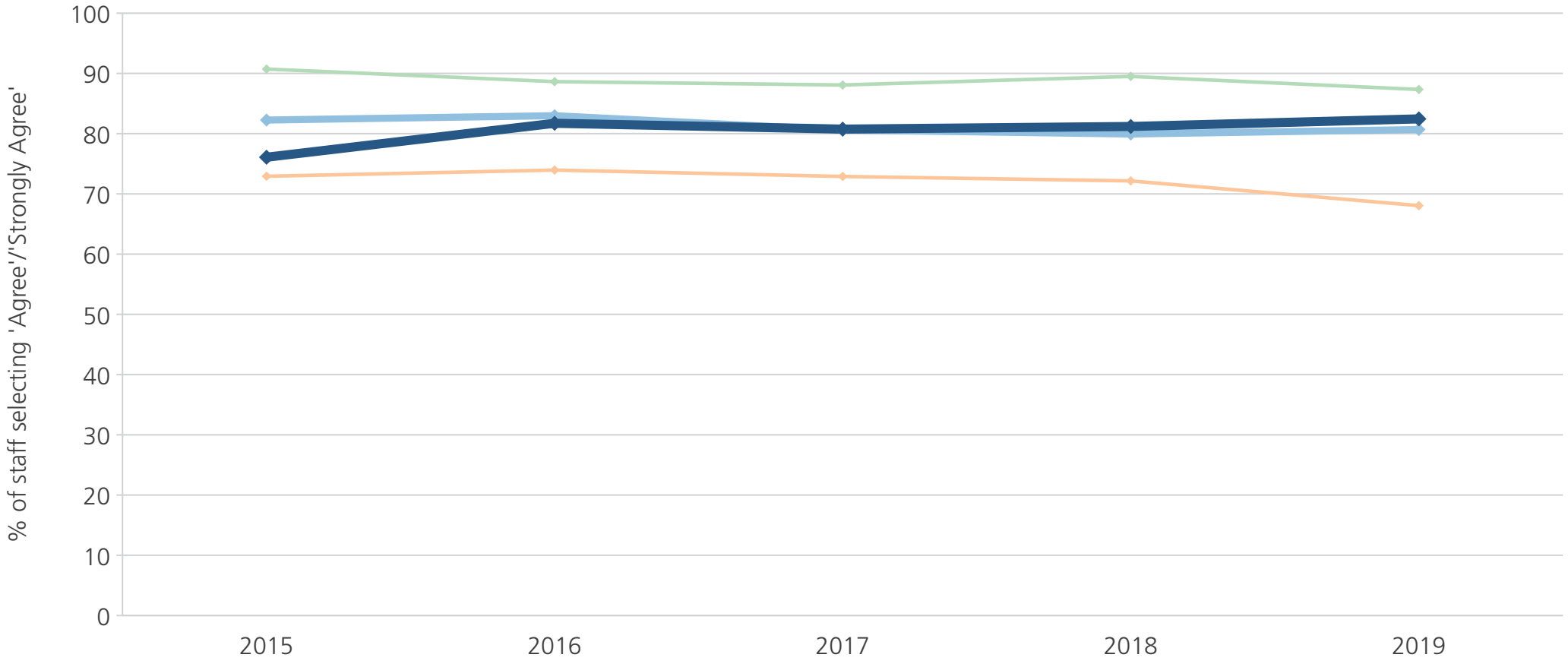
	2018	2019
Best	28.3%	31.2%
Your org	27.1%	28.1%
Average	20.9%	21.9%
Worst	14.6%	17.6%
Responses	1,965	2,112



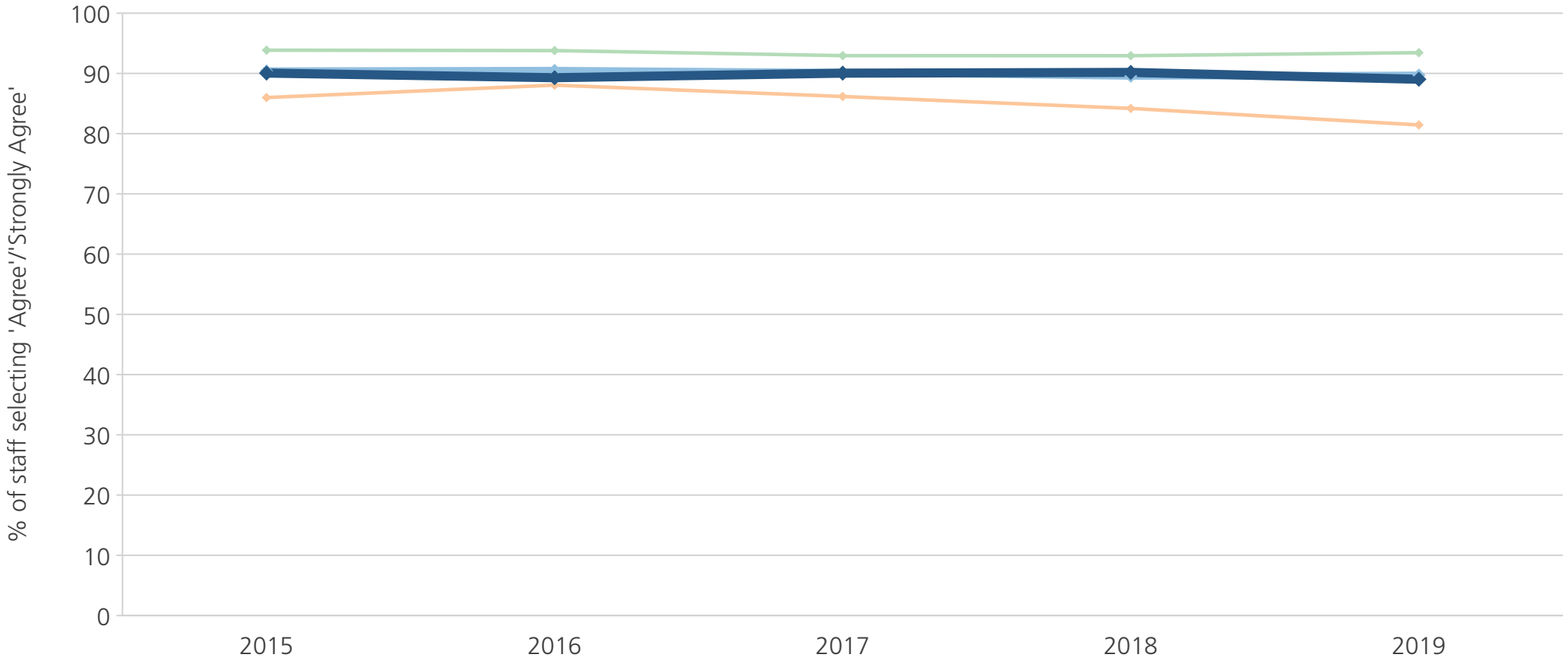
	2018	2019
Best	61.0%	60.9%
Your org	56.5%	59.7%
Average	53.8%	53.9%
Worst	47.0%	48.6%
Responses	1,957	2,114



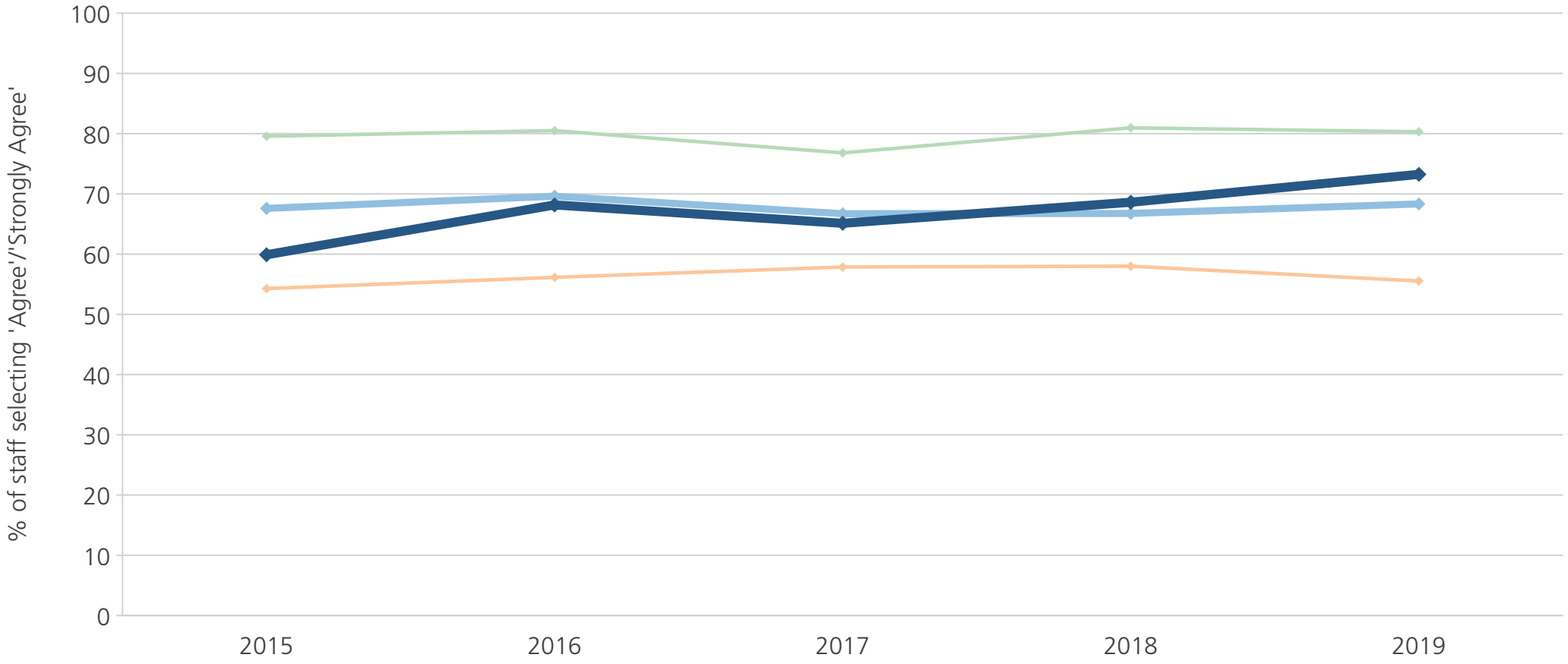
	2018	2019
Best	55.4%	57.4%
Your org	48.6%	50.7%
Average	42.8%	44.1%
Worst	32.2%	36.8%
Responses	1,959	2,109



	2015	2016	2017	2018	2019
Best	90.7%	88.6%	88.1%	89.5%	87.3%
Your org	76.1%	81.7%	80.8%	81.2%	82.5%
Average	82.3%	83.0%	80.6%	79.9%	80.7%
Worst	72.9%	74.0%	72.9%	72.2%	68.0%
Responses	217	1,175	1,424	1,605	1,741



	2015	2016	2017	2018	2019
Best	93.9%	93.8%	93.0%	92.9%	93.4%
Your org	90.1%	89.3%	90.0%	90.2%	89.0%
Average	90.4%	90.5%	90.2%	89.5%	89.7%
Worst	86.0%	88.1%	86.2%	84.2%	81.4%
Responses	236	1,284	1,592	1,787	1,929



	2015	2016	2017	2018	2019
Best	79.6%	80.5%	76.8%	81.0%	80.3%
Your org	59.9%	68.2%	65.1%	68.6%	73.2%
Average	67.6%	69.6%	66.7%	66.8%	68.3%
Worst	54.3%	56.1%	57.9%	58.0%	55.5%
Responses	207	1,156	1,416	1,580	1,722

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Survey Coordination Centre

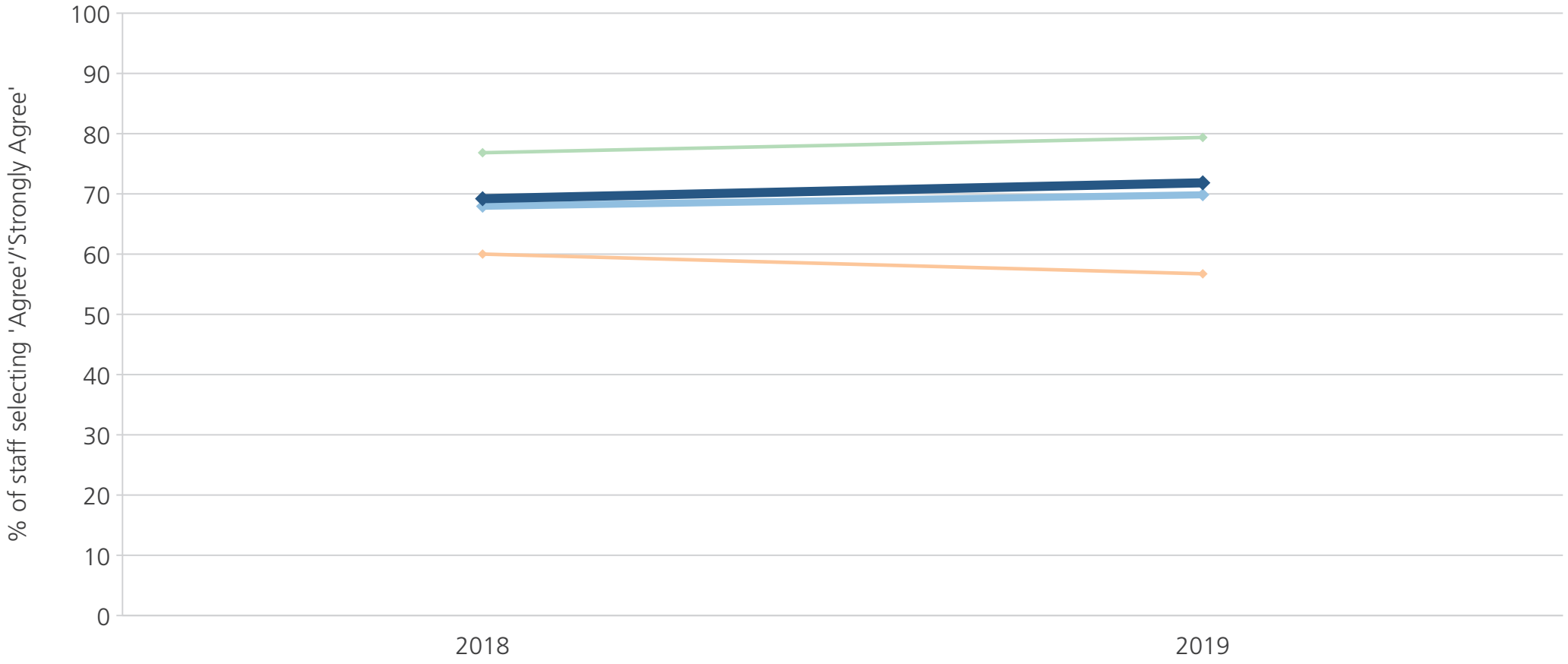
NHS England

Question results – Your managers

Warrington and Halton Hospitals NHS Foundation Trust

2019 NHS Staff Survey Results

2019 NHS Staff Survey Results > Question results > Your managers > Q8a > My immediate manager encourages me at work

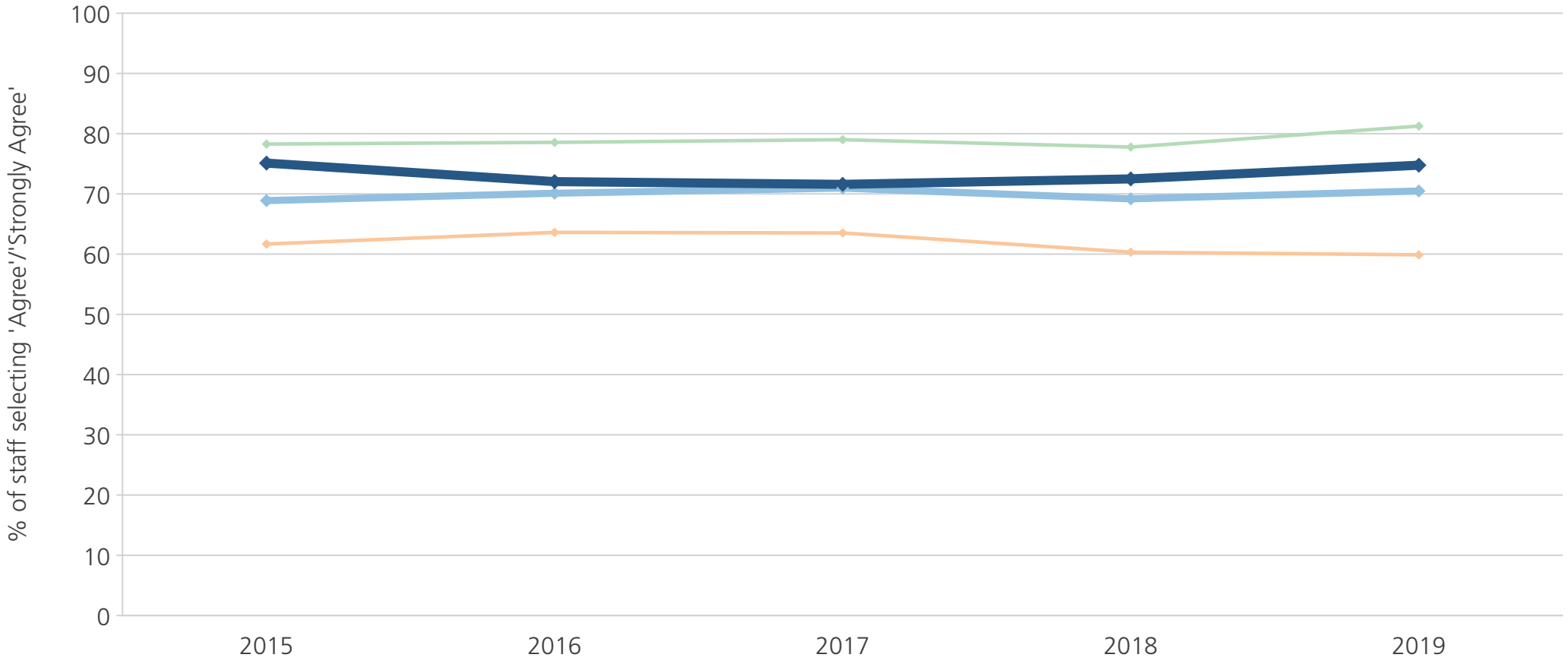


	2018	2019
Best	76.8%	79.4%
Your org	69.2%	71.8%
Average	67.9%	69.9%
Worst	60.0%	56.7%
Responses	1,975	2,121

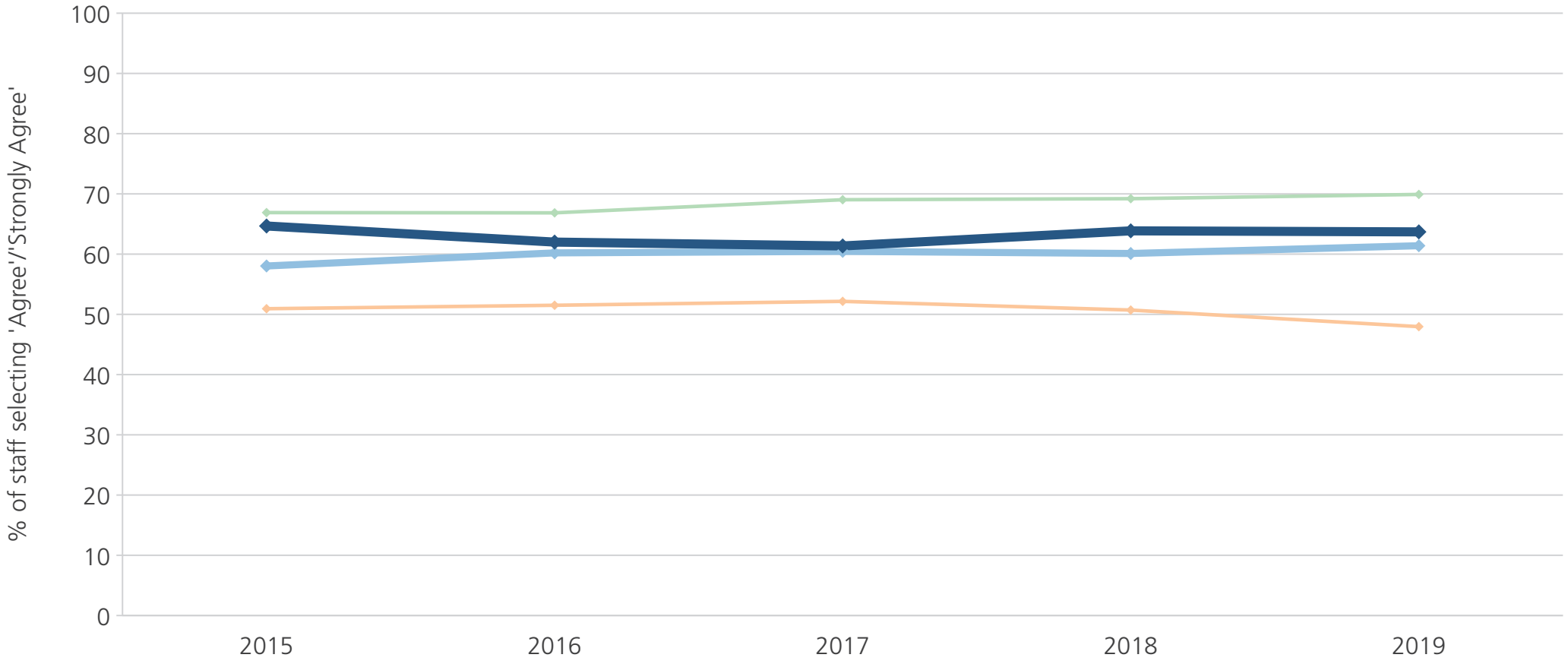
Survey Coordination Centre

2019 NHS Staff Survey Results > Question results > Your managers > Q8b **>**
My immediate manager can be counted on to help me with a difficult task at work

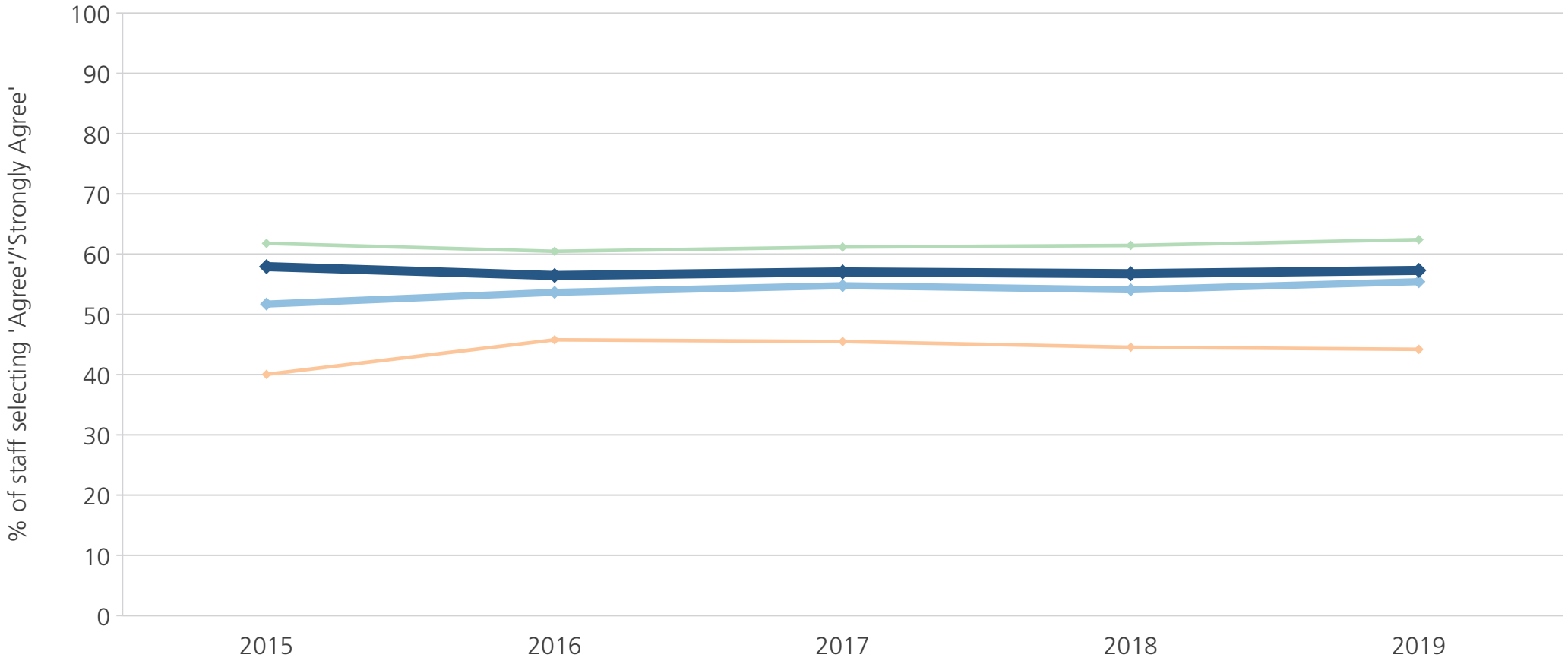
NHS England



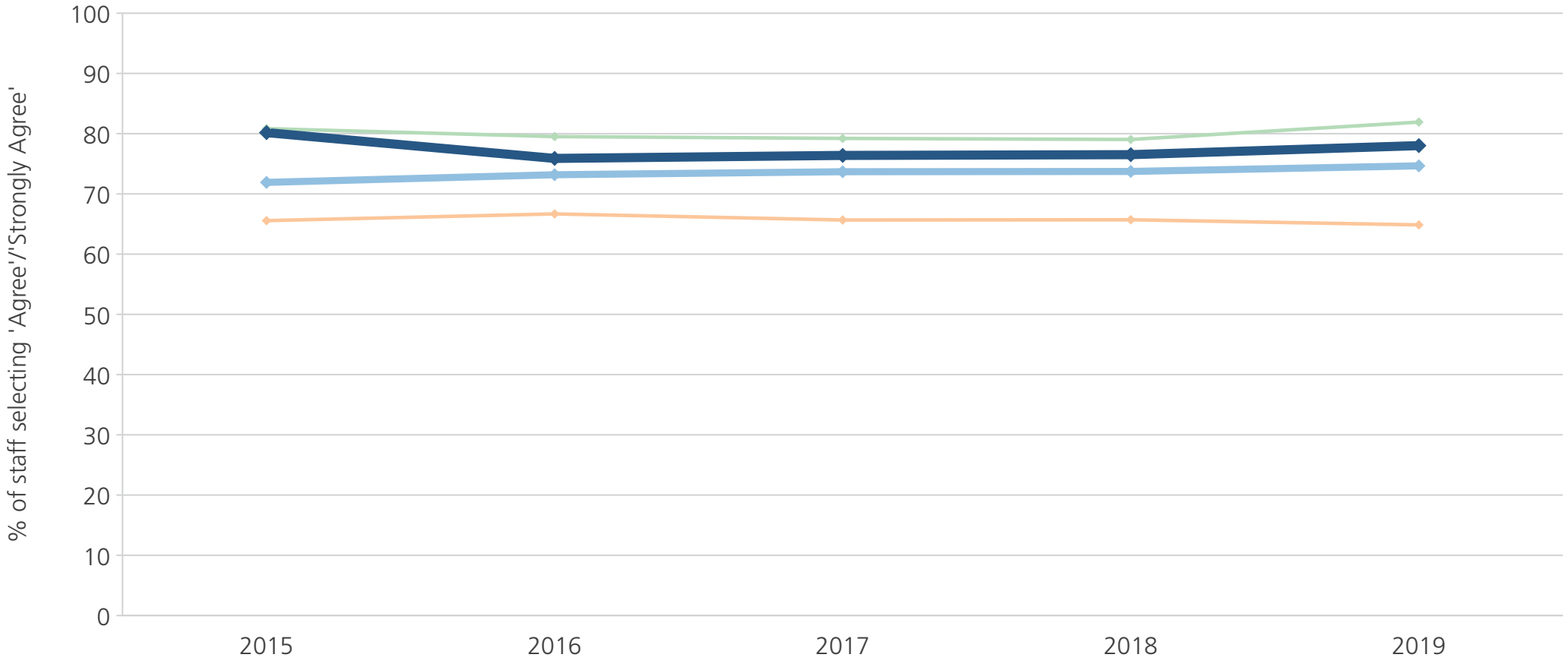
	2015	2016	2017	2018	2019
Best	78.3%	78.6%	79.0%	77.8%	81.3%
Your org	75.1%	72.0%	71.6%	72.5%	74.8%
Average	68.9%	70.1%	71.0%	69.2%	70.5%
Worst	61.7%	63.6%	63.5%	60.3%	59.9%
Responses	272	1,461	1,784	1,972	2,118



	2015	2016	2017	2018	2019
Best	66.9%	66.9%	69.0%	69.2%	69.9%
Your org	64.7%	62.0%	61.4%	63.9%	63.7%
Average	58.0%	60.2%	60.5%	60.1%	61.4%
Worst	50.9%	51.5%	52.2%	50.7%	48.0%
Responses	273	1,457	1,785	1,971	2,116

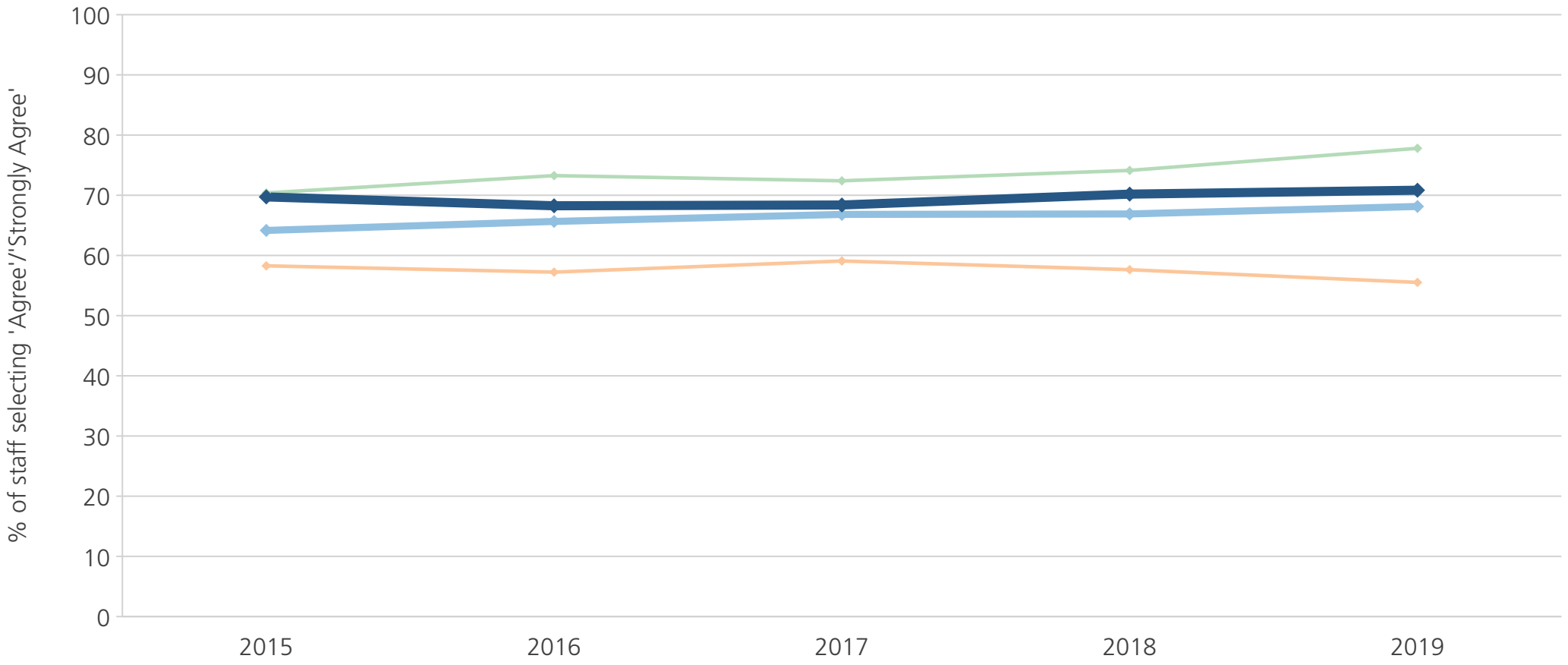


	2015	2016	2017	2018	2019
Best	61.8%	60.5%	61.2%	61.4%	62.4%
Your org	57.9%	56.4%	57.0%	56.8%	57.3%
Average	51.7%	53.7%	54.8%	54.1%	55.4%
Worst	40.0%	45.8%	45.5%	44.5%	44.2%
Responses	273	1,456	1,790	1,969	2,113

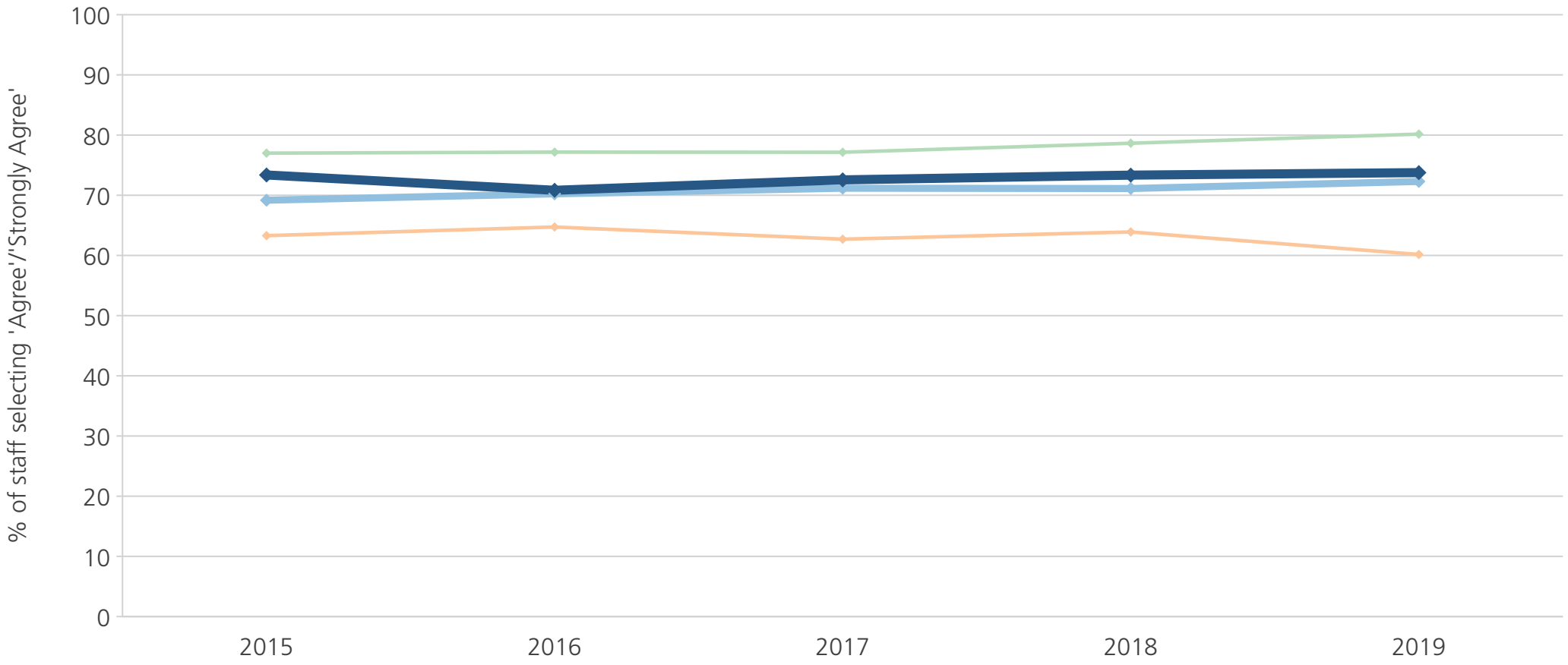


	2015	2016	2017	2018	2019
Best	80.8%	79.5%	79.2%	79.0%	81.9%
Your org	80.2%	75.9%	76.4%	76.5%	78.0%
Average	71.9%	73.2%	73.7%	73.7%	74.7%
Worst	65.6%	66.7%	65.7%	65.7%	64.9%
Responses	273	1,456	1,782	1,970	2,115

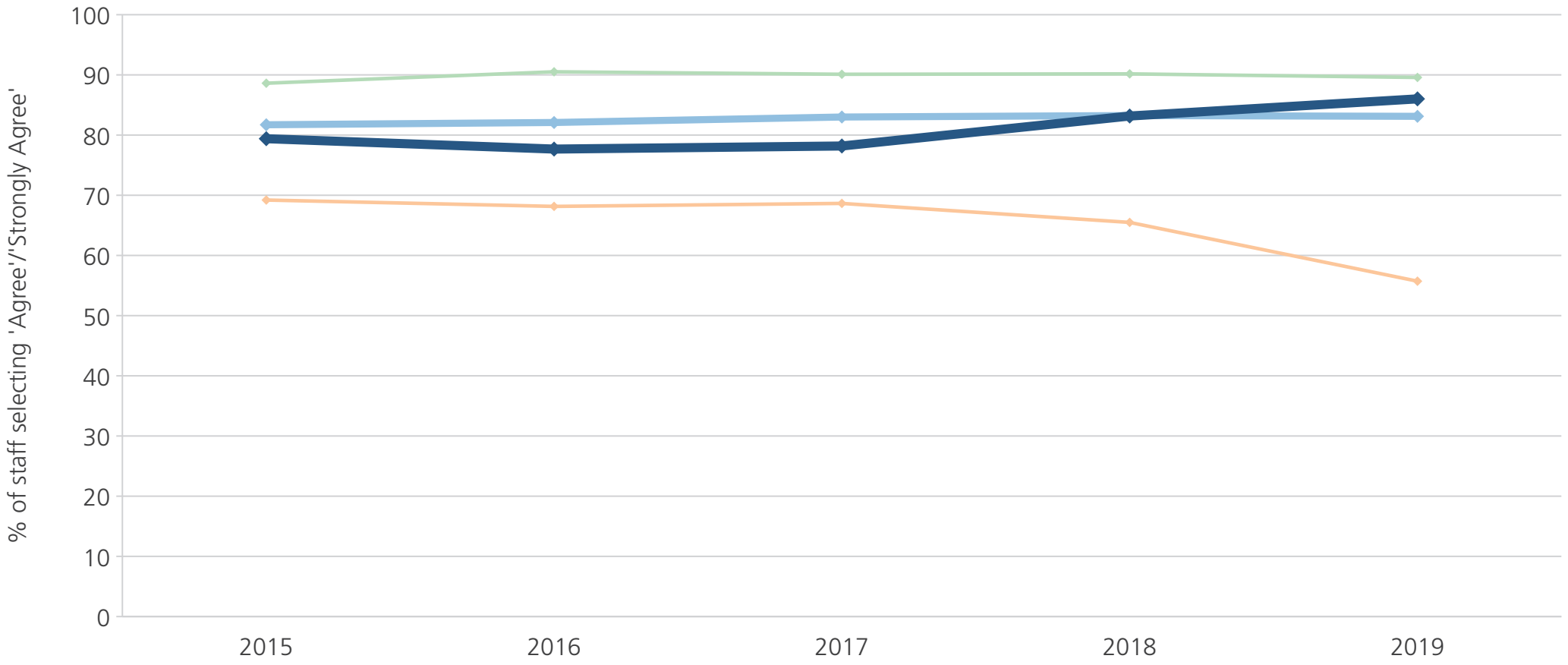
2019 NHS Staff Survey Results > Question results > Your managers > Q8f > My immediate manager takes a positive interest in my health and well-being



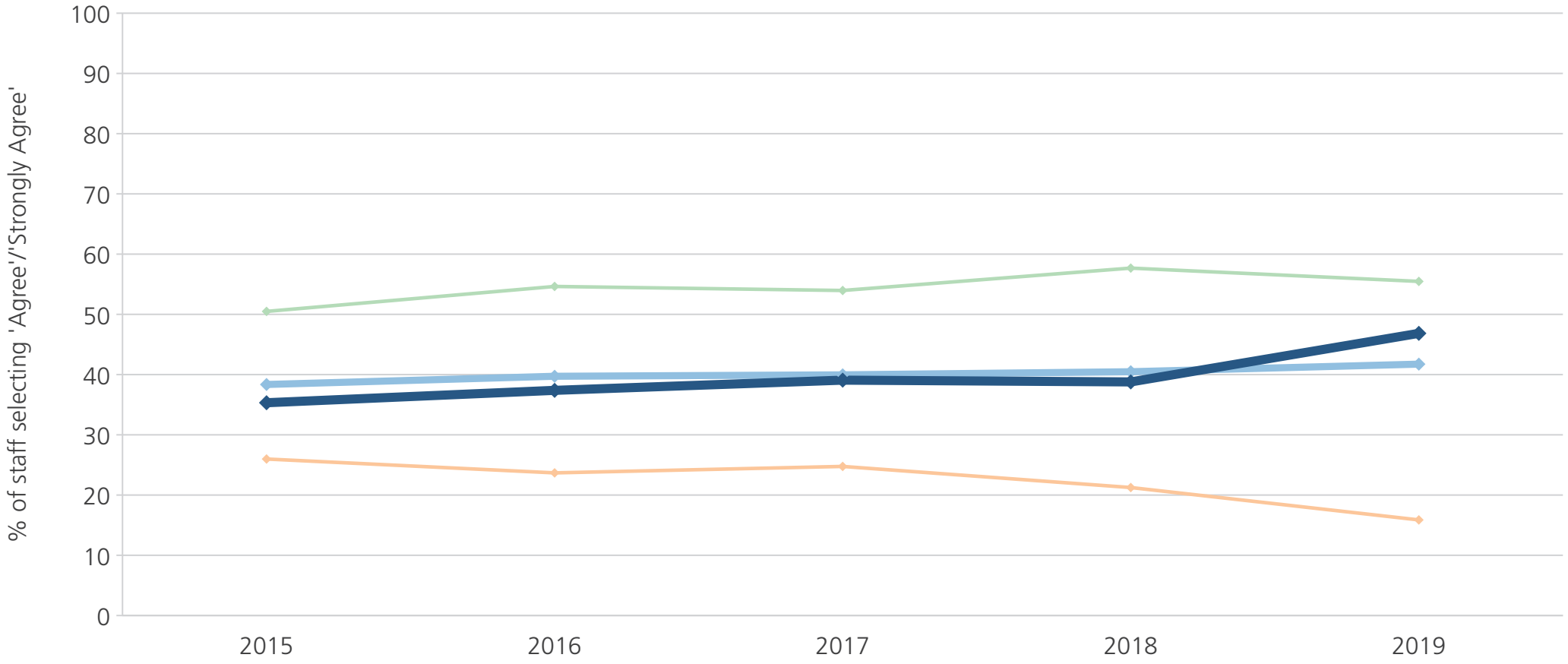
	2015	2016	2017	2018	2019
Best	70.4%	73.3%	72.4%	74.1%	77.8%
Your org	69.7%	68.3%	68.4%	70.2%	70.8%
Average	64.2%	65.6%	66.8%	66.9%	68.1%
Worst	58.3%	57.2%	59.1%	57.6%	55.5%
Responses	273	1,456	1,784	1,973	2,116



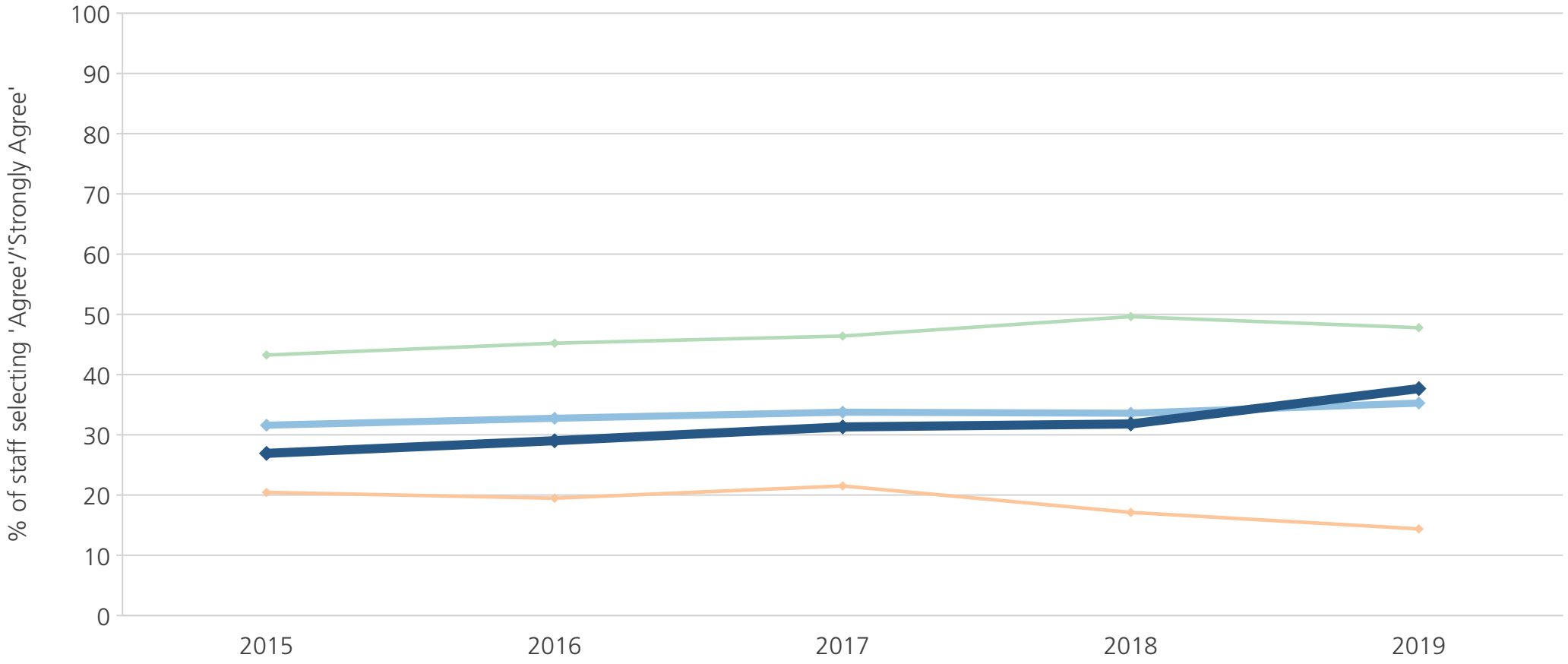
	2015	2016	2017	2018	2019
Best	77.0%	77.2%	77.1%	78.6%	80.2%
Your org	73.4%	70.8%	72.6%	73.3%	73.8%
Average	69.2%	70.2%	71.2%	71.1%	72.3%
Worst	63.3%	64.7%	62.7%	63.9%	60.2%
Responses	272	1,456	1,785	1,976	2,113



	2015	2016	2017	2018	2019
Best	88.6%	90.5%	90.1%	90.2%	89.6%
Your org	79.4%	77.7%	78.2%	83.2%	86.0%
Average	81.7%	82.1%	83.0%	83.2%	83.1%
Worst	69.2%	68.1%	68.6%	65.5%	55.7%
Responses	274	1,461	1,787	1,979	2,127

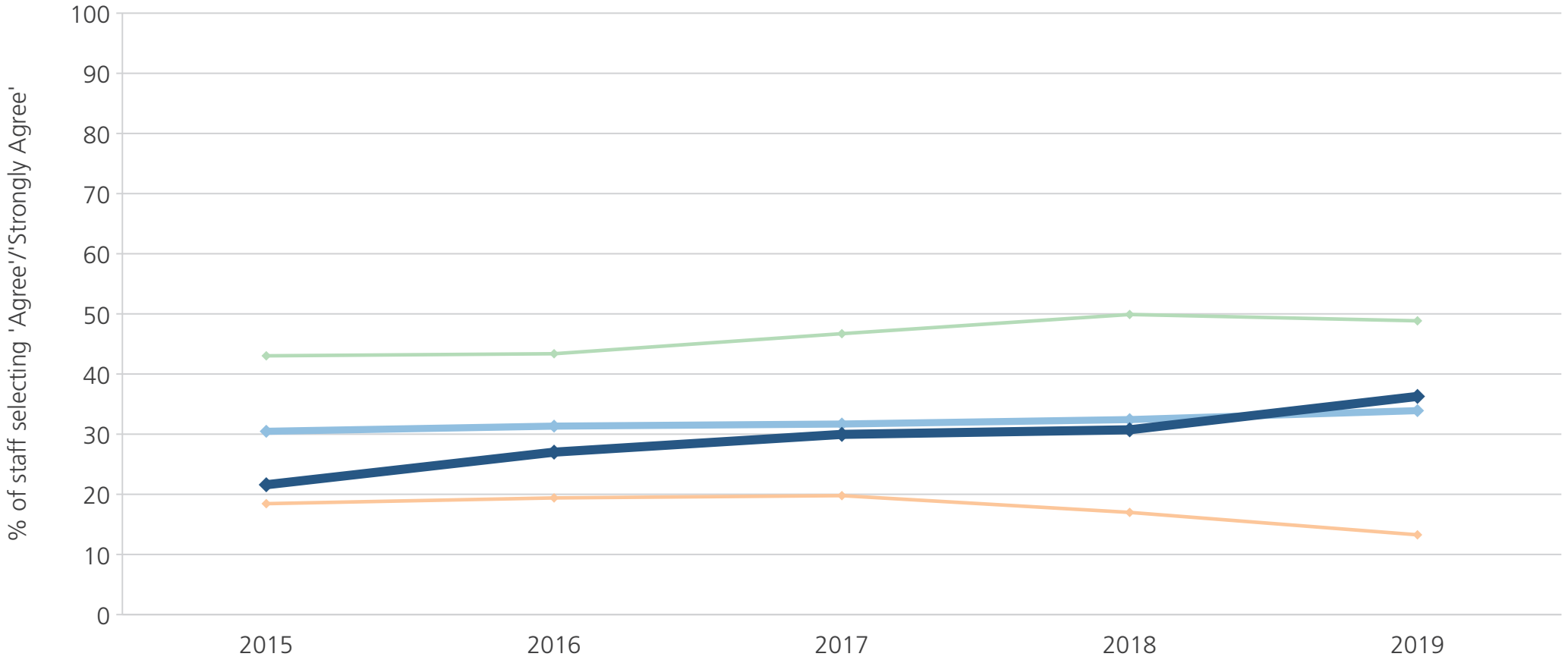


	2015	2016	2017	2018	2019
Best	50.5%	54.6%	54.0%	57.7%	55.5%
Your org	35.3%	37.4%	39.1%	38.8%	46.8%
Average	38.4%	39.7%	40.0%	40.5%	41.7%
Worst	26.0%	23.7%	24.8%	21.2%	15.9%
Responses	274	1,458	1,784	1,972	2,121



	2015	2016	2017	2018	2019
Best	43.2%	45.2%	46.4%	49.6%	47.8%
Your org	26.9%	29.0%	31.3%	31.8%	37.7%
Average	31.6%	32.7%	33.8%	33.6%	35.3%
Worst	20.4%	19.5%	21.5%	17.1%	14.4%
Responses	274	1,456	1,784	1,972	2,121

2019 NHS Staff Survey Results > Question results > Your managers > Q9d > Senior managers act on staff feedback



	2015	2016	2017	2018	2019
Best	43.0%	43.4%	46.7%	49.9%	48.8%
Your org	21.6%	27.0%	30.0%	30.7%	36.3%
Average	30.5%	31.3%	31.7%	32.4%	33.9%
Worst	18.4%	19.4%	19.8%	17.0%	13.3%
Responses	273	1,457	1,780	1,965	2,116

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Survey Coordination Centre

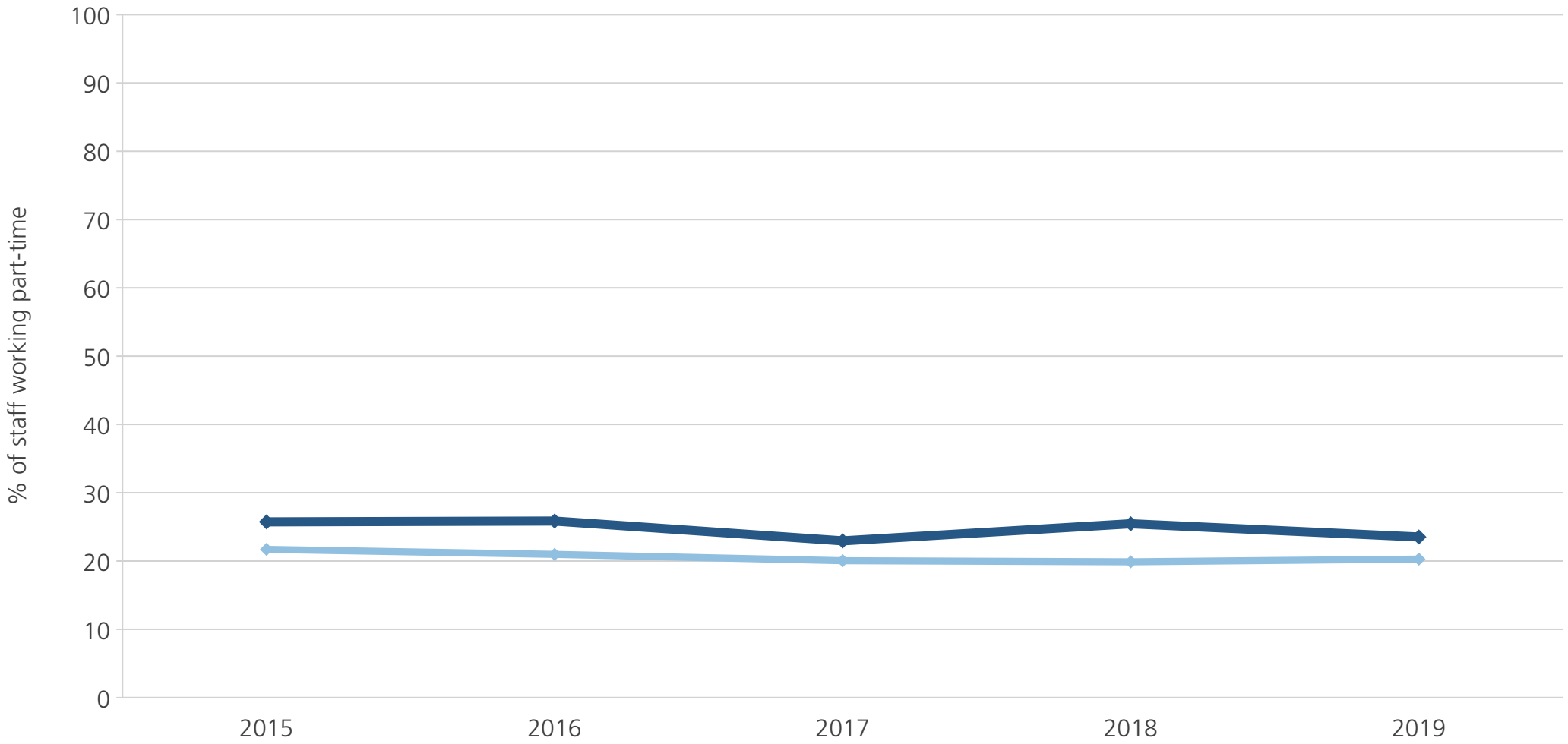
NHS England

Question results – Your health, well-being and safety at work

Warrington and Halton Hospitals NHS Foundation Trust

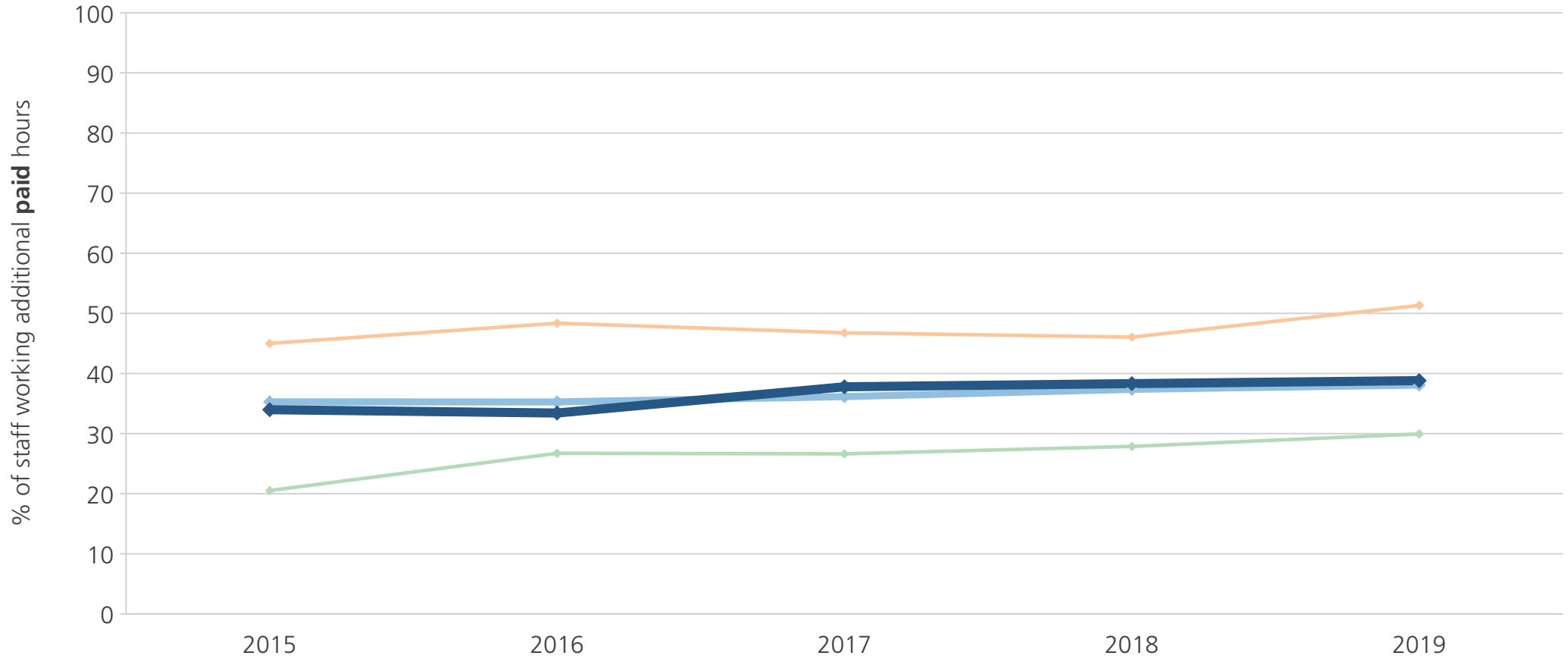
2019 NHS Staff Survey Results

2019 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q10a > How many hours a week are you contracted to work?



	2015	2016	2017	2018	2019
Your org	25.7%	25.9%	23.0%	25.5%	23.5%
Average	21.7%	21.0%	20.0%	19.9%	20.3%
Responses	272	1,435	1,734	1,921	2,028

2019 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q10b **>** On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours?

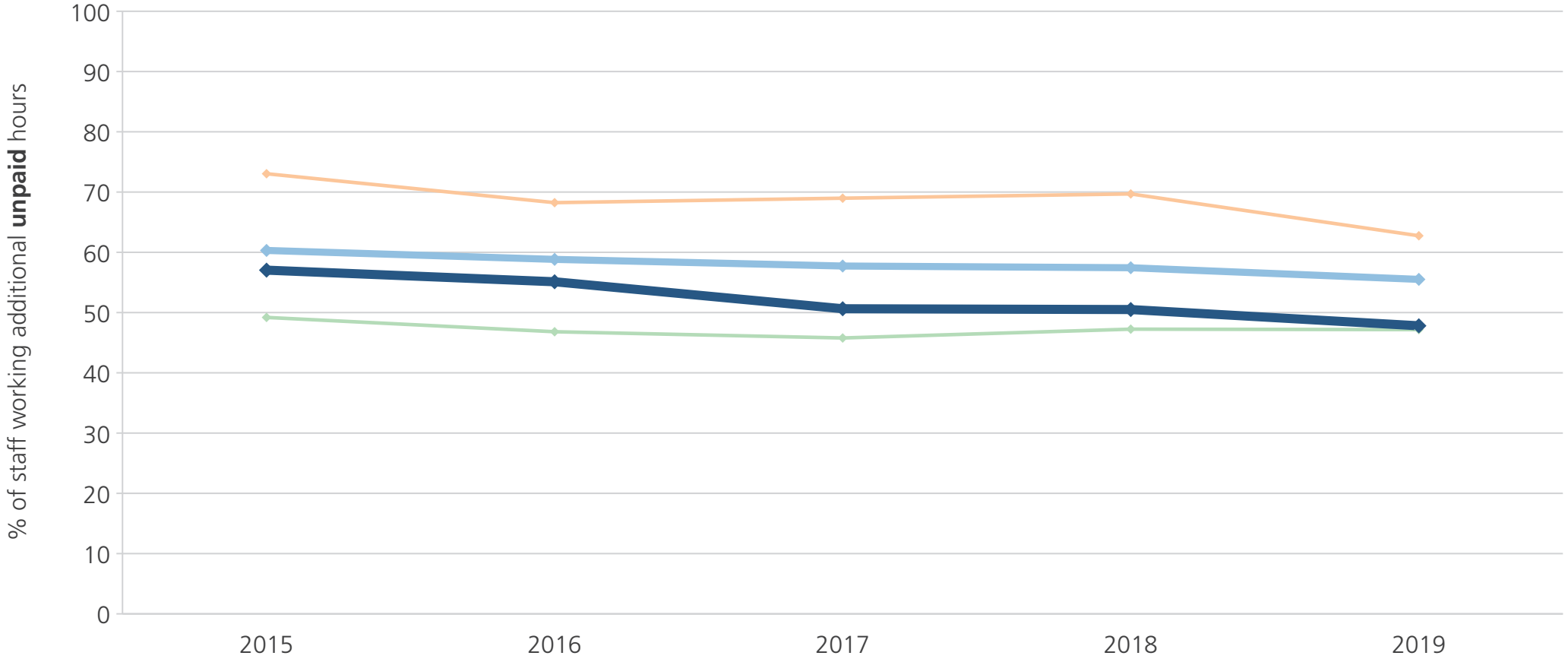


	2015	2016	2017	2018	2019
Worst	45.0%	48.4%	46.8%	46.1%	51.3%
Your org	34.0%	33.4%	37.8%	38.3%	38.8%
Average	35.3%	35.3%	36.2%	37.4%	38.1%
Best	20.5%	26.7%	26.6%	27.9%	29.9%
Responses	267	1,402	1,695	1,898	2,032

Survey Coordination Centre

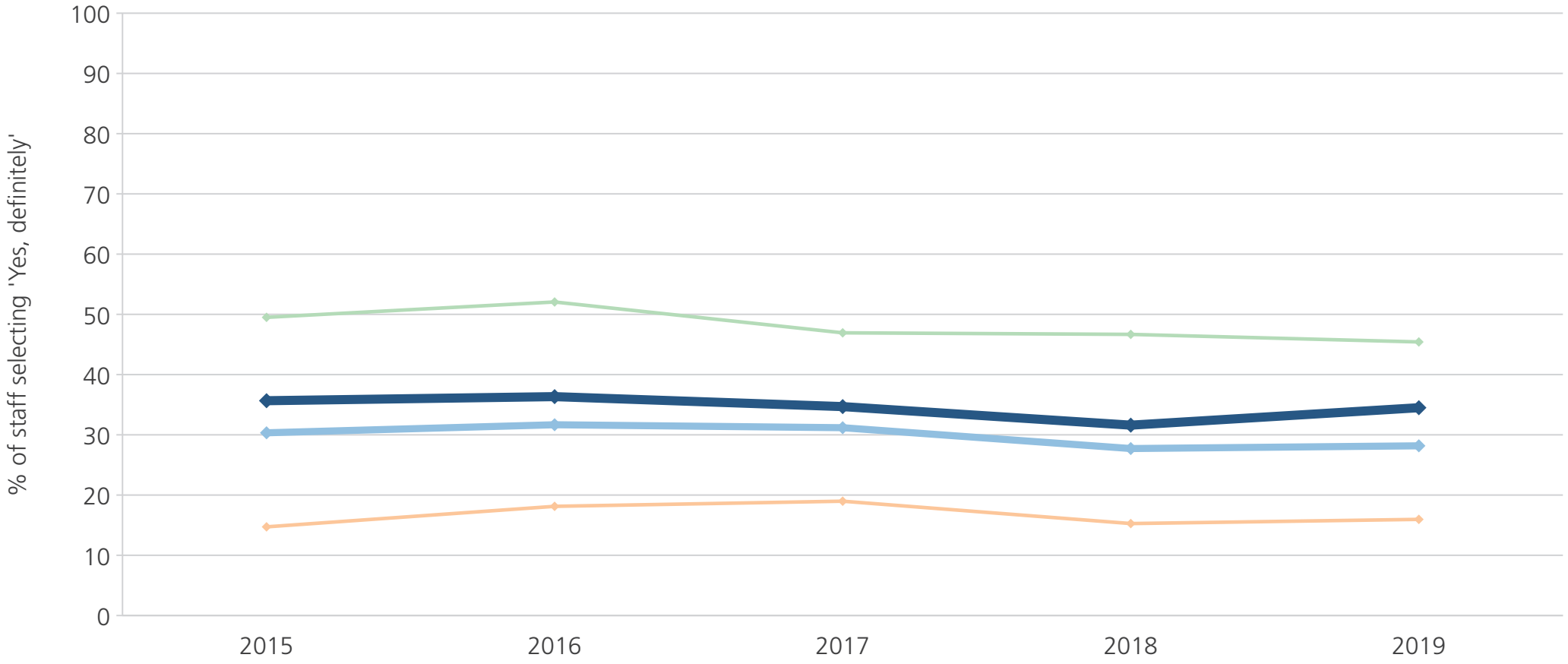
2019 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q10c **>** On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours?

NHS England

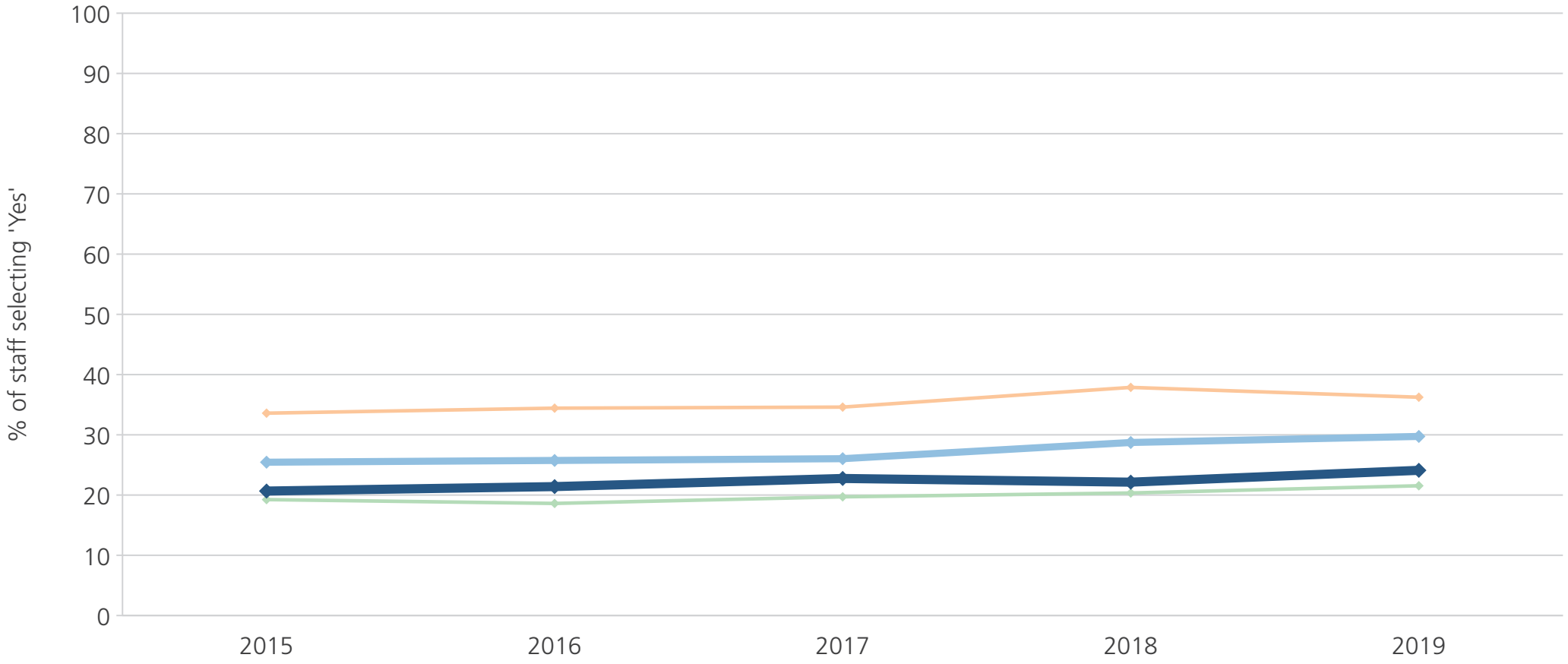


	2015	2016	2017	2018	2019
Worst	73.0%	68.2%	69.0%	69.7%	62.7%
Your org	57.0%	55.1%	50.6%	50.5%	47.8%
Average	60.3%	58.8%	57.7%	57.4%	55.5%
Best	49.2%	46.8%	45.8%	47.2%	47.2%
Responses	266	1,383	1,687	1,901	2,026

2019 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q11a > Does your organisation take positive action on health and well-being?



	2015	2016	2017	2018	2019
Best	49.5%	52.1%	46.9%	46.7%	45.4%
Your org	35.7%	36.3%	34.7%	31.6%	34.5%
Average	30.3%	31.7%	31.2%	27.7%	28.2%
Worst	14.7%	18.1%	19.0%	15.3%	16.0%
Responses	271	1,452	1,770	1,945	2,094

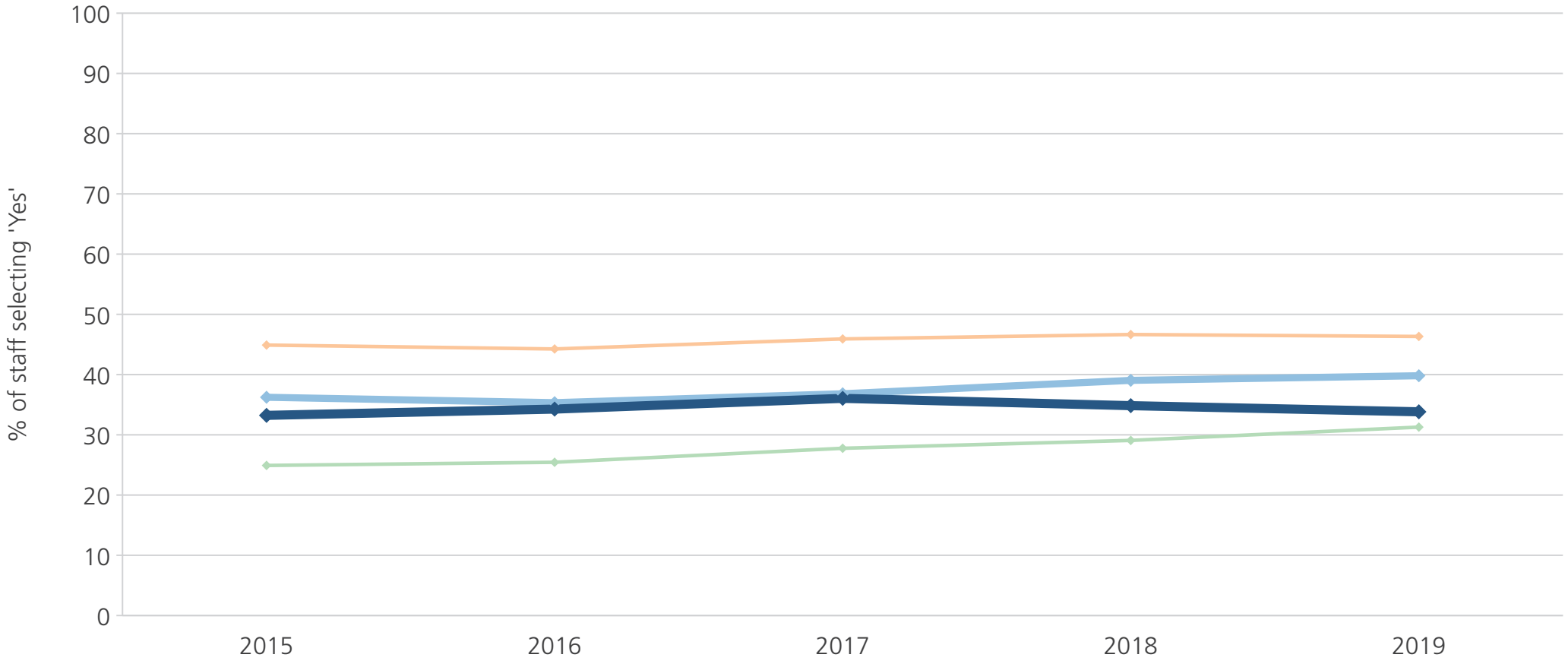


	2015	2016	2017	2018	2019
Worst	33.6%	34.4%	34.6%	37.9%	36.2%
Your org	20.7%	21.4%	22.8%	22.1%	24.1%
Average	25.5%	25.7%	26.0%	28.7%	29.7%
Best	19.2%	18.6%	19.7%	20.3%	21.5%
Responses	274	1,455	1,777	1,959	2,088

Survey Coordination Centre

2019 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q11c **>** During the last 12 months have you felt unwell as a result of work related stress?

NHS England



	2015	2016	2017	2018	2019
Worst	44.9%	44.3%	45.9%	46.7%	46.3%
Your org	33.2%	34.3%	36.1%	34.8%	33.8%
Average	36.2%	35.3%	36.8%	39.0%	39.8%
Best	24.9%	25.4%	27.8%	29.1%	31.3%
Responses	274	1,459	1,783	1,960	2,098

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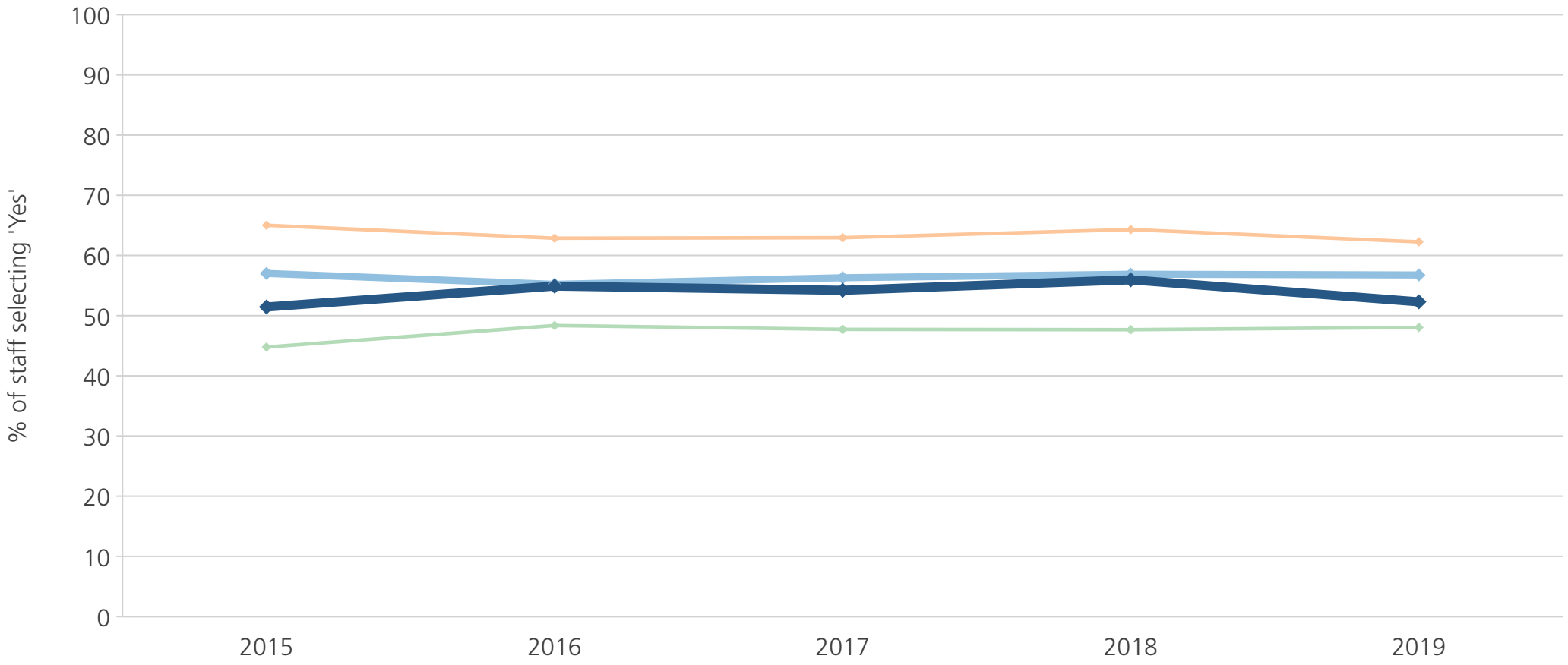
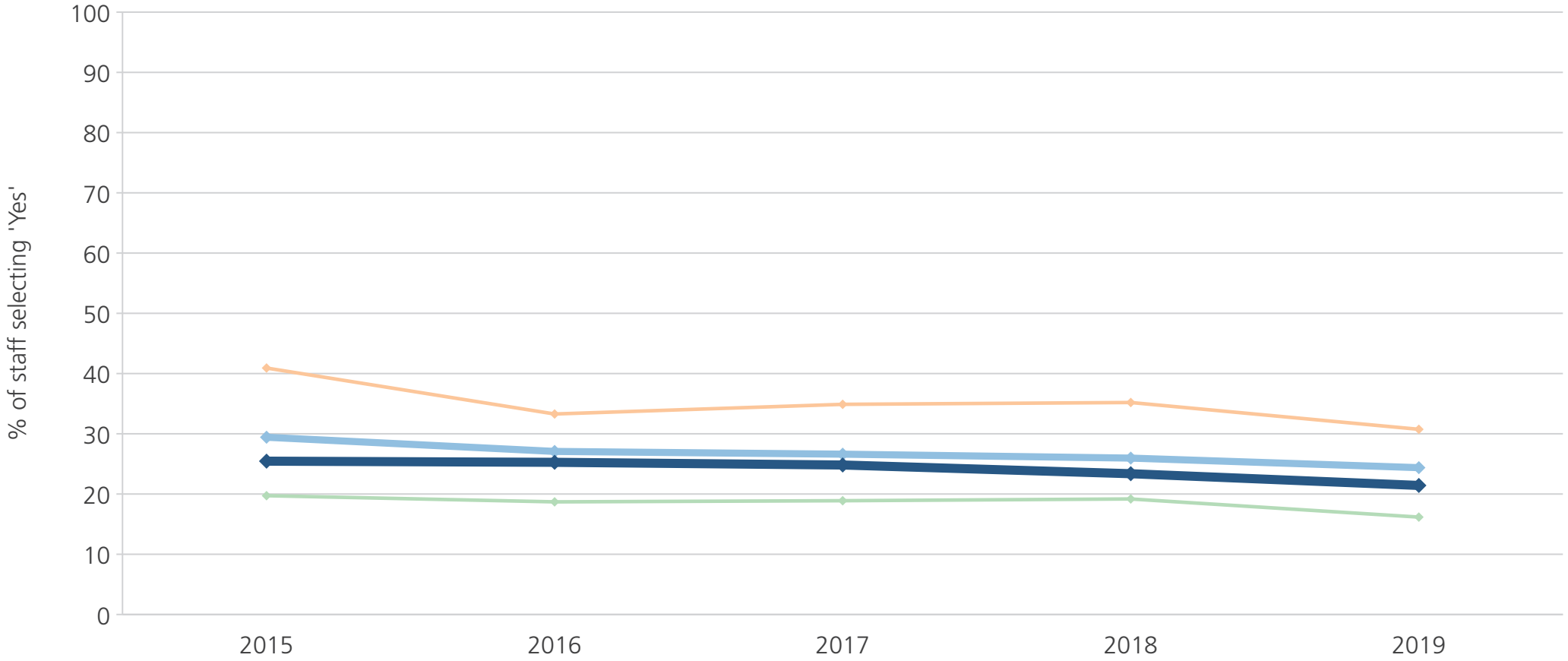
2019 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q11d
> In the last three months have you ever come to work despite not feeling well enough to perform your duties?



	2015	2016	2017	2018	2019
Worst	65.0%	62.9%	62.9%	64.3%	62.3%
Your org	51.4%	54.9%	54.2%	55.9%	52.3%
Average	57.0%	55.2%	56.3%	56.9%	56.8%
Best	44.8%	48.4%	47.7%	47.7%	48.0%
Responses	274	1,453	1,785	1,959	2,101

2019 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q11e > Have you felt pressure from your manager to come to work?

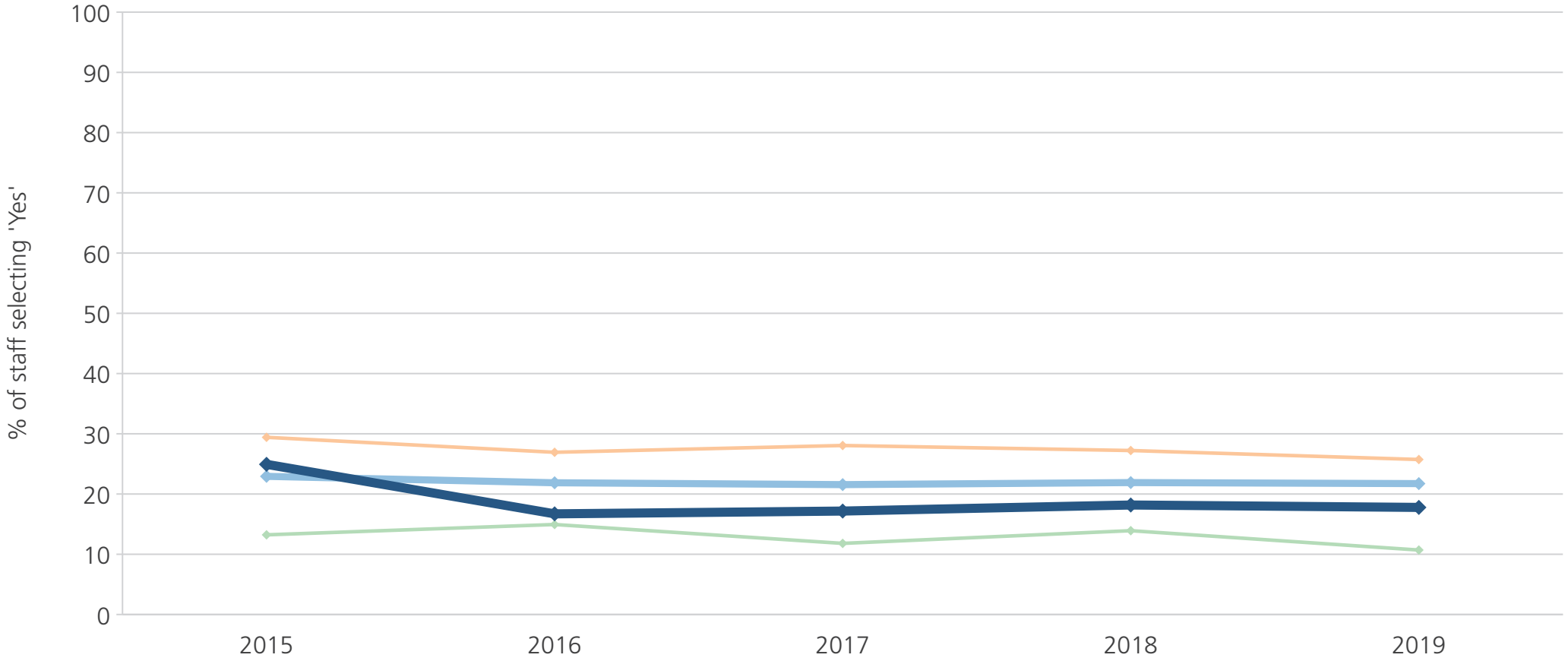
This question was only answered by people who responded to Q11d.



	2015	2016	2017	2018	2019
Worst	40.9%	33.3%	34.9%	35.2%	30.7%
Your org	25.5%	25.3%	24.8%	23.4%	21.4%
Average	29.4%	27.1%	26.6%	26.0%	24.4%
Best	19.7%	18.7%	18.9%	19.2%	16.2%
Responses	136	779	950	1,066	1,086

2019 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q11f > Have you felt pressure from colleagues to come to work?

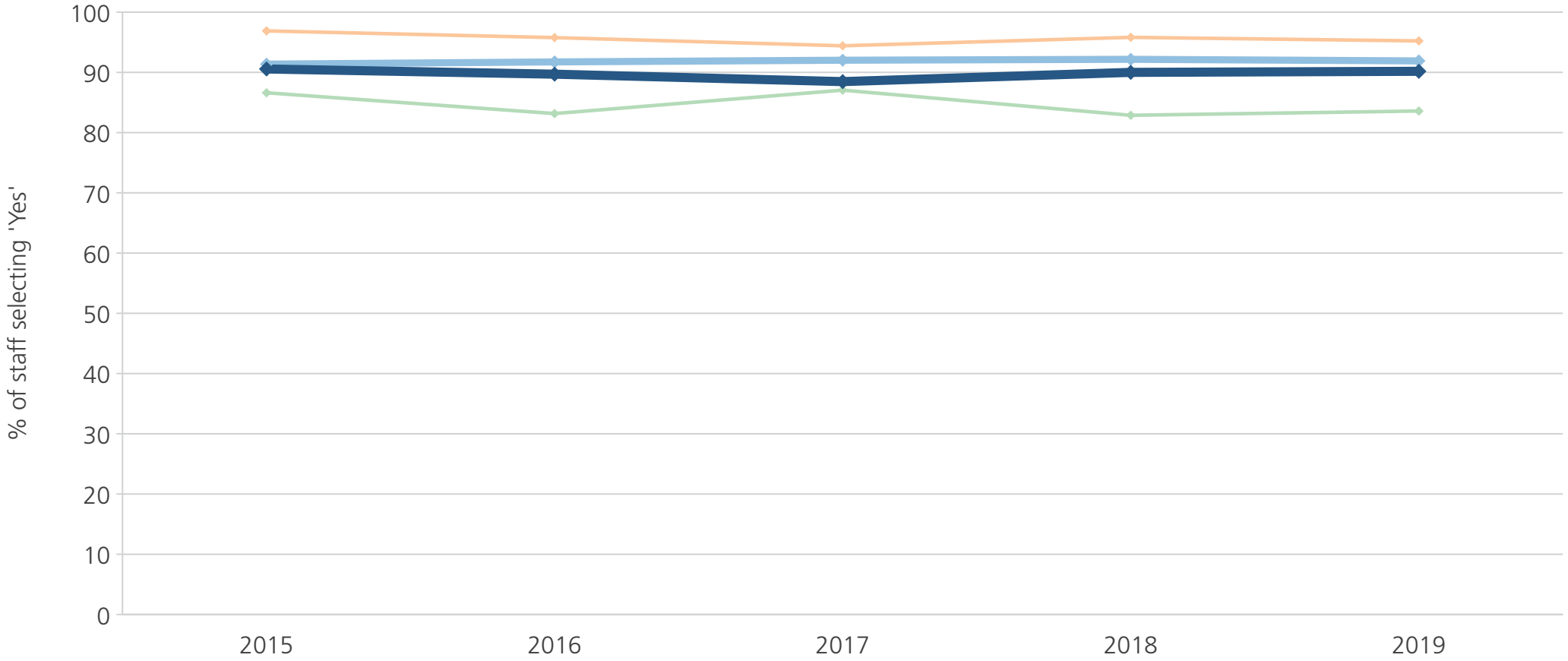
This question was only answered by people who responded to Q11d.



	2015	2016	2017	2018	2019
Worst	29.4%	26.9%	28.1%	27.2%	25.7%
Your org	24.9%	16.7%	17.2%	18.2%	17.8%
Average	22.9%	21.9%	21.6%	21.9%	21.7%
Best	13.2%	14.9%	11.8%	13.9%	10.7%
Responses	137	778	946	1,061	1,083

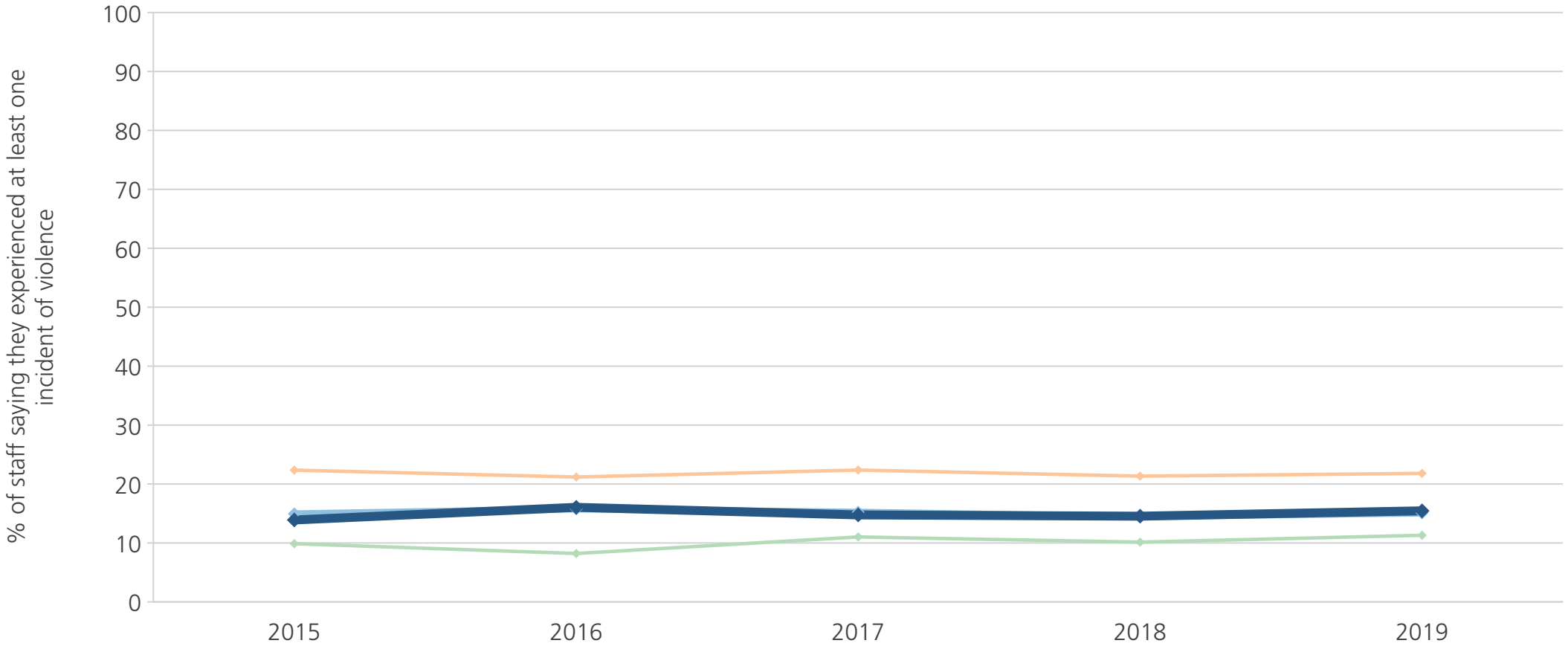
2019 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q11g > Have you put yourself under pressure to come to work?

This question was only answered by people who responded to Q11d.



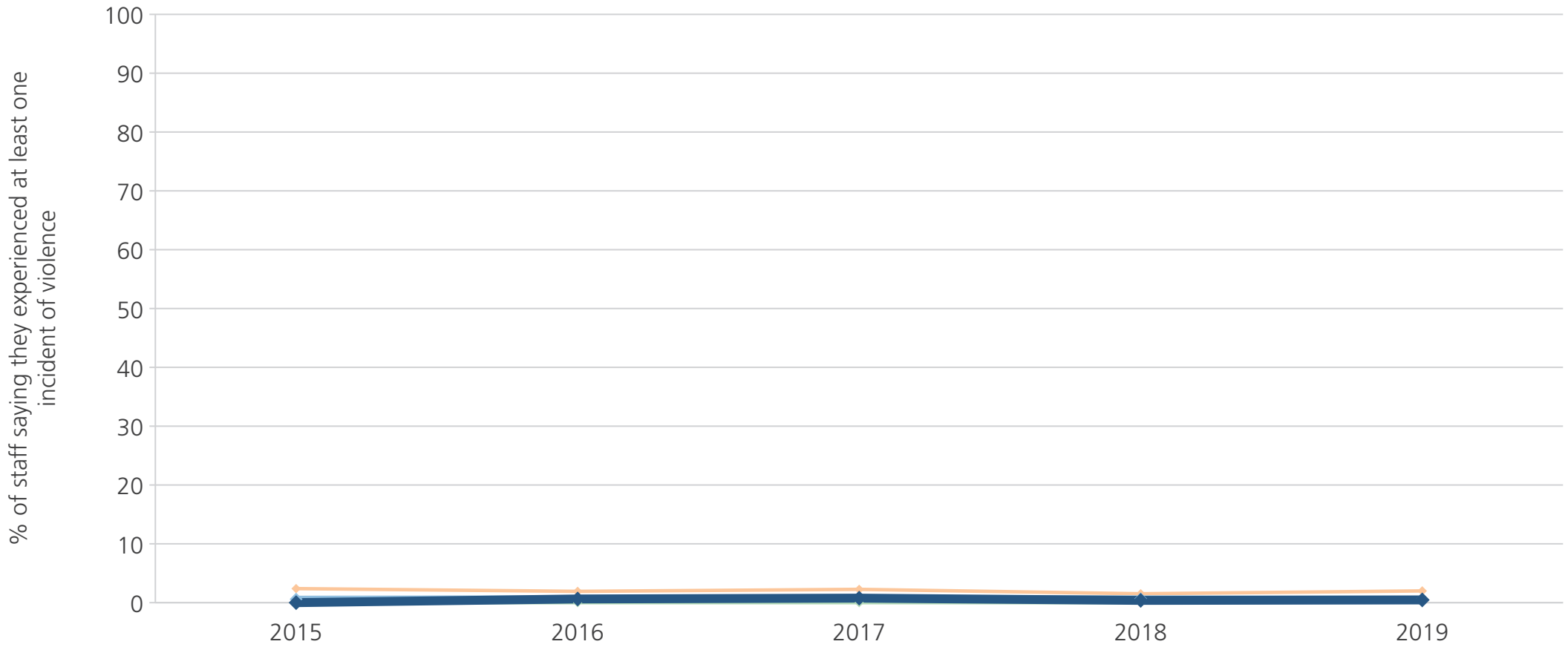
	2015	2016	2017	2018	2019
Worst	96.9%	95.8%	94.4%	95.8%	95.2%
Your org	90.6%	89.7%	88.5%	90.0%	90.2%
Average	91.4%	91.7%	92.0%	92.2%	91.9%
Best	86.6%	83.2%	87.0%	82.9%	83.6%
Responses	138	783	958	1,075	1,092

2019 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q12a > In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?



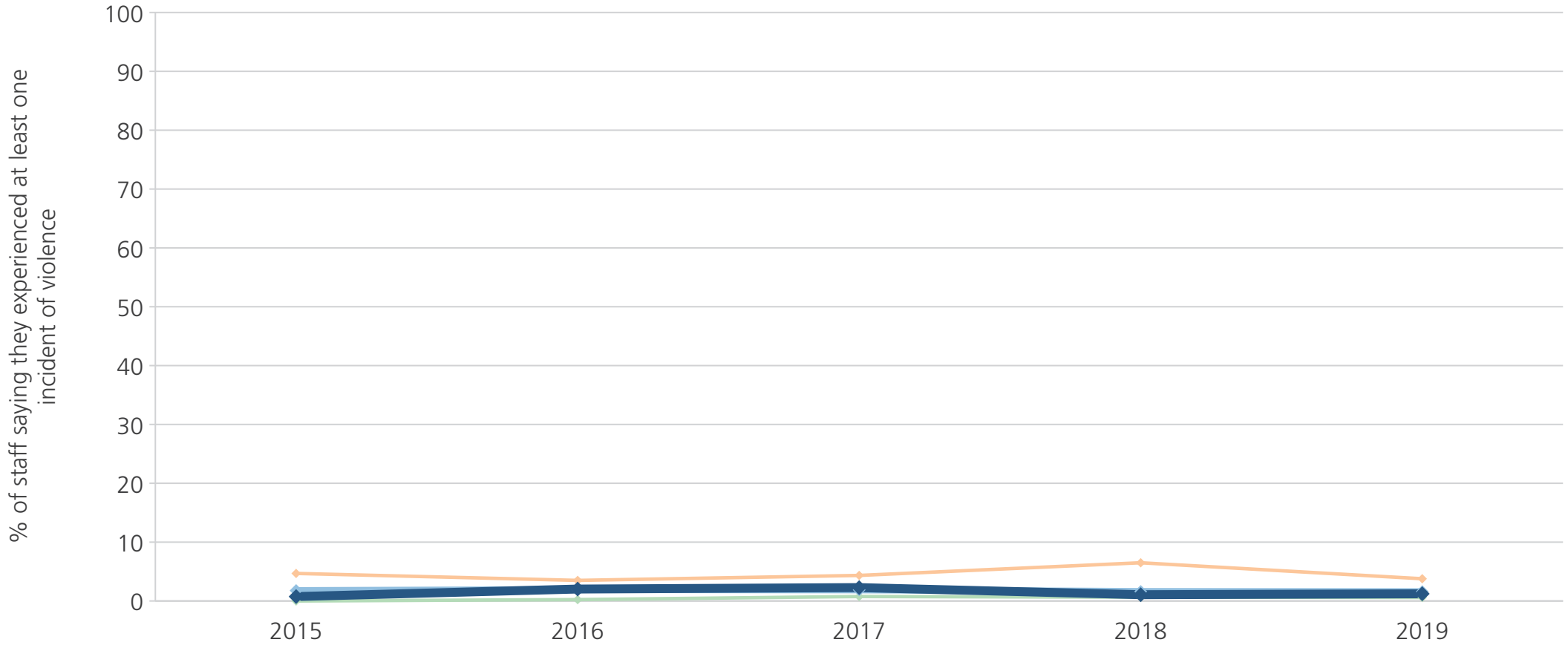
	2015	2016	2017	2018	2019
Worst	22.4%	21.2%	22.4%	21.3%	21.8%
Your org	13.9%	16.0%	14.8%	14.5%	15.5%
Average	14.9%	15.8%	15.2%	14.5%	15.1%
Best	9.9%	8.2%	11.0%	10.1%	11.3%
Responses	273	1,451	1,771	1,962	2,106

2019 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q12b > In the last 12 months how many times have you personally experienced physical violence at work from managers?

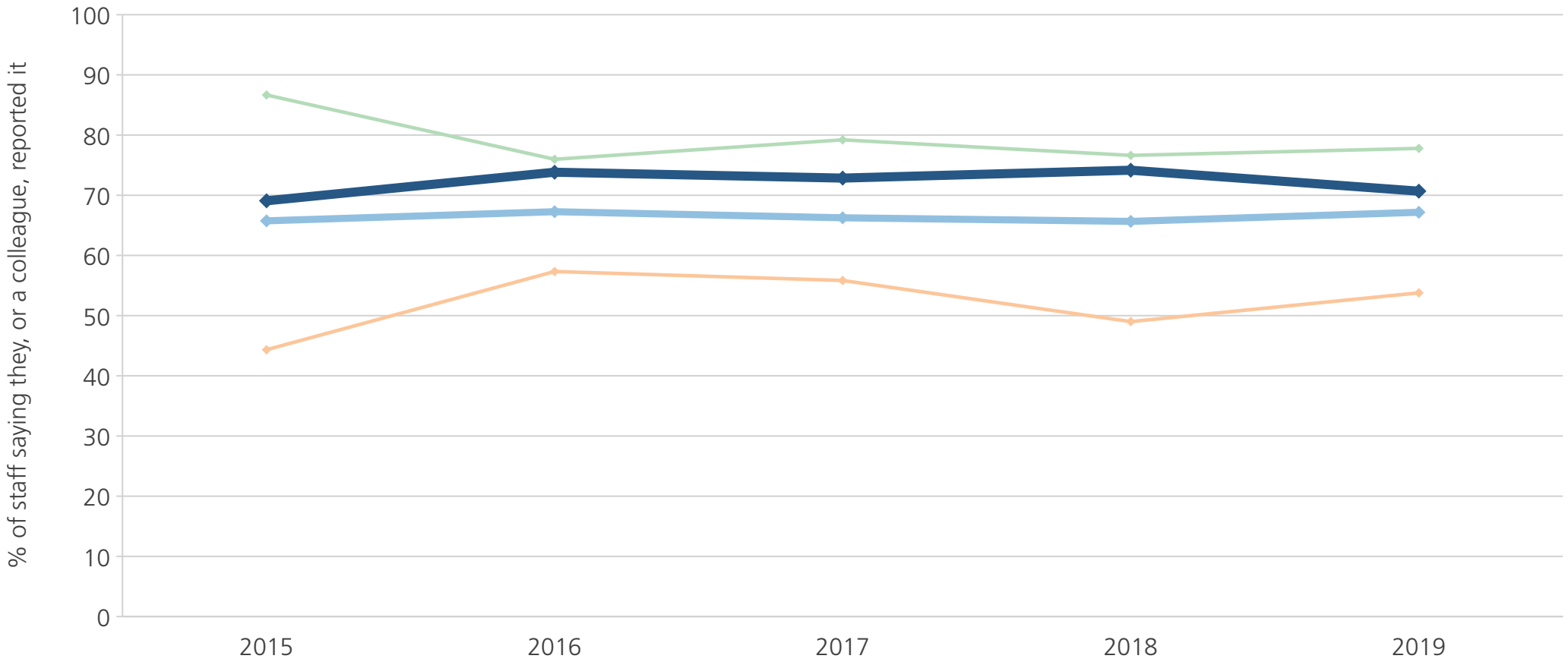


	2015	2016	2017	2018	2019
Worst	2.4%	1.9%	2.3%	1.5%	2.0%
Your org	0.0%	0.6%	0.8%	0.4%	0.5%
Average	0.6%	0.7%	0.7%	0.7%	0.6%
Best	0.0%	0.0%	0.0%	0.0%	0.1%
Responses	273	1,431	1,757	1,946	2,098

2019 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q12c **>** In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?



	2015	2016	2017	2018	2019
Worst	4.7%	3.5%	4.3%	6.5%	3.8%
Your org	0.7%	2.0%	2.3%	1.1%	1.2%
Average	1.8%	1.9%	1.9%	1.6%	1.6%
Best	0.0%	0.2%	0.8%	0.6%	0.6%
Responses	273	1,429	1,747	1,936	2,084



	2015	2016	2017	2018	2019
Best	86.7%	76.0%	79.2%	76.6%	77.8%
Your org	69.1%	73.8%	72.9%	74.2%	70.7%
Average	65.8%	67.3%	66.3%	65.7%	67.2%
Worst	44.3%	57.3%	55.8%	49.0%	53.8%
Responses	30	173	209	205	253

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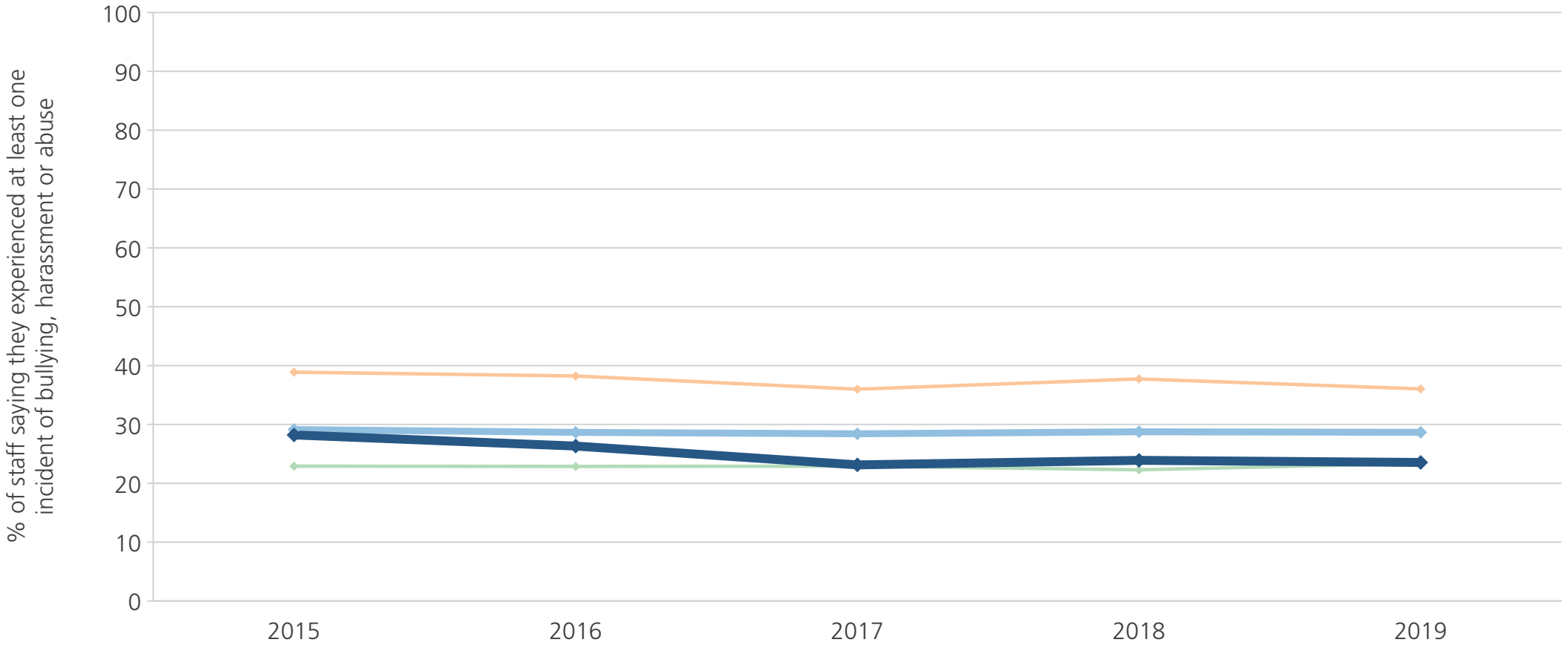
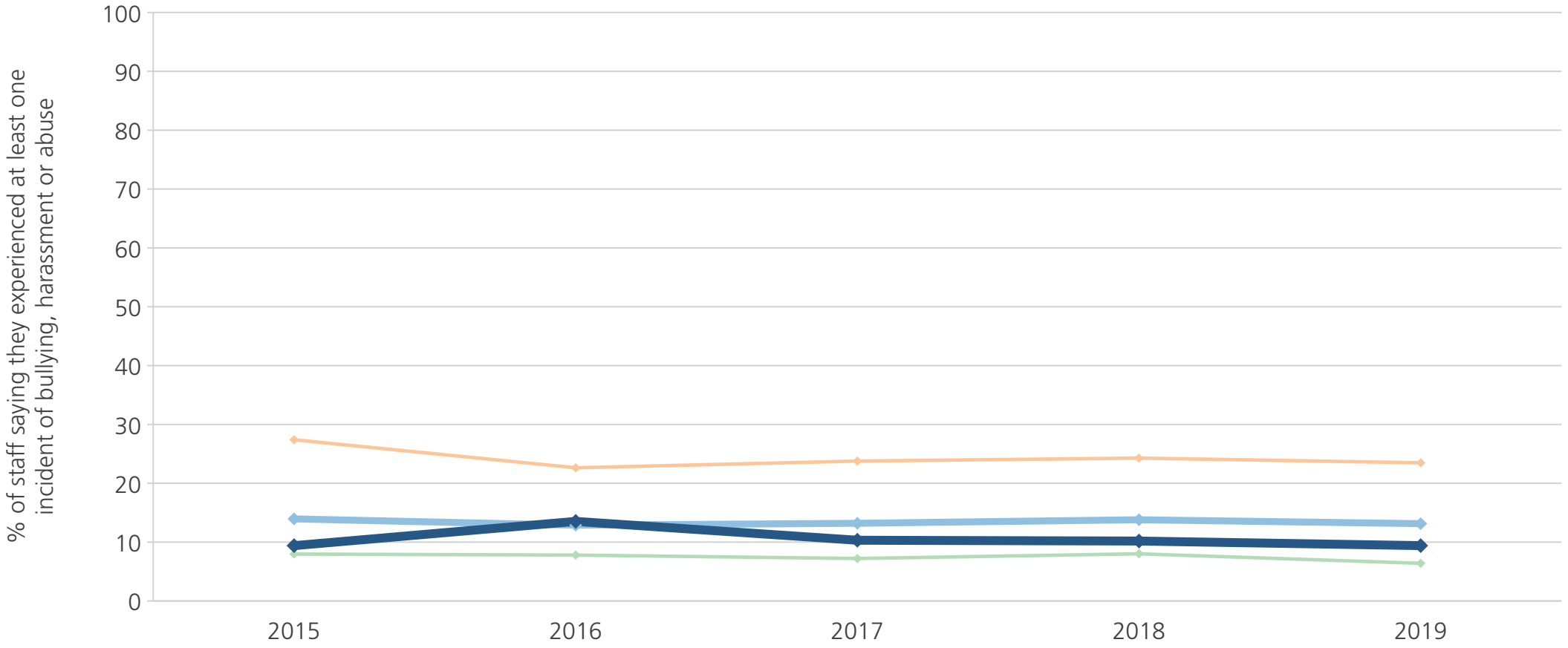
2019 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q13a **>** In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?



	2015	2016	2017	2018	2019
Worst	38.9%	38.2%	36.0%	37.7%	36.0%
Your org	28.2%	26.3%	23.1%	23.9%	23.5%
Average	29.1%	28.7%	28.4%	28.7%	28.7%
Best	22.9%	22.9%	22.9%	22.3%	23.4%
Responses	273	1,446	1,769	1,961	2,099

2019 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q13b **>** In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?

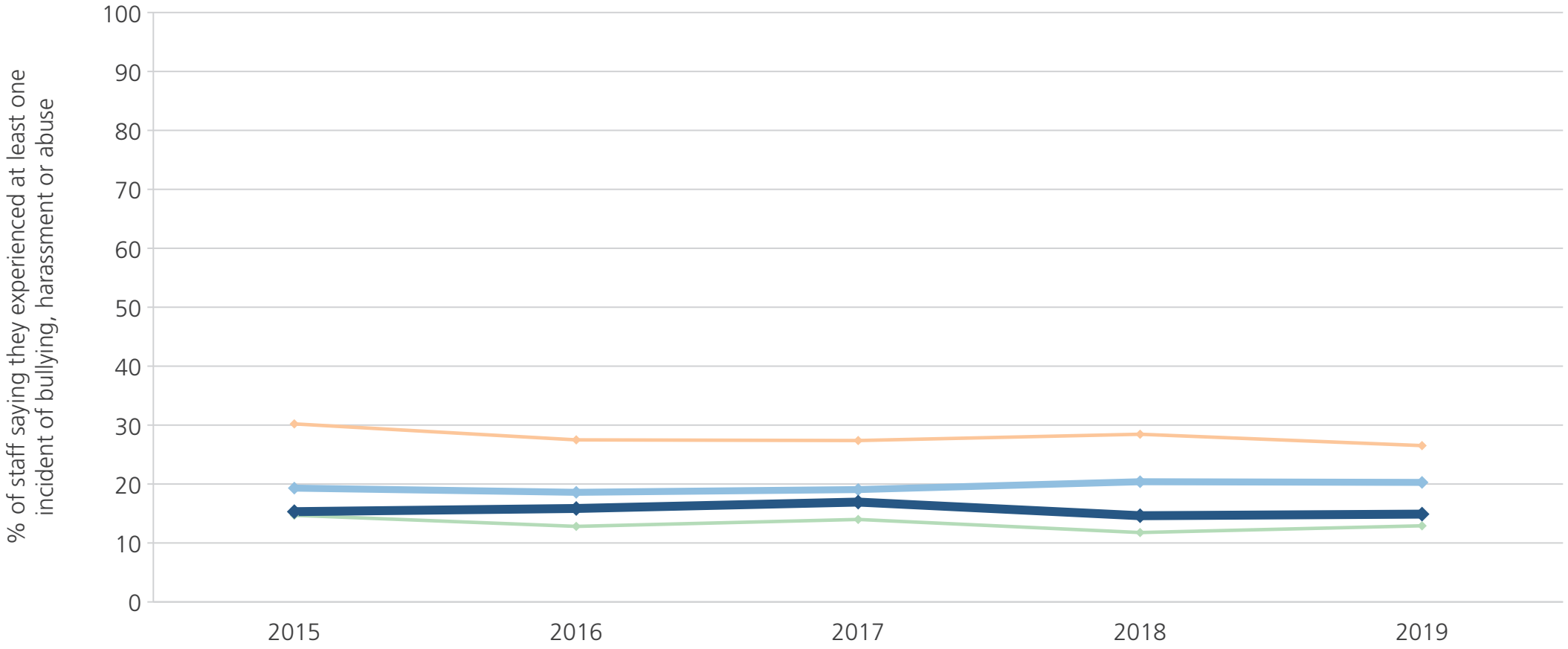


	2015	2016	2017	2018	2019
Worst	27.4%	22.6%	23.8%	24.3%	23.5%
Your org	9.4%	13.5%	10.3%	10.2%	9.4%
Average	14.0%	12.9%	13.2%	13.8%	13.1%
Best	8.0%	7.8%	7.2%	8.0%	6.4%
Responses	270	1,428	1,749	1,937	2,089

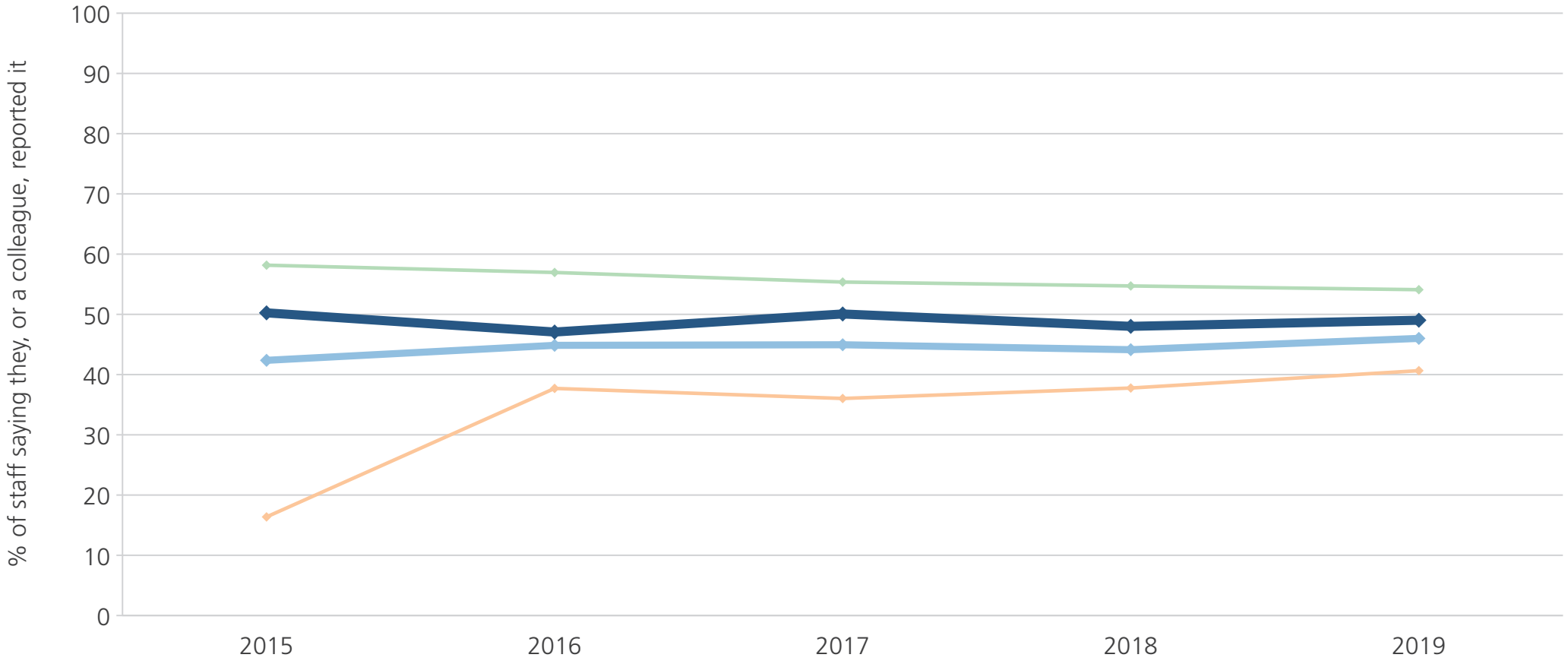
Survey Coordination Centre

2019 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q13c **>** In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?

NHS England

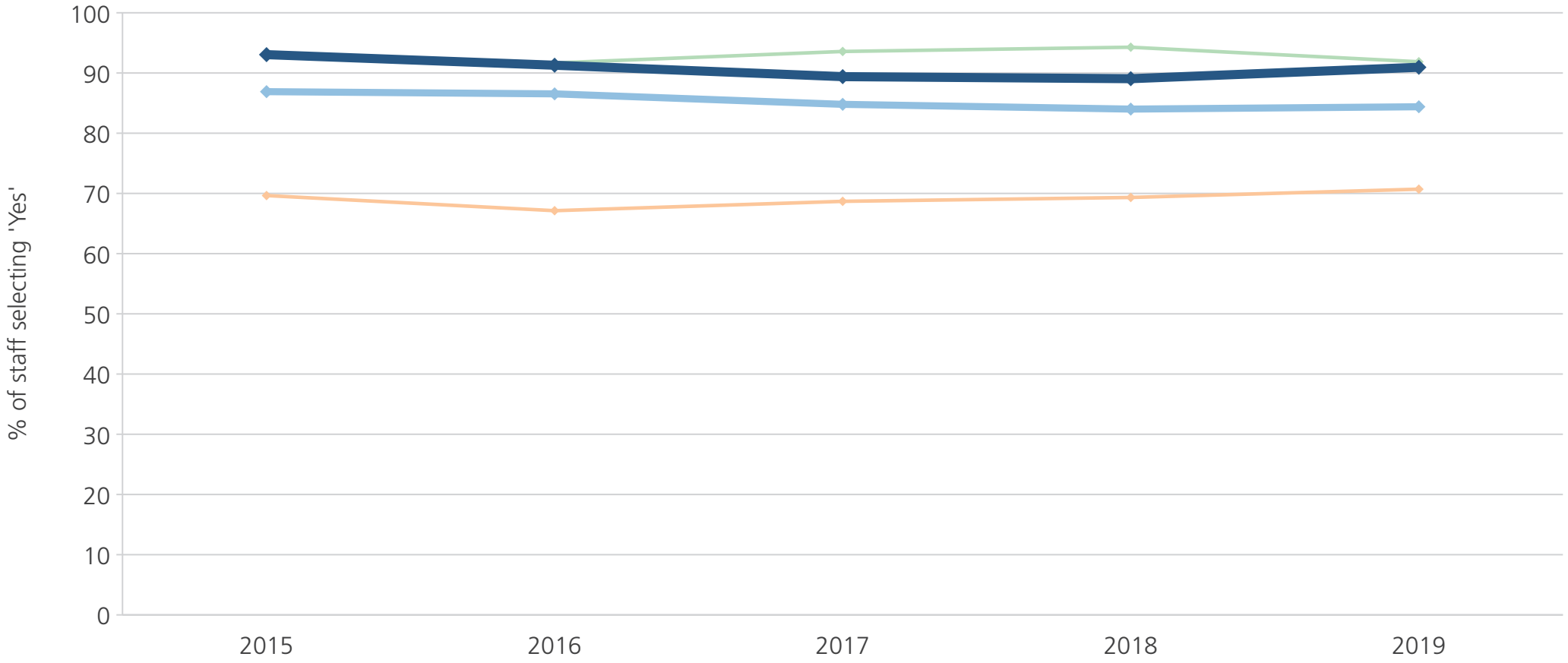


	2015	2016	2017	2018	2019
Worst	30.2%	27.5%	27.4%	28.4%	26.5%
Your org	15.3%	15.9%	16.9%	14.6%	14.9%
Average	19.3%	18.6%	19.1%	20.4%	20.3%
Best	14.7%	12.8%	14.0%	11.8%	12.9%
Responses	270	1,425	1,750	1,923	2,080



	2015	2016	2017	2018	2019
Best	58.2%	57.0%	55.4%	54.7%	54.1%
Your org	50.2%	47.1%	50.1%	48.0%	49.0%
Average	42.4%	44.9%	45.0%	44.1%	46.0%
Worst	16.4%	37.7%	36.0%	37.8%	40.7%
Responses	86	458	529	525	597

2019 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q14 > Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?

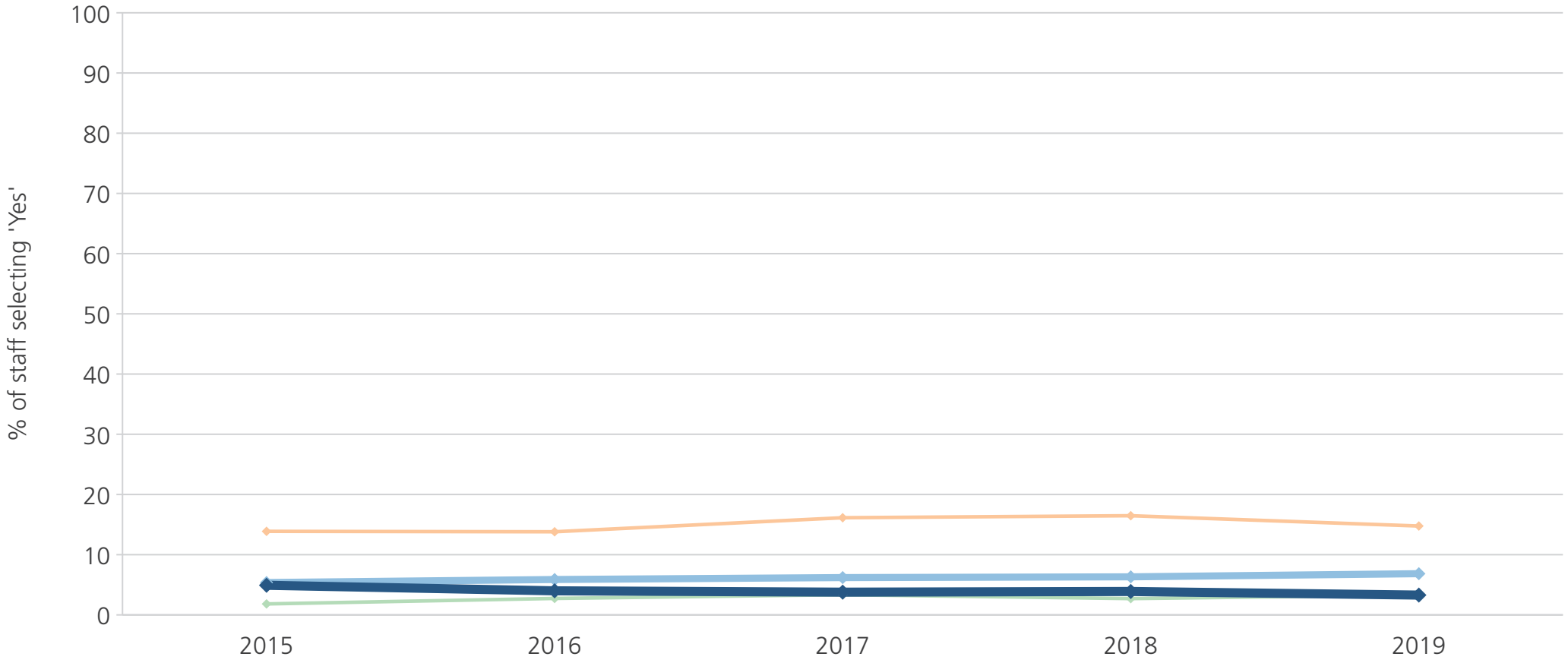


	2015	2016	2017	2018	2019
Best	93.3%	91.7%	93.6%	94.3%	91.9%
Your org	93.0%	91.3%	89.4%	89.1%	90.9%
Average	86.9%	86.5%	84.8%	84.0%	84.4%
Worst	69.6%	67.1%	68.7%	69.3%	70.7%
Responses	200	999	1,205	1,322	1,481

Survey Coordination Centre

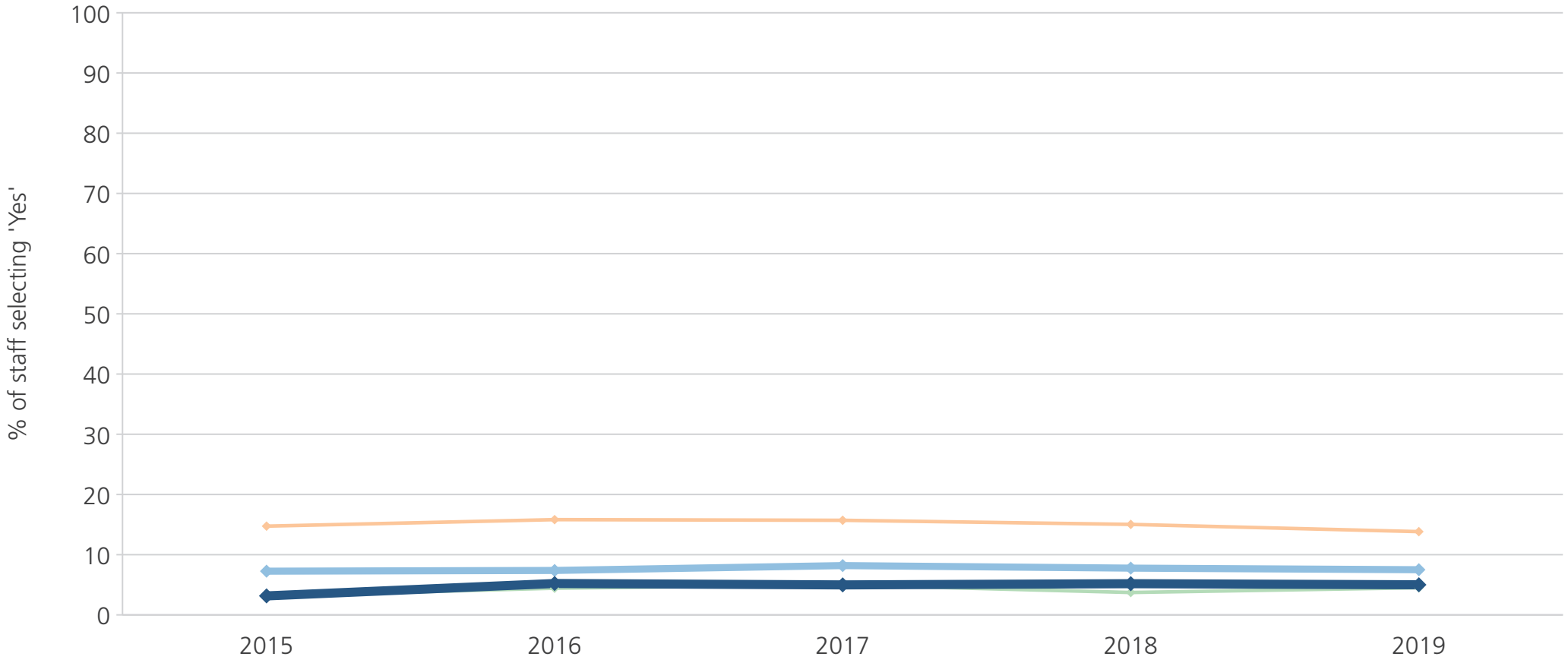
2019 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q15a > In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?

NHS England



	2015	2016	2017	2018	2019
Worst	13.9%	13.8%	16.1%	16.5%	14.8%
Your org	4.9%	4.0%	3.8%	3.9%	3.3%
Average	5.4%	5.9%	6.2%	6.3%	6.8%
Best	1.8%	2.7%	3.3%	2.7%	3.3%
Responses	272	1,456	1,771	1,955	2,103

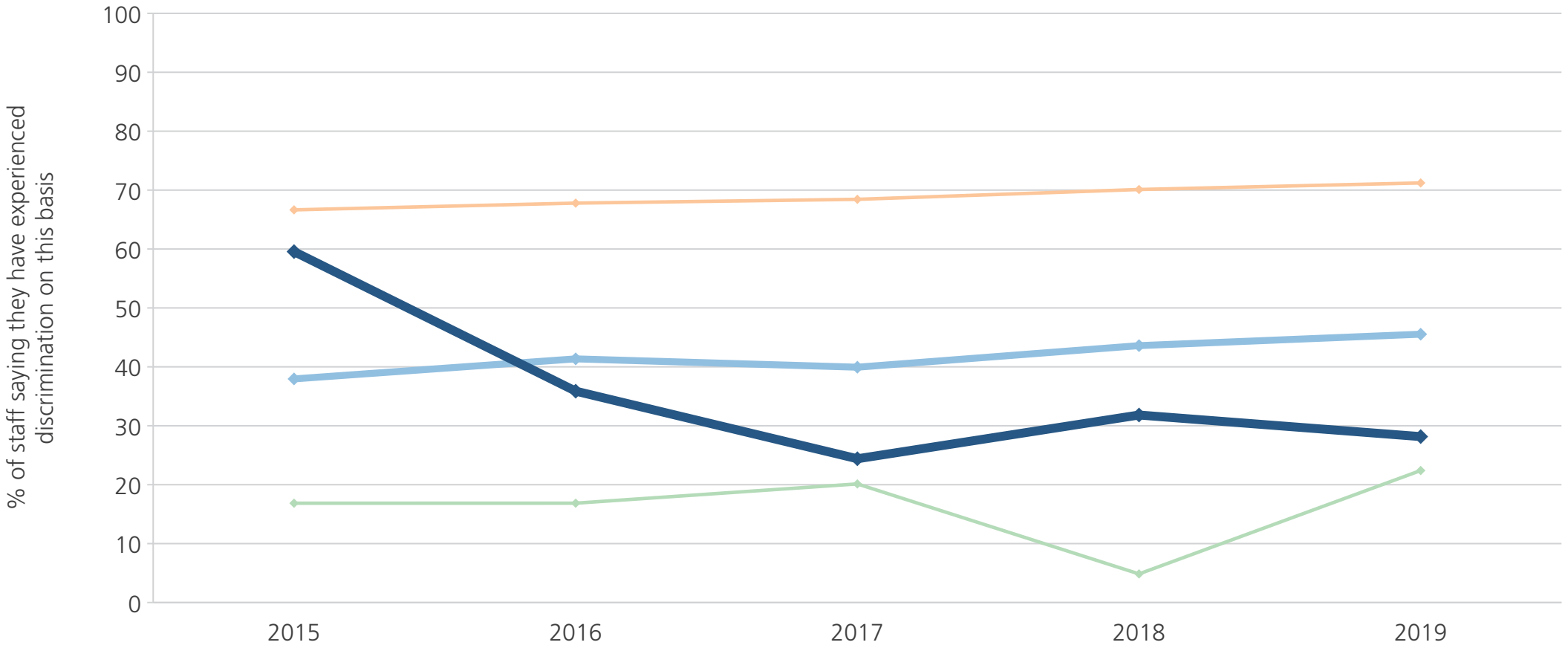
2019 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q15b **>** In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?



	2015	2016	2017	2018	2019
Worst	14.7%	15.8%	15.7%	15.0%	13.8%
Your org	3.2%	5.2%	5.0%	5.2%	5.0%
Average	7.3%	7.4%	8.2%	7.8%	7.5%
Best	3.2%	4.4%	5.0%	3.7%	4.5%
Responses	271	1,445	1,769	1,944	2,090

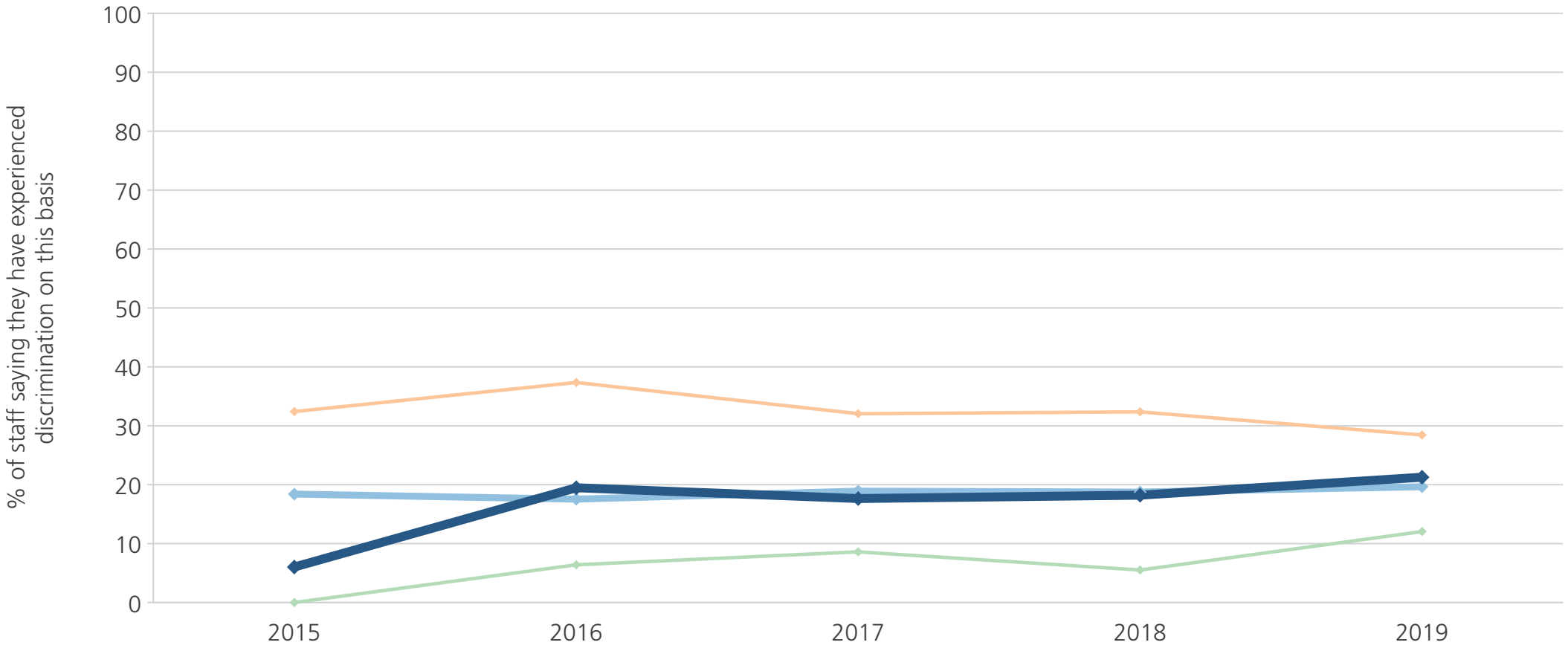
2019 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q15c.1 > On what grounds have you experienced discrimination? - Ethnic background

This question was only answered by staff who reported experiencing at least one incident of discrimination in the last 12 months.



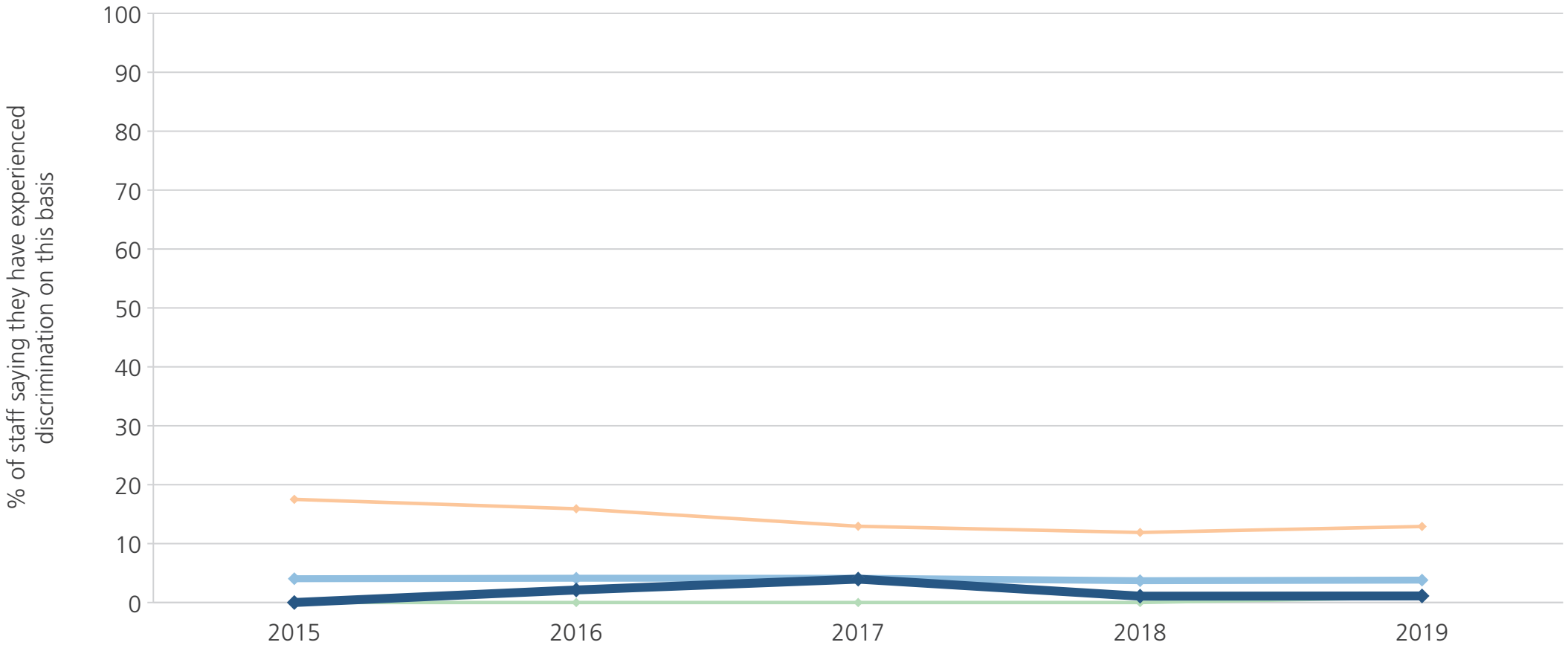
	2015	2016	2017	2018	2019
Worst	66.6%	67.8%	68.4%	70.1%	71.2%
Your org	59.6%	35.9%	24.4%	31.8%	28.2%
Average	38.0%	41.4%	39.9%	43.6%	45.5%
Best	16.9%	16.9%	20.1%	4.9%	22.4%
Responses	15	102	123	133	146

This question was only answered by staff who reported experiencing at least one incident of discrimination in the last 12 months.



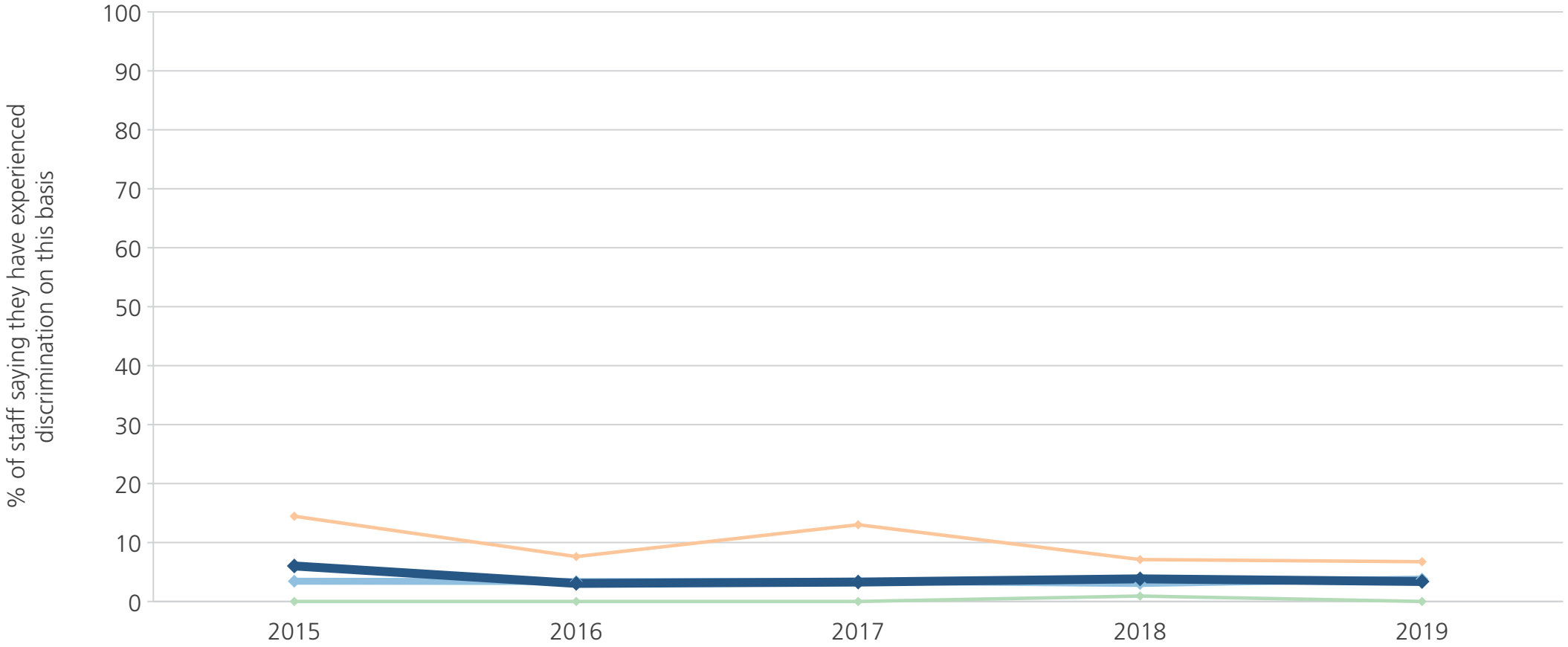
	2015	2016	2017	2018	2019
Worst	32.4%	37.3%	32.0%	32.4%	28.4%
Your org	6.0%	19.5%	17.6%	18.2%	21.3%
Average	18.4%	17.5%	18.9%	18.7%	19.7%
Best	0.0%	6.4%	8.6%	5.5%	12.0%
Responses	15	102	123	133	146

This question was only answered by staff who reported experiencing at least one incident of discrimination in the last 12 months.



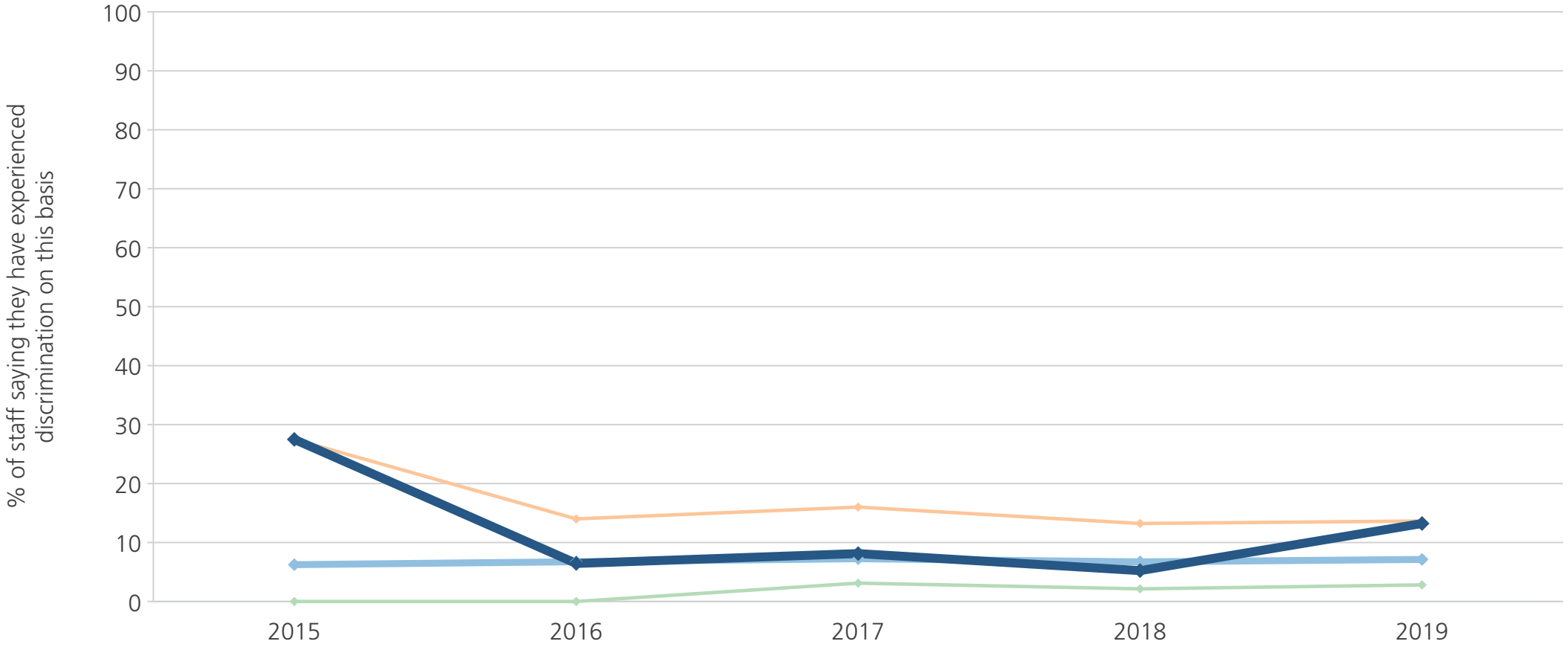
	2015	2016	2017	2018	2019
Worst	17.5%	15.9%	12.9%	11.9%	12.9%
Your org	0.0%	2.1%	4.0%	1.1%	1.1%
Average	4.0%	4.1%	4.1%	3.7%	3.8%
Best	0.0%	0.0%	0.0%	0.0%	0.9%
Responses	15	102	123	133	146

This question was only answered by staff who reported experiencing at least one incident of discrimination in the last 12 months.



	2015	2016	2017	2018	2019
Worst	14.5%	7.6%	13.0%	7.1%	6.7%
Your org	6.0%	3.1%	3.3%	3.8%	3.4%
Average	3.4%	3.4%	3.4%	3.1%	3.8%
Best	0.0%	0.0%	0.0%	0.9%	0.0%
Responses	15	102	123	133	146

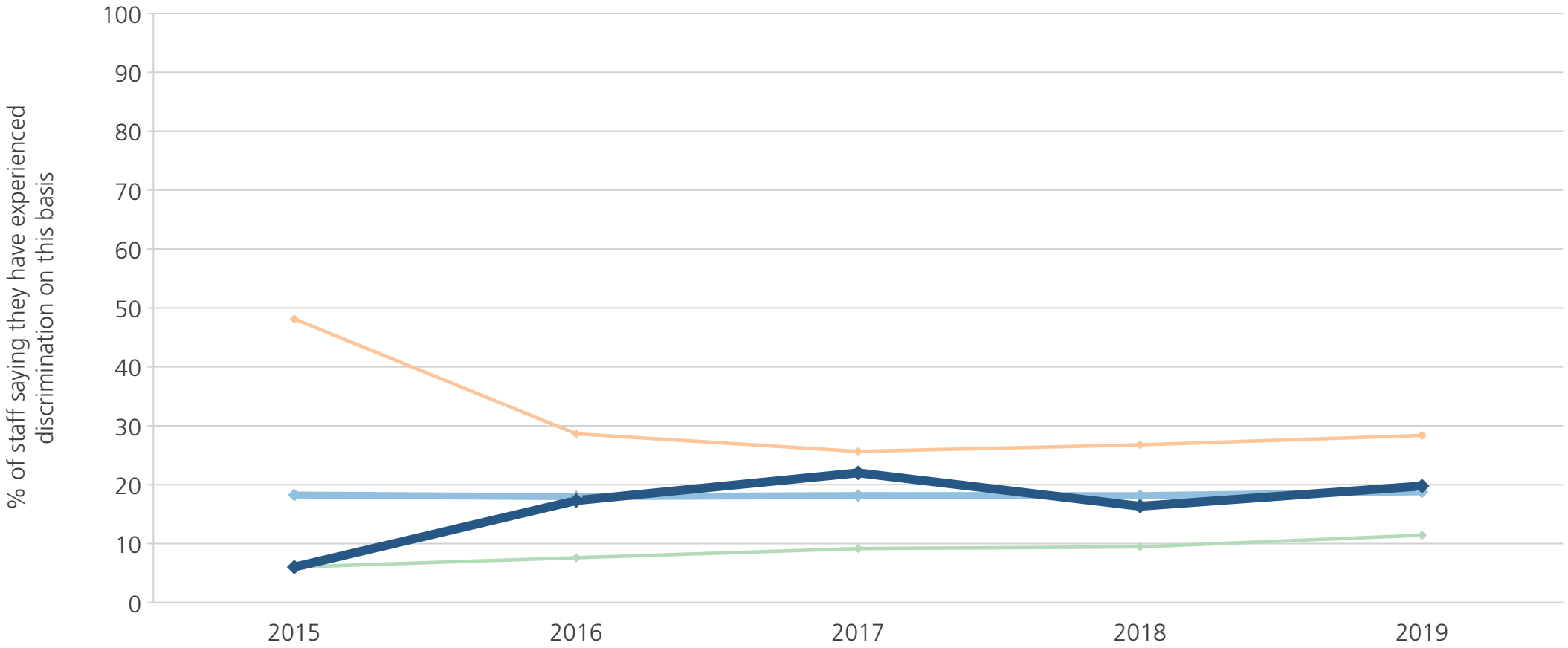
This question was only answered by staff who reported experiencing at least one incident of discrimination in the last 12 months.



	2015	2016	2017	2018	2019
Worst	27.5%	14.0%	16.0%	13.2%	13.6%
Your org	27.5%	6.4%	8.1%	5.2%	13.2%
Average	6.2%	6.7%	7.3%	6.7%	7.1%
Best	0.0%	0.0%	3.1%	2.1%	2.8%
Responses	15	102	123	133	146

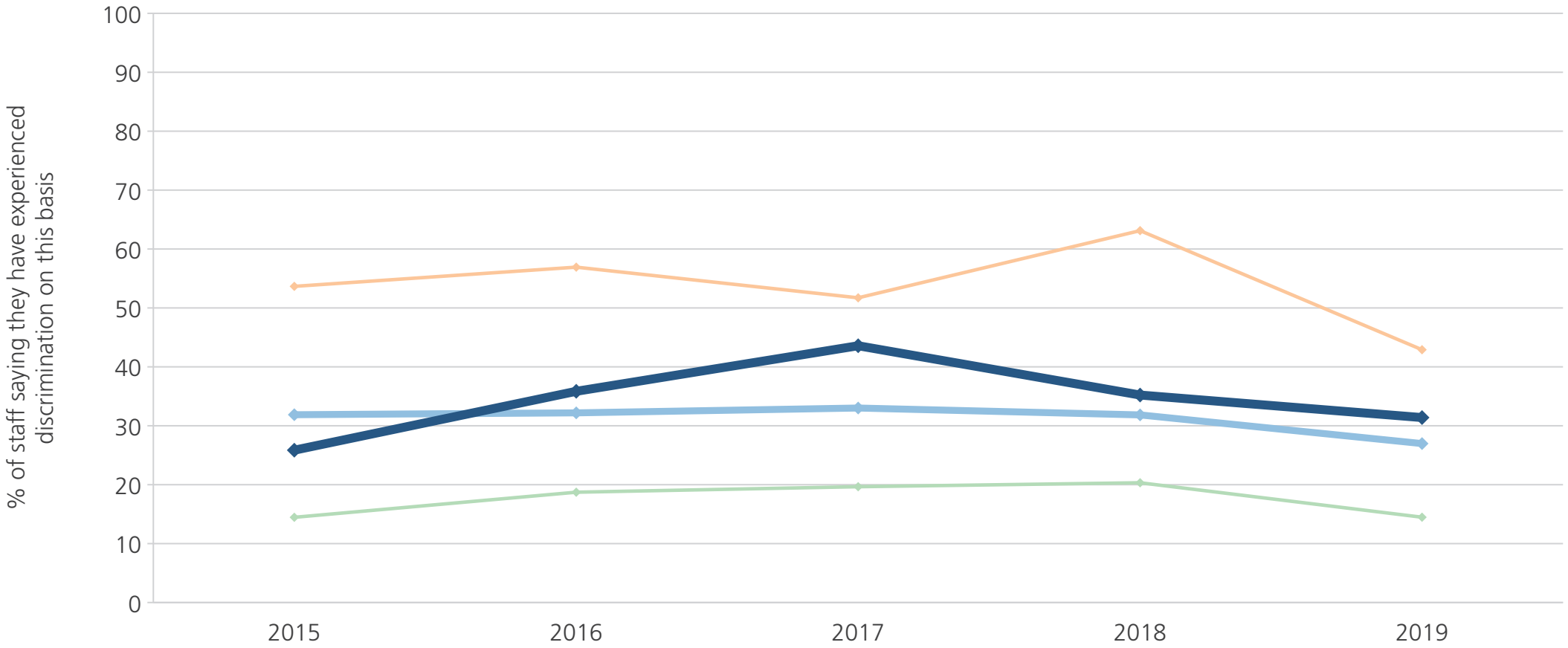
2019 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q15c.6 > On what grounds have you experienced discrimination? - Age

This question was only answered by staff who reported experiencing at least one incident of discrimination in the last 12 months.

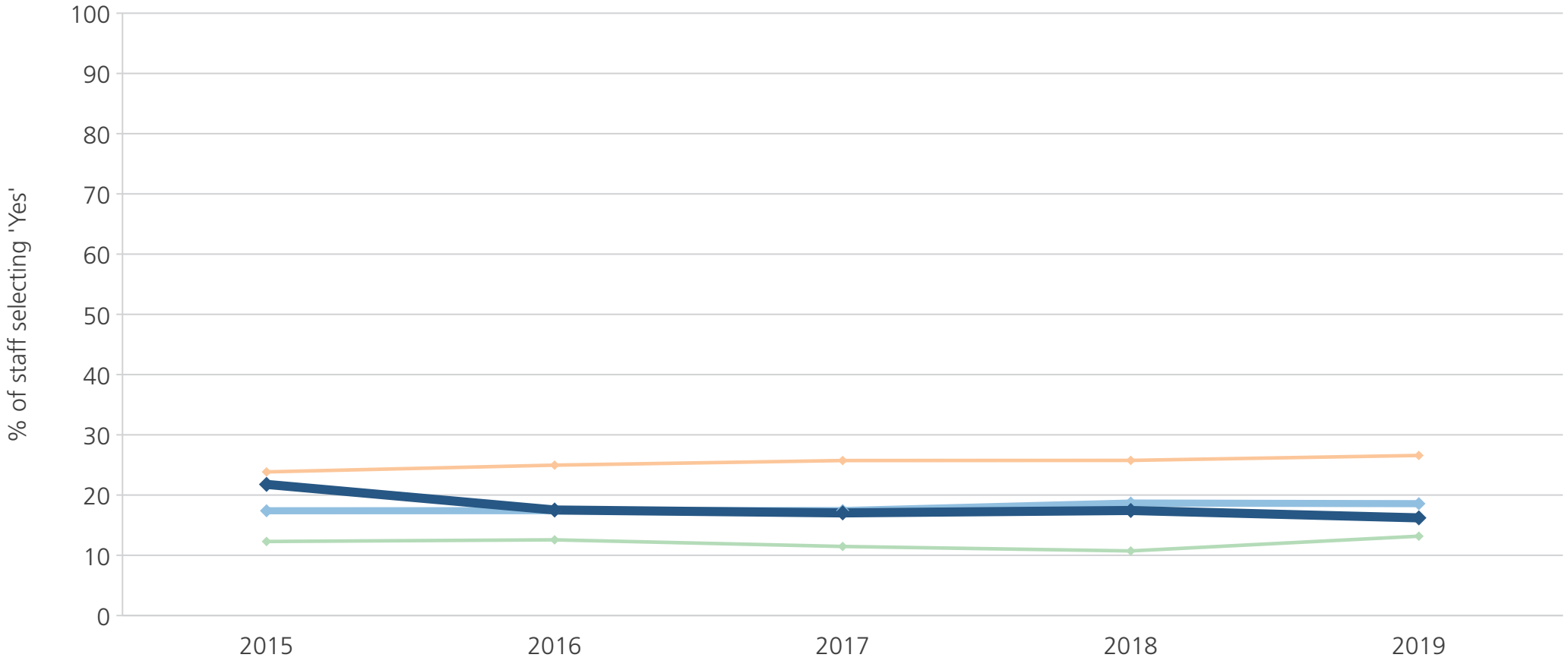


	2015	2016	2017	2018	2019
Worst	48.1%	28.6%	25.6%	26.8%	28.4%
Your org	6.0%	17.3%	22.0%	16.3%	19.8%
Average	18.2%	18.0%	18.2%	18.1%	18.8%
Best	6.0%	7.6%	9.2%	9.5%	11.4%
Responses	15	102	123	133	146

This question was only answered by staff who reported experiencing at least one incident of discrimination in the last 12 months.



	2015	2016	2017	2018	2019
Worst	53.7%	56.9%	51.7%	63.1%	42.9%
Your org	25.9%	35.8%	43.6%	35.2%	31.4%
Average	31.9%	32.2%	33.0%	31.8%	27.0%
Best	14.5%	18.7%	19.7%	20.3%	14.5%
Responses	15	102	123	133	146



	2015	2016	2017	2018	2019
Worst	23.8%	25.0%	25.7%	25.8%	26.6%
Your org	21.8%	17.5%	17.0%	17.4%	16.2%
Average	17.4%	17.4%	17.4%	18.7%	18.6%
Best	12.3%	12.6%	11.5%	10.7%	13.2%
Responses	272	1,437	1,763	1,935	2,089

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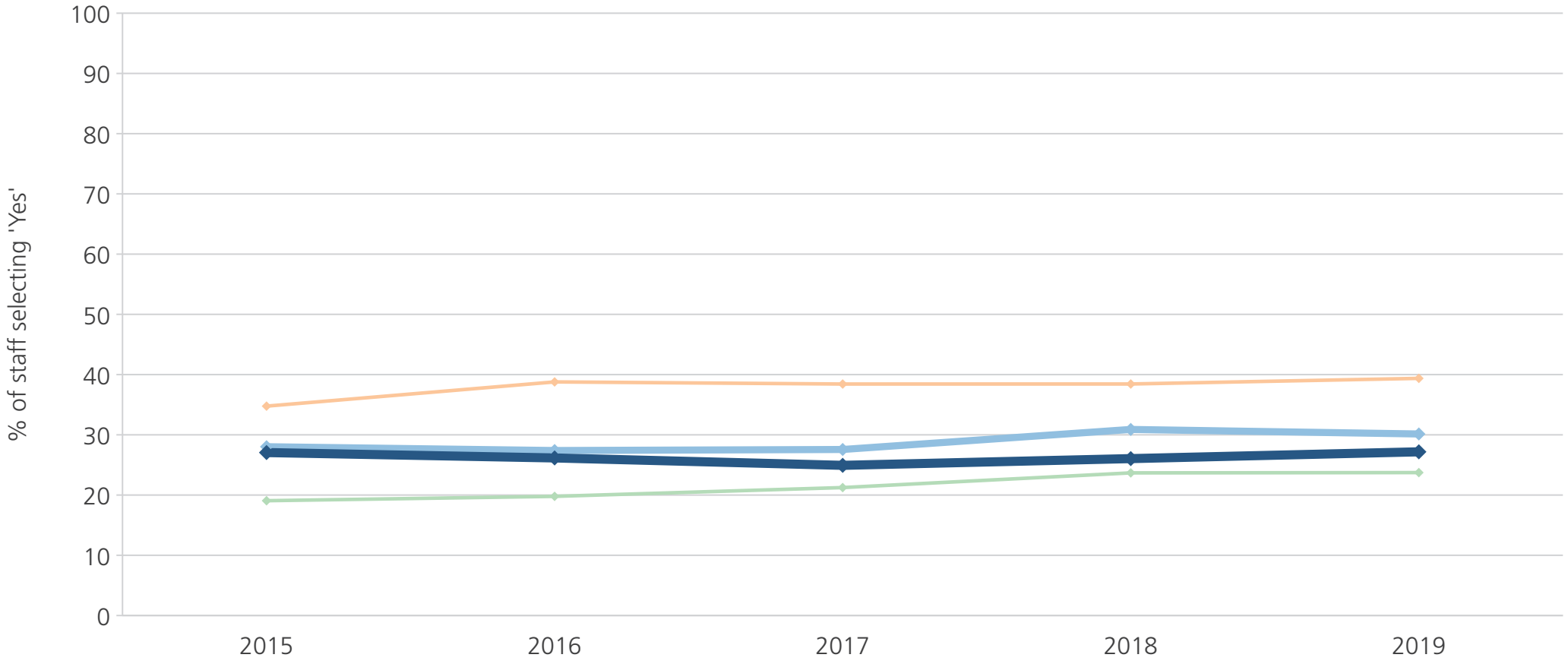
Survey Coordination Centre

2019 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q16b **>**
In the last month have you seen any errors, near misses, or incidents that could have hurt patients / service users?

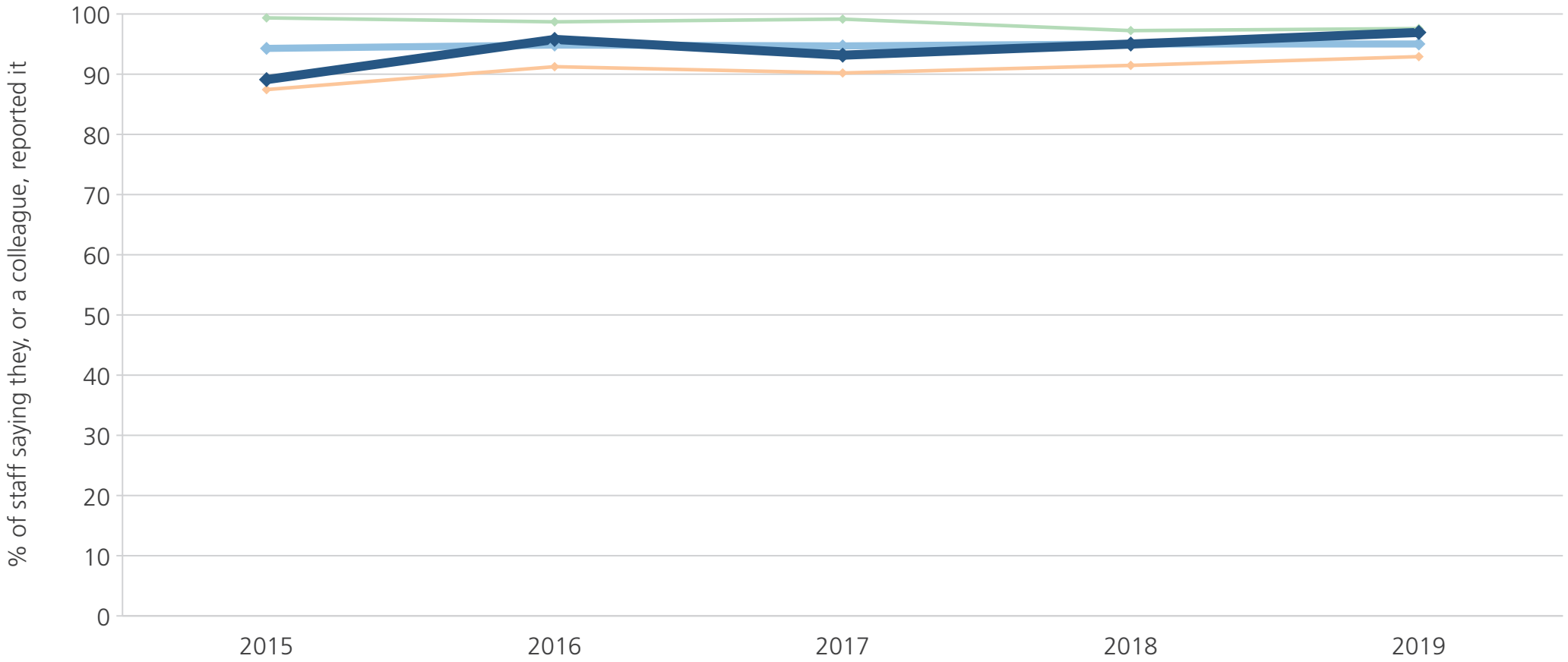
NHS England



	2015	2016	2017	2018	2019
Worst	34.8%	38.8%	38.4%	38.4%	39.4%
Your org	27.1%	26.2%	24.9%	26.0%	27.2%
Average	28.0%	27.4%	27.6%	30.9%	30.1%
Best	19.1%	19.8%	21.2%	23.7%	23.7%
Responses	265	1,416	1,735	1,914	2,068

2019 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q16c **>** The last time you saw an error, near miss or incident that could have hurt staff or patients / service users, did you or a colleague report it?

This question was only answered by staff who reported observing at least one error, near miss or incident in the last month.



	2015	2016	2017	2018	2019
Best	99.4%	98.7%	99.2%	97.2%	97.6%
Your org	89.1%	95.8%	93.2%	95.0%	96.9%
Average	94.3%	94.8%	94.7%	95.0%	95.0%
Worst	87.4%	91.2%	90.2%	91.5%	92.9%
Responses	80	366	447	502	565

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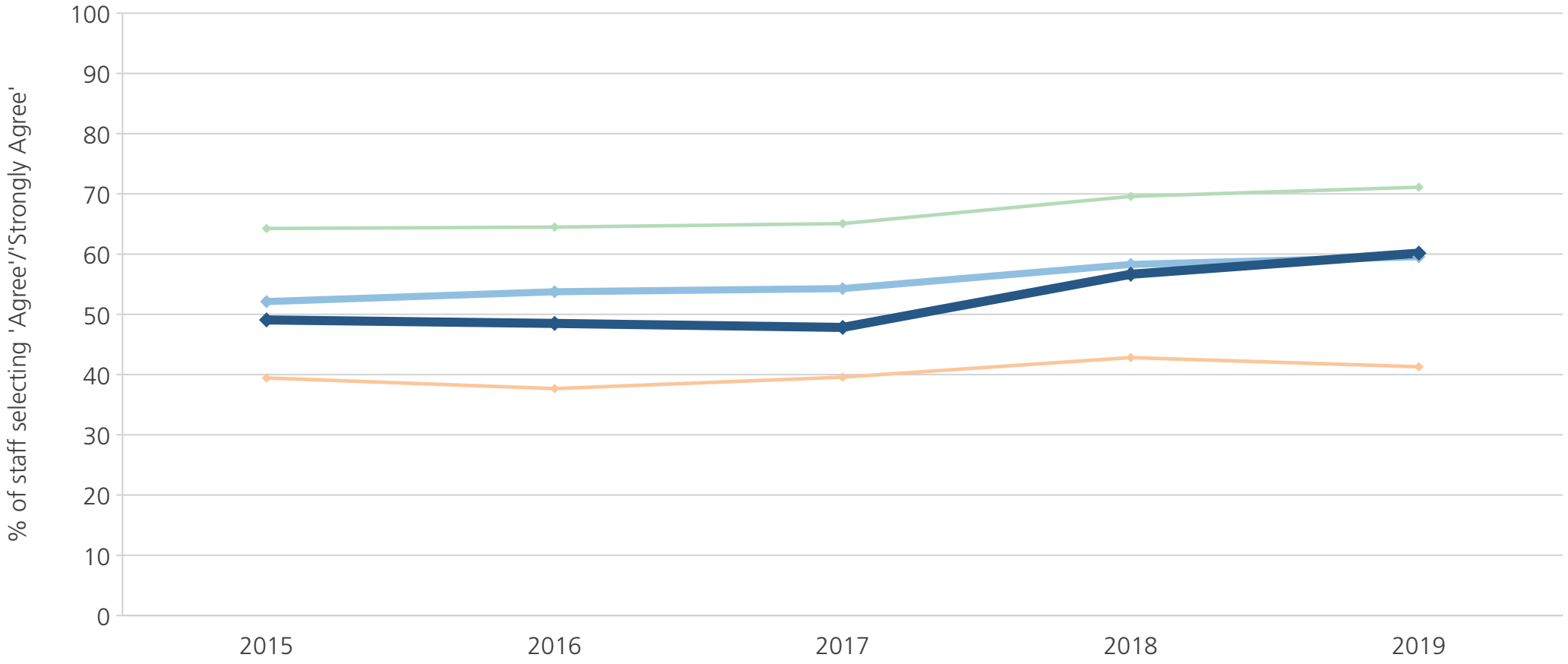
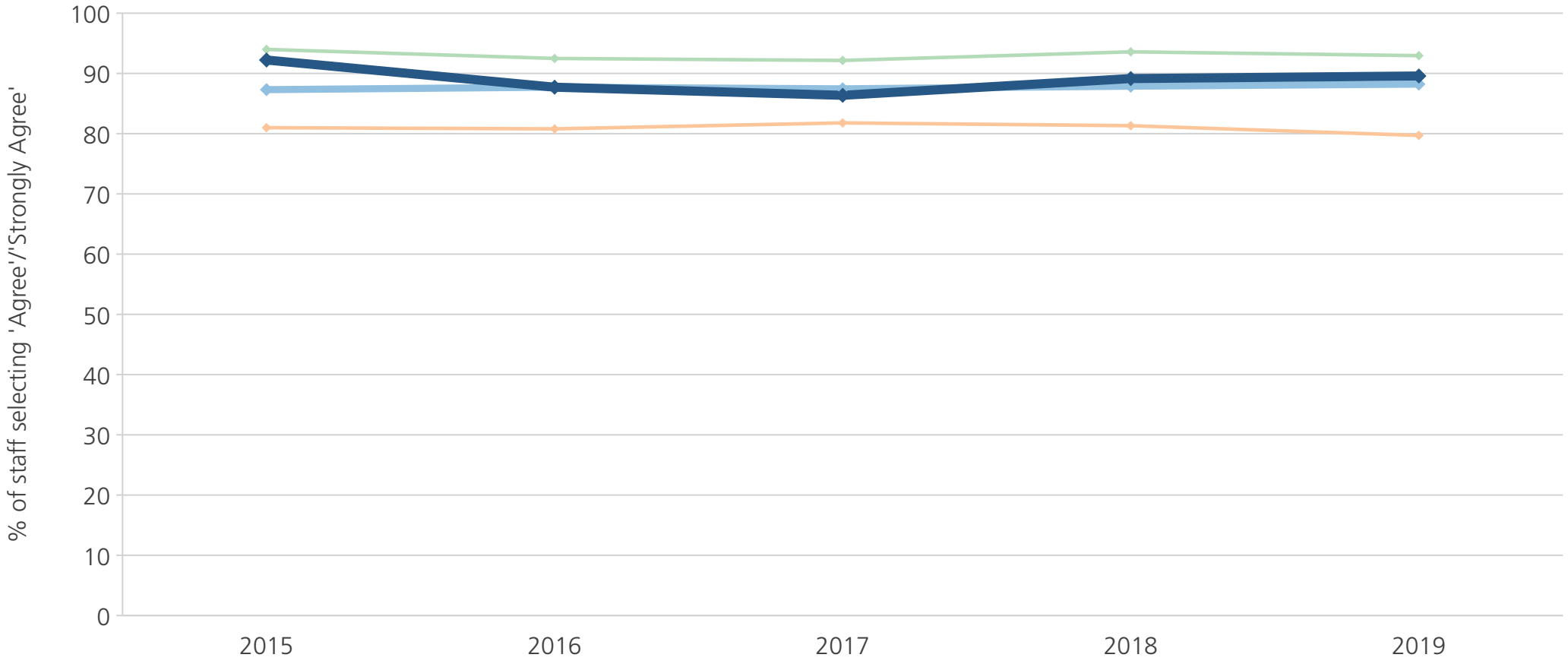
2019 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q17a > My organisation treats staff who are involved in an error, near miss or incident fairly



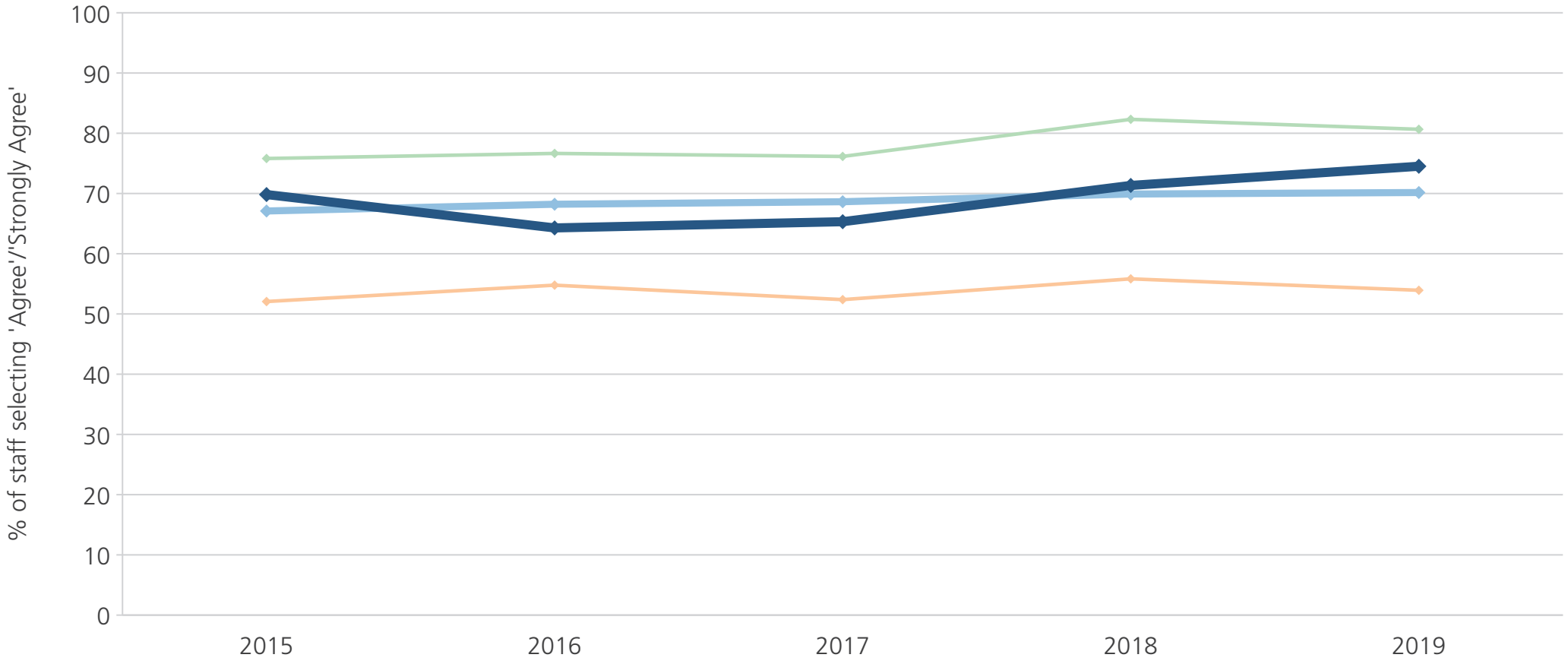
	2015	2016	2017	2018	2019
Best	64.3%	64.5%	65.1%	69.6%	71.1%
Your org	49.1%	48.5%	47.8%	56.7%	60.2%
Average	52.1%	53.8%	54.3%	58.3%	59.6%
Worst	39.4%	37.7%	39.6%	42.8%	41.3%
Responses	222	1,197	1,458	1,474	1,702

2019 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q17b > My organisation encourages us to report errors, near misses or incidents

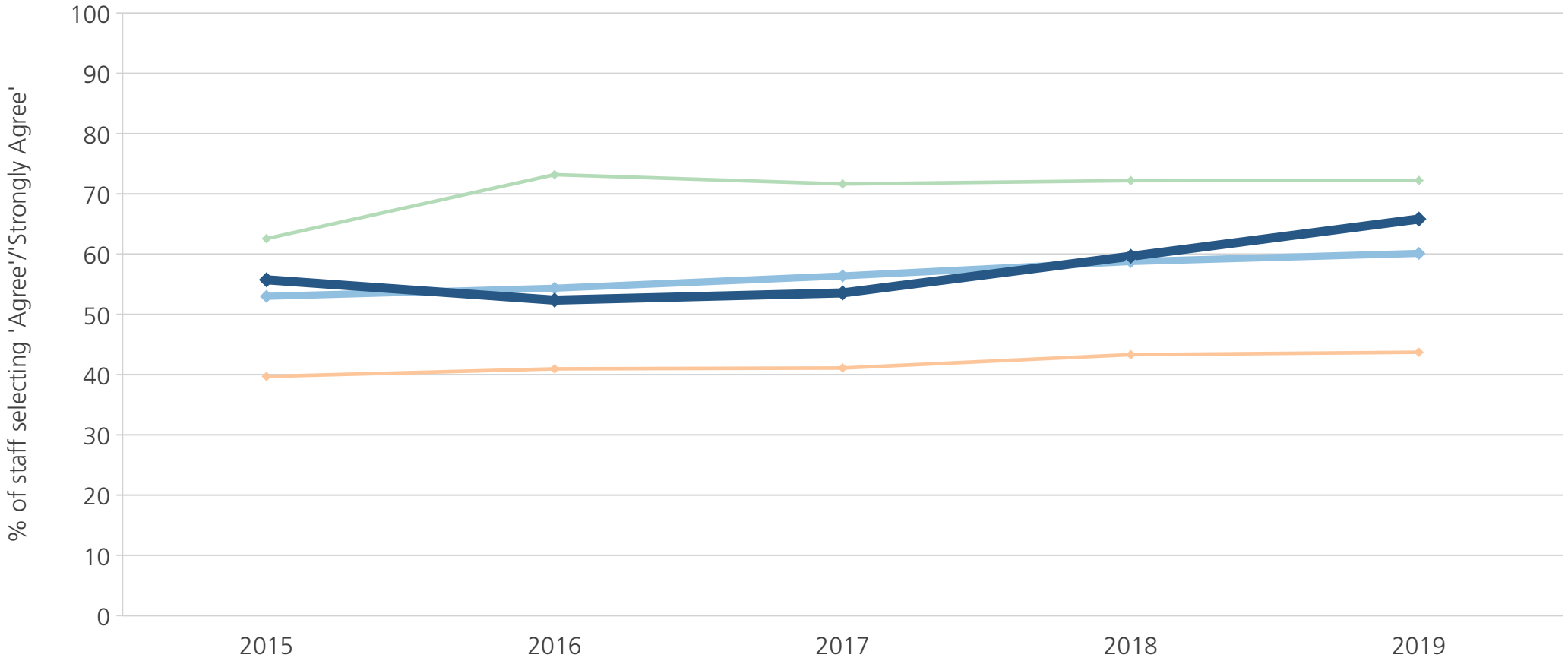


	2015	2016	2017	2018	2019
Best	94.0%	92.5%	92.2%	93.6%	93.0%
Your org	92.2%	87.7%	86.4%	89.1%	89.6%
Average	87.3%	87.7%	87.4%	87.9%	88.2%
Worst	81.0%	80.8%	81.8%	81.3%	79.7%
Responses	268	1,429	1,718	1,895	2,056

2019 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q17c **>** When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again

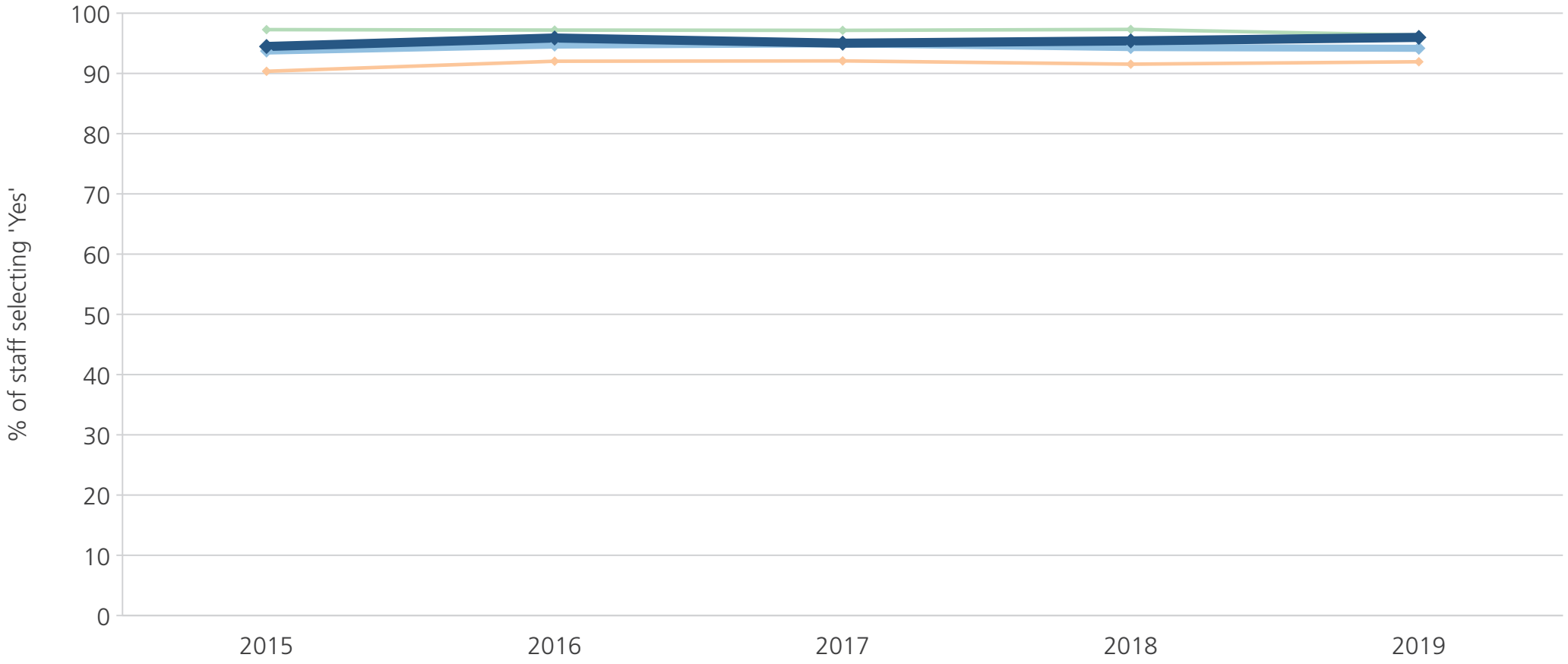


	2015	2016	2017	2018	2019
Best	75.8%	76.7%	76.2%	82.3%	80.7%
Your org	69.8%	64.3%	65.3%	71.3%	74.5%
Average	67.1%	68.2%	68.6%	69.9%	70.2%
Worst	52.1%	54.8%	52.4%	55.8%	53.9%
Responses	248	1,328	1,617	1,727	1,921



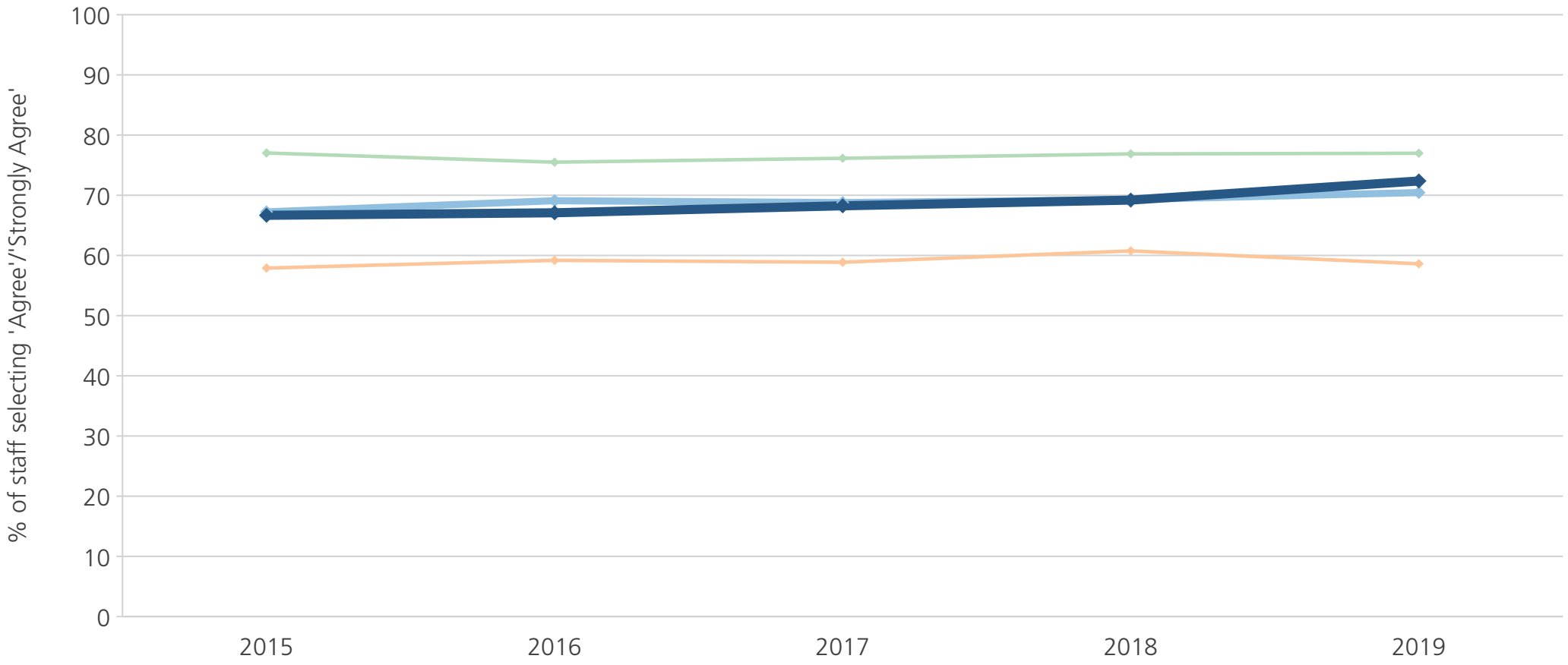
	2015	2016	2017	2018	2019
Best	62.6%	73.2%	71.6%	72.2%	72.2%
Your org	55.7%	52.4%	53.6%	59.6%	65.8%
Average	53.0%	54.3%	56.4%	58.8%	60.1%
Worst	39.7%	41.0%	41.1%	43.3%	43.7%
Responses	252	1,337	1,618	1,776	1,960

2019 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q18a > If you were concerned about unsafe clinical practice, would you know how to report it?



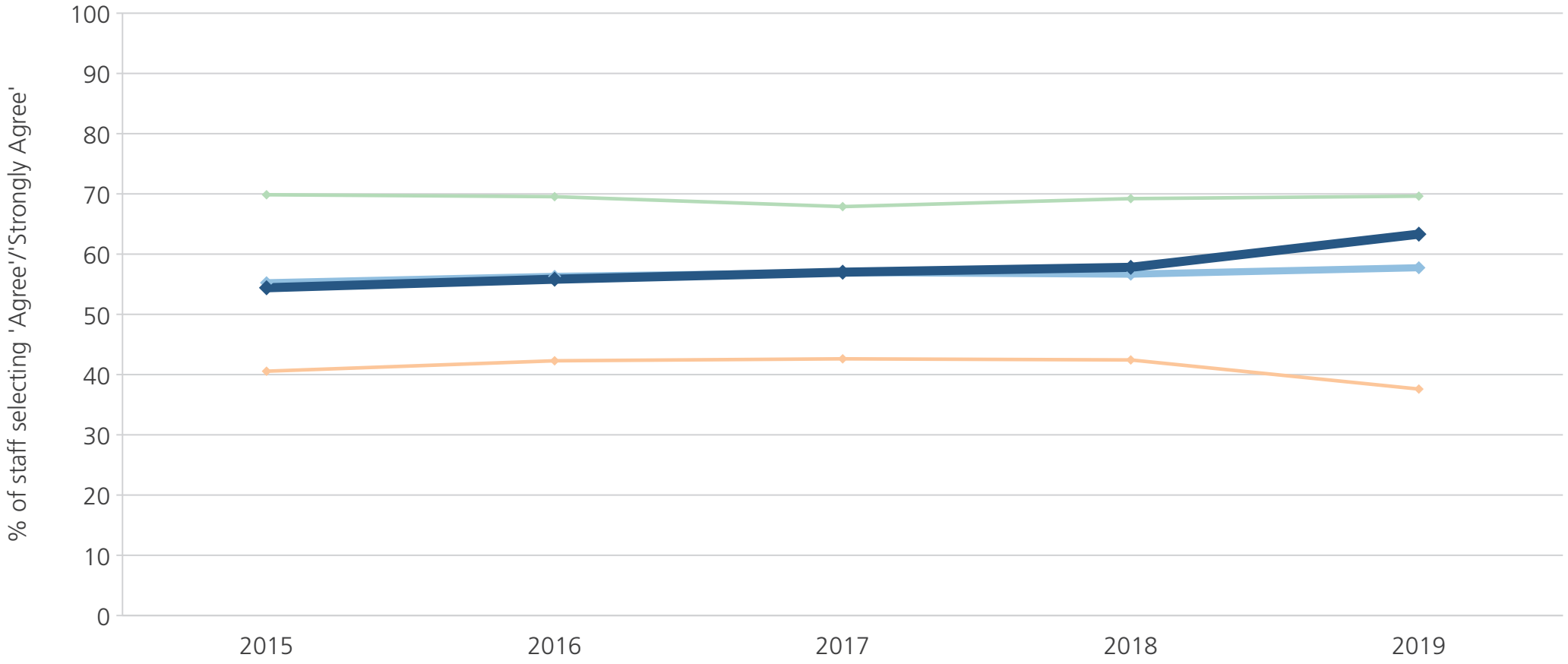
	2015	2016	2017	2018	2019
Best	97.3%	97.2%	97.1%	97.3%	96.4%
Your org	94.5%	95.9%	95.0%	95.4%	96.0%
Average	93.7%	94.7%	94.9%	94.3%	94.2%
Worst	90.4%	92.0%	92.1%	91.5%	91.9%
Responses	256	1,299	1,582	1,754	1,893

2019 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q18b > I would feel secure raising concerns about unsafe clinical practice



	2015	2016	2017	2018	2019
Best	77.0%	75.5%	76.1%	76.9%	77.0%
Your org	66.7%	67.1%	68.2%	69.2%	72.4%
Average	67.2%	69.1%	68.8%	69.3%	70.4%
Worst	57.9%	59.2%	58.9%	60.8%	58.6%
Responses	271	1,446	1,760	1,959	2,092

2019 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q18c > I am confident that my organisation would address my concern



	2015	2016	2017	2018	2019
Best	69.9%	69.5%	67.9%	69.2%	69.6%
Your org	54.4%	55.8%	57.0%	57.8%	63.3%
Average	55.2%	56.3%	56.9%	56.7%	57.7%
Worst	40.6%	42.3%	42.6%	42.4%	37.6%
Responses	270	1,442	1,757	1,956	2,093

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Survey Coordination Centre

NHS England

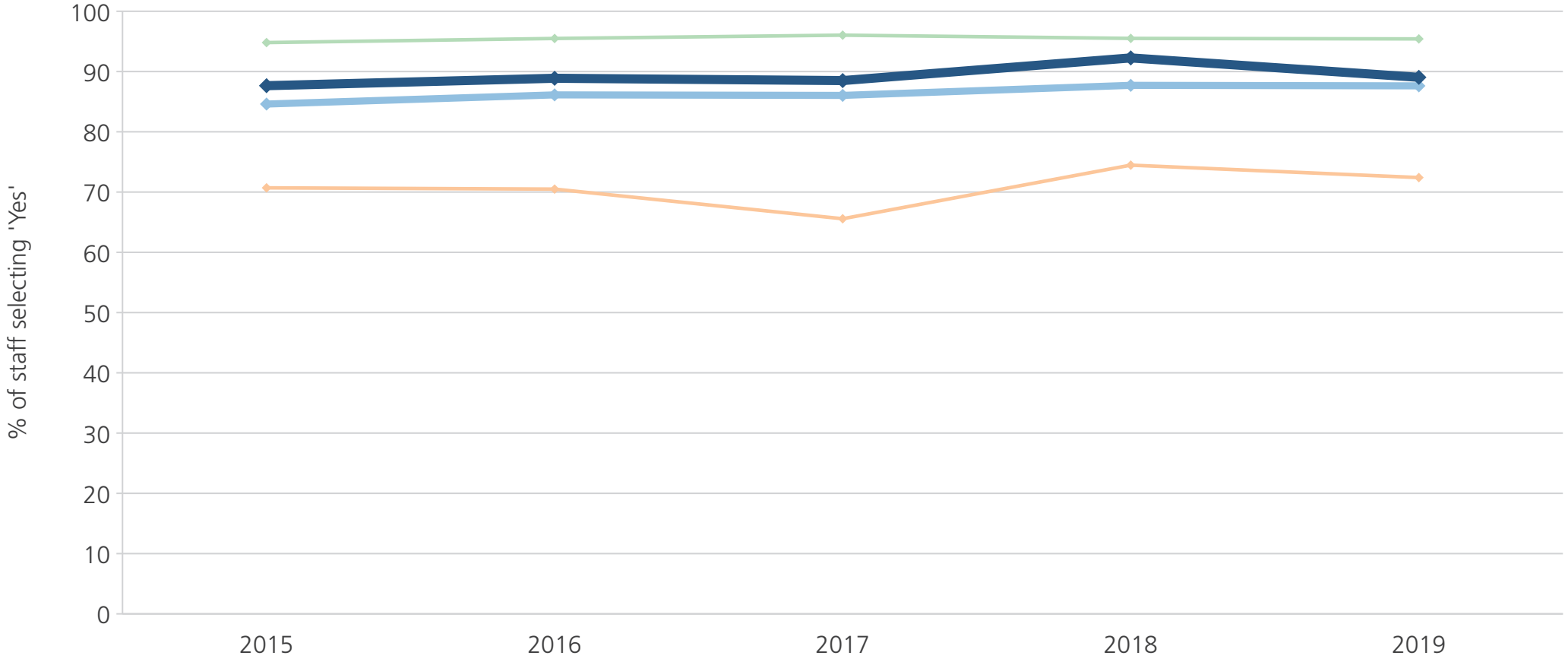
Question results – Your personal development

Warrington and Halton Hospitals NHS Foundation Trust

2019 NHS Staff Survey Results

2019 NHS Staff Survey Results > Question results > Your personal development

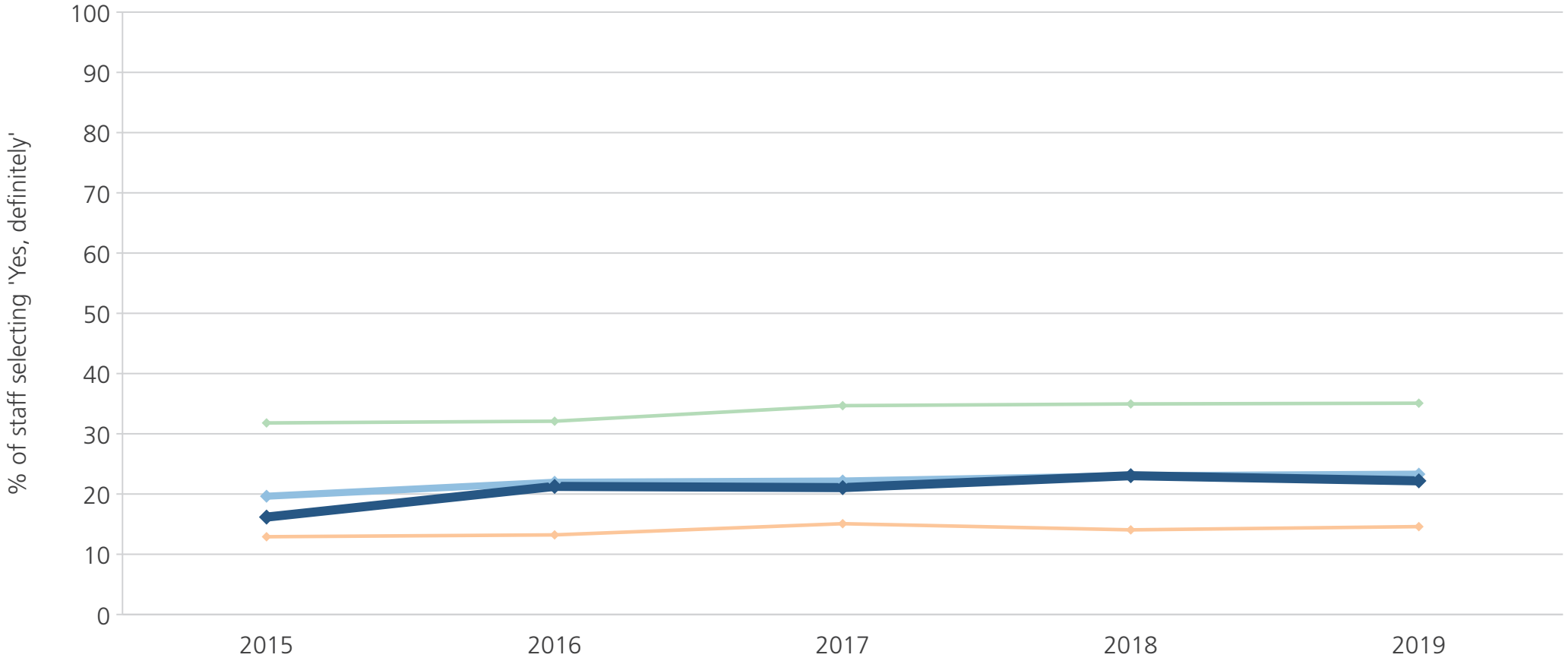
> Q19a > In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?



	2015	2016	2017	2018	2019
Best	94.8%	95.5%	96.0%	95.5%	95.4%
Your org	87.7%	88.9%	88.5%	92.3%	89.0%
Average	84.6%	86.1%	86.0%	87.7%	87.6%
Worst	70.7%	70.5%	65.6%	74.5%	72.4%
Responses	264	1,409	1,709	1,918	2,039

2019 NHS Staff Survey Results > Question results > Your personal development > Q19b > It helped me to improve how I do my job

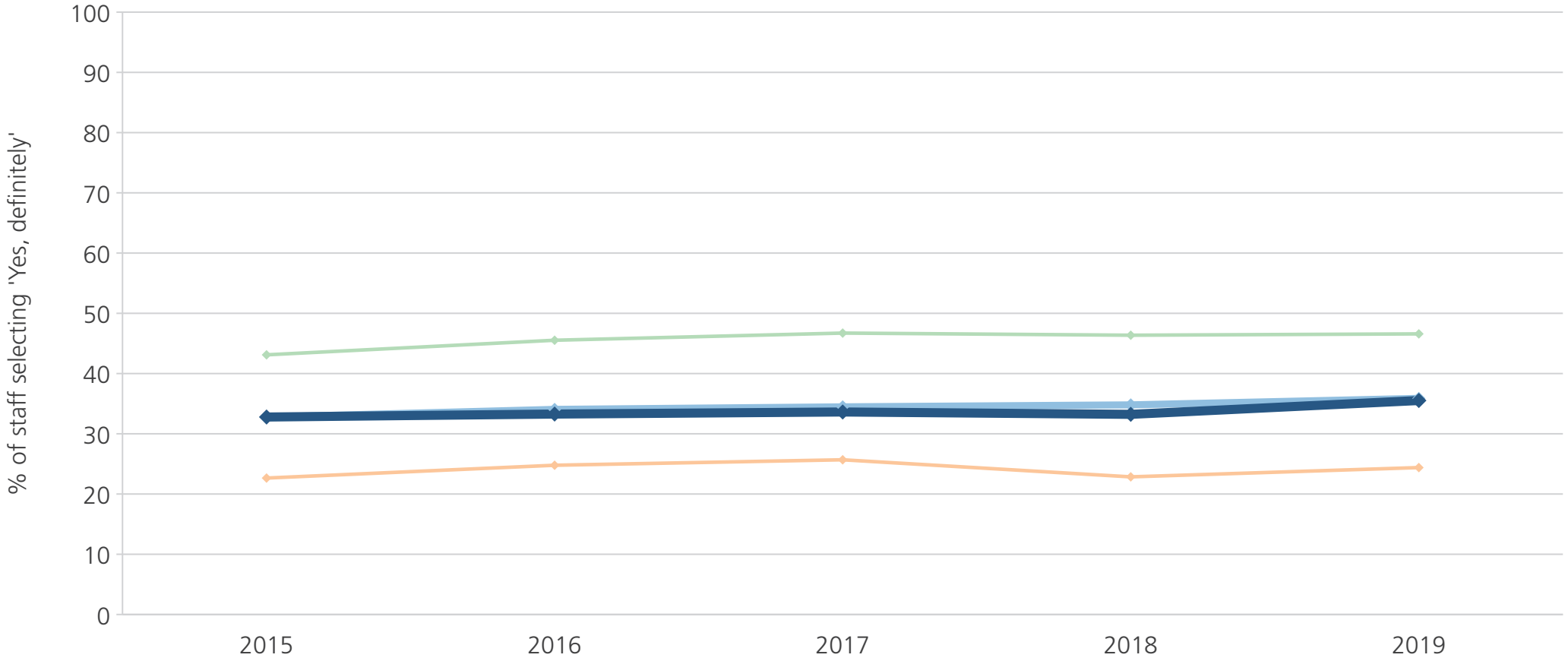
This question was only answered by staff who selected 'Yes' on q19a.



	2015	2016	2017	2018	2019
Best	31.8%	32.1%	34.7%	35.0%	35.1%
Your org	16.2%	21.3%	21.1%	23.0%	22.2%
Average	19.6%	22.0%	22.2%	23.0%	23.3%
Worst	12.9%	13.2%	15.1%	14.1%	14.6%
Responses	228	1,231	1,490	1,753	1,800

2019 NHS Staff Survey Results > Question results > Your personal development > Q19c > It helped me agree clear objectives for my work

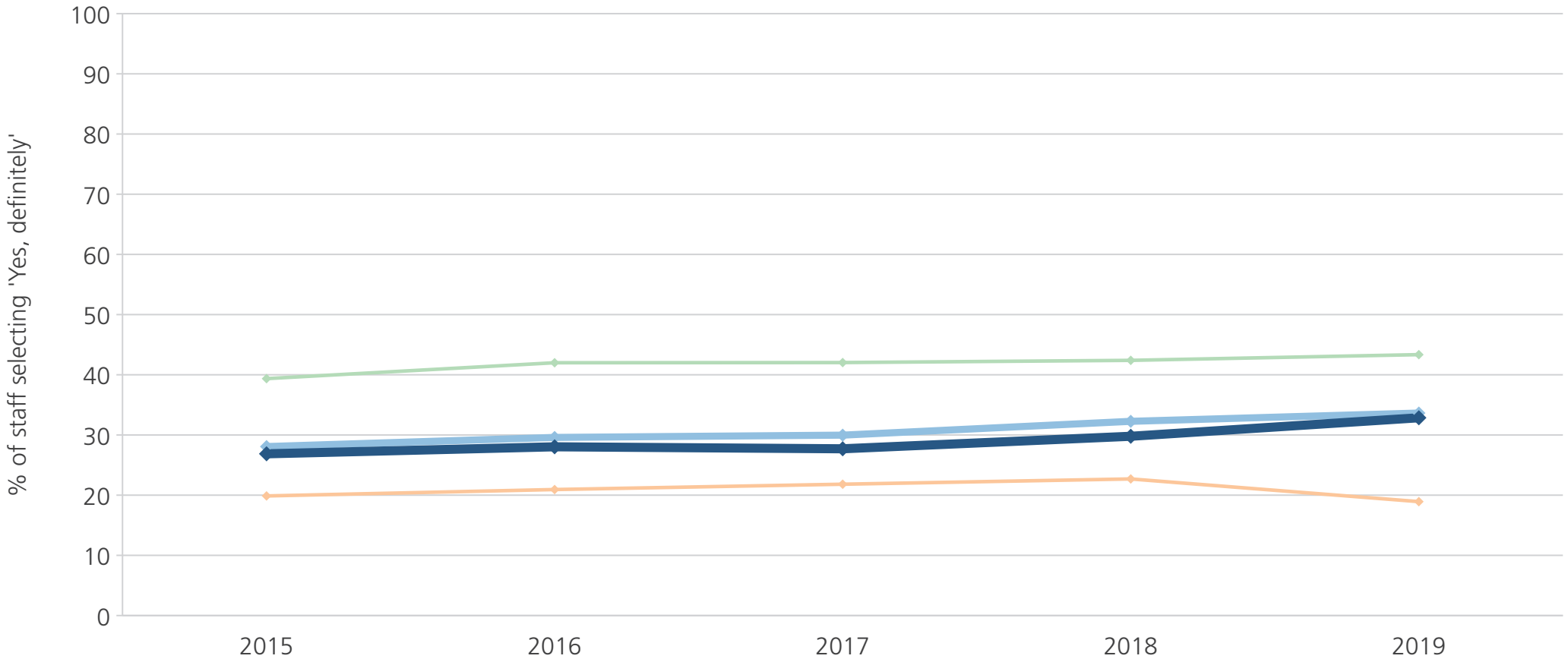
This question was only answered by staff who selected 'Yes' on q19a.



	2015	2016	2017	2018	2019
Best	43.1%	45.5%	46.7%	46.4%	46.6%
Your org	32.8%	33.3%	33.6%	33.2%	35.5%
Average	32.8%	34.1%	34.5%	34.8%	35.9%
Worst	22.6%	24.8%	25.7%	22.8%	24.4%
Responses	226	1,234	1,485	1,747	1,795

2019 NHS Staff Survey Results > Question results > Your personal development > Q19d > It left me feeling that my work is valued by my organisation

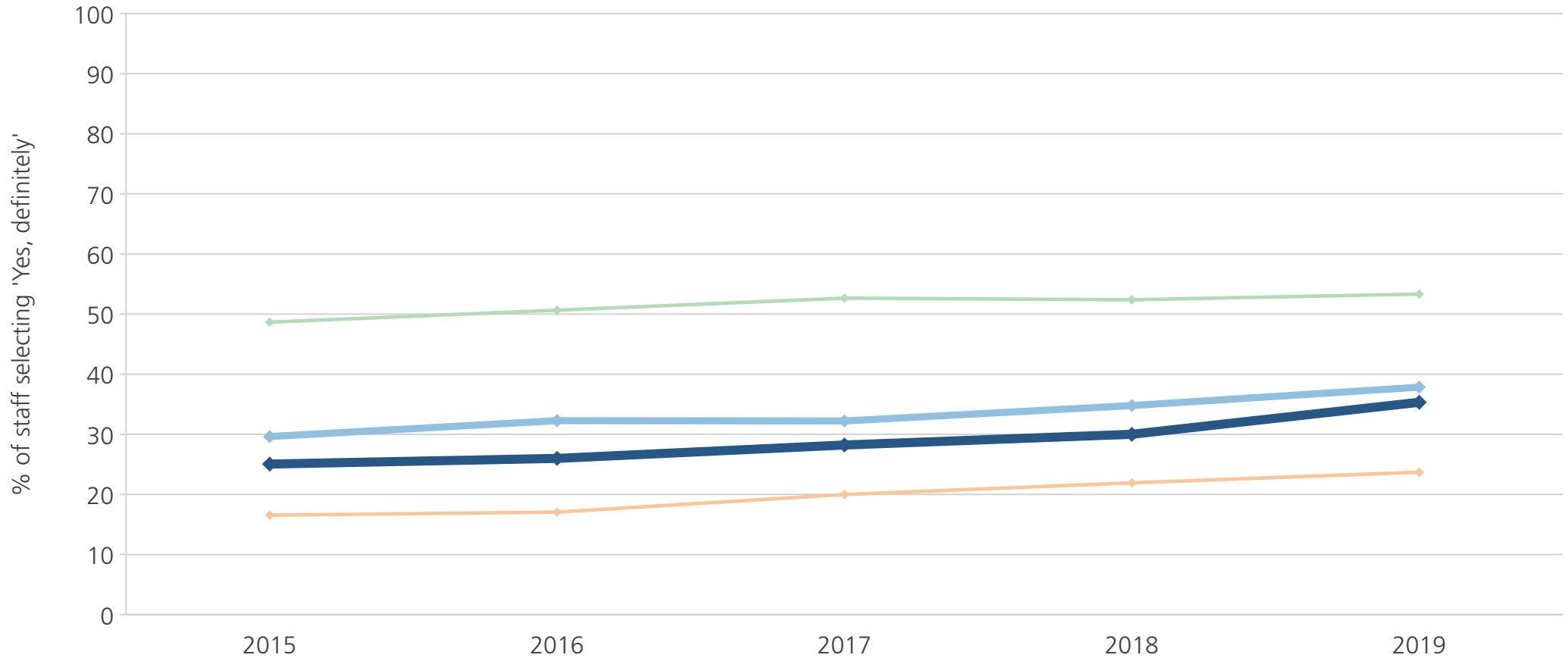
This question was only answered by staff who selected 'Yes' on q19a.



	2015	2016	2017	2018	2019
Best	39.4%	42.0%	42.0%	42.4%	43.3%
Your org	26.9%	28.0%	27.7%	29.8%	32.9%
Average	28.1%	29.6%	30.0%	32.3%	33.6%
Worst	19.9%	20.9%	21.8%	22.7%	18.9%
Responses	226	1,229	1,474	1,744	1,792

2019 NHS Staff Survey Results > Question results > Your personal development > Q19e > The values of my organisation were discussed as part of the appraisal process

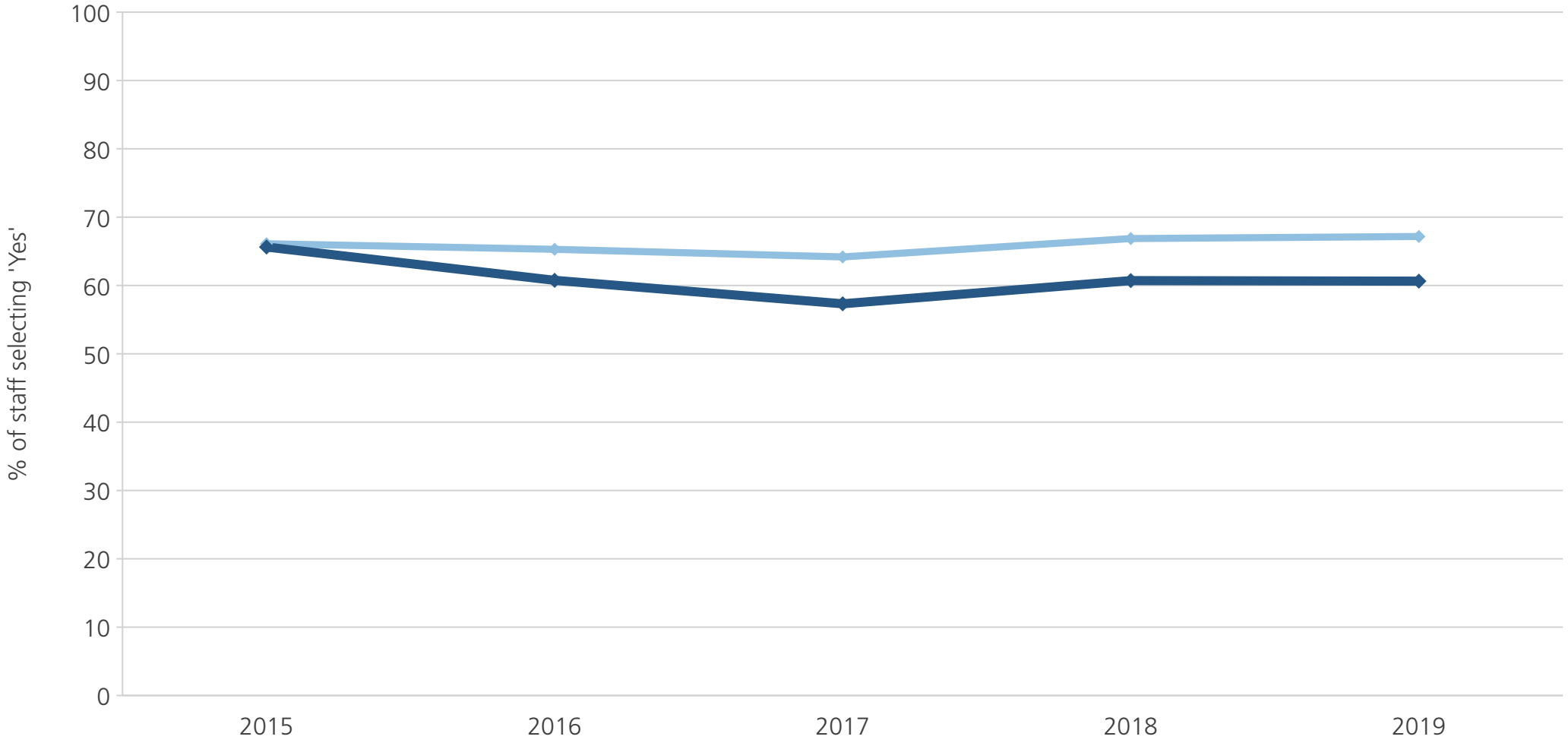
This question was only answered by staff who selected 'Yes' on q19a.



	2015	2016	2017	2018	2019
Best	48.7%	50.7%	52.7%	52.4%	53.3%
Your org	25.0%	26.0%	28.2%	30.0%	35.3%
Average	29.6%	32.3%	32.2%	34.8%	37.8%
Worst	16.5%	17.1%	20.0%	21.9%	23.7%
Responses	225	1,208	1,464	1,729	1,780

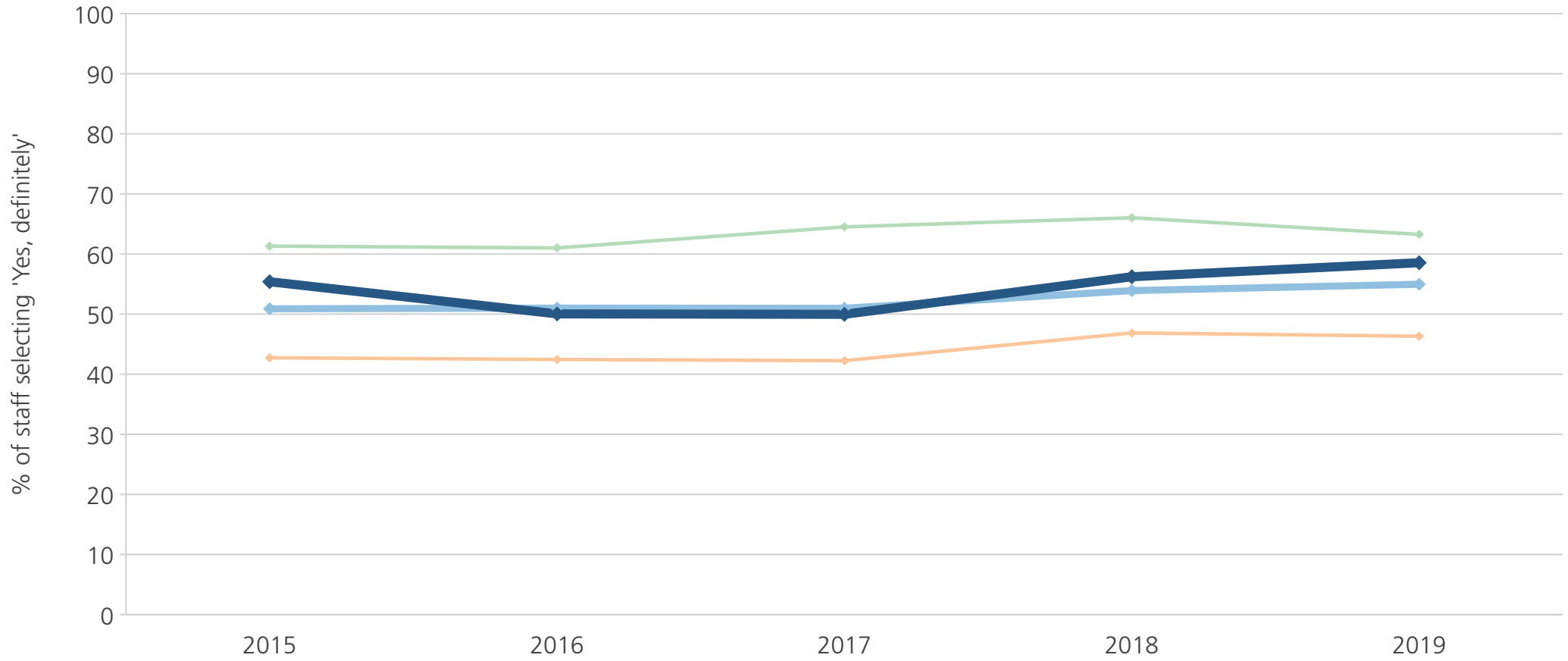
2019 NHS Staff Survey Results > Question results > Your personal development > Q19f > Were any training, learning or development needs identified?

This question was only answered by staff who selected 'Yes' on q19a.



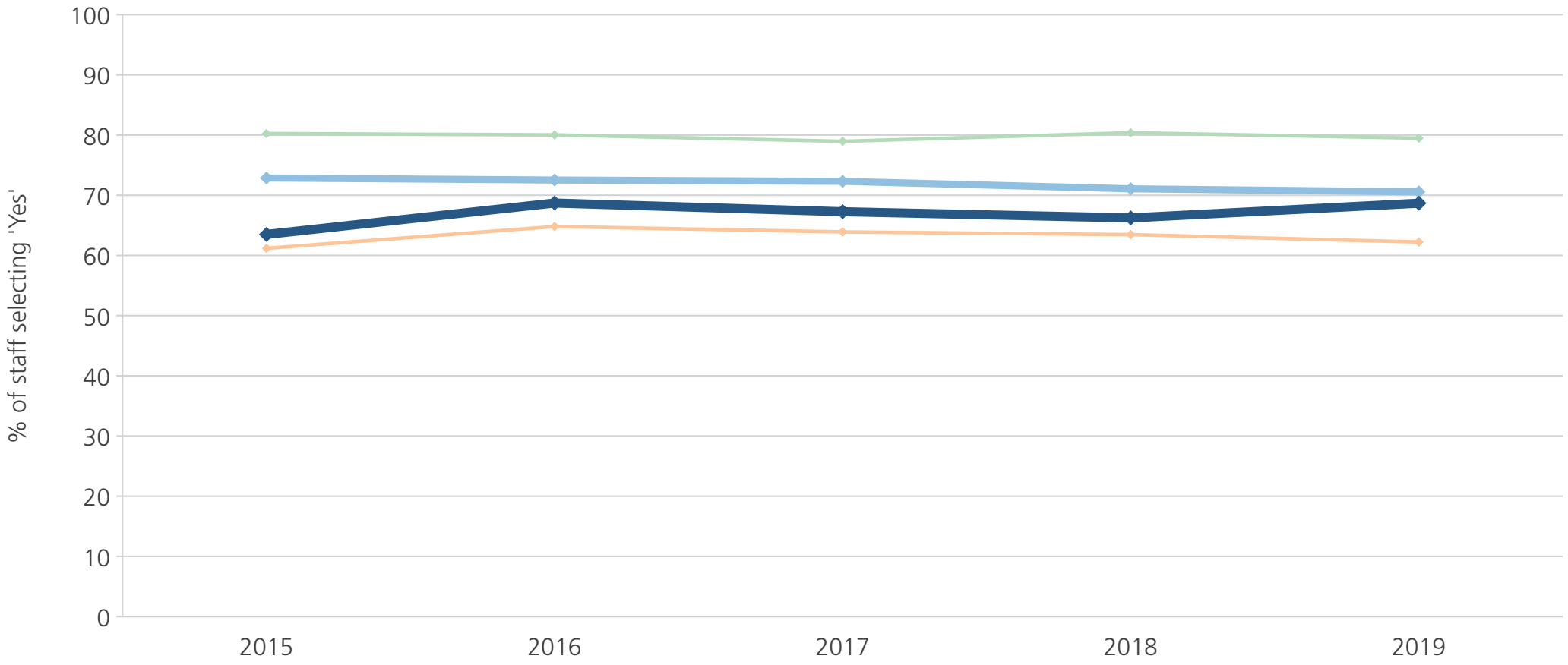
	2015	2016	2017	2018	2019
Your org	65.6%	60.8%	57.3%	60.7%	60.6%
Average	66.1%	65.3%	64.2%	66.9%	67.2%
Responses	224	1,195	1,448	1,713	1,773

This question was only answered by staff who selected 'Yes' on q19f.



	2015	2016	2017	2018	2019
Best	61.3%	61.0%	64.5%	66.0%	63.3%
Your org	55.4%	50.0%	50.0%	56.2%	58.6%
Average	50.9%	51.0%	51.0%	53.9%	55.0%
Worst	42.7%	42.5%	42.3%	46.9%	46.3%
Responses	145	708	816	1,024	1,058

2019 NHS Staff Survey Results > Question results > Your personal development > Q20 > Have you had any (non-mandatory) training, learning or development in the last 12 months?



	2015	2016	2017	2018	2019
Best	80.3%	80.0%	79.0%	80.4%	79.5%
Your org	63.5%	68.7%	67.3%	66.2%	68.7%
Average	72.9%	72.5%	72.3%	71.1%	70.6%
Worst	61.2%	64.8%	63.9%	63.5%	62.2%
Responses	266	1,402	1,728	1,895	2,043

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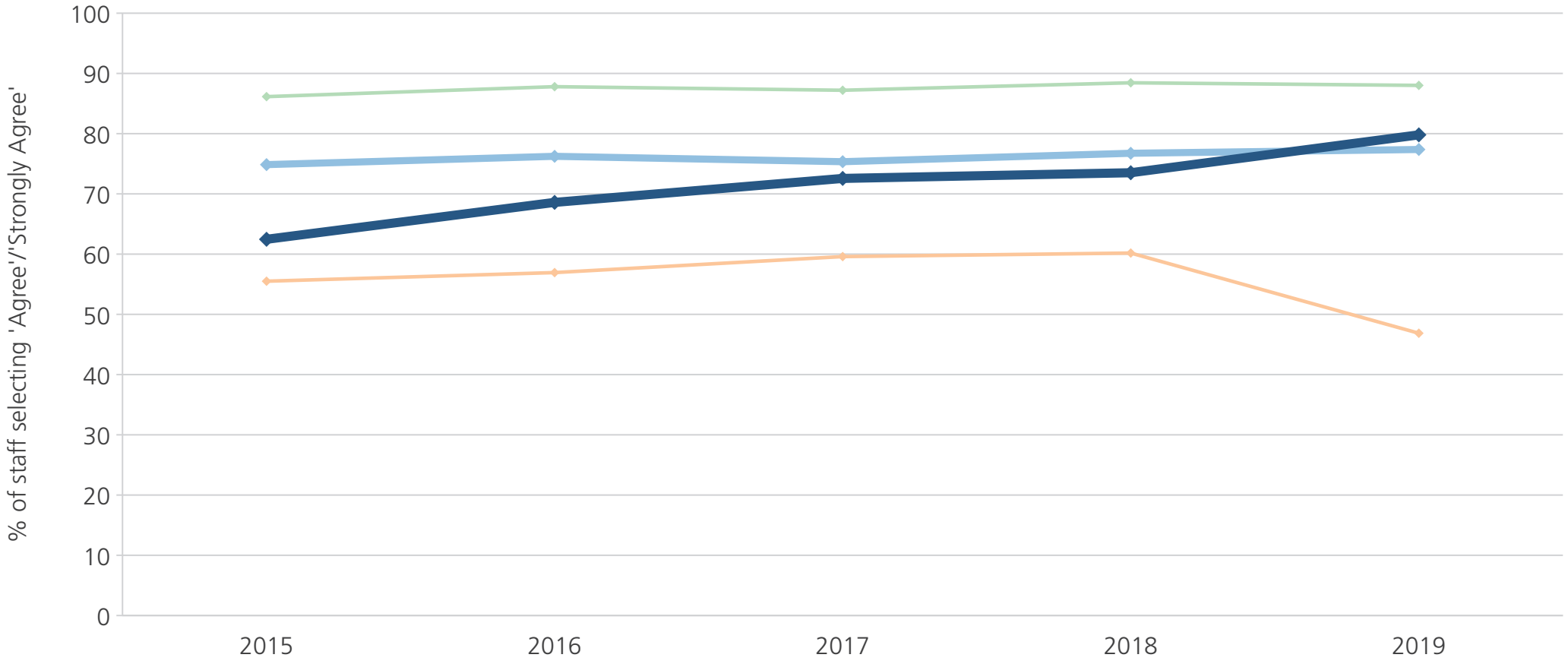
Survey Coordination Centre

NHS England

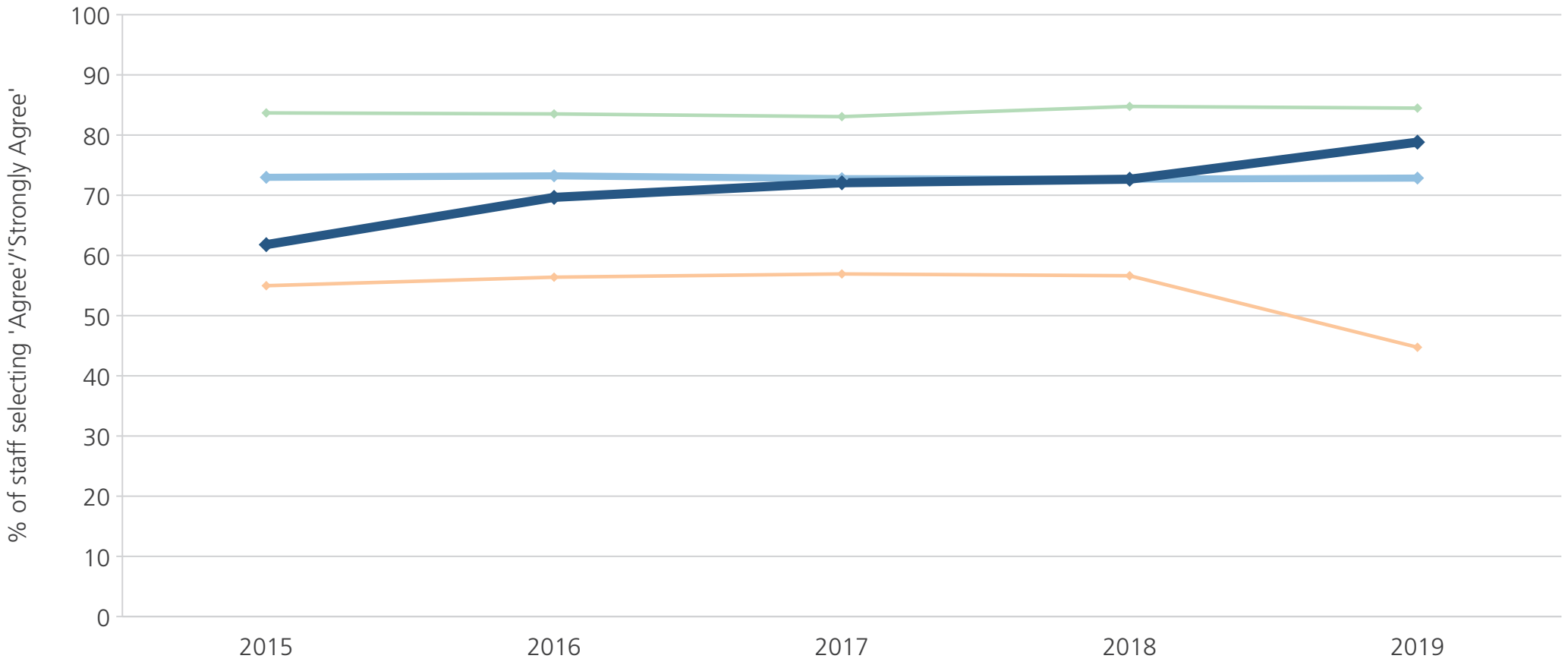
Question results – Your organisation

Warrington and Halton Hospitals NHS Foundation Trust

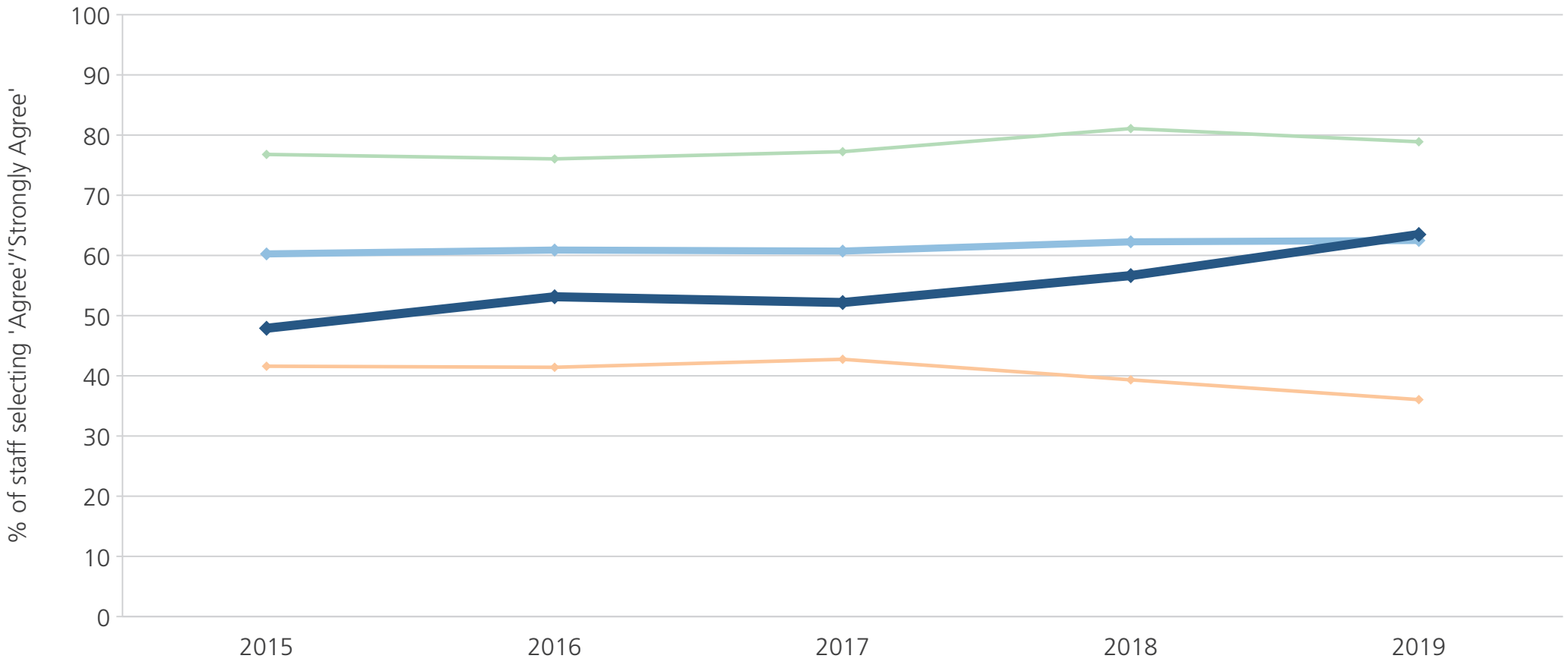
2019 NHS Staff Survey Results



	2015	2016	2017	2018	2019
Best	86.1%	87.8%	87.2%	88.4%	88.0%
Your org	62.5%	68.6%	72.6%	73.5%	79.8%
Average	74.9%	76.2%	75.3%	76.7%	77.4%
Worst	55.5%	56.9%	59.6%	60.2%	46.9%
Responses	267	1,446	1,753	1,941	2,082

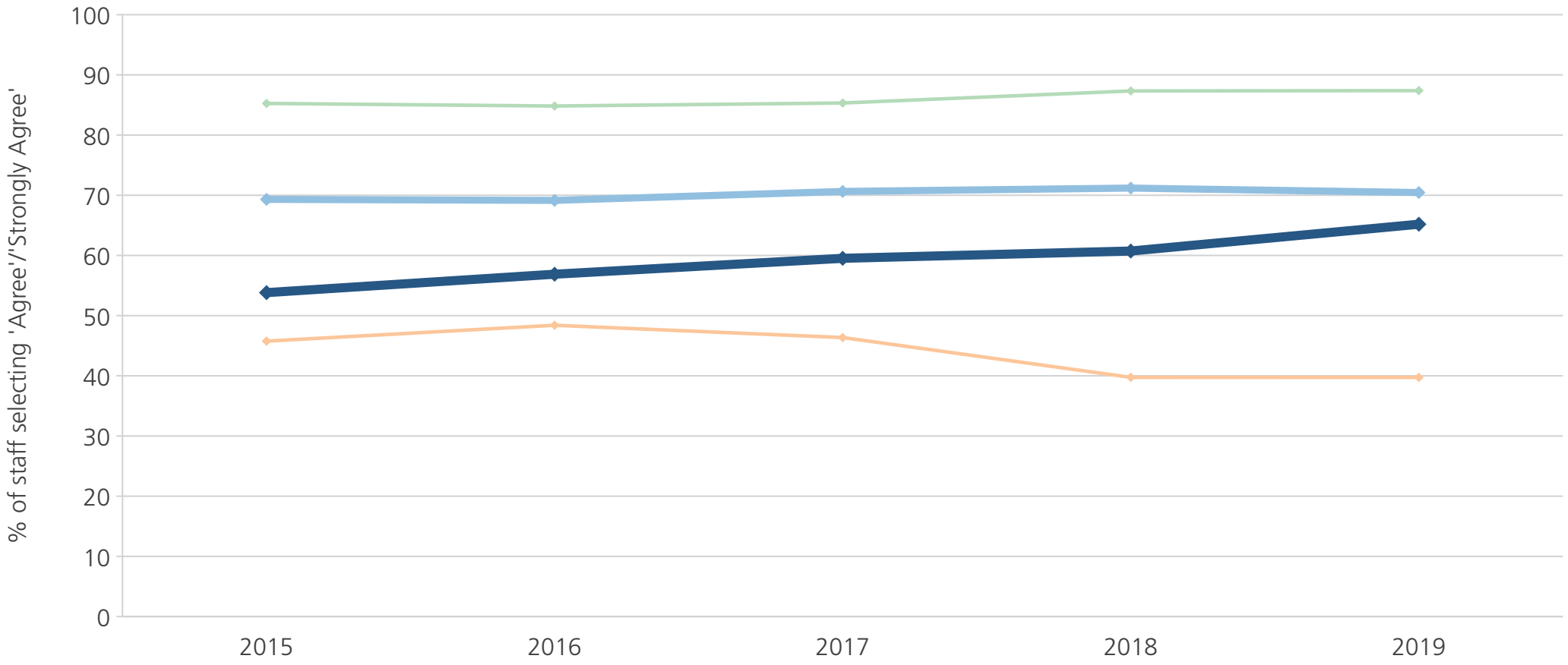


	2015	2016	2017	2018	2019
Best	83.7%	83.5%	83.1%	84.8%	84.5%
Your org	61.8%	69.6%	72.1%	72.7%	78.8%
Average	73.0%	73.2%	72.8%	72.7%	72.9%
Worst	55.0%	56.4%	56.9%	56.6%	44.7%
Responses	267	1,442	1,752	1,938	2,077



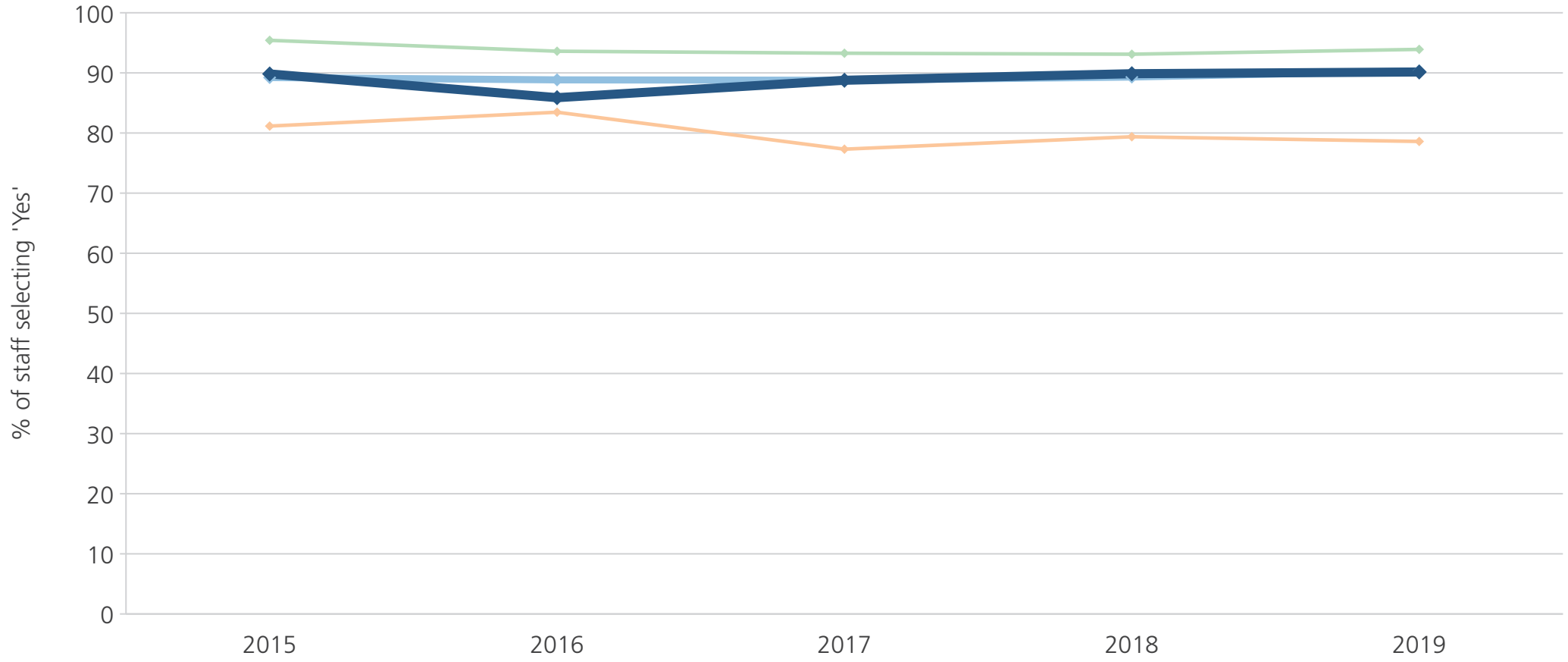
	2015	2016	2017	2018	2019
Best	76.8%	76.0%	77.2%	81.1%	78.9%
Your org	47.9%	53.1%	52.2%	56.7%	63.5%
Average	60.3%	60.9%	60.7%	62.3%	62.5%
Worst	41.6%	41.4%	42.7%	39.3%	36.0%
Responses	268	1,443	1,754	1,936	2,081

2019 NHS Staff Survey Results > Question results > Your organisation > Q21d > If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation



	2015	2016	2017	2018	2019
Best	85.3%	84.8%	85.3%	87.3%	87.4%
Your org	53.8%	56.9%	59.5%	60.7%	65.2%
Average	69.3%	69.1%	70.6%	71.2%	70.5%
Worst	45.8%	48.4%	46.4%	39.7%	39.7%
Responses	268	1,436	1,752	1,941	2,078

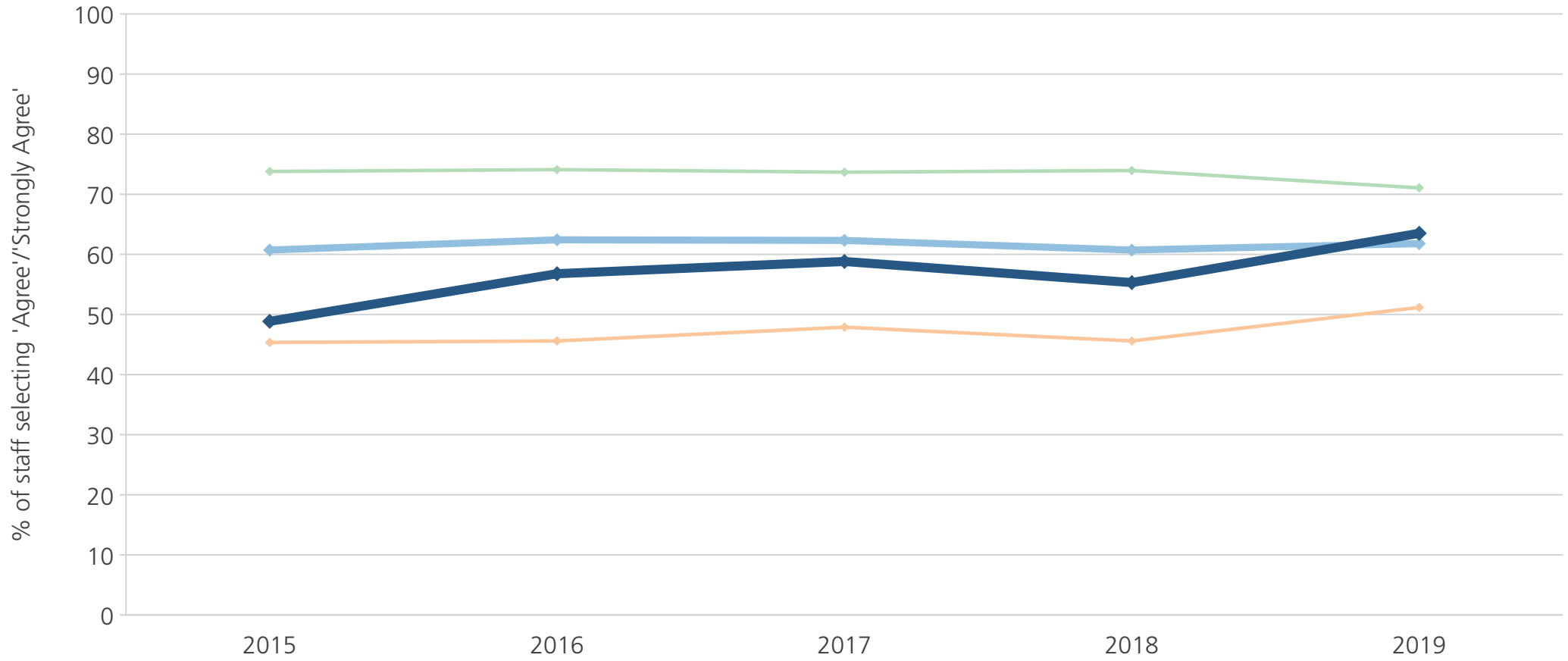
2019 NHS Staff Survey Results > Question results > Your organisation > Q22a > Is patient / service user experience feedback collected within your directorate / department? (e.g. Friends and Family Test, patient surveys etc.)



	2015	2016	2017	2018	2019
Best	95.4%	93.6%	93.3%	93.1%	93.9%
Your org	89.8%	85.9%	88.8%	89.9%	90.1%
Average	89.2%	88.8%	88.8%	89.3%	90.3%
Worst	81.2%	83.5%	77.3%	79.4%	78.6%
Responses	177	889	1,100	1,280	1,359

2019 NHS Staff Survey Results > Question results > Your organisation >
Q22b > I receive regular updates on patient / service user experience feedback in my directorate / department (e.g. via line managers or communications teams)

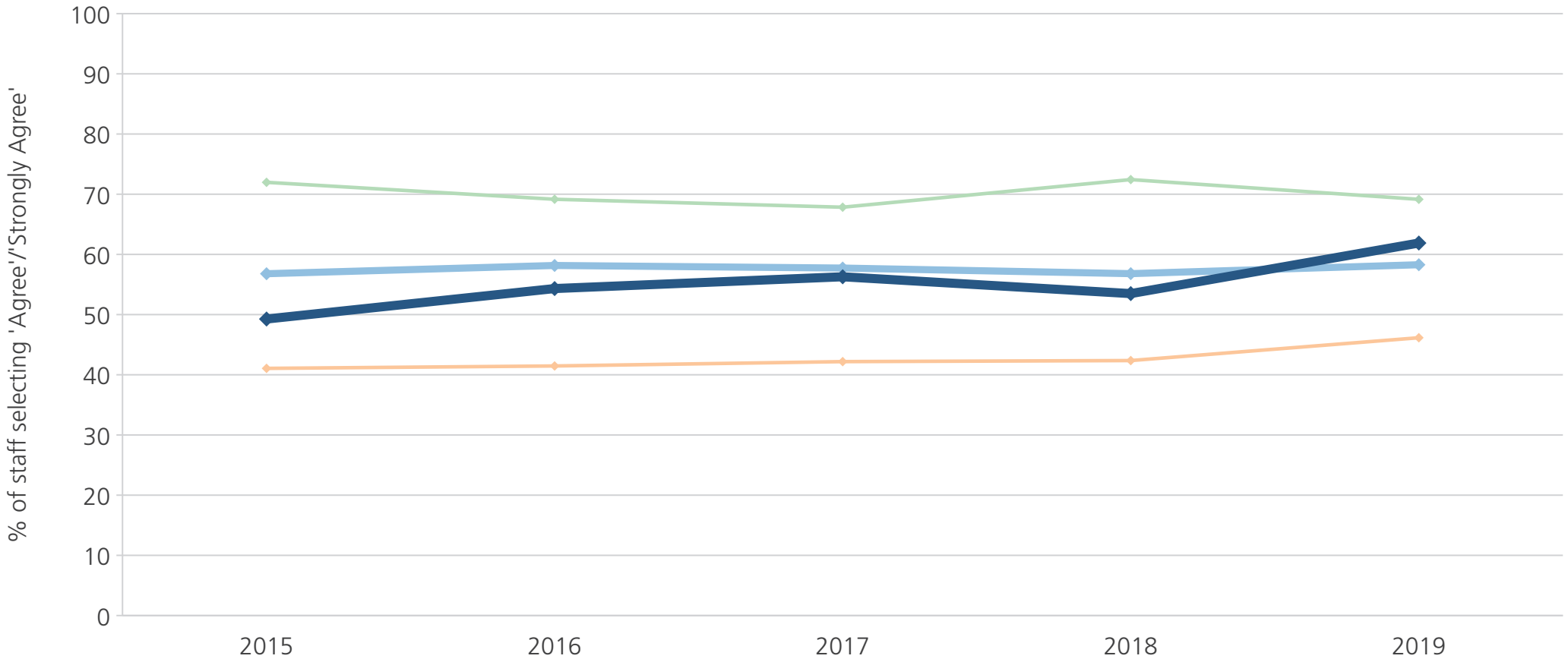
This question was only answered by staff who selected 'Yes' on q22a.



	2015	2016	2017	2018	2019
Best	73.8%	74.1%	73.7%	74.0%	71.1%
Your org	48.9%	56.8%	58.8%	55.3%	63.5%
Average	60.7%	62.4%	62.3%	60.7%	61.8%
Worst	45.4%	45.6%	47.9%	45.6%	51.2%
Responses	150	715	926	1,087	1,167

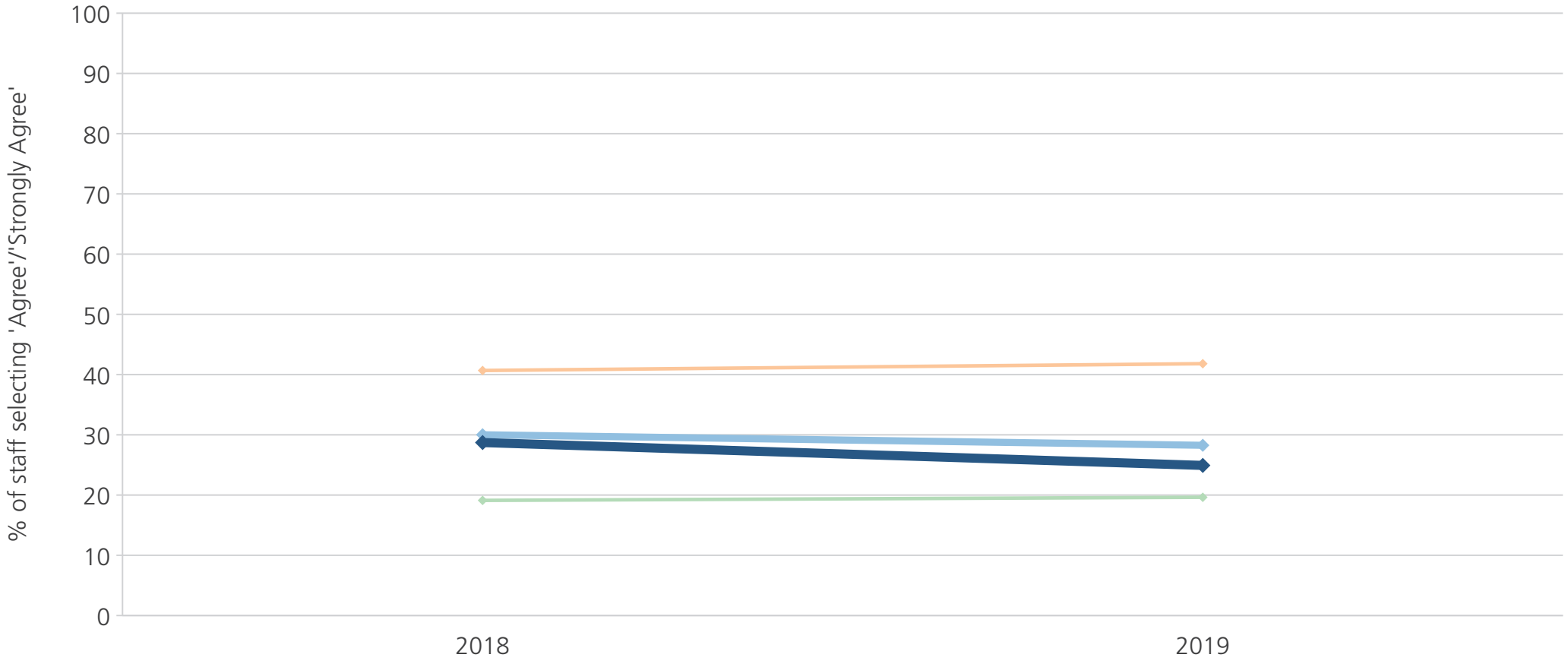
2019 NHS Staff Survey Results > Question results > Your organisation > Q22c > Feedback from patients / service users is used to make informed decisions within my directorate / department

This question was only answered by staff who selected 'Yes' on q22a.



	2015	2016	2017	2018	2019
Best	72.0%	69.2%	67.8%	72.4%	69.1%
Your org	49.3%	54.3%	56.3%	53.5%	61.9%
Average	56.8%	58.2%	57.7%	56.8%	58.3%
Worst	41.1%	41.5%	42.2%	42.4%	46.2%
Responses	135	659	863	1,016	1,105

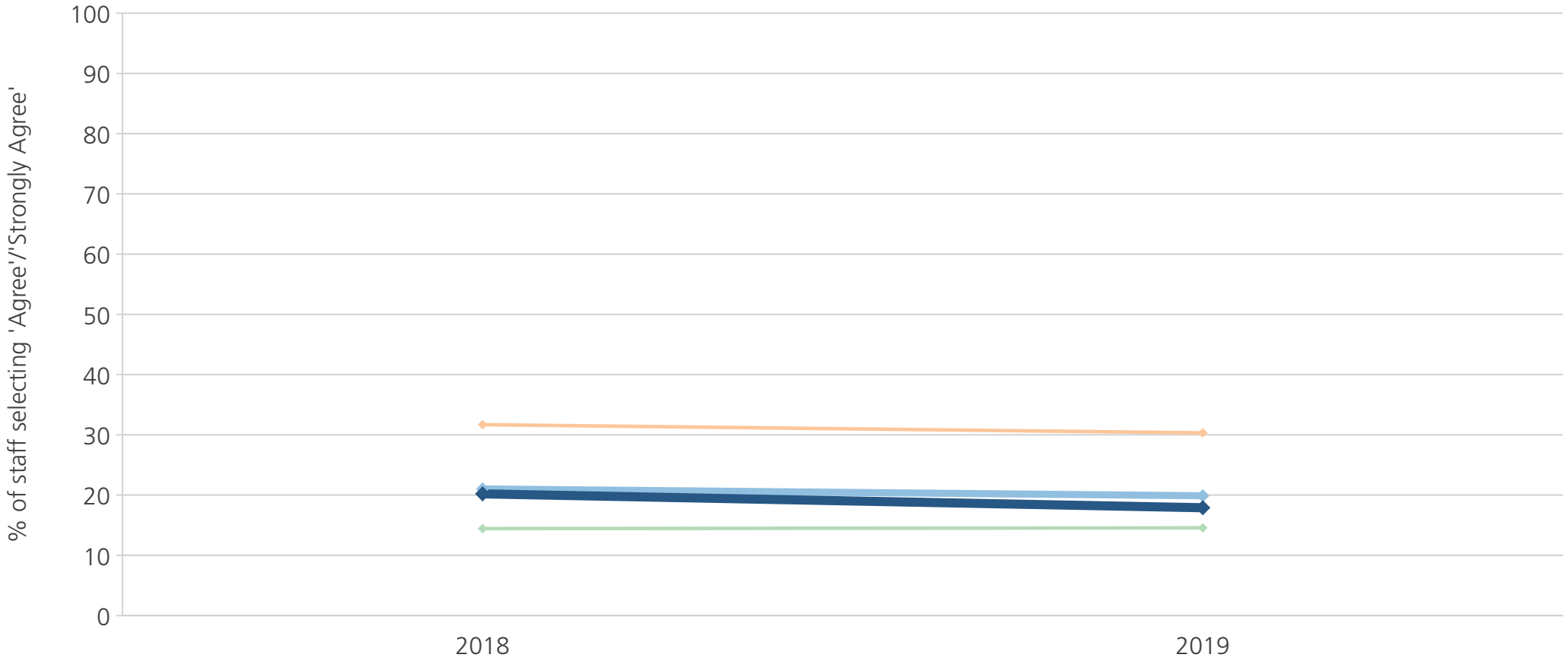
2019 NHS Staff Survey Results > Question results > Your organisation > Q23a > I often think about leaving this organisation



	2018	2019
Worst	40.7%	41.8%
Your org	28.7%	24.9%
Average	30.0%	28.3%
Best	19.1%	19.6%
Responses	1,952	2,096

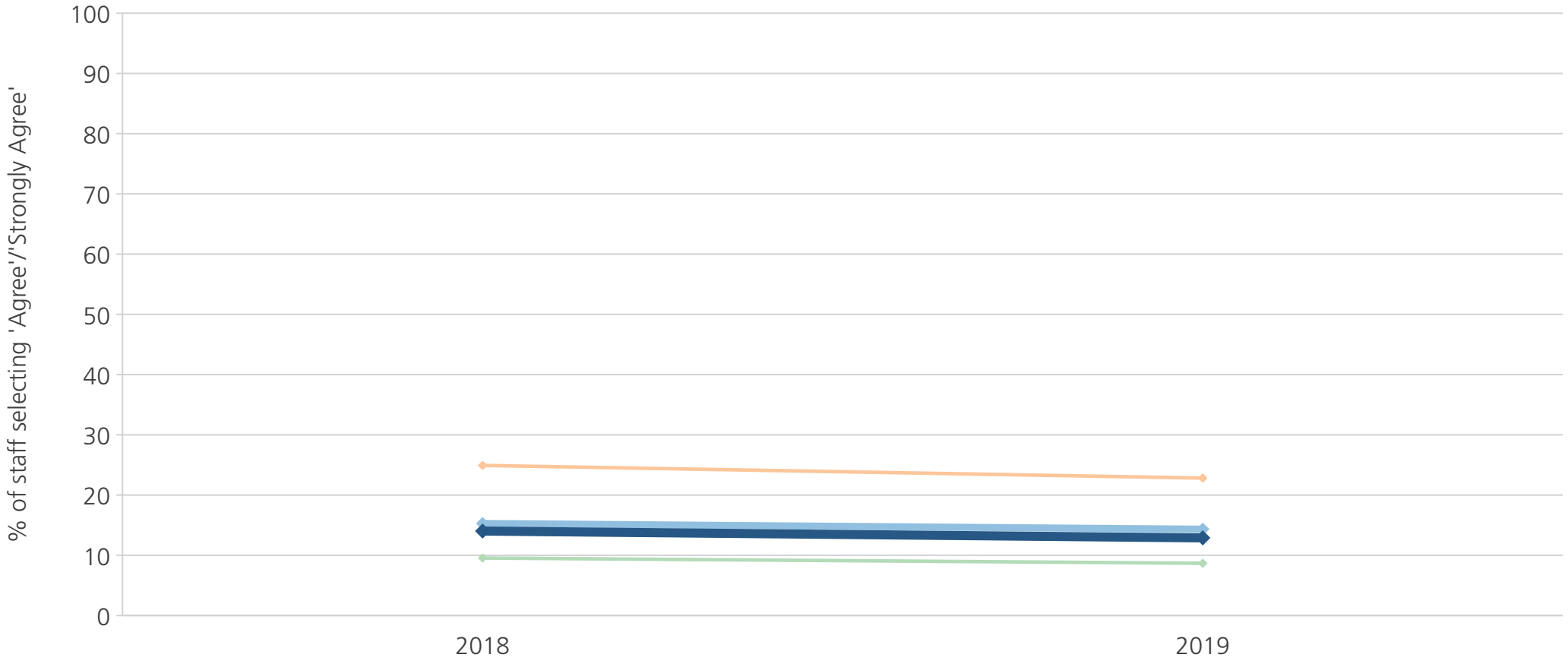
2019 NHS Staff Survey Results > Question results > Your organisation >

Q23b > I will probably look for a job at a new organisation in the next 12 months



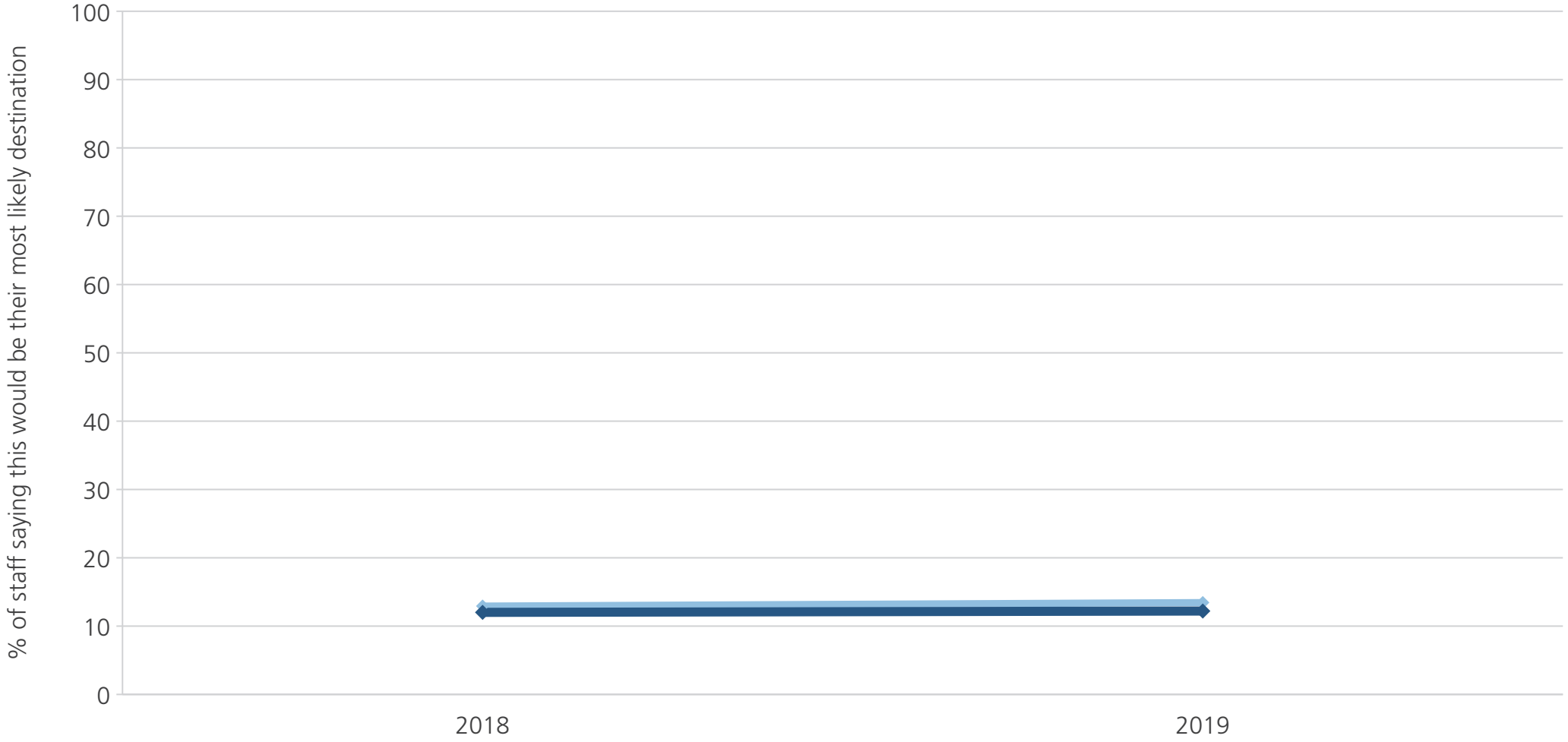
	2018	2019
Worst	31.7%	30.3%
Your org	20.2%	17.9%
Average	21.0%	19.9%
Best	14.4%	14.5%
Responses	1,943	2,090

2019 NHS Staff Survey Results > Question results > Your organisation > Q23c > As soon as I can find another job, I will leave this organisation



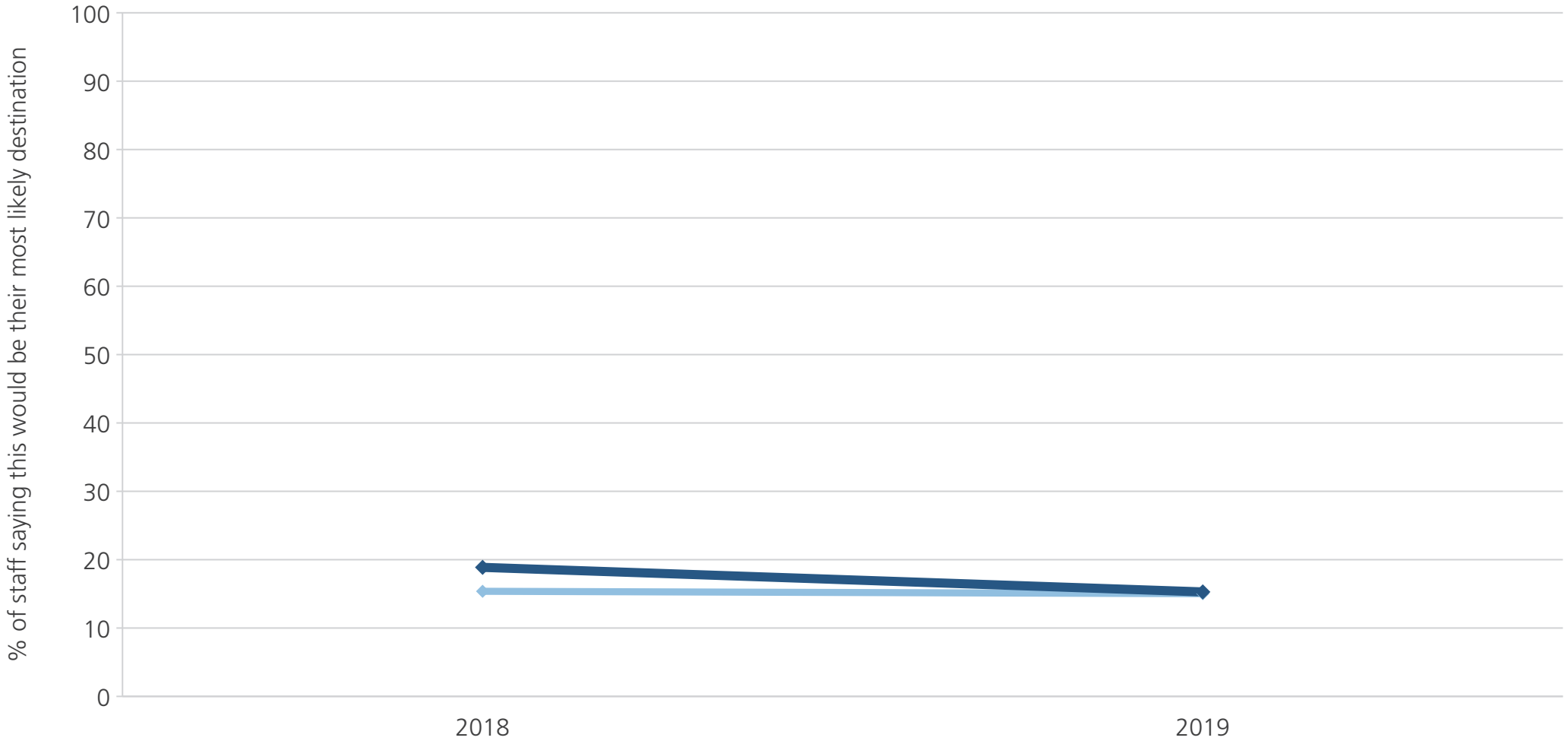
	2018	2019
Worst	24.9%	22.8%
Your org	14.0%	12.9%
Average	15.3%	14.3%
Best	9.5%	8.7%
Responses	1,937	2,078

2019 NHS Staff Survey Results > Question results > Your organisation >
Q23d.1 > If you are considering leaving your current job, what would be your most likely destination? - I would want to move to another job within this organisation



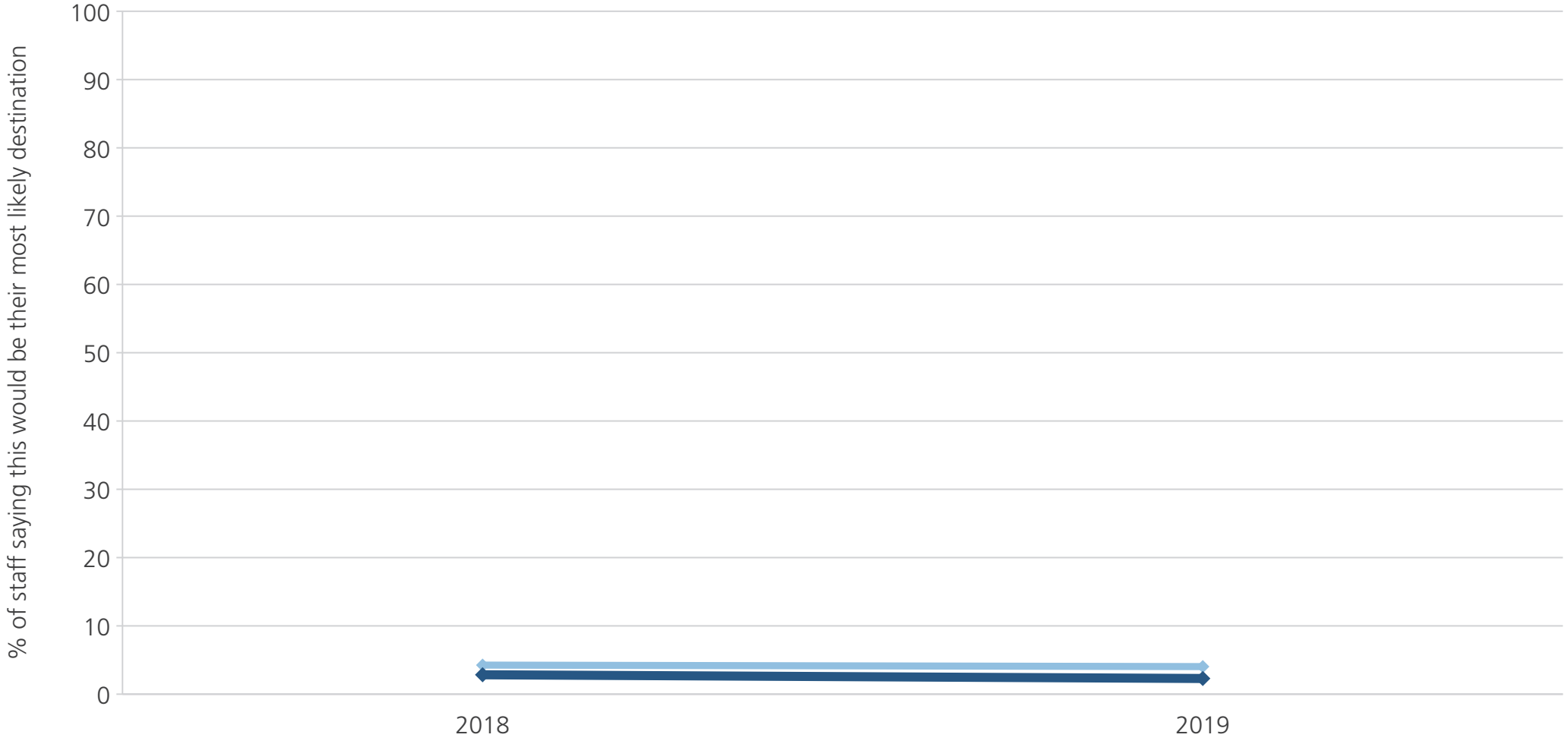
	2018	2019
Your org	12.0%	12.2%
Average	12.9%	13.4%
Responses	1,690	1,786

2019 NHS Staff Survey Results > Question results > Your organisation > Q23d.2 > If you are considering leaving your current job, what would be your most likely destination? - I would want to move to a job in a different NHS trust/organisation



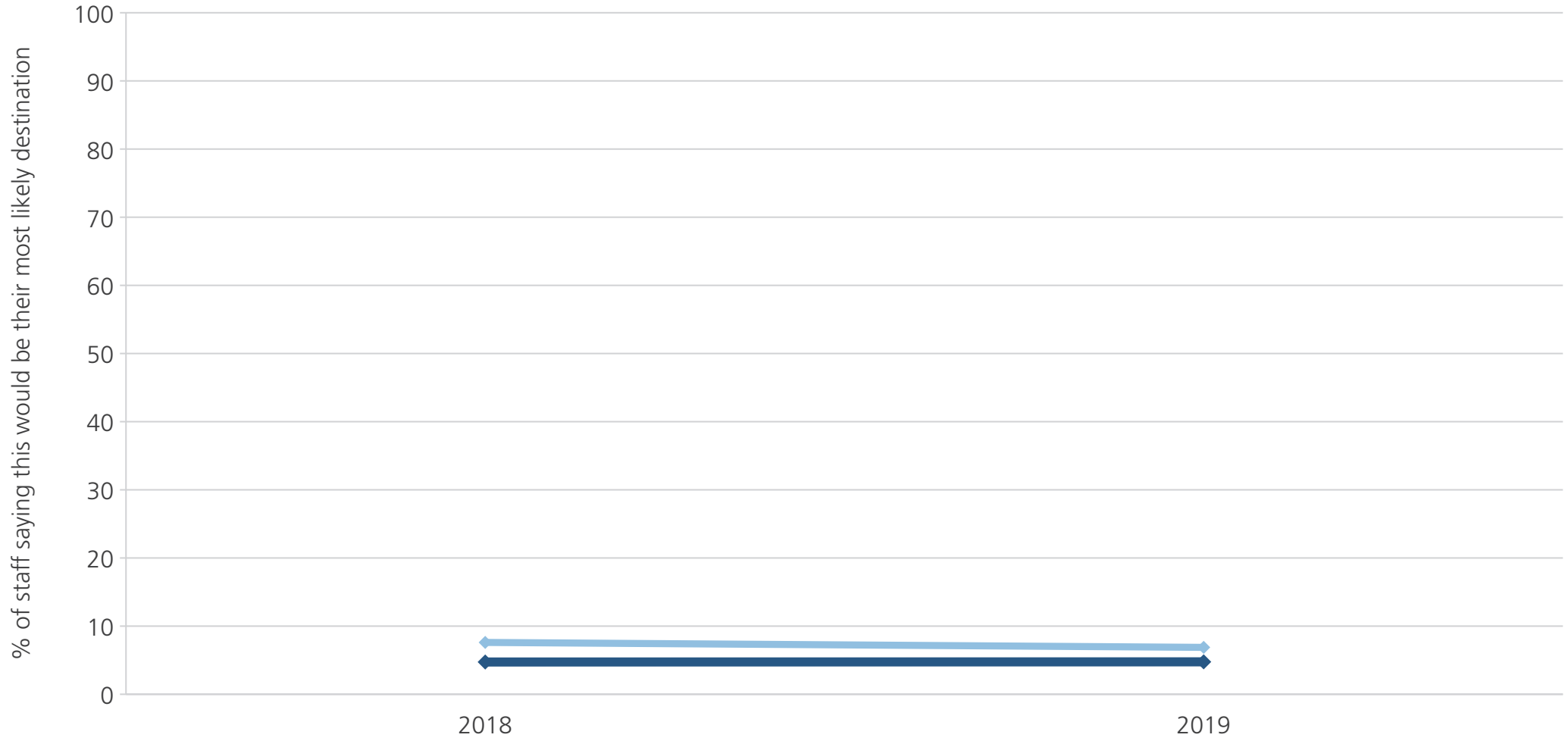
	2018	2019
Your org	18.9%	15.3%
Average	15.4%	15.0%
Responses	1,690	1,786

2019 NHS Staff Survey Results > Question results > Your organisation > Q23d.3 > If you are considering leaving your current job, what would be your most likely destination? - I would want to move to a job in healthcare, but outside the NHS



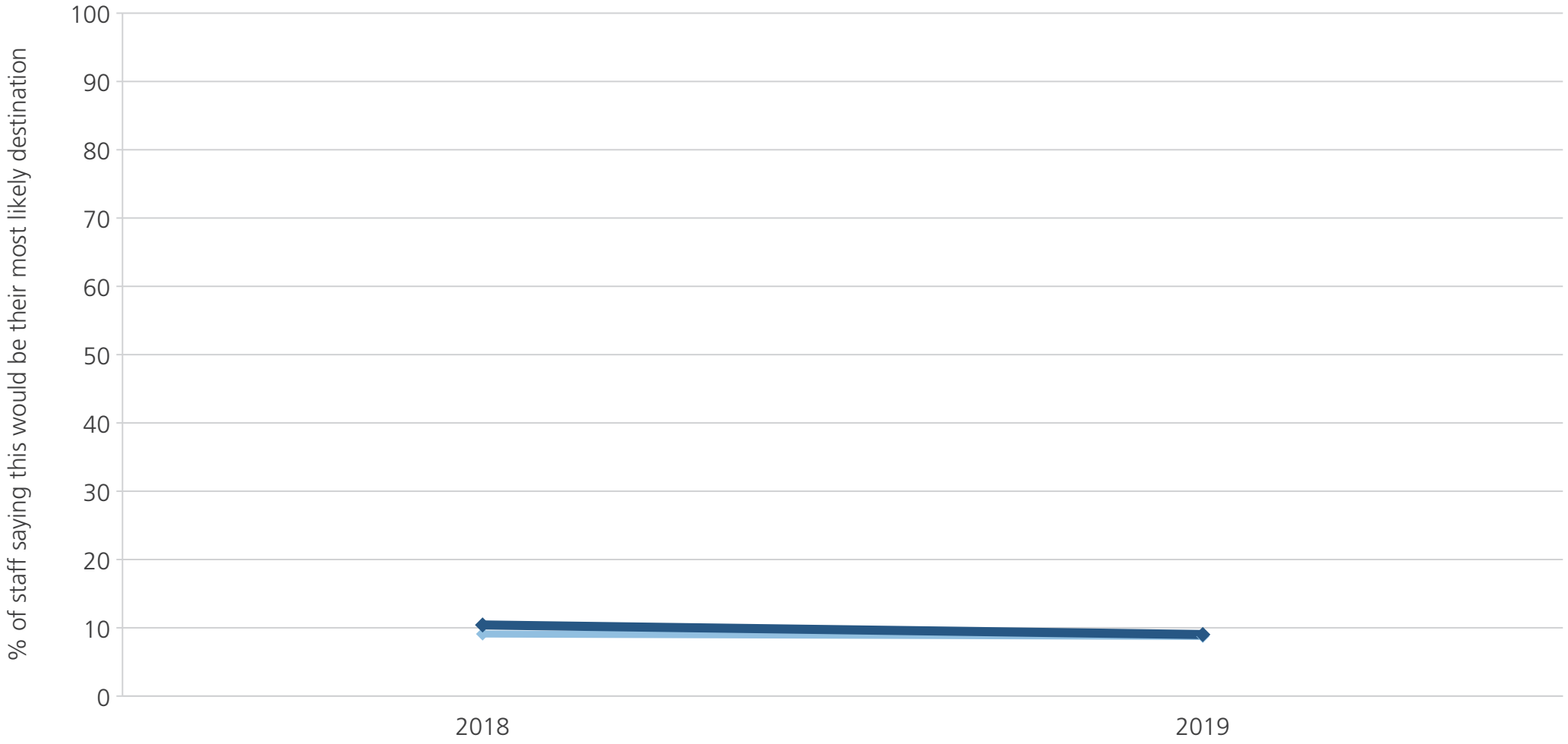
	2018	2019
Your org	2.8%	2.3%
Average	4.3%	4.0%
Responses	1,690	1,786

2019 NHS Staff Survey Results > Question results > Your organisation >
Q23d.4 > If you are considering leaving your current job, what would be your most likely destination? - I would want to move to a job outside healthcare



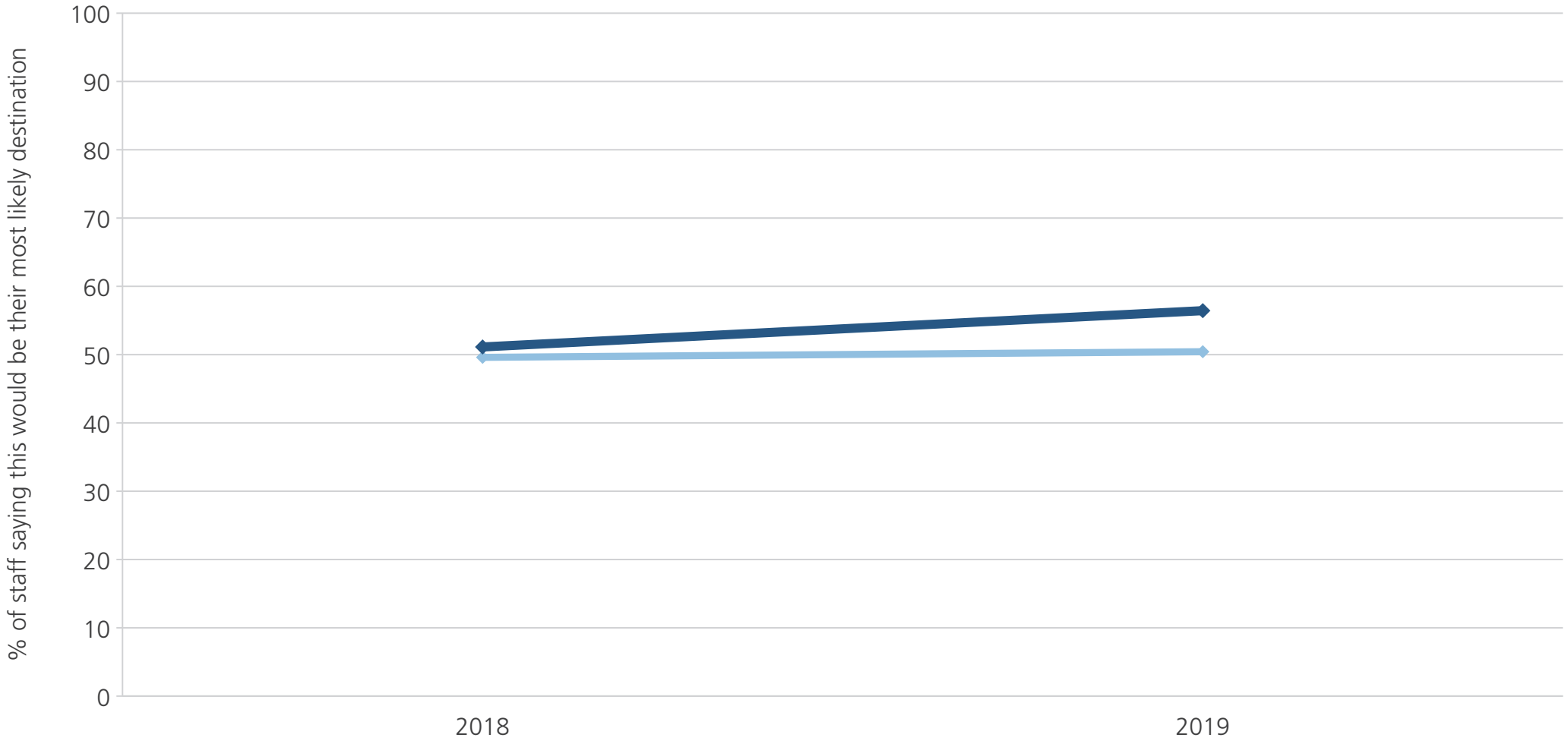
	2018	2019
Your org	4.7%	4.8%
Average	7.6%	6.9%
Responses	1,690	1,786

2019 NHS Staff Survey Results > Question results > Your organisation > Q23d.5 > If you are considering leaving your current job, what would be your most likely destination? - I would retire or take a career break



	2018	2019
Your org	10.4%	9.0%
Average	9.1%	8.7%
Responses	1,690	1,786

2019 NHS Staff Survey Results > Question results > Your organisation > Q23d.9 **>** If you are considering leaving your current job, what would be your most likely destination? - I am not considering leaving my current job



	2018	2019
Your org	51.1%	56.4%
Average	49.6%	50.4%
Responses	1,690	1,786

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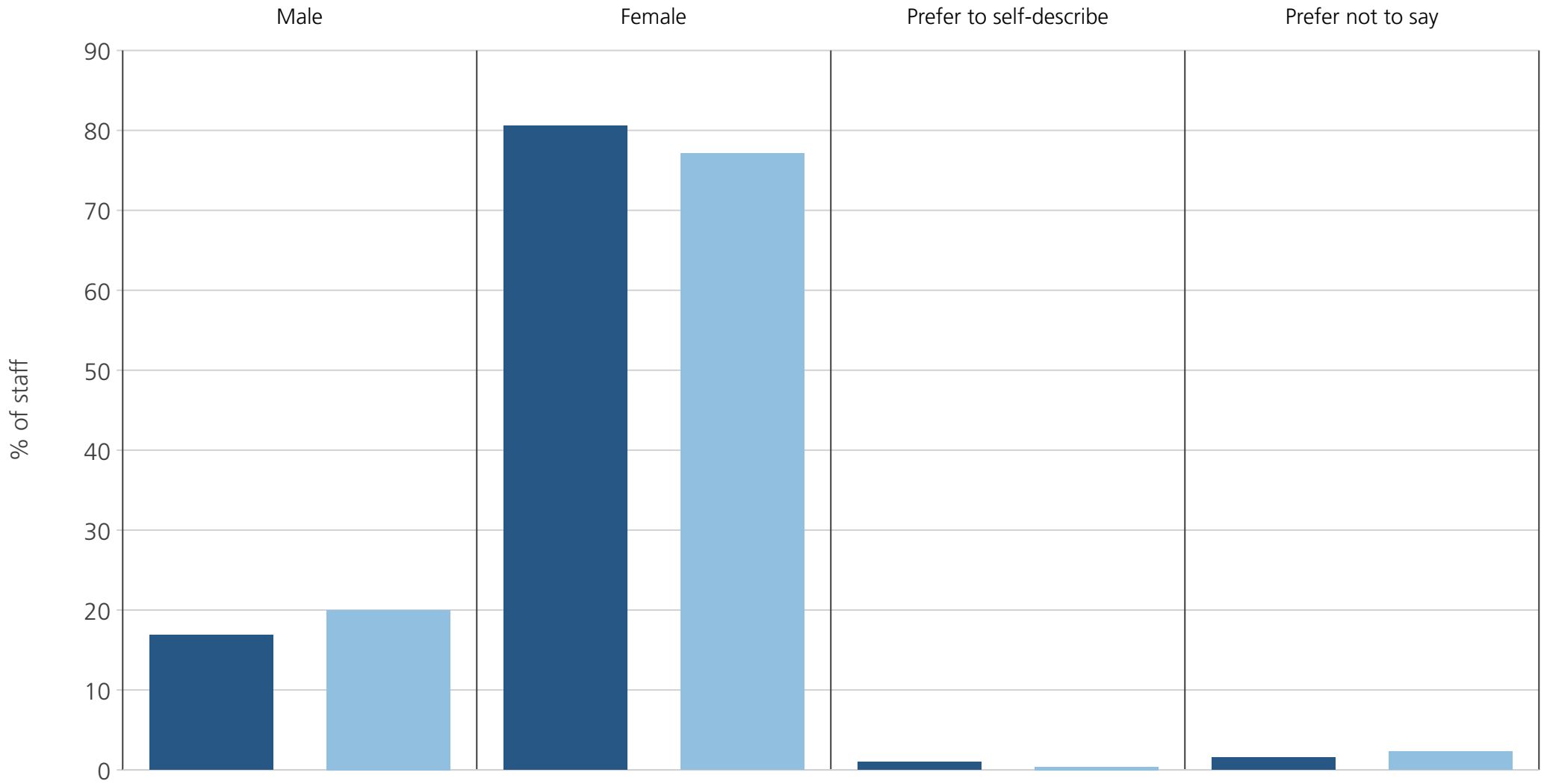
Survey Coordination Centre

NHS England

Question results – Background details

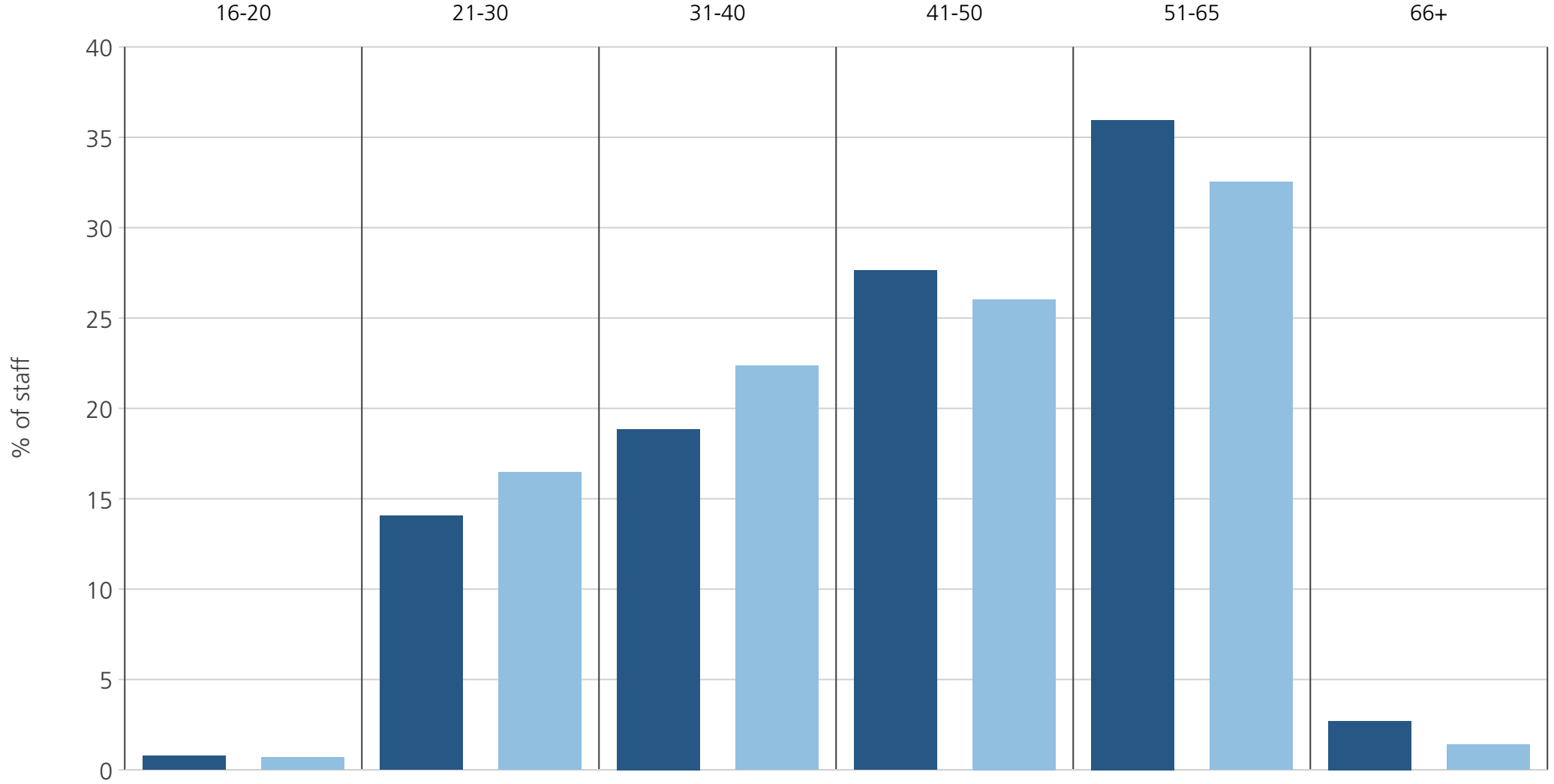
Warrington and Halton Hospitals NHS Foundation Trust

2019 NHS Staff Survey Results

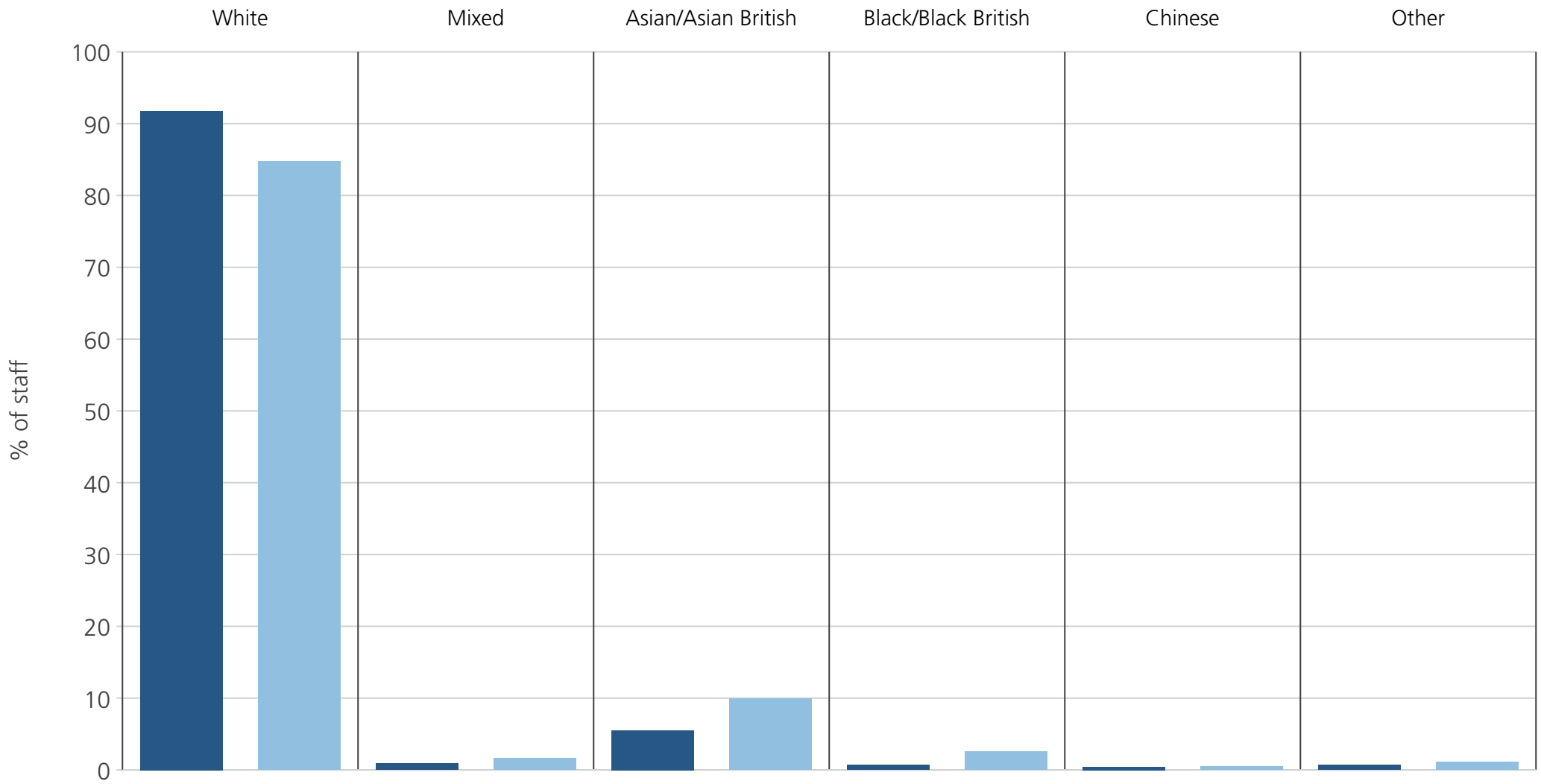


	Male	Female	Prefer to self-describe	Prefer not to say
Your org	16.9%	80.6%	1.0%	1.6%
Average	20.0%	77.1%	0.4%	2.3%
Responses	2,080	2,080	2,080	2,080

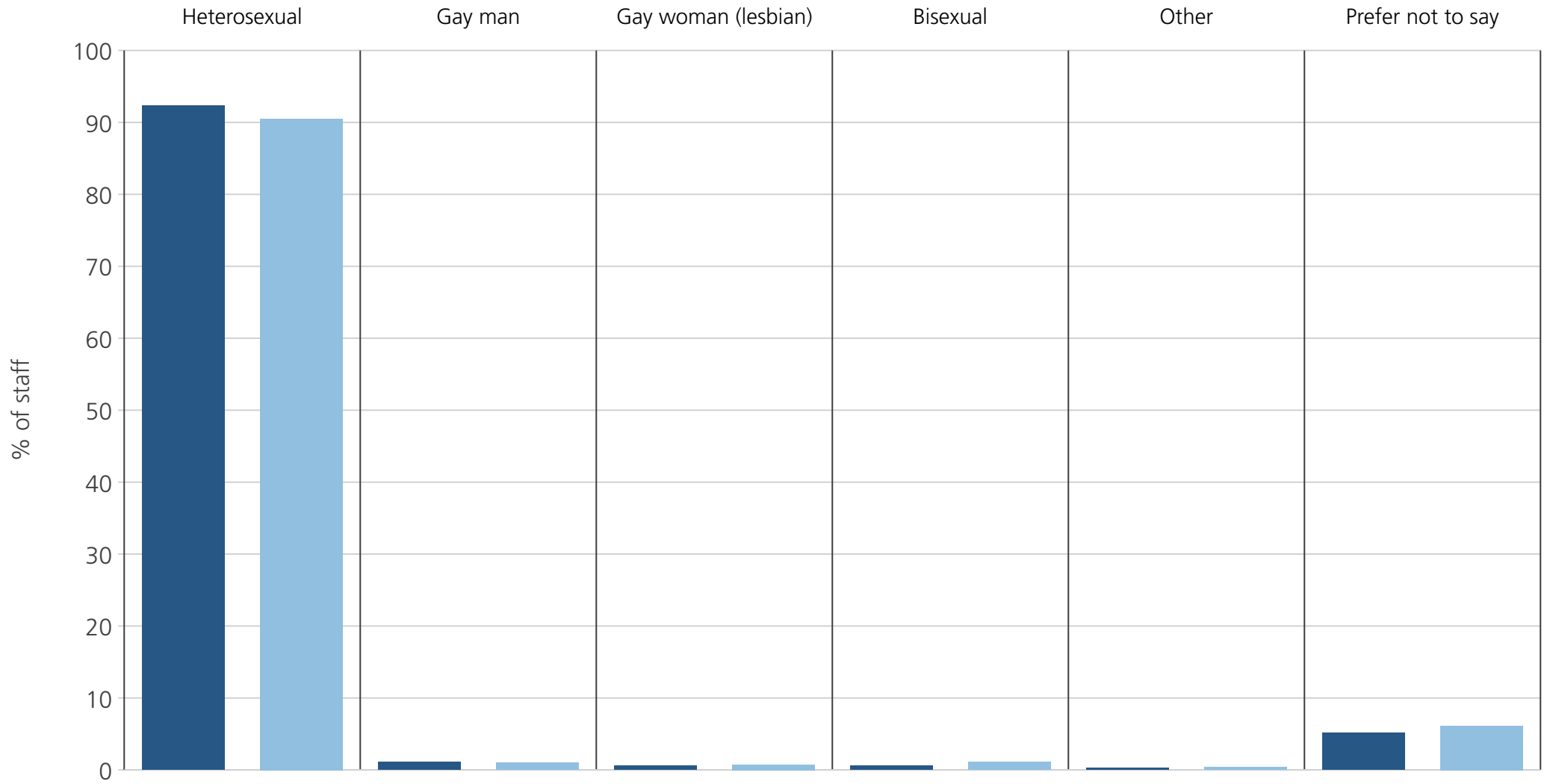
2019 NHS Staff Survey Results > Question results > Background details > Age



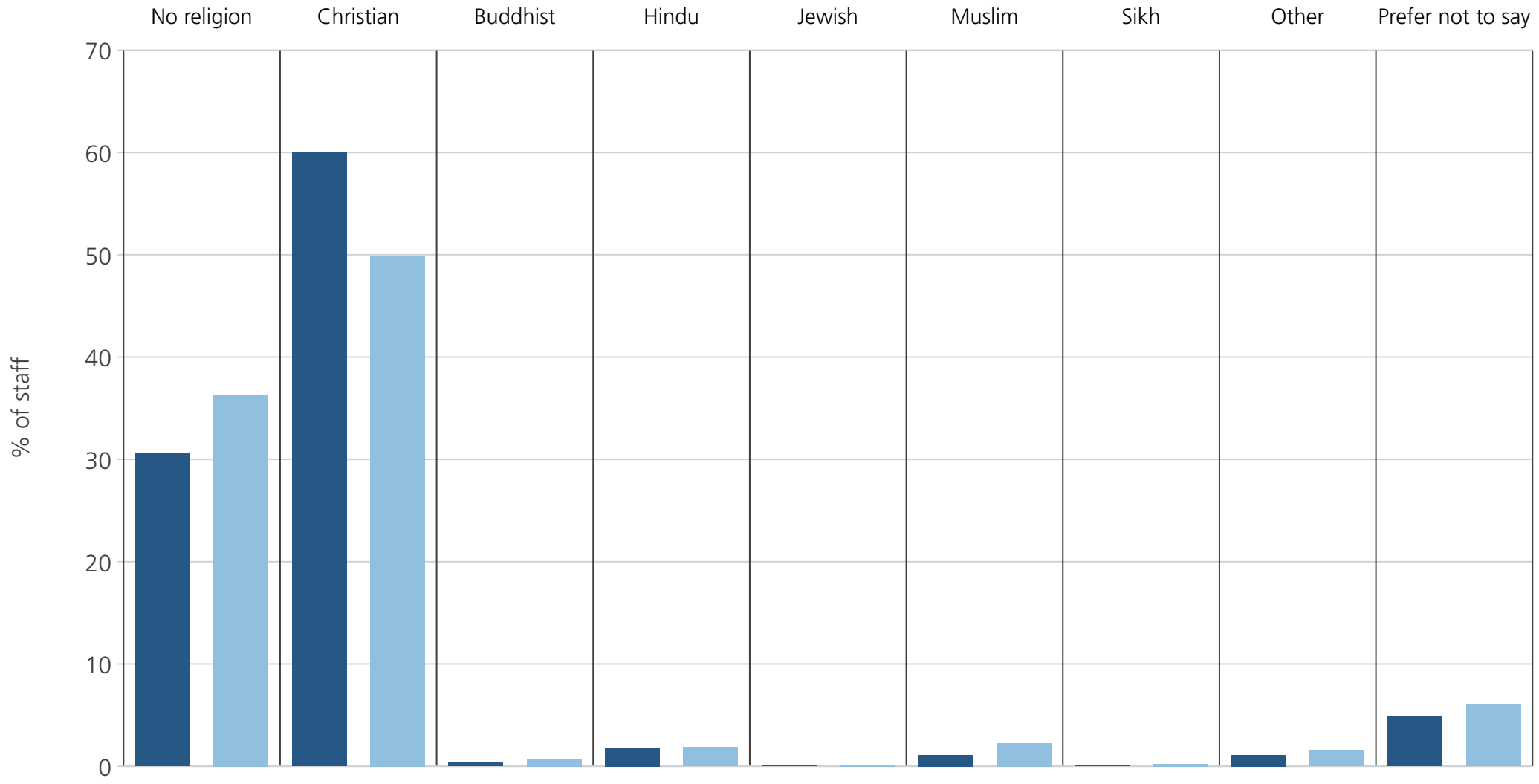
	16-20	21-30	31-40	41-50	51-65	66+
Your org	0.8%	14.1%	18.8%	27.6%	36.0%	2.7%
Average	0.7%	16.5%	22.4%	26.0%	32.5%	1.4%
Responses	2,069	2,069	2,069	2,069	2,069	2,069



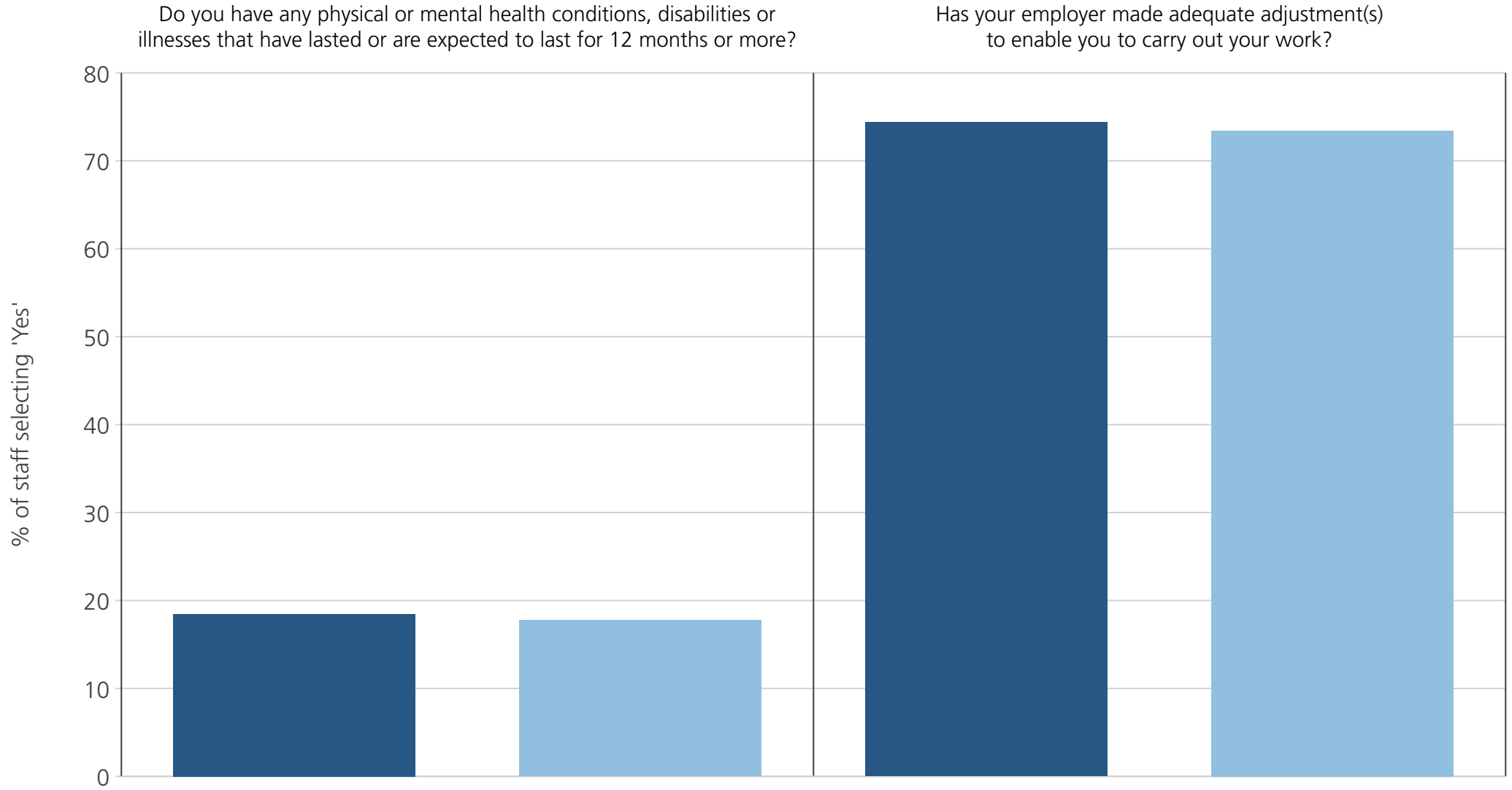
	White	Mixed	Asian/Asian British	Black/Black British	Chinese	Other
Your org	91.8%	0.9%	5.5%	0.7%	0.4%	0.7%
Average	84.8%	1.6%	10.0%	2.6%	0.5%	1.1%
Responses	2,085	2,085	2,085	2,085	2,085	2,085



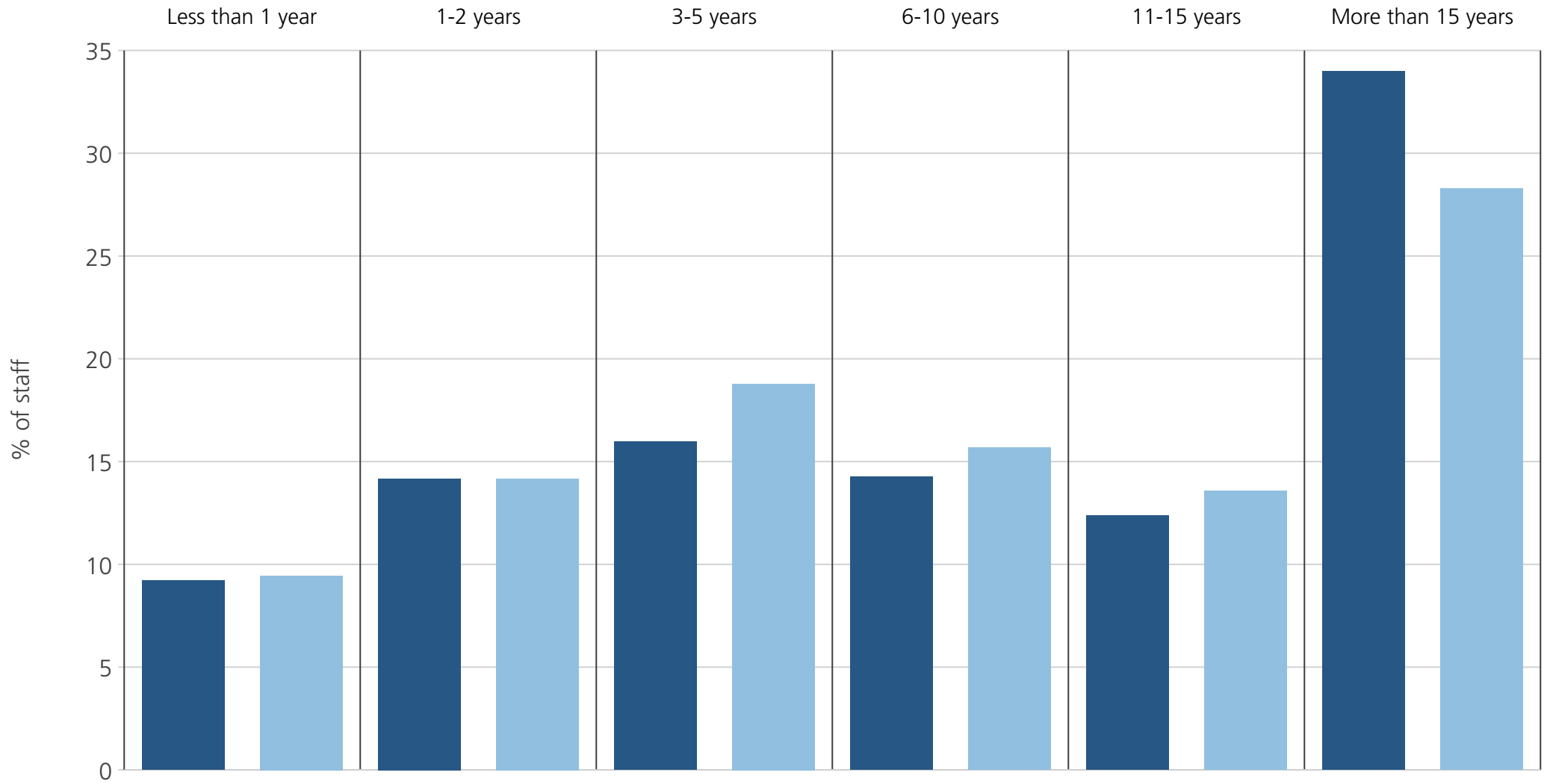
	Heterosexual	Gay man	Gay woman (lesbian)	Bisexual	Other	Prefer not to say
Your org	92.3%	1.1%	0.6%	0.6%	0.3%	5.1%
Average	90.5%	1.0%	0.7%	1.1%	0.4%	6.1%
Responses	2,080	2,080	2,080	2,080	2,080	2,080



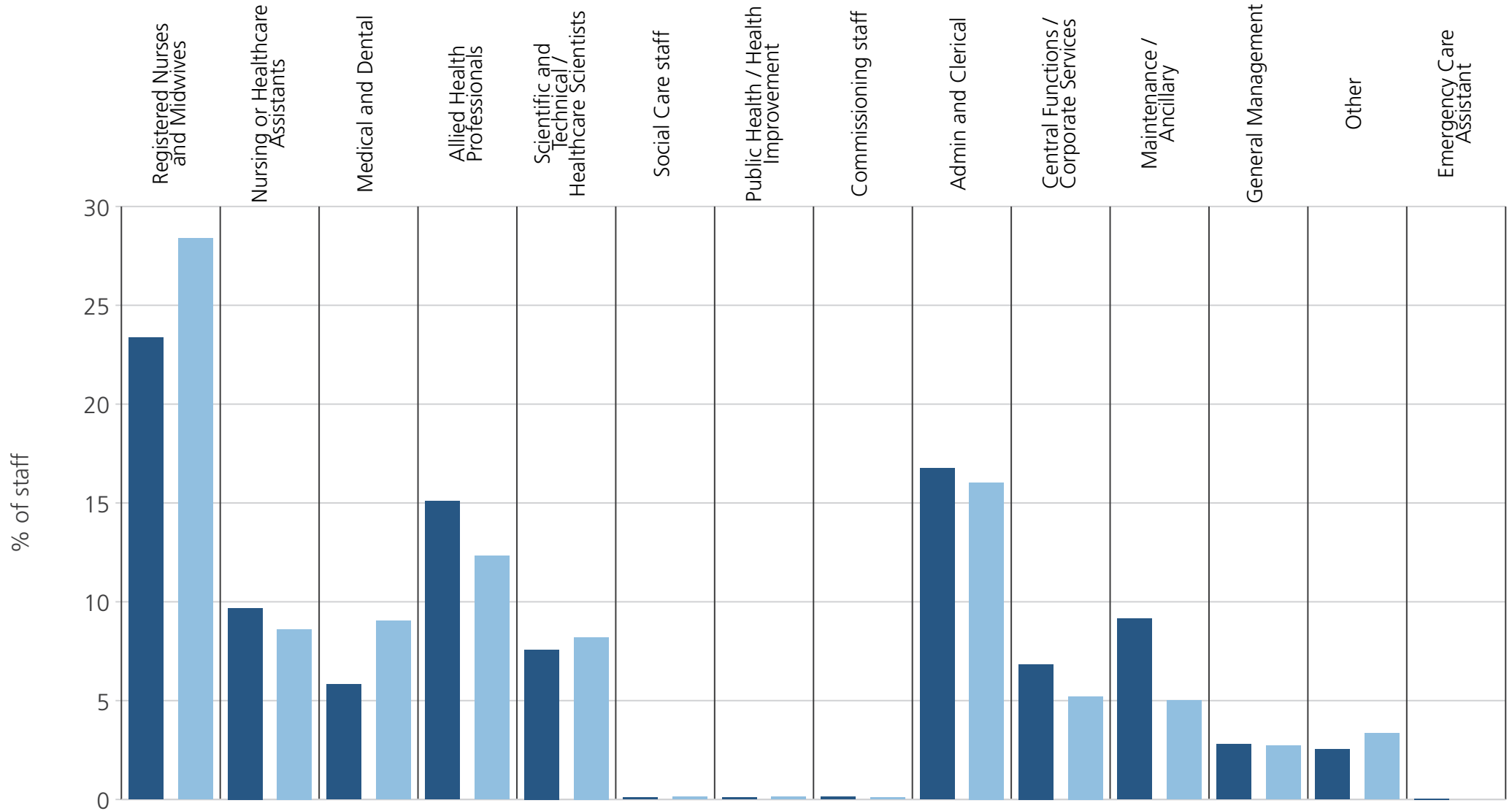
	No religion	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Other	Prefer not to say
Your org	30.6%	60.1%	0.4%	1.8%	0.0%	1.1%	0.0%	1.1%	4.9%
Average	36.3%	49.9%	0.7%	1.8%	0.1%	2.3%	0.2%	1.6%	6.0%
Responses	2,081	2,081	2,081	2,081	2,081	2,081	2,081	2,081	2,081



	Do you have any physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last for 12 months or more?	Has your employer made adequate adjustment(s) to enable you to carry out your work?
Your org	18.5%	74.4%
Average	17.8%	73.4%
Responses	2,085	228

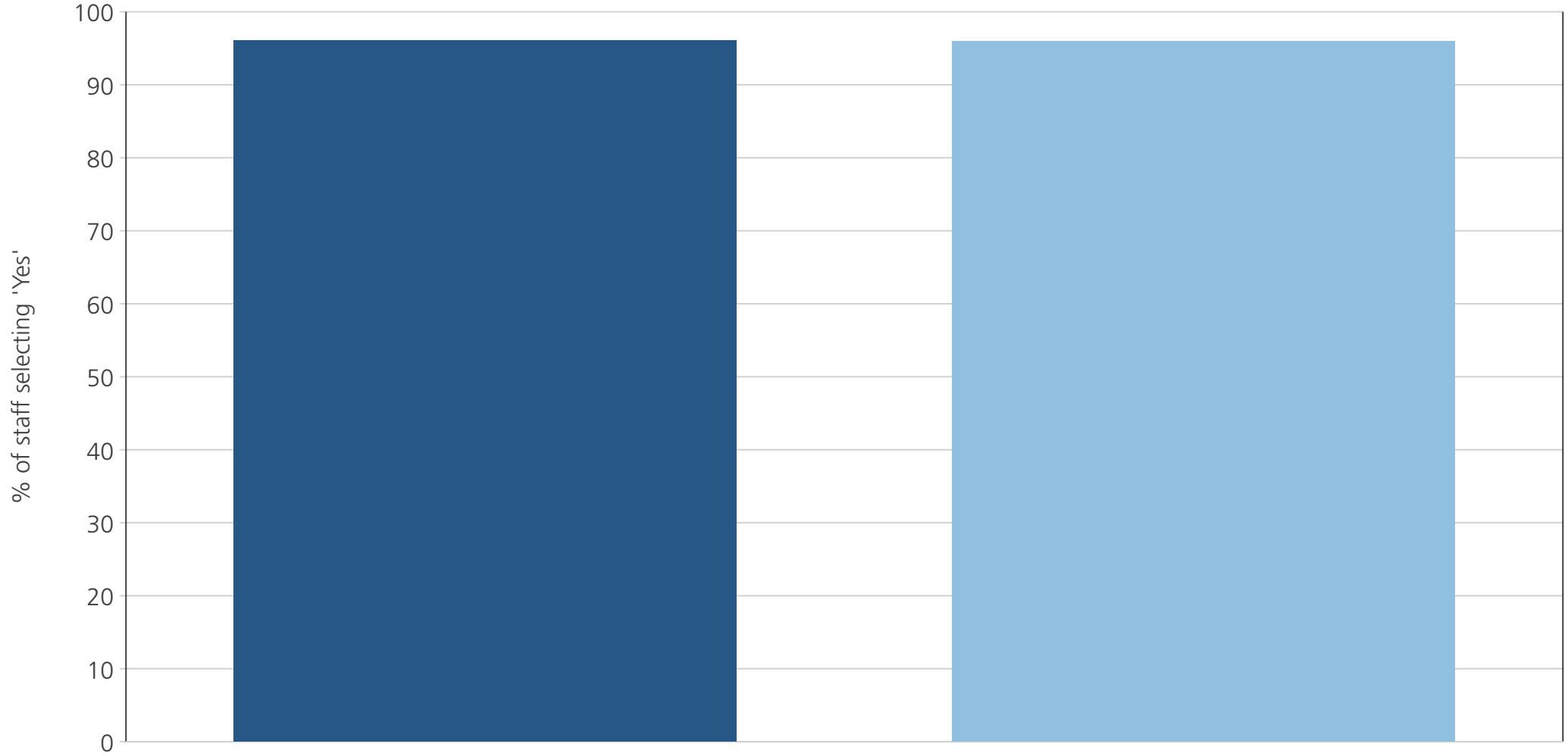


	Less than 1 year	1-2 years	3-5 years	6-10 years	11-15 years	More than 15 years
Your org	9.2%	14.2%	16.0%	14.3%	12.4%	34.0%
Average	9.5%	14.2%	18.8%	15.7%	13.6%	28.3%
Responses	2,053	2,053	2,053	2,053	2,053	2,053

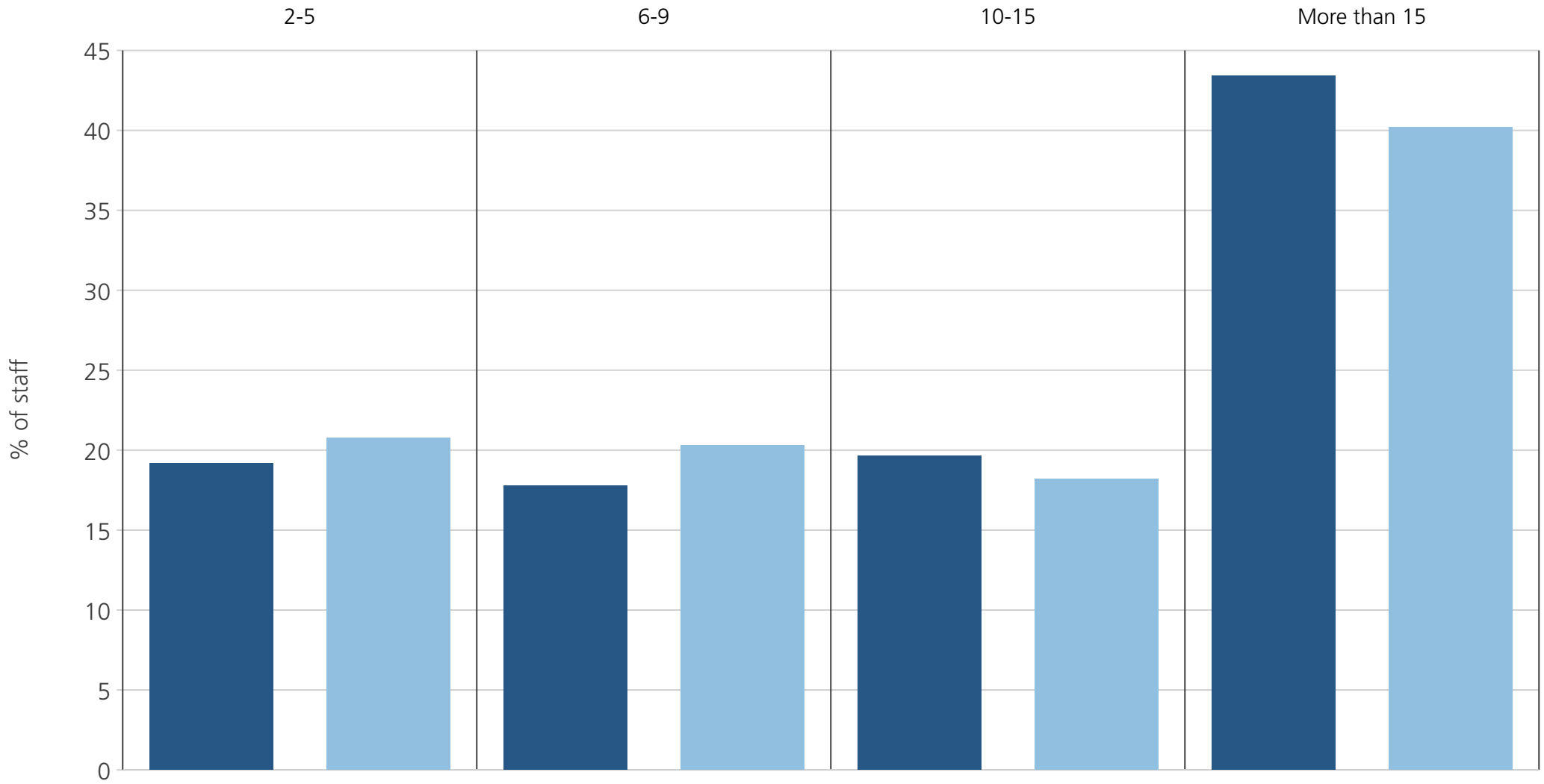


	Registered Nurses and Midwives	Nursing or Healthcare Assistants	Medical and Dental	Allied Health Professionals	Scientific and Technical / Healthcare Scientists	Social Care staff	Public Health / Health Improvement	Commissioning staff	Admin and Clerical	Central Functions / Corporate Services	Maintenance / Ancillary	General Management	Other	Emergency Care Assistant
Your org	23.4%	9.7%	5.8%	15.1%	7.6%	0.1%	0.1%	0.1%	16.8%	6.8%	9.1%	2.8%	2.5%	0.0%
Average	28.4%	8.6%	9.0%	12.3%	8.2%	0.1%	0.1%	0.1%	16.0%	5.2%	5.0%	2.7%	3.3%	0.0%
Responses	2,046	2,046	2,046	2,046	2,046	2,046	2,046	2,046	2,046	2,046	2,046	2,046	2,046	2,046

Do you work in a team?



Your org	96.0%
Average	96.0%
Responses	2,015



	2-5	6-9	10-15	More than 15
Your org	19.2%	17.8%	19.6%	43.4%
Average	20.8%	20.3%	18.2%	40.2%
Responses	1,909	1,909	1,909	1,909

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Survey Coordination Centre

NHS England

Workforce Equality Standards

Warrington and Halton Hospitals NHS Foundation Trust

2019 NHS Staff Survey Results

Survey Coordination Centre

Workforce Equality Standards

NHS England

This section contains data required for the NHS Staff Survey indicators used in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). Data presented in this section are unweighted.

Full details of how the data are calculated are included in the Technical Document, available to download from our results website.

Workforce Race Equality Standard (WRES)

- This contains data for each organisation required for the NHS Staff Survey indicators used in the Workforce Race Equality Standard (WRES). It includes the 2017, 2018 and 2019 trust/CCG and benchmarking group median results for q13a, q13b&c combined, q14, and q15b split by ethnicity (by white / BME staff).

Workforce Disability Equality Standard (WDES)

- This contains data for each organisation required for the NHS Staff Survey indicators used in the Workforce Disability Equality Standard (WDES). It includes the 2018 and 2019 trust/CCG and benchmarking group median results for q5f, q11e, q13, and q14 split by disabled staff compared to non-disabled staff. It also shows results for q28b (for disabled staff only), and the staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.

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Survey Coordination Centre

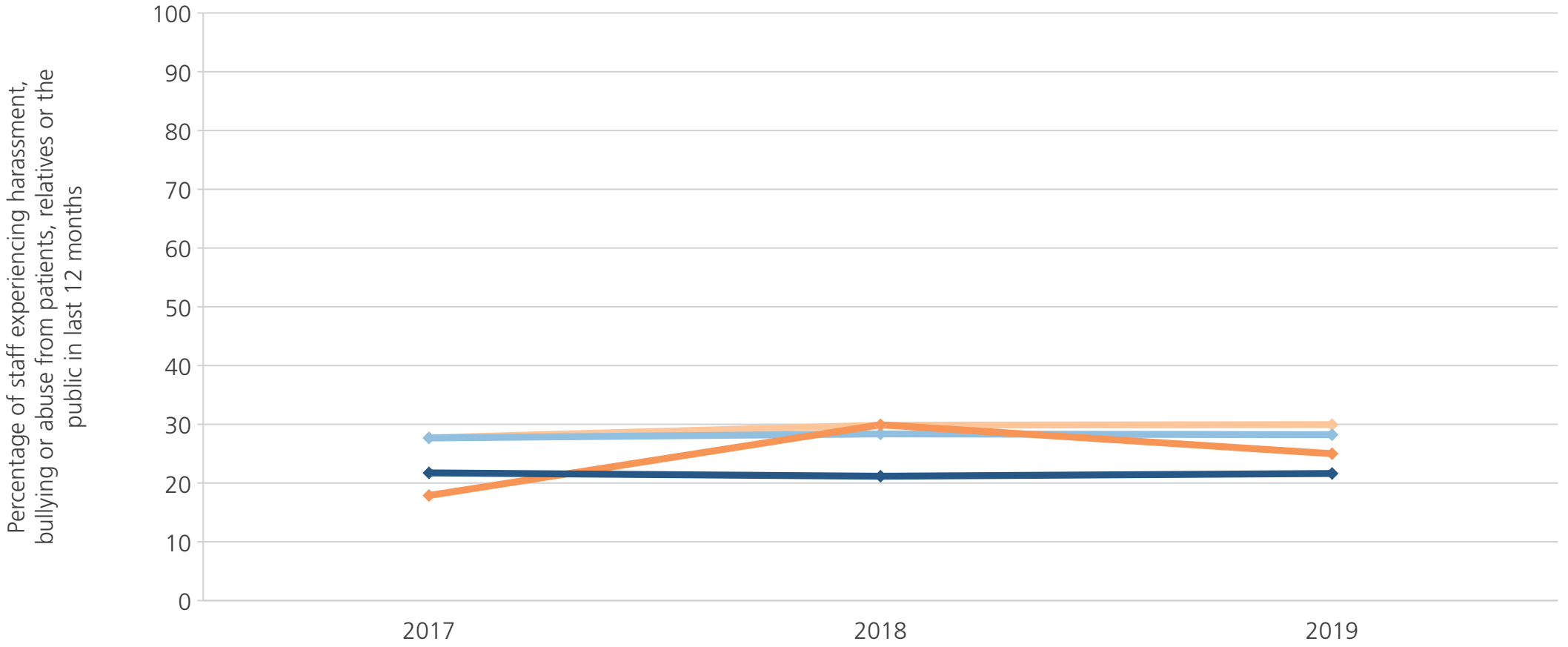
NHS England

Workforce Race Equality Standard (WRES)

Warrington and Halton Hospitals NHS Foundation Trust

2019 NHS Staff Survey Results

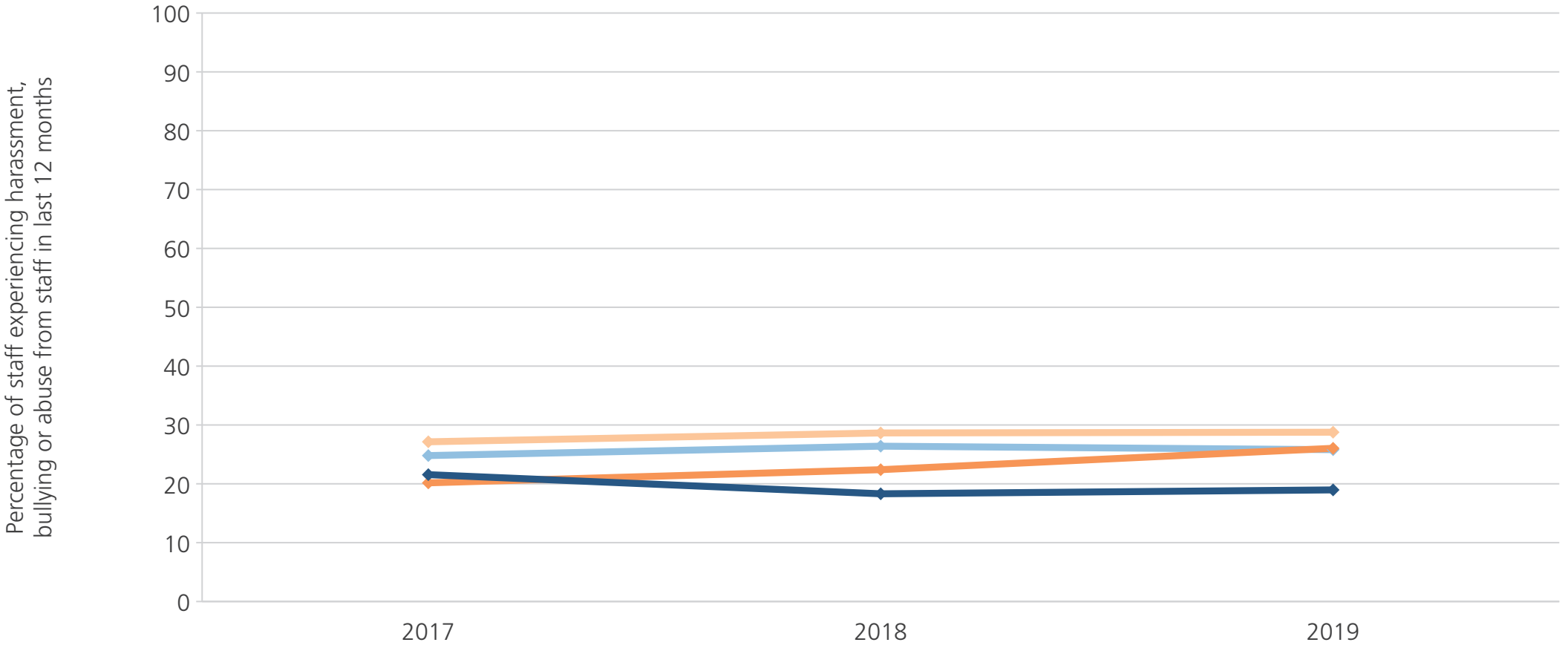
2019 NHS Staff Survey Results > WRES > Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months



	2017	2018	2019
White: Your org	21.7%	21.2%	21.6%
BME: Your org	17.9%	29.9%	25.0%
White: Average	27.7%	28.4%	28.2%
BME: Average	27.7%	29.8%	29.9%
White: Responses	1,606	1,791	1,891
BME: Responses	123	127	168

Average calculated as the median for the benchmark group

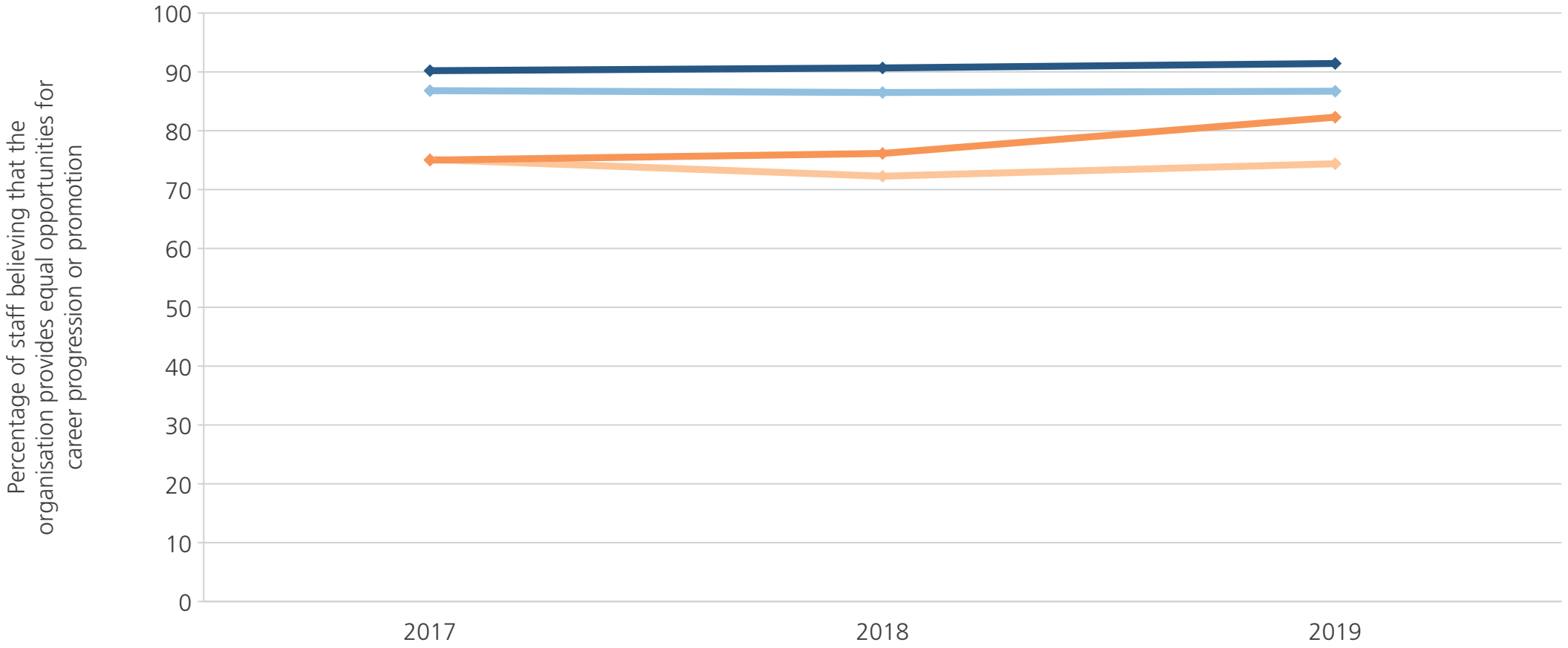
2019 NHS Staff Survey Results > WRES > Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months



	2017	2018	2019
White: Your org	21.6%	18.3%	19.0%
BME: Your org	20.2%	22.4%	26.0%
White: Average	24.8%	26.4%	25.8%
BME: Average	27.1%	28.6%	28.8%
White: Responses	1,605	1,781	1,893
BME: Responses	124	125	169

Average calculated as the median for the benchmark group

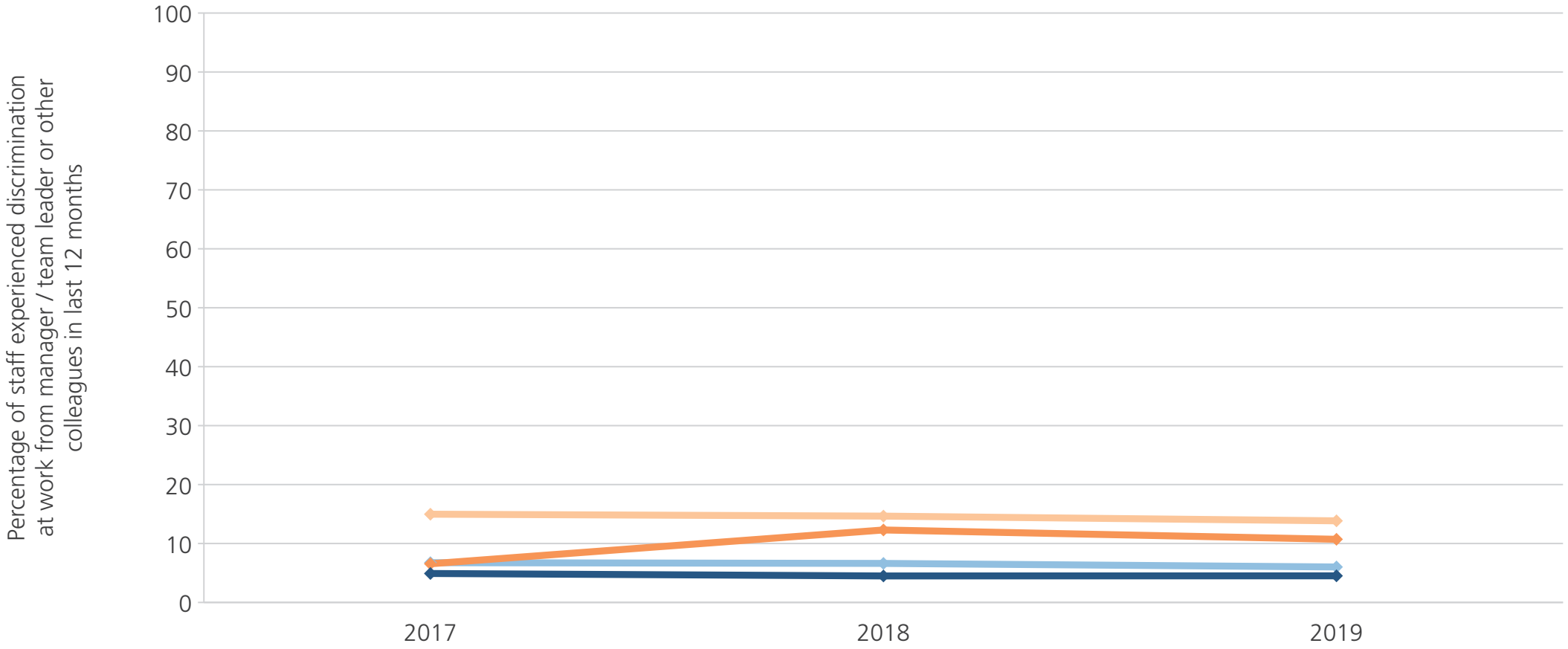
2019 NHS Staff Survey Results > WRES > Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion



	2017	2018	2019
White: Your org	90.2%	90.7%	91.4%
BME: Your org	75.0%	76.1%	82.3%
White: Average	86.8%	86.5%	86.7%
BME: Average	75.1%	72.3%	74.4%
White: Responses	1,102	1,211	1,341
BME: Responses	76	88	113

Average calculated as the median for the benchmark group

2019 NHS Staff Survey Results > WRES > Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months



	2017	2018	2019
White: Your org	4.9%	4.5%	4.5%
BME: Your org	6.6%	12.3%	10.7%
White: Average	6.7%	6.6%	6.0%
BME: Average	15.0%	14.6%	13.8%
White: Responses	1,609	1,780	1,883
BME: Responses	122	122	168

Average calculated as the median for the benchmark group

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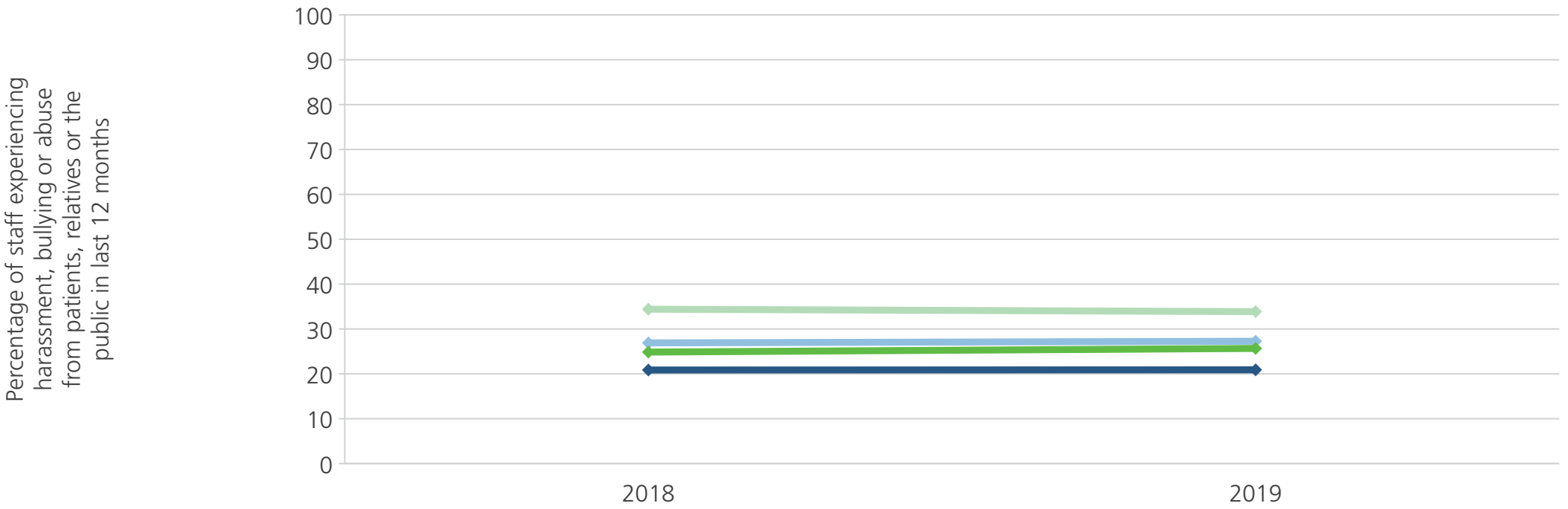
NHS England

Workforce Disability Equality Standard (WDES)

Warrington and Halton Hospitals NHS Foundation Trust

2019 NHS Staff Survey Results

2019 NHS Staff Survey Results > WDES > Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

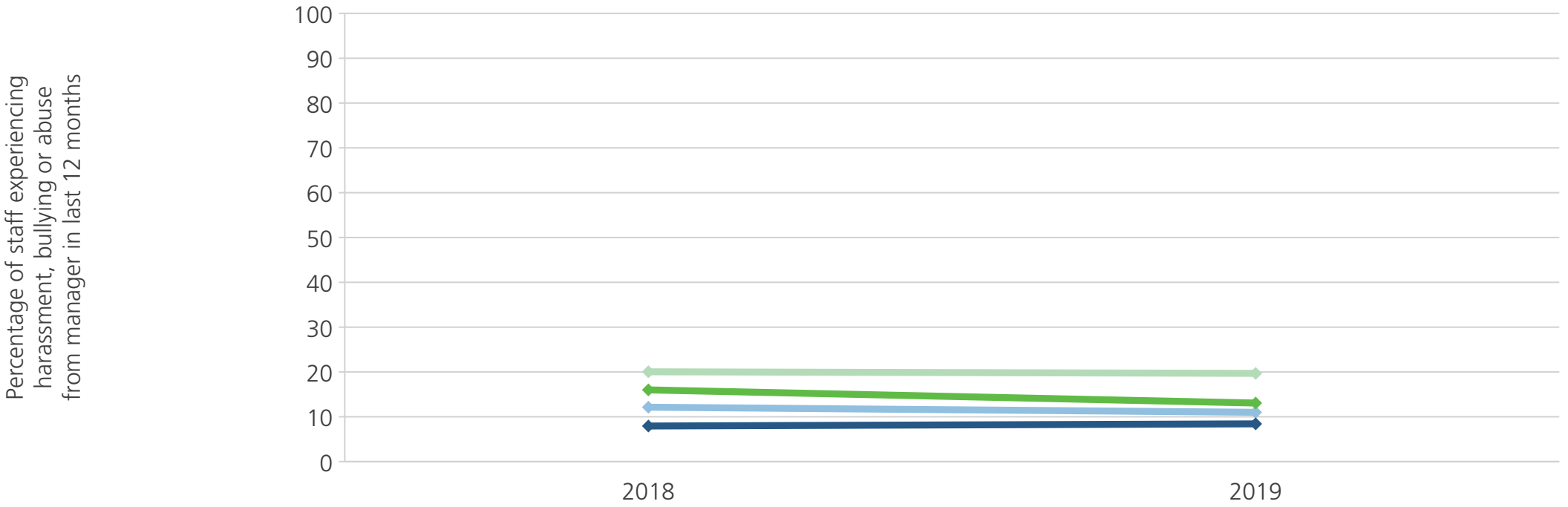


	2018	2019
Disabled staff: Your org	24.8%	25.7%
Non-disabled staff: Your org	20.9%	20.9%
Disabled staff: Average	34.4%	33.9%
Non-disabled staff: Average	26.9%	27.3%

Disabled staff: Responses	330	378
Non-disabled staff: Responses	1,592	1,680

Average calculated as the median for the benchmark group

2019 NHS Staff Survey Results > WDES > Percentage of staff experiencing harassment, bullying or abuse from manager in last 12 months

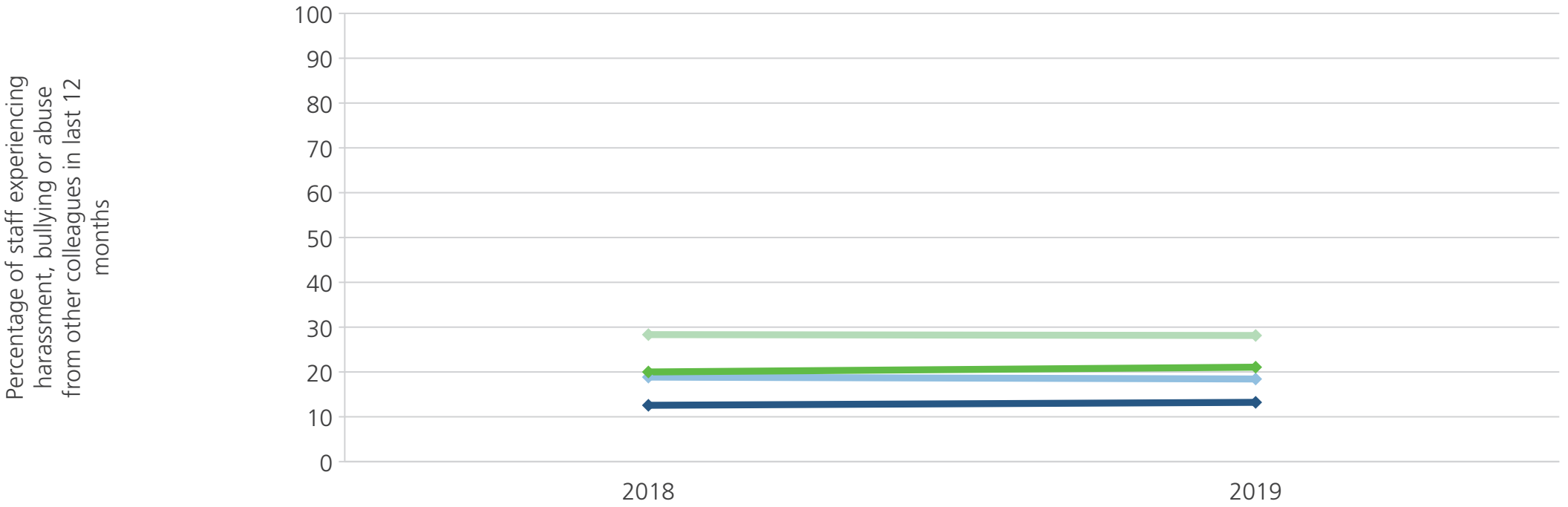


Disabled staff: Your org	16.0%	13.1%
Non-disabled staff: Your org	7.9%	8.4%
Disabled staff: Average	20.0%	19.7%
Non-disabled staff: Average	12.1%	11.0%

Disabled staff: Responses	325	375
Non-disabled staff: Responses	1,574	1,674

Average calculated as the median for the benchmark group

2019 NHS Staff Survey Results > WDES > Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months

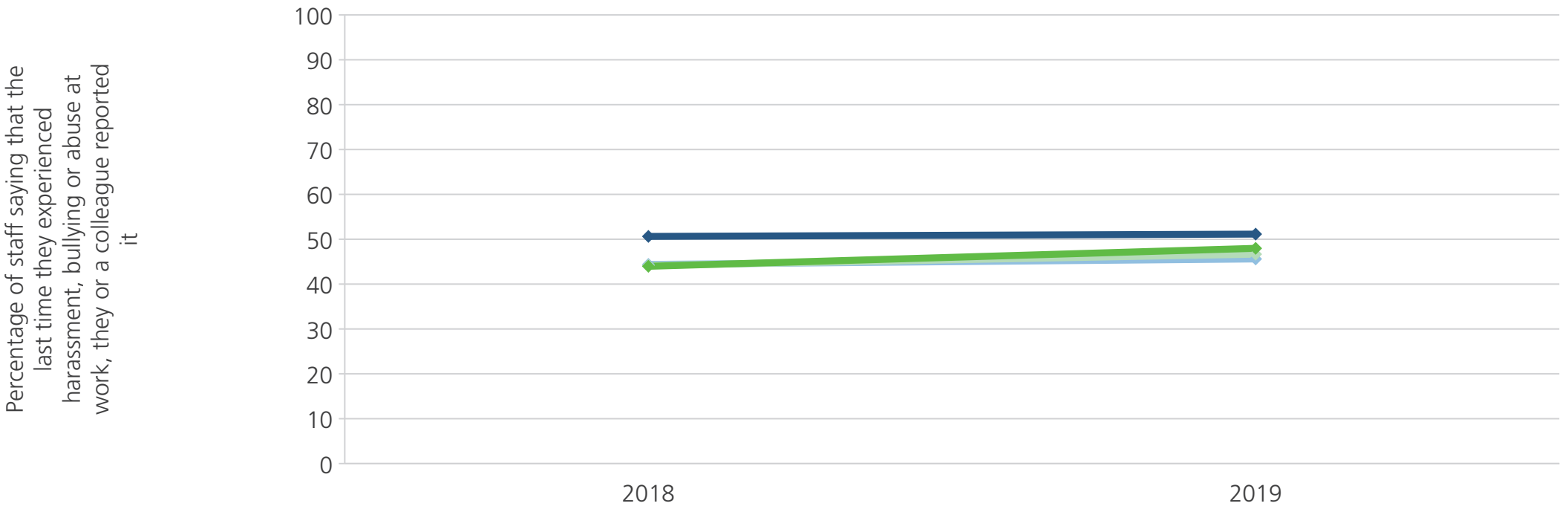


Disabled staff: Your org	20.0%	21.1%
Non-disabled staff: Your org	12.6%	13.2%
Disabled staff: Average	28.3%	28.1%
Non-disabled staff: Average	18.9%	18.4%

Disabled staff: Responses	325	375
Non-disabled staff: Responses	1,560	1,664

Average calculated as the median for the benchmark group

2019 NHS Staff Survey Results > WDES > Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it

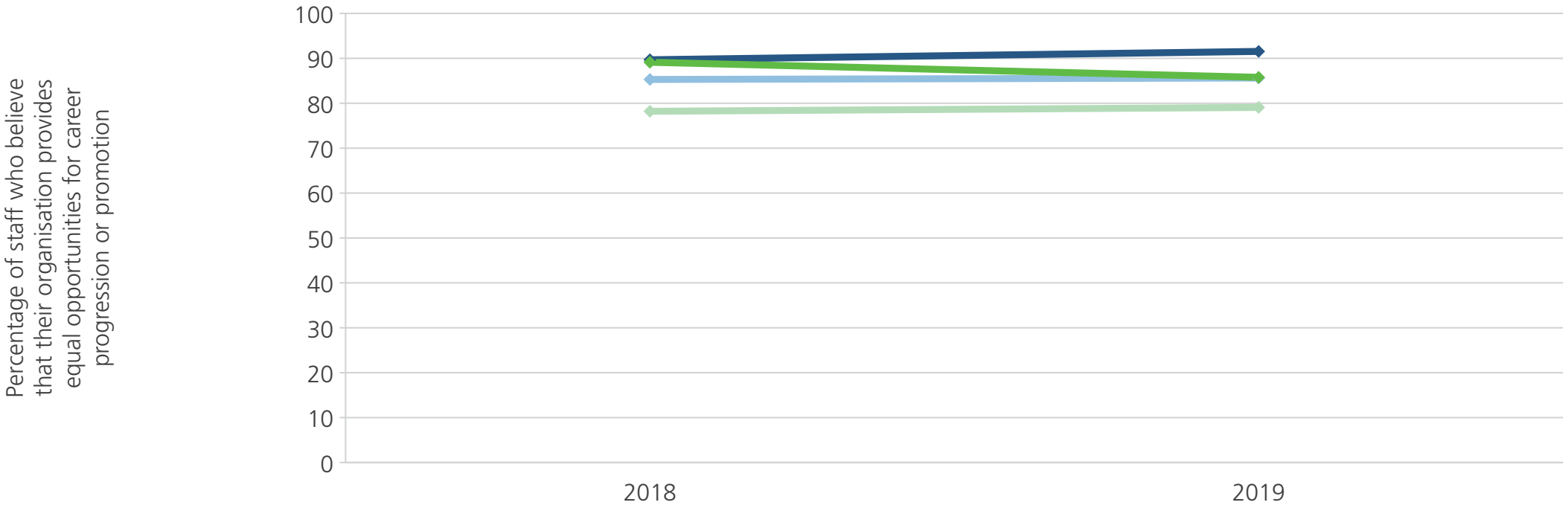


Disabled staff: Your org	44.0%	48.0%
Non-disabled staff: Your org	50.6%	51.1%
Disabled staff: Average	44.2%	46.7%
Non-disabled staff: Average	44.4%	45.6%

Disabled staff: Responses	116	148
Non-disabled staff: Responses	395	438

Average calculated as the median for the benchmark group

2019 NHS Staff Survey Results > WDES > Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion

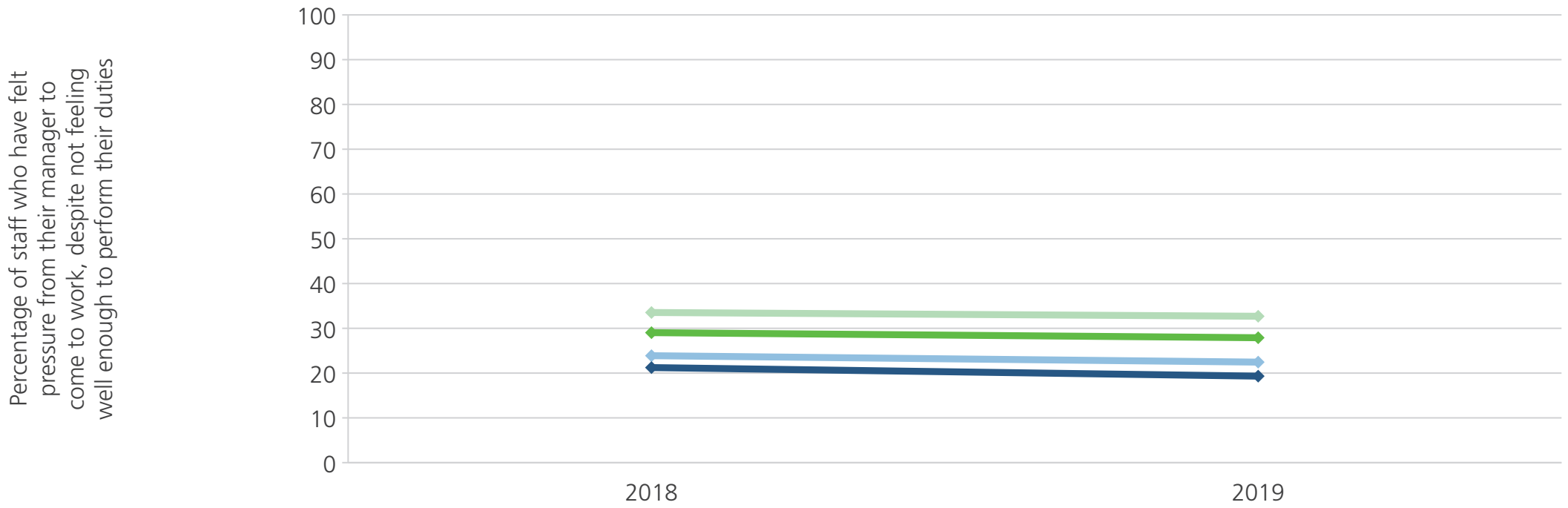


	2018	2019
Disabled staff: Your org	89.1%	85.8%
Non-disabled staff: Your org	89.7%	91.5%
Disabled staff: Average	78.2%	79.1%
Non-disabled staff: Average	85.3%	85.6%

Disabled staff: Responses	184	246
Non-disabled staff: Responses	1,115	1,206

Average calculated as the median for the benchmark group

2019 NHS Staff Survey Results > WDES > Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

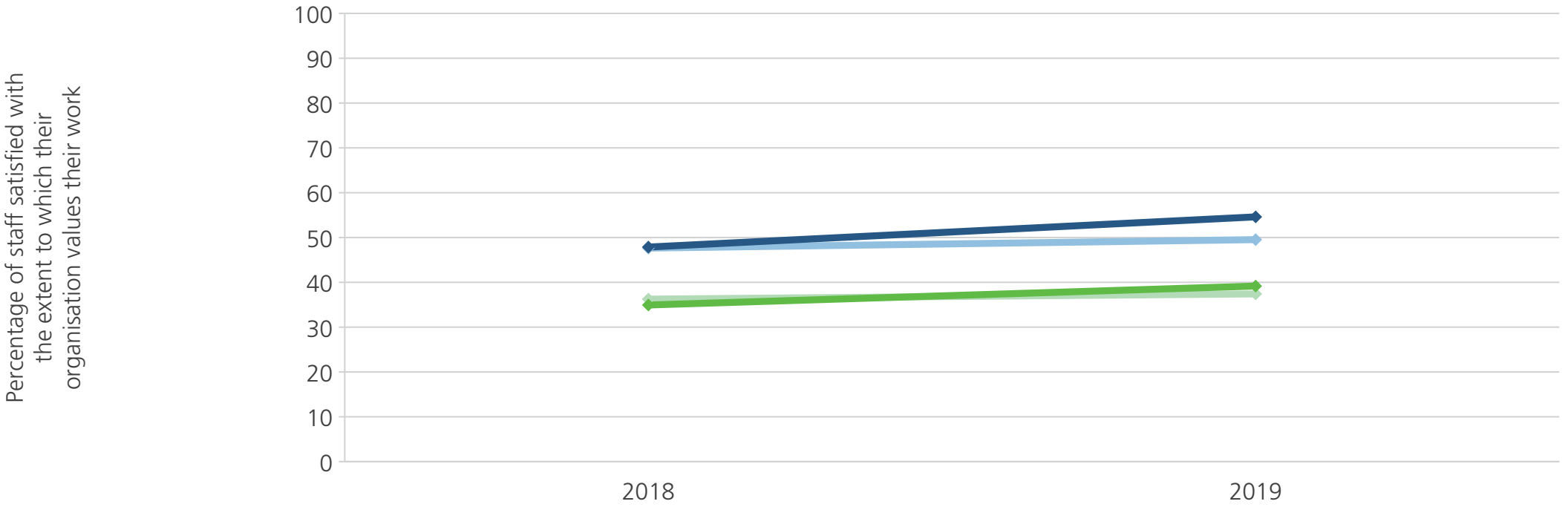


	2018	2019
Disabled staff: Your org	29.0%	27.9%
Non-disabled staff: Your org	21.2%	19.3%
Disabled staff: Average	33.5%	32.7%
Non-disabled staff: Average	23.9%	22.4%

Disabled staff: Responses	248	276
Non-disabled staff: Responses	796	792

Average calculated as the median for the benchmark group

2019 NHS Staff Survey Results > WDES > Percentage of staff satisfied with the extent to which their organisation values their work

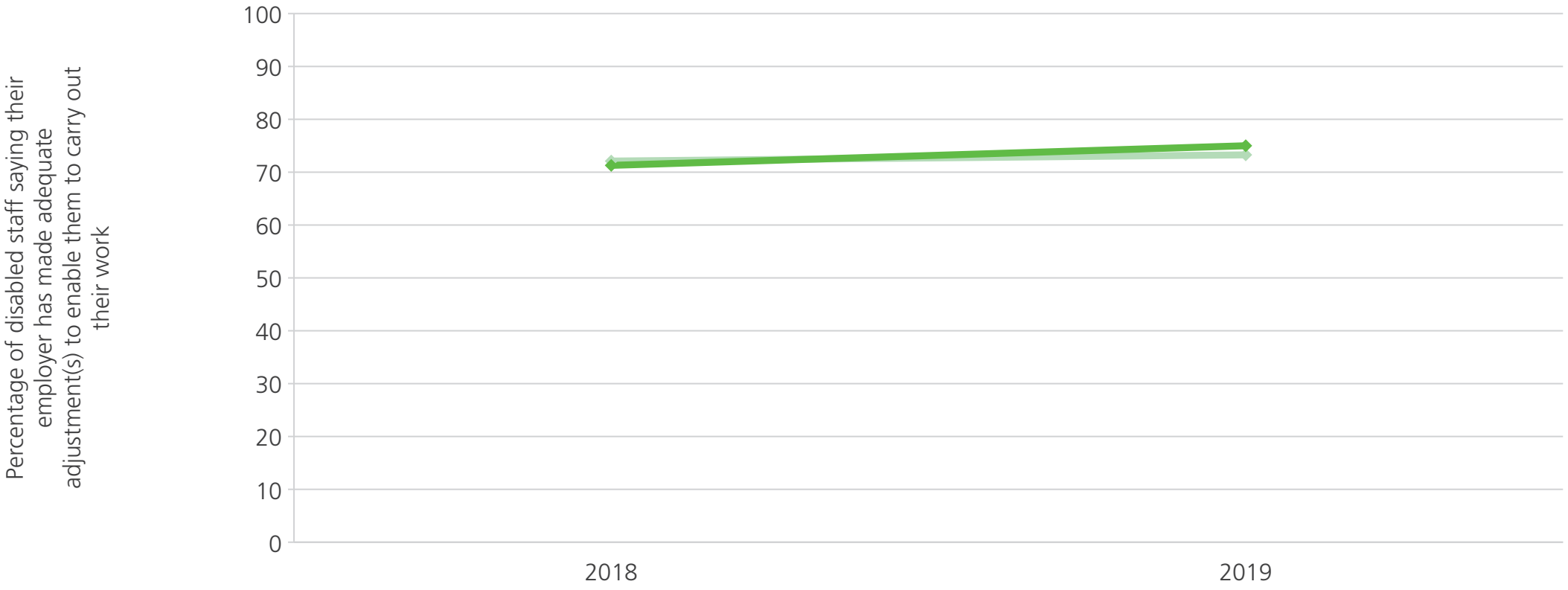


Disabled staff: Your org	34.9%	39.2%
Non-disabled staff: Your org	47.9%	54.6%
Disabled staff: Average	36.3%	37.4%
Non-disabled staff: Average	47.6%	49.5%

Disabled staff: Responses	332	383
Non-disabled staff: Responses	1,596	1,683

Average calculated as the median for the benchmark group

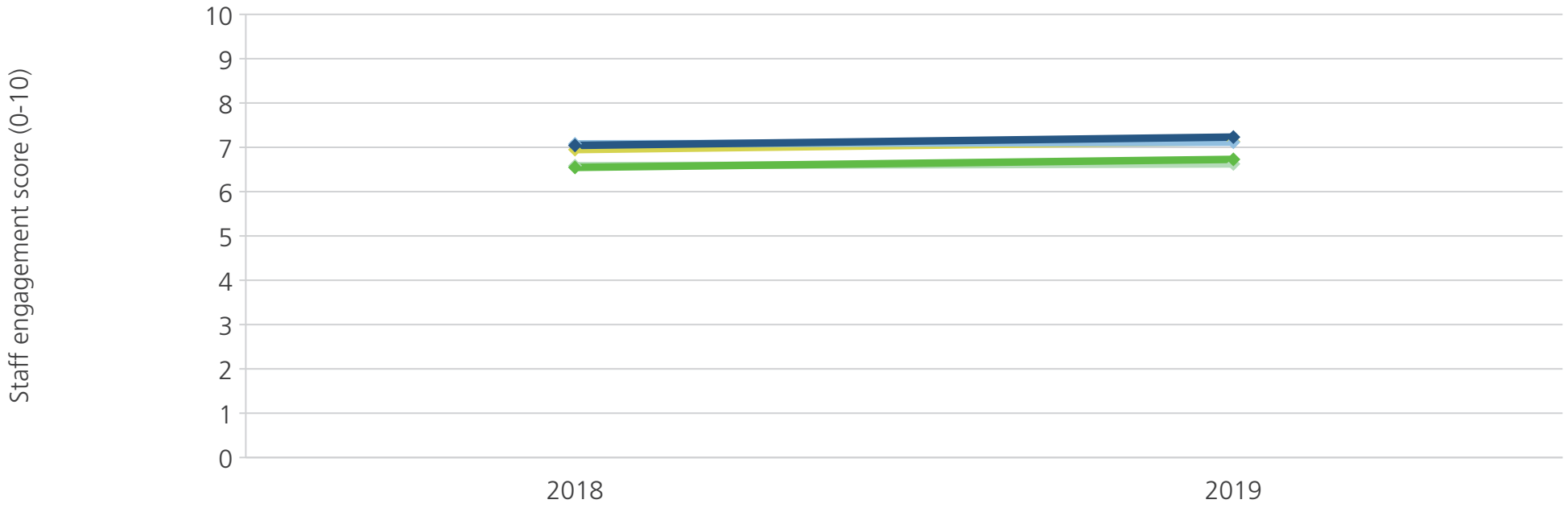
2019 NHS Staff Survey Results > WDES > Percentage of disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work



	2018	2019
Disabled staff: Your org	71.3%	75.0%
Disabled staff: Average	72.1%	73.3%
Disabled staff: Responses	202	228

Average calculated as the median for the benchmark group

2019 NHS Staff Survey Results > WDES > Staff engagement score (0-10)



Organisation average	6.9	7.1
Disabled staff: Your org	6.5	6.7
Non-disabled staff: Your org	7.0	7.2
Disabled staff: Average	6.6	6.6
Non-disabled staff: Average	7.1	7.1

Organisation Responses	1,979	2,127
Disabled staff: Responses	335	385
Non-disabled staff: Responses	1,605	1,693

Average calculated as the median for the benchmark group

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Appendices

Warrington and Halton Hospitals NHS Foundation Trust

2019 NHS Staff Survey Results

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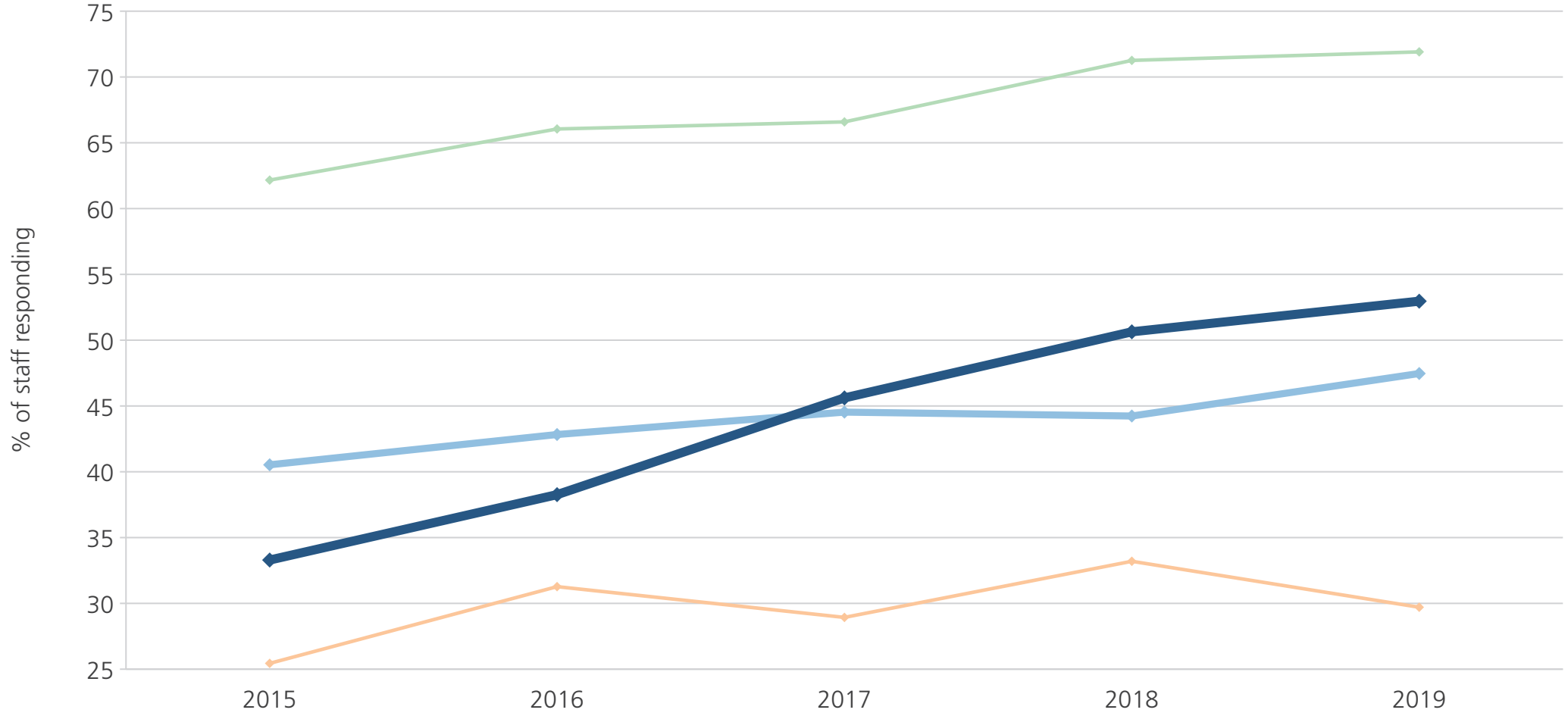
Appendix A: Response rate

Warrington and Halton Hospitals NHS Foundation Trust

2019 NHS Staff Survey Results



	2015	2016	2017	2018	2019
Best	62.2%	66.0%	66.6%	71.3%	71.9%
Your org	33.3%	38.3%	45.6%	50.6%	53.0%
Median	40.5%	42.8%	44.5%	44.2%	47.5%
Worst	25.4%	31.3%	28.9%	33.2%	29.7%

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Appendix B: Significance testing - 2018 v 2019 theme results

Warrington and Halton Hospitals NHS Foundation Trust

2019 NHS Staff Survey Results

The table below presents the results of significance testing conducted on this year's theme scores and those from last year*. It details the organisation's theme scores for both years and the number of responses each of these are based on.

The final column contains the outcome of the significance testing: ↑ indicates that the 2019 score is significantly higher than last year's, whereas ↓ indicates that the 2019 score is significantly lower. If there is no statistically significant difference, you will see 'Not significant'. When there is no comparable data from the past survey year, you will see 'N/A'.

Theme	2018 score	2018 respondents	2019 score	2019 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.3**	1957	**9.4**	2103	Not significant
Health & wellbeing	**6.2**	1968	**6.3**	2108	Not significant
Immediate managers	**7.0**	1979	**7.1**	2121	Not significant
Morale	**6.2**	1943	**6.4**	2090	↑
Quality of appraisals	**5.3**	1752	**5.5**	1801	↑
Quality of care	**7.5**	1634	**7.7**	1758	↑
Safe environment - Bullying & harassment	**8.4**	1946	**8.4**	2099	Not significant
Safe environment - Violence	**9.5**	1946	**9.4**	2100	Not significant
Safety culture	**6.7**	1969	**6.9**	2101	↑
Staff engagement	**7.0**	1979	**7.1**	2127	↑
Team working	**6.6**	1958	**6.8**	2104	↑

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

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Appendix C: Tips on using your benchmark report

Warrington and Halton Hospitals NHS Foundation Trust

2019 NHS Staff Survey Results

Data in the benchmark reports

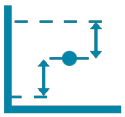
The following pages include tips on how to read, interpret and use the data in this report. The **suggestions are aimed at users who would like some guidance on how to understand the data** in this report. These suggestions are by no means the only way to analyse or use the data, but have been included to aid users transitioning from the previous version of the benchmark report and those who are new to the Staff Survey.

Key points to note

There are a number of differences in this benchmark report compared to the style of benchmark reports prior to the 2018 survey, which are worth noting

- Key Findings have been replaced by themes. The themes cover eleven areas of staff experience and present results in these areas in a clear and consistent way. All of the eleven themes are scored on a 0-10 scale, where a higher score is more positive than a lower score. These theme scores are created by scoring question results and grouping these results together.

- A key feature of the reports is that they **provide organisations with up to 5 years of trend data** across theme **and** question results. Trend data provides a much **more reliable indication of whether the most recent results represent a change from the norm** for an organisation than comparing the most recent results to those from the previous year. Taking a longer term view will help organisations to identify trends over several years that may have been missed when comparisons were drawn solely between the current and previous year.



- **Question results are benchmarked** so that organisations can make comparisons to their peers on specific areas of staff experience. Question results provide organisations with more granular data that will help them to identify particular areas of concern. The trend data are benchmarked so that organisations can identify how results on each question have changed for themselves and their peers over time by looking at a single graph.

1. Reviewing theme results

When analysing theme results, it is easiest to start with the **theme overview** page to quickly identify areas which are doing better or worse in comparison to other organisations in the given benchmarking group.

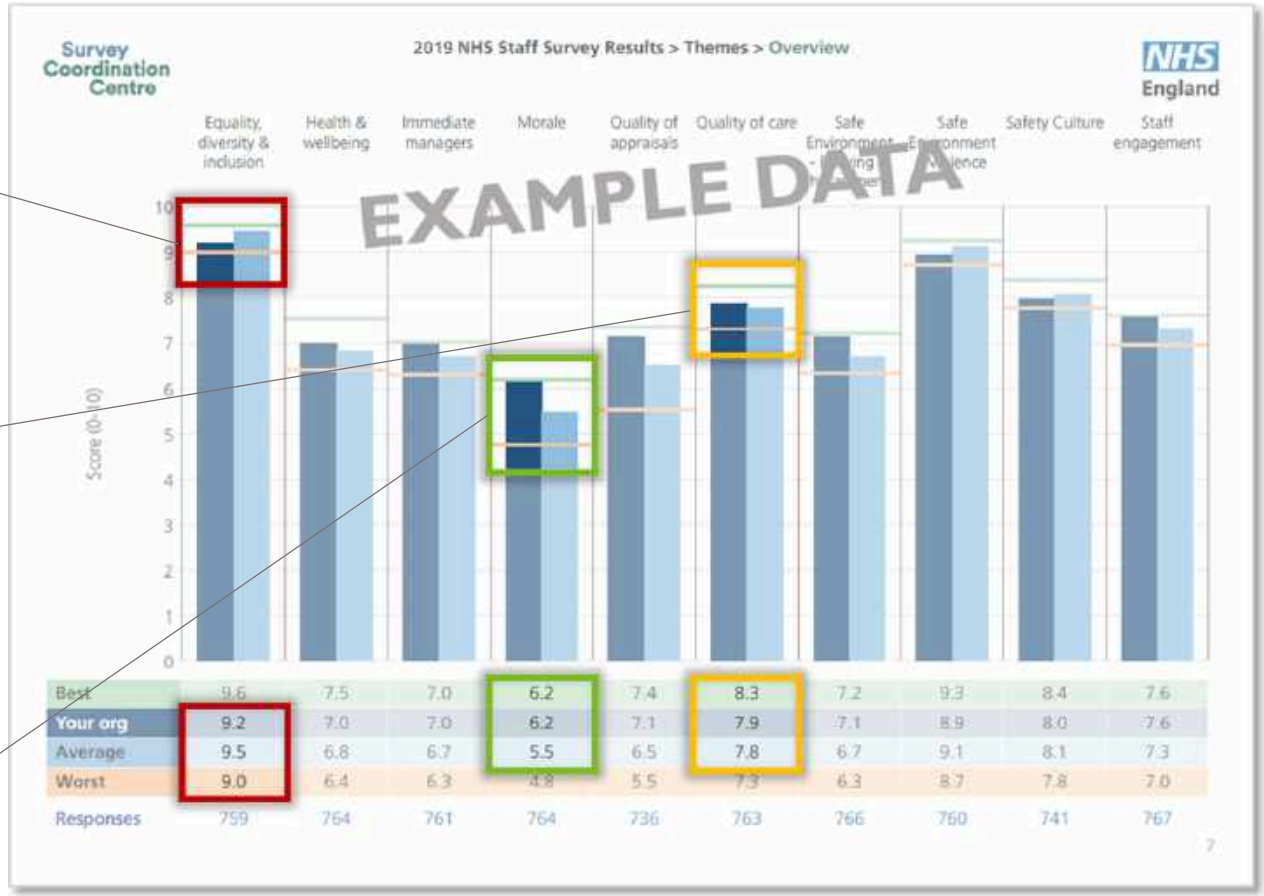
It is important to **consider each theme result within the range of its benchmarking group 'Best' and 'Worst' scores**, rather than comparing theme scores to one another. Comparing organisation scores to the benchmarking group average is another important point of reference.

Areas to improve

- By checking where the 'Your org' column/value is lower than the benchmarking group 'Average' you can quickly identify areas for improvement.
- It is worth looking at the difference between the 'Your org' result and the benchmarking group 'Worst' score. The closer your organisation's result is to the worst score, the more concerning the result.
- Results where your organisation's score is only marginally better than the 'Average', but still lags behind the best result by a notable margin, could also be considered as areas for further improvement.

Positive outcomes

- Similarly, using the overview page it is easy to identify themes which show a positive outcome for your organisation, where 'Your org' scores are distinctly higher than the benchmarking group 'Average' score.
- Positive stories to report could be ones where your organisation approaches or matches the benchmarking group's 'Best' score.



Only one example is highlighted for each point

2. Reviewing theme results in more detail

Review trend data

Trend data can be used to identify measures which have been consistently improving for your organisation (i.e. showing an upward trend) over the past years and ones which have been declining over time. These charts can **help establish if there is genuine change in the results** (if the results are consistently improving or declining over time), or whether a change between years is just a minor **year-on-year** fluctuation.

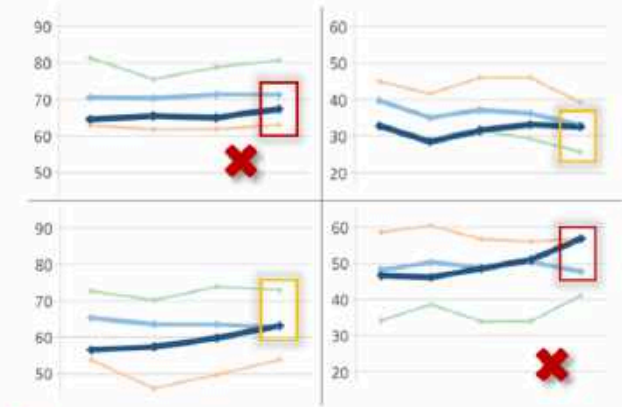
	2015	2016	2017	2018	2019
Best	6.3	6.5	6.3	6.3	6.2
Your org	5.7	5.8	5.8	6.0	6.2
Average	5.8	5.7	5.8	5.6	5.5
Worst	4.7	4.8	4.4	4.8	4.8
Responses	344	803	668	738	764

Benchmarked trend data also allows you to review local changes and benchmark comparisons at the same time, allowing for various types of questions to be considered: e.g. how have the results for my organisation changed over time? Is my organisation improving faster than our peers?

Review questions feeding into the themes

In order to understand exactly which factors are driving your organisation's theme score, you should review the questions feeding into the theme. The **'Detailed information'** section contains the questions contributing to each theme, grouped together, thus they can be reviewed easily without the need to search through the 'Question results' section. By comparing 'Your org' scores to the benchmarking group 'Average', 'Best' and 'Worst' scores for each question, the **questions which are driving your organisation's theme results can be identified**.

For themes where results need improvement, action plans can be formulated to **focus on the areas where the organisation's results fall between the benchmarking group average and worst results**. Remember to keep an eye out for questions where a lower percentage is a better outcome – such as questions on violence or harassment, bullying and abuse.



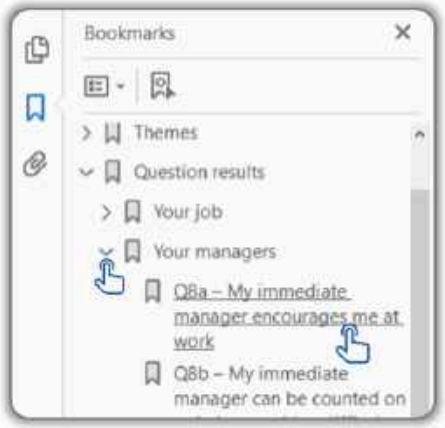
✖ = Negative driver, org result falls between average & worst benchmarking group result for question

3. Reviewing question results

This benchmark report displays results for all questions in the questionnaire, including benchmarked trend data wherever available. While this a key feature of the report, at first glance the amount of information contained on more than 170 pages might appear daunting. The below suggestions aim to provide some guidance on how to get started with navigating through this set of data. It's also worth noting that new for 2019 is a PDF summary version of this benchmark report. This presents the same data as this main benchmark report, but does not include the detailed question level reporting.

Identifying questions of interest

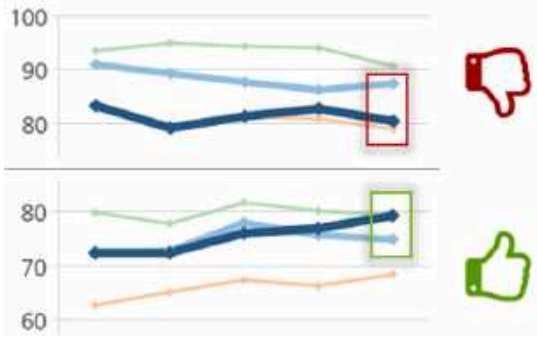
Use the bookmarks bar to navigate directly to questions of interest



- **Pre-defined questions of interest – key questions for your organisation**
  - Most organisations will have questions which have traditionally been a focus for them. Questions which have been targeted with internal policies or programmes, or whose results are of heightened importance due to organisation values or because they are considered a proxy for key issues. Outcomes for these questions can now be assessed on the backdrop of benchmark and historical trend data.
  - **Note:** The bookmarks bar allows for easy navigation through the report, allowing subsections of the report to be folded, for quick access to questions through hyperlinks.

- **Identifying questions of interest based on the results in this report**

  The methods recommended to review your theme results can also be applied to pick out question level results of interest. However, **unlike themes where a higher score always indicates a better result, it is important to keep an eye out for questions where a lower percentage relates to a better outcome** (see details on the 'Using the report' page in the 'Introduction' section).



- [To identify areas of concern]: look for questions where the organisation value falls between the benchmarking group average and the worst score, particularly questions where your organisation result is very close to the worst score. Review changes in the trend data to establish if there has been a decline or stagnation in results across multiple years, but consider the context of how the trust has performed in comparison to its benchmarking group over this period. A positive trend for a question that is still below the average result can be seen as good progress to build on further in the future.
- [When looking for positive outcomes]: search for results where your organisation is closest to the benchmarking group best result (but remember to consider results for previous years), or ones where there is a clear trend of continued improvement over multiple years.

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NHS England

Appendix D: Additional reporting outputs

Warrington and Halton Hospitals NHS Foundation Trust

2019 NHS Staff Survey Results

Additional reporting outputs

Below are links to other key reporting outputs which complement this report. A full list and more detailed explanation of the reporting outputs is included in the Technical Document.

Supporting documents

Basic Guide: Provides a brief overview of the NHS Staff Survey data and details on what is contained in each of the reporting outputs.

Technical Document: Contains technical details about the NHS Staff Survey data, including: data cleaning, weighting, benchmarking, theme, historical comparability of organisations and questions in the survey.

Other local results

Benchmark summary reports: A PDF summary version of this benchmark report, that produces the same data, but does not include the detailed question level reporting.

Local Breakdowns: Dashboards containing results for each organisation broken down by demographic characteristics. Data is available for up to five years where possible.

Directorate Reports: Reports containing theme results split by directorate (locality) for Warrington and Halton Hospitals NHS Foundation Trust.

National results

National Trend Data and **National Breakdowns**: Dashboards containing national results – data available for five years where possible.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/03/42 b**			
SUBJECT:	**Annual Report of the Strategic People Committee 2019 - 2020**			
DATE OF MEETING:	25 March 2020			
AUTHOR(S):	Anita Wainwright, Non-Executive Director			
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Director of HR & OD			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#115 Failure to provide adequate staffing levels in some specialities and wards. #145 (a) Failure to deliver our strategic vision.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report seeks to deliver assurance to the Trust Board that the Strategic People Committee has met its Terms of Reference and has gained assurance throughout the reporting period of the Trust's performance.			
PURPOSE: *(please select as appropriate)*	Information	Approval	To note ✓	Decision
RECOMMENDATION:	Trust Board are asked to note for assurance the content of the annual Chair's report of the Strategic People Committee, and ensure it meets its purpose.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	SPC/20/03/21		
	Date of meeting	18 March 2020		
	Summary of Outcome	Annual Report approved to progress to Trust Board		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	Choose an item.			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

SUBJECT	**Annual Report of the Strategic People Committee 2019 - 2020**	**AGENDA REF:**	**BM/20/03/42 b**

1. BACKGROUND/CONTEXT

The Strategic People Committee is required to report annually to the Board outlining the work it has undertaken during the year, and where necessary, highlighting any areas of concern. This paper presents the Strategic People Committee Annual Report which covers the reporting period 1st April 2019 to 31st March 2020.

The Strategic People Committee (the Committee) is accountable to the Board of Directors (the Board) for providing oversight and assurance on all aspects of the workforce, including strategy, Equality Diversity and Inclusion, recruitment and retention, delivery, organisational development, staff engagement, medical education, leadership and culture, employee wellbeing and the regulatory standards relevant to workforce experience and resourcing.

The Strategic People Committee is also accountable to the Board for ensuring that the three Strategic People Objectives set by the overall Trusts Strategy is implemented throughout the organisation and that organisational strategic workforce risks are managed appropriately.

This report details the membership and role of the Committee and the work it has undertaken during the reporting period.

During the reporting period, the Committee has been composed of 2 Non-Executive Directors with a quorum of 2 (including the Chair). Any Non-Executive Director is able to attend the Committee to cover any absence.

During the reporting period, there were 6 meetings. The Strategic People Committee attendance record is attached in **Appendix 1**.

2. Terms of Reference, Business Cycle and Assurance

The Committee's Terms of Reference were approved in Quarter 4 (March 2019) 2018/19 for implementation in 2019/20, as was the business cycle, to ensure they remained fit for purpose and also in line with the roll out of the revised Trust meetings structure. The 18 March 2020 meeting will receive and approve a revised Terms of Reference for 2020/21 and business cycle, with amendments to Section 3. Membership – specific changes to job titles and Section Nine: Administrative Arrangements – specific changes to the timeframe for submission of papers. The 2020/21 Terms of Reference are attached in **Appendix 2.** The Strategic People Committee continues to focus on assurance monitoring, with its reporting sub committees meeting on a more frequent basis to deliver the agenda. High level briefings are provided to the Strategic People Committee for assurance purposes. Reporting sub committees are constantly under review, ensuring ongoing scrutiny.

3. Frequency of Meetings and Summary of Activity

The Committee met 6 times during the year. A summary of the activity covered at these meetings follows:

- **HRD Report on National, Regional and Local Workforce Priorities**

  The Committee has had regular updates on in relation to the strategic People Priorities for the Trust, as a result of local, regional and national priorities.

  Local:
  - WHH Leadership Model
  - Developing High Performing Teams
  - Trust Board Development Programme by Good Governance Institute
  - Board to Board – Memorandum of Understanding between the Trust and Bridgewater Community Healthcare NHS Foundation Trust
  - Improving People Practices – Trust Response to Recommendations
  - Collaboration between Bridgewater Health Care NHS Foundation Trust (BCHT) and Warrington & Halton Hospitals NHS Foundation Trust (WHH)
  - Workforce Health and Wellbeing Framework

  Regional:
  - Cheshire & Merseyside – Proposed Human Resources Defining the Future State Vision
  - Cheshire & Merseyside Collaboration at Scale – Human Resources & Organisational Development Priorities Update
  - Regional Director of People
  - Cheshire & Merseyside Collaboration at Scale – Standardised Rate Card Implementation

  National:
  - Long Terms NHS Plan – Workforce Implementation Plan (WIP)
  - Talk Health and Care Portal http://dhscworkforce.crowdicity.com/

- NHS Pensions
- The Long Term Plan for the NHS – Update on NHS People Plan
- Cheshire & Merseyside Collaboration at Scale – Standardised Rate Card Implementation
- COVID-19 - Staffing
- Immigration Policy
- Military March 2020
- Employment Law Changes - April 2020

In addition updates of enabling strategies have been provided e.g. Equality, Diversity and Inclusion Strategy.

- **Risk Management**

The Strategic People Committee receives an update of strategic risks on the Board Assurance Framework (BAF). It has been agreed that the Board receives an update on all strategic risks and any changes that have been made to the strategic risk register, following review at Quality Assurance Committee. A Risk Review Group has been established reporting to Quality Assurance Committee, for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately.

The Strategic People Committee receives any notable updates on those risks linked to Strategic Objective 2:

We will … be the best place to work with a diverse, engaged workforce that is fit for the future

o May 2019

BAF:
No new risks have been escalated to the BAF
No amendments to the ratings of any risks on the BAF that are linked to Strategic Objective 2
Existing Risk - 241 – Risk Score Unchanged

o July 2019

BAF:
No new risks have been escalated to the BAF
No amendments to the ratings of any risks on the BAF that are linked to Strategic Objective 2.
No amendments to the titles of any risks on the BAF that are linked to Strategic Objective 2.
No risks linked to Strategic Objective 2 have been de-escalated from the BAF.

Workforce Risk Register:
The following risks have been added to the workforce since the Committee was previously updated in May 2019:
Risk 950: Failure to fulfil staffing requirements via WLIs and additional PAs, caused by reductions to annual and lifetime pensions allowances, resulting in non-compliance with performance targets and service delivery requirements.

The following risks have been closed since the Committee was previously updated in May 2019:
Risk 853: Failure to deliver an effective Equality, Diversity and Inclusion service caused by a lack of.

- September 2019

BAF:
No new risks have been escalated to the BAF
No amendments to the ratings of any risks on the BAF that are linked to Strategic Objective 2.
No amendments to the titles of any risks on the BAF that are linked to Strategic Objective 2.
No risks linked to Strategic Objective 2 have been de-escalated from the BAF.

Workforce Risk Register:
The following risk was added since the Committee was previously updated in July 2019:

Risk to the delivery of the required educational needs for the Undergraduate Medical Workforce in relational to clinical skills, simulation and support in practice. Caused by increased demand from the University and changes in the training curriculum to increase support in the following areas:

- Clinical Skills
- Pharmacy
- Simulation
- Support in practice

The following risk was closed since the Committee was previously updated in July 2019:

Failure to successfully engage the Workforce, caused by the potential for an adverse working culture which resulted in the consequential loss of discretionary effort and productivity, or loss of talented colleagues to other organisations, which would impact patient care, staff morale and delivery of the Trust's strategic objectives No risks have been amended since the Committee was previously updated in July 2019.

- November 2019

BAF:
No new risks have been escalated to the BAF
No amendments to the ratings of any risks on the BAF that are linked to Strategic Objective 2.
No amendments to the titles of any risks on the BAF that are linked to Strategic Objective 2.
No risks linked to Strategic Objective 2 have been de-escalated from the BAF.

Workforce Risk Register:
No workforce risks have been added since the Committee was previously updated in September 2019.

- January 2020

BAF:
No new risks have been escalated to the BAF
No amendments to the ratings of any risks on the BAF that are linked to Strategic Objective 2.
No amendments to the titles of any risks on the BAF that are linked to Strategic Objective 2.
No risks linked to Strategic Objective 2 have been de-escalated from the BAF.

Workforce Risk Register:
No workforce risks have been added since the Committee was previously updated in September 2019.

- March 2020

BAF:
No new risks have been escalated to the BAF
No amendments to the ratings of any risks on the BAF that are linked to Strategic Objective 2.
No amendments to the titles of any risks on the BAF that are linked to Strategic Objective 2.
No risks linked to Strategic Objective 2 have been de-escalated from the BAF.

Workforce Risk Register:
No workforce risks have been added since the Committee was previously updated in September 2019.

- **CQC – Getting to Good, Moving to Outstanding - Staff**

  - May 2020

The Trust was inspected across the 3 areas of:

- Use of Resources (UoR) - 2 April 2019
- Core Services April 2019 – 8 days in total across 3 weeks
- Well Led 30 April, 1 & 2 May 2019

Each of the Key Lines of Enquiry were presented as evidence to the Inspectors and a comprehensive series of interviews were undertaken as part of all 3 inspection elements.

The draft report – Factual Accuracy checking report – is expected in June 2019 once the CQC & NHSI have triangulated the information, evidence and their observations.
Following the UoR Inspection specific attention was given to the Model Hospital data used.

The Committee received assurance on all 3 inspections highlighted above and awaited the final inspection outcome to be represented at the next Committee.

- July 2020

The Committee was updated that the Trust had received an overall GOOD rating for Core services and Well Led and a Requires Improvement for Use of Resources.

- **Workforce Key Performance Indicator recommendations for 2020/21**

In April 2017, the Trust Board approved the implementation of the Performance Assurance Framework (PAF) which sets out the approach for ensuring effective systems are in place for monitoring, managing and improving Trust performance against a range of indicators.

As part of the introduction of the PAF, the Trust implemented the Integrated Performance Report (IPR) dashboard which brings together indicators from a range of sources including;

Contractual Standards, CQC Insight Indicators and Indicators relating to NHSI Oversight Framework. This dashboard provides assurance and oversight of performance at Trust Board level. The IPR is reviewed at each Trust Board meeting under the headings of Quality, Access & Performance, Workforce and Finance & Sustainability.

All IPR indicators are reviewed annually to ensure they are remain relevant and up to date and to introduce any new indicators which are required.

New Indicators

KPI	RAG Criteria	Rationale
Agency Rate Card Compliance	Green = 60% or Above Amber = 50%-59% Red = Below 50%	An agency rate card was implemented across Cheshire & Merseyside in December 2019 in order to reduce costs of agency staff across the network. This KPI is being introduced to ensure the Trust is in compliance with the rate card.
% Use of Apprenticeship Levy	Green = 85% or Above Amber = 50%-84% Red = Below 50%	Introduced in May 2017, the apprenticeship levy and the achievement of an associated workforce target have provided significant challenges to large public sector bodies including WHH. Whilst work continues towards full utilisation of the financial levy contribution and achievement of the 2.3% of workforce undertaking apprenticeships target, significant progress cannot be achieved without a wider organisational approach to apprenticeships. Significant work has been undertaken to ensure appropriate governance is now in place to review, monitor and exception report against organisational apprenticeship activity, it is felt that now is the right time to introduce organisational level KPI's to promote organisational ownership of the apprenticeship challenge, ensure the delivery of an organisational approach to apprenticeships and subsequently, achieve both full utilisation of the apprenticeship levy financial contribution and the workforce metric.
% Workforce carrying out an Apprenticeship Qualification	Green = 2.3% or Above Amber = 1.5%-2.2% Red = Below 1.5%	
Role Specific Training	Green = 85% or Above Amber = 70%-85% Red = Below 70%	The reporting for role specific training takes place at the Education Governance Committee alongside mandatory training. The topics covered as part of role specific training, although not part of core skills frame work, are vital for patient and staff safety and experience and therefore it is recommended these are sighted by the Trust Board.

Strategic people Committee endorsed the recommendations for new indicators relating to the Workforce section of the dashboard, for final approval by Trust Board.

- **Policies and Procedure Approved**

  - Secondment Policy
  - Special Leave Policy
  - Annual Leave Policy
  - Dignity at Work Policy
  - Equality, Diversity and Inclusion Policy
  - Temporary Staffing Policy
  - Professional Clinical Registration Policy Nursing Associates
  - Recovery of Employee Overpayments and Outstanding Debt Policy
  - Study and Professional Leave Policy for non-training grade medical staff
  - Annual leave policy

- Policy on Time Off for Recognised Representatives and members of Trade Unions/Staff Organisations
- Clinical Excellence Awards
- Special leave Policy

- **People Strategy Delivery**

The People Strategy delivery outcomes have been reported to the Committee on a quarterly basis providing an update on progress, achievement of objectives to agreed milestones and giving assurance to members that it has addressed regional and national priorities as they have emerged during the year.

Within the People Strategy Delivery report, the Equality, Diversity and Inclusion delivery update is also provided, giving assurance to the Committee on the strategic objectives and pledges.

- **Employee Relations**

The Committee receives assurance on the key issues in relation to employee relations across the Trust, in particular employee relations case work (with a focus on suspension/exclusion) and partnership working.

Key themes relating to partnership working include:
• Junior Doctor Experience
• Trade Union Facilities Time
• Flu Campaign

- **Regulatory and Statutory monitoring**

The Committee continued to monitor the statutory and regulatory requirements relating to workforce throughout the year. This included monitoring national surveys, employment law updates, people KPIs, Equality and Diversity etc.

The Committee received assurance and / or approved the submission of:

- Equality Duty Assurance Report (EDAR) PSED Standard
- Workforce Equality Assurance Report (WEAR) PSED Standard
- Equality Delivery System 2 (EDS2) – March 2020
- Gender Pay Report – March 2020
- Workforce Race Equality Standards (WRES)
- Workforce Disability Equality Standard (WDES)
- Facilities Time off Annual Report
- Guardian Quarterly Report, Safe Working Hours – Junior Doctors in Training
- Freedom to Speak Up – Workforce Update
- Monthly Nursing Staffing Report
- HENW/GMC Annual Reports
- GMC Patient Survey Response Report
- HENW Local Education Provider (LEP) Report
- HENW Monitoring Visit (Annual Assessment Visit)
- GMC National Trainee Survey

- GMC Revalidation Annual Report (Medical Appraisal)
- NHSE Statement of Compliance & NHSE Annual Organisational Audit (AQA)

4. Issues Carried Forward

There are a number of issues which the Committee will carry forward into 2020/21:

- Implementation of the People and Equality, Diversity and People Priorities for the year
- Delivery of other NHS People Plan once published e.g. national People Promise domains and the Leadership Compact.
- eRostering for Medical Staff within the organisation

5. Summary

The Committee has evolved in year, with a significant review of terms of reference and remit. The chair of Committee encourage honest and open discussion, so that areas of success can be celebrated and areas of improvement escalated and actioned. Escalation has been to Trust Board or to other assurance Committees as appropriate to the matter.

6. RECOMMENDATIONS

Trust Board are asked to:
Note for assurance the content of the annual Chair's report of the Strategic People Committee, and ensure it meets its purpose.

Anita Wainwright, Non-Executive Director & Chair of Strategic People Committee

Warrington and Halton Teaching Hospitals NHS

STRATEGIC PEOPLE COMMITTEE ANNUAL RECORD 2019-20

	22.05.19	24.07.19	18.09.19	20.11.19	22.01.20	18.03.20	% attendance Excl deputy	% attendance Incl deputy
CORE MEMBERS								
Anita Wainwright, Non-Executive Director, Chair	✓	✓	✓	✓	✓	✓	100%	100%
Ian Jones, Non-Executive Director	✓	✓	✓	✓	✓	✓	100%	100%
Margaret Bamforth, Non-Executive Director *(wef July 2019)*		✓	A	✓	A	✓	60%	60%
Michelle Cloney, Director of Human Resources and Org Development	✓	✓	✓	✓	✓	✓	100%	100%
Simon Constable, Executive Medical Director & Deputy CEO *(to Oct 19)*	✓	A/D	A/D					
Lucy Gardner, Director of Strategy	A	A	A	A	✓	✓	33.3%	
Chris Evans, Chief Operating Officer	✓	A	A/D	A/D	✓	A	33.3%	66.6%
Kimberley Salmon-Jamieson, Chief Nurse	✓	✓	✓	A/D	✓	A/D	66.6%	100%
Alex Crowe Medical Director (acting EMD wef 11/2019)	✓	✓	✓	A/D	✓	A/D	66.6%	100%
Andrea McGee, Director of Finance + Commercial Development	✓	A	A	✓	A/D	A/D	33.3%	66.6%
Pat McLaren, Director of Community Engagement	A	A	A	A	A	✓		
Deborah Smith, Deputy HRD	✓	A/D	✓	✓	✓	A/D	66.6%	100%
IN ATTENDANCE								
Julie Burke, Secretary to Trust Board (Minutes)	✓	✓	A	✓	✓	✓		
Wendy Johnson, Head of Education Development and Wellbeing		✓						
Helen Dixon, Head of HR Business Partners		X/D						
John Culshaw, Trust Secretary		A	✓	✓	✓	✓		
Spencer McKee, Head of Medial Staffing and Education (to Aug 2019)								
Dan Moore, Deputy Chief Operating Officer			X/D					
Caroline Williams, Associate Director Integrated Care				X/D				
Rachel Browning, Associate Chief Nurse Clinical Effectiveness				X/D				
Anne Robinson, Acting Deputy Medical Director				X/D				
Lynn Simpson, Head of Management Accounts					X/D			
Colin Jenkins, Public Governors	✓	✓	✓	✓	✓	A		

Key: A = Apologies A/D = apologies with deputy attending X/D = Attendance as Deputy Xp = Part R = Left Trust