Warrington and Halton Hospital NHS Foundation Trust
Board of Directors
Agenda

Wednesday 28th January 2015, time 1300 - 1800hrs
Trust Conference Room, Warrington Hospital

1300 ***15mins***	***W&HHFT/TB/15/01***	***Welcome, Apologies & Declarations of Interest***		Chairman
	W&HHFT/TB/15/02	***Minutes of the previous meeting held on 26th November 2014***	Paper	to be published following approval
	W&HHFT/TB/15/03	***Action Plan***	Paper	
1305 ***10mins***	***W&HHFT/TB/15/04***	***Chairman's Report***	Verbal	Chairman
1315 ***15mins***	***W&HHFT/TB/15/05***	***Chief Executives Report***	Verbal	Chief Executive

Quality

1330 ***15mins***	***W&HHFT/TB/15/06***	***Presentation: Patient Story***	Presentation	Director of Nursing, Governance and OD
1345 ***10mins***	***W&HHFT/TB/15/07***	***Verbal Report from the Chair of the Quality Governance Committee***	Verbal	Mike Lynch, Non-Executive Director
1355 ***20mins***	***W&HHFT/TB/15/08***	***Quality Dashboard***	Paper	Director of Nursing, Governance and OD
1415 ***15mins***	***W&HHFT/TB/15/09***	***Q3 Infection Control Report***	Paper	Director of Nursing, Governance and OD
1430 ***15mins***	***W&HHFT/TB/15/10***	***Complaints: Patient Experience Quarter 3 Report***	Paper	Director of Nursing, Governance and OD
1445 ***10mins***	***W&HHFT/TB/15/11***	***End of Life Care – Report from the Responsible Director for End of Life Care***	Presentation	Liz O'Brien, Palliative Care Consultant
1455 ***10mins***	***W&HHFT/TB/15/12***	***Patient Experience Strategy – Briefing paper***	Paper	Director of Nursing, Governance and OD
1505 ***05mins***	***W&HHFT/TB/15/13***	***AQUA Board to Board Action Plan – for noting***	Paper	Director of Nursing, Governance and OD
	W&HHFT/TB/15/14	***CQC Intelligent Monitoring Report – for noting***	Paper	Director of Nursing, Governance and OD
1510 ***15mins***	***Break***			

People

1525 ***10mins***	***W&HHFT/TB/15/15***	***Verbal Report from the Chair of the Strategic People Committee***	Verbal	Lynne Lobley, Non-Executive Director
1535 ***15mins***	***W&HHFT/TB/15/16***	***Workforce and Educational Development Key Performance Indicators***	Paper	Director of Nursing, Governance and OD
1550 ***10mins***	***W&HHFT/TB/15/17***	***Equality Duty Assurance Report – for noting***	Paper	Director of Nursing, Governance and OD
1600 ***05mins***	***W&HHFT/TB/15/18***	***Ward Staffing Levels***	Paper	Director of Nursing, Governance and OD
1605 ***15mins***	***W&HHFT/TB/15/19***	***QPS Behaviours Framework***	Paper	Suzanne Douglas, Organisational Development Manager

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1620 ***05mins***	***Break***			

Sustainability

1625 ***10mins***	***W&HHFT/TB/15/20***	***Verbal Report from the Chair of the Finance and Sustainability Committee***	Verbal	Carol Withenshaw, Non-Executive Director
1635 ***15mins***	***W&HHFT/TB/15/21***	***Q3 Finance Report***	Paper	Director of Finance & Corporate Development
1650 ***10mins***	***W&HHFT/TB/15/22***	***i. Strategic Framework*** ***ii. Strategic Planning Process 2015***	Paper/ Presentation	Director of Finance & Corporate Development
1700 ***15mins***	***W&HHFT/TB/15/23***	***Corporate Performance Report***	Paper	Chief Operating Officer
1715 ***10mins***	***W&HHFT/TB/15/24***	***Corporate Risk Report***	Paper	Director of Nursing, Governance and OD
	W&HHFT/TB/15/25	***Board Assurance Framework***	Paper	Executive
1725 ***10mins***	***W&HHFT/TB/15/26***	***Q3 Monitor Governance Statement***	Paper	Director of Finance & Corporate Development
1735 ***10mins***	***W&HHFT/TB/15/27***	***Lorenzo project approval***	Paper	Director of IM&T
1745 ***15mins***	***W&HHFT/TB/15/28***	***Other Board Committee Reports:*** ***i. Approval of Warrington and Halton Hospitals NHS FT Charitable Fund.*** ***ii. Approval of the Finance and Sustainability Committee Terms of Reference*** ***iii. Minutes for Noting:*** ***a) Finance and Sustainability Committee held on 19 November 2014*** ***b) Quality Governance Committee held on 11 November 2014***	 Paper Paper Paper Paper	 Chair of the CFC Chair of the FSC
	W&HHFT/TB/15/29	***Any Other Business***		
1800 ***ends***		***Dates of next meeting*** *25th February 2015*		

TRUST BOARD
ACTION PLAN – Current / Outstanding Actions
Meeting: Trust Board 28th January 2015

Meeting date	Minute Reference	Action	Responsibility & Target Dates	Status	
27-11-2014	TB/14/172	Director of Nursing and Organisational Development to share the content of the RCOG Report, suitably redacted to remove any identifiable personal/patient information, with those who had contributed to its findings.	Director of Nursing and Organisational Development	Director of Nursing and Organisational Development met with the families and provided copies of the RCOG Report	Action Discharged
27-11-2014	TB/14/175(i)	Medical Director to provide additional information on the performance for advancing quality; Heart Failure following the reduced cumulative score of 100% in April 2014 to 84.3% in August 2014.	Medical Director	To be reported in quality dashboard See agenda item TB/15/08	Action Discharged
27-11-2014	TB/14/175(ii)	Director of Nursing and Organisational Development to provide additional supporting information on the Friends and Family Test that showed why the response rate was falling in A&E.	Director of Nursing and Organisational Development	To be reported in quality dashboard See agenda item TB/15/08	Action discharged

27-11-2014	TB/14/176	Director of Nursing and Organisational Development to amend the Quality Strategy to take account of amendments discuss in the meeting and with the other Executive Directors agree as part of the review the reporting lines for Emergency Planning, Information Governance and Corporate Records.	Director of Nursing and Organisational Development	The Quality Strategy has been amended to take account of comments raised by the Board at the November meeting. Amendments have been made to the Terms of Reference of the FSC to support discussions within the executive regarding reporting requirements of the sub committees; Information Governance and Business Continuity.	Action discharged
27-11-2014	TB/14/180(i)	Director of Finance to provide to the FSC a breakdown of CIP identified by EY against what, following internal review, could be implemented.	Director of Finance	Paper distributed to the Board.	Action discharged
27-11-2014	TB/14/180(ii)	Director of Finance to provide a breakdown of specialty income/revenue performance.	Director of Finance	Distributed to the Board by email on 27 November 2014.	Action Discharged
27-11-2014	TB/14/184	The Chief Operating Officer and Executive Directors to review risk 1.1 in the BAF and assess whether the risk score and residual risk was appropriate given the current impact of pressure on A&E in delivery of the national and local targets.	The Chief Operating Officer and Executive Directors	See agenda item TB/15/25	Action Discharged

BOARD OF DIRECTORS

WHH/B/2015/ **004**

SUBJECT:	**Chairman's Report**
DATE OF MEETING:	28th January 2015
DIRECTOR:	Chairman

BOARD OF DIRECTORS

WHH/B/2015/ **005**

SUBJECT:	**Chief Executive Report**
DATE OF MEETING:	28th January 2015
EXECUTIVE DIRECTOR:	Chief Executive

BOARD OF DIRECTORS

WHH/B/2015/ **006**

SUBJECT:	**Patient Story** **A story that highlights the problems a young lady with learning disabilities encountered during her stay on a surgical ward.**
DATE OF MEETING:	28th January 2015
DIRECTOR:	Director of Nursing and Organisational Development

BOARD OF DIRECTORS

WHH/B/2015/ **007**

SUBJECT:	**Verbal Report from the Chair of the Quality Governance Committee**
DATE OF MEETING:	28th January 2015
DIRECTOR:	Mike Lynch

BOARD OF DIRECTORS

WHH/B/2015/ **008**

SUBJECT:	**QUALITY DASHBOARD (2014/2015) JANUARY 2015**
DATE OF MEETING:	28th January 2015
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	Ros Harvey (Corporate Nursing Programmes Manager) Hannah Gray (Clinical Effectiveness Manager)
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance Choose an item.
LINK TO STRATEGIC OBJECTIVES:	Choose an item. All Choose an item.
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework SO1/1.3 Failure to achieve infection control targets in accordance with the Risk Assessment Framework Choose an item. Choose an item. Choose an item.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED:	None
EXECUTIVE SUMMARY (KEY ISSUES):	The Quality Dashboard provides a monthly update on KPIs for 2014/2015 from the:- • CQUINs – National (Local CQUINs will be monitored by the CQUIN monitoring group and reported by exception if required). • Quality Contract • Quality Account - Improvement Priorities • Quality Account – Quality Indicators • Sign up to Safety – national patient safety topics • Open and Honest Exception reports are included for non-compliant indicators

	including HCAI; Care Indicators; Pressure Ulcer CQUIN; AQ Heart Failure and Mixed Sex Occurrences.	
RECOMMENDATION:	***The Board is asked to:*** 1. Note that the data for a number of indicators can change month on month. This applies to incidents (including pressure ulcers and falls), as incident type and severity can alter once reviewed, complaints and concerns as complaints can become concerns (and vice versa), with the agreement of complainants, and to mortality data which is rebased. 2. Note progress and compliance against the key performance indicators 3. Approve actions planned to mitigate areas of exception	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

1. Key Performance Indicators

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
Intelligent Monitoring																			
Banding March 14 = 5	Not set						3						5						
Number of elevated risks March 2014 = 1	Not set						2						1						
Number of risks March 2014 = 4	Not set						5						3						
Safety																			
Mortality																			
HSMR (12 month rolling)	<=100 = G, As expected = A, Higher than expected = R	QI, IP, QC	98	98	98		98	98	99		102								102
SHMI (12 month rolling)	<=100 = G, As expected = A, Higher than expected = R	QI, IP, QC	108	108	107		107	109	108										108
Total deaths in hospital	Not set		99	89	76	264	74	81	97	252	95	80	135	310					826
Regulation 28 - Prevention of future deaths report	Not set		0	0	0	0	0	0	0	0	0	0	0						0
Incidents resulting in Moderate, Major or Catastrophic harm																			
Incidents resulting in moderate, major or catastrophic harm	TBC	QC	7	11	4	22	3	6	10	21	4	6	2	12					55
Incidents of moderate, major or catastrophic harm under investigation	N/A		2	3	2	7	0	2	3	5	3	16	23	42					54

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
Falls																			
All falls (approved)	Not set		91	78	87	256	89	78	79	246	76	70	95	241					743
Moderate, major and catastrophic harm falls (approved)	<=13 per year	IP	1	2	2	5	2	3	0	5	0	0	0	0					10
Moderate, major and catastrophic harm falls (awaiting approval)	N/A		0	0	0	0	0	0	2	2	0	4	2	6					8
Major and catastrophic harm falls (approved)	<=2 per year	QC	0	0	1	1	0	0	0	0	0	0	0	0					1
Pressure Ulcers																			
Grade 3 and 4 Hospital Acquired (Avoidable)	<=6 per year	IP	1	1	0	2	0	0	0	0	0	0	0	0					2
Grade 3 and 4 Hospital Acquired (Unavoidable)	<=10	QC	0	0	0	0	1	0	1	2	0	0	0	0					2
Grade 3 and 4 Hospital Acquired (Under review)	N/A		0	0	0	0	0	0	1	1	2	0	1	3					4
Grade 2 Hospital Acquired	<=101 per year	IP	3	8	2	13	12	3	3	18	9	5	5	19					50
Grade 2 Hospital Acquired – stretch target	<=90 per year	IP	3	8	2	13	12	3	3	18	9	5	5	19					50

(20% reduction)																		
	Threshold	**IC**	**A**	**M**	**J**	**Q1**	**J**	**A**	**S**	**Q2**	**O**	**N**	**D**	**Q3**	**J**	**F**	**M**	**Q4**	**YTD**
Grade 2 Hospital Acquired (under review)	N/A		0	0	0	0	0	0	0	0	0	1	4	5					5
% RCA / mini investigation completed	100%	IP	100	100	100	100	100	100	100	100	100	100	100	100					100
YT% of patients with a pressure ulcer (Community or hospital acquired) (ST)	<=3.99% (November 2014 – March 2015) (median YTD)	C	4.92	3.07 amended	3.73		3.37	5.63 amended	4.95		4.34	5.90	4.65						
Health Care Acquired Infections																			
MRSA	0= green, 1-5=amber, >5 red	QC, IP	0	1	0	1	0	0	1	1	0	0	1	1					3
Clostridium difficile	<=26 per year	QC, IP	2	3	2	7	1	7	1	9	3	1	3	7					23
MSSA	Not set		1	0	1	2	1	0	0	1	1	1	2	4					7
Out of hours transfers	TBC	BK	1	2	5	8	1	5	1	7	3	0	7	10					25
Never Events	0 per year	QC	0	0	0	0	0	0	0	0	0	0	0	0					0
Number of cardiac arrests in hospital wards, outside A&E, Theatres, CCU and ICU'.	Annual: <75 = G 75 – 85 = A >85 = Red	QC	8	11	7	26	3	13	6	22	5	7	13	25					73
Medicines Safety Thermometer % harm free (ST)	TBC	IP	PILOT	PILOT	PILOT		PILOT	PILOT	98.3		99.2	97.4	99.2						
VTE																			
% of patients risk assessed	>=95%	QC	95.55	95.92	95.61		95.33	95.30	95.31		95.64	95.91	95.47						

% of eligible patients having prophylaxis (ST)	100%	QC	92	99.8	93		100	99.6	100		100	100	100						
	Threshold	**IC**	**A**	**M**	**J**	**Q1**	**J**	**A**	**S**	**Q2**	**O**	**N**	**D**	**Q3**	**J**	**F**	**M**	**Q4**	**YTD**
Number of patients who developed a HA VTE	Baseline TBC	QC	7	8	4	19	12	0	0	12	0								31
Number of patients who developed a HA VTE (under review)			0	0	1	1	1	5	4	10	7								18
% free from harm (ST)		OH	97.3	99.2	97.8		98	96.4	98		97.4	96.5	98						
Catheter Acquired Urinary Tract Infections																			
CA – UTI: Number of catheterised patients who developed a UTI (ST)	<=3 per month	IP	4	2	2	8	2	4	5	11	0	5	1	6					
CA – UTI % of catheterised patients who developed a UTI (ST)	<=0.6% each month	IP	0.76	0.38	0.39		0.40	0.89	0.99		0	0.92	0.19						
Dementia																			
Dementia Assessment % (Part 1)	>=90%	C	94.55	95.69	95.43*		94.26	96.59	92.45		92.70	96.61	96.29						
Dementia Assessment % (Part 2)	>=90%	C	100	100	100*		100	100	91.89		100	100	97.22						
Dementia Assessment % (Part 3)	>=90%	C	100	100	100*		100	100	100		100	100	100						

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
Care Indicators																			
Falls - risk assessment % compliance	>=95%	IP	100	95	95	96.6	98.8	98.9	98	98.7	99	98	99	97					
Waterlow - risk assessment % compliance	>=95%	IP	98	92.7	88.3	93	95.6	93.3	83	90.6	96	98	100	95					
MUST - risk assessment measures	>=95%	IP	57.2	59.4	60	58.9	81.6	71.1	75	75.9	83	83	94	77					
Effectiveness																			
Advancing Quality % compliance (cumulative scores)																			
Acute MI	>=95%	IP, C	100	98.4	98.9		98.4	98.8	99		98.37								98.37
Hip and Knee	>=95%	IP, C	95.2	96.5	95		96.4	96.7	96.9		97.23								97.23
Heart failure	>=90.2%	IP, C	100	90.9	87.9		83.1	84.3	83.7		84.31								84.31
Pneumonia	>=73.9%	IP, C	68.6	72.8	74.4		75.1	76.1	75.2		74.66								74.66
Stroke	>=60.4%	IP, C	69.7	61.4	57		58.3	60	60.7		61.76								61.76
COPD (data not yet released)	>=50%	IP, C						PILOT	PILOT										
Patient Reported Outcome Measures (PROMS)																			
Hip replacement (Average health gain)	0.44 (latest England average Mar 2014)	IP,QC		Still provisional data													0.41		0.40
Knee replacement (Average health gain)	0.32 (latest England average Mar 2014)	IP,QC		Still provisional data													0.34		0.34
Groin surgery (Average health gain)	0.085 (latest England average Mar 2014)	IP,QC		Still provisional data													0.065		0.065
Patient Experience																			

Always events (Q1&2 implementation, Q3 data collection)	TBC	IP									84%	100%	100%			
	Threshold	**IC**	**A**	**M**	**J**	**Q1**	**J**	**A**	**S**	**Q2**	**O**	**N**	**D**	**Q3**		
Mixed sex occurrences	0	QC	6	3	0		0	0	0	0	0	0	5			14
Friends and family test (patients' views)																
Friends and Family Test**. Star rating**	TBC		4.54	4.5	4.58		4.53	4.6	4.58		4.6	4.61	4.59			
Friends and Family Test Inpatients **Net promoter changed to % recommending Trust – November 2014.**	>=95% (National average changes each month including independent)	OH	76	74	81		76	77	94		95	97				
Friends and Family Test A&E **Net promoter changed to % recommending Trust – November 2014.**	>=87% (National average changes each month)	OH	42	35	41		40	45	82		85	87				
Friends and family response rate (A&E)	Q1 – >=15% Q4 - >=20%	C	23.08	18.52	20.79	20.75	19.55	17.58	14.51	17.26	13.57	17.86	16.48	15.93		18.01
Friends and family response rate (inpatients)	Q1 – >=25% Q4 - >=30% March 2015 achieve >=40%	C	27.32	26.83	34.62	29.55	32.20	30.02	26.39	29.55	32.85	30.99	28.44	30.77		29.96
Friends and family test (staff views)																
Staff friends and family question (needing care) (Extremely likely and likely responses from F&F quarterly staff survey)	TBC Q3 Staff survey results	C				70.9				72	STAFF SURVEY					

Staff F&F place to work (as above)	Q3 Staff survey results					66.8				67									
	Threshold	**IC**	**A**	**M**	**J**	**Q1**	**J**	**A**	**S**	**Q2**	**O**	**N**	**D**	**Q3**					
Complaints and concerns																			
Number of concerns received	Not set	IP	2	9	6	17	16	10	6	32	5	4	2	11					60
Number of complaints received **Please see note below.**	2013/2014 received 422 (No threshold set)	IP	31	40	38	109	52	30	31	113	52	34	37	123					345
% of complaints resolved within the agreed timescale	>=94%	IP	94.44	95.24	100	96.51	96.88	100	97.5	98.23	97.92	100	100	99.1					98.05

ST = Safety Thermometer. This is a survey carried out on one day a month on all wards. The survey provides a point prevalence figure e.g. of the number of inpatients who have a hospital acquired pressure ulcer on that day. The figure is NOT the total number of incidents in the month.

Key: YTD = Year to date, ST = Safety Thermometer (monthly point prevalence survey), IC = Inclusion criteria

Inclusion criteria key: Improvement priority (IP), National Quality related CQUINs (C), Local quality related CQUINs by exception*(CE), Quality Account indicators (QI), CQC Intelligent Monitoring quality related 'Elevated risks' and 'risks'(CQC), National Patient Safety Priorities (related to Sign up to Safety campaign) (SS), Contract KPIs (Quality section only) not considered at other forums (QC), Directive from Sir Bruce Keogh (BK), Open and Honest (OH)

2. Exception reporting

Care Indicators

High Quality Care was a local CQUIN for 2013/2014. The care indicators audit was a process which was developed as part of this CQUIN to audit compliance with risk assessments for Falls, Waterlow and MUST Risk Assessments. The Trust identified this as an important aspect of quality of care and thus agreed to continue monitoring as a Quality Indicator for the Quality Accounts in 2014/2015. The results (random sample) indicate sustained compliance with the falls risk assessment, Waterlow is again compliant in December at 100% and MUST has shown a significant improvement in December to just below the agreed threshold at 94%. The Patient Quality & Safety Champion has increased surveillance via the Dawes assessments in order to improve compliance going forward.

MRSA and Clostridium Difficile

MRSA bacteraemia
The Trust reported 1 MRSA bacteraemia in December. The Trust has reported 3 hospital apportioned cases YTD.

Clostridium difficile
3 hospital apportioned cases of Clostridium difficile were reported in December. One of these cases was reported due to diagnosis of pseudomembranous colitis (as per mandatory requirements) in the absence of a toxin positive result. Discussion took place with the mandatory surveillance team as histology findings differed from sigmoidoscopy report. Reporting of this case was carried out as per directive from the mandatory surveillance team.
The total number of hospital apportioned cases is 23 YTD against the threshold of 26 cases.

Advancing Quality – Heart failure

Heart Failure
The nursing and medical teams continue to work toward patients with Heart Failure receiving the treatment they require and in the vast majority of patients this is the case. We are working on looking at the fails which are in the main due to patients who were admitted and discharged with a diagnosis of Heart Failure within 24 hours. We are looking to develop a document similar to that used in the pneumonia work stream in support of this. Importantly, it must be noted that concerns were raised at our last AQ meeting that there may be issues with accuracy of recording heart failure patients who may not eventually have heart failure (it would really be unusual only to be admitted for 24 hours with this condition). Our most recent data reflects two patients where we did not provide discharge instructions. One of these patients was subsequently found not to have heart failure. Meetings have taken place with AQuA to assist us in resolving these issues.

Mixed Sex Occurrences

There were a total of five patients involved in mixed sex accommodation breaches reported in December 2014. Four patients in ICU/HDU were delayed transfers from the unit due to the high activity at the time. Two of these went into a second day breach, so the total penalty for the four patients (sixdays) is £1,500. There was also a delayed transfer from CCU with a penalty of an additional £250. Two root cause analysis have been completed for the breaches.

Cardiac Arrests

- The Acute Care Team, who provide the Medical Emergency Team (MET), is being strengthened by 1 WTE Nurse per shift.
- We are continuing to make improvements to the 'i bleep' system to make this as effective as possible
- The NEWS has been rolled out across all wards and is audited by the Acute Care Team.
- An acute illness management competency package has been developed, which is aimed specifically at ward based nursing and medical staff.
- We are improving methods by which we make decisions to support end of life care

4. KPI Updates

Pressure ulcer (Community or hospital acquired) (ST)

This indicator is in place to monitor progress with the national CQUIN - The number of patients recorded as having a category 2-4 pressure ulcer (old or new) as measured using the NHS Safety Thermometer on the day of each monthly survey / Total number of patients surveyed on the day.
The Trust median baseline for October to March 2014 was established at 3.99. We have agreed improvement value of <=3.99 with commissioners. The Trust is required to show improvement in the period November 2014 to March 2015. The Trust is currently over the target of 3.99. The main issue is old PU (known as community). Analysis of "old to new" shows that the rate has increased due to the number of old PU's Work being undertaken to identify the patients who are admitted from care homes and directly from home and we will then identify themes e.g. location of PU and long term conditions to share with care homes and GP's. Commissioners have agreed that a report outlining community vs hospital acquired will address any concerns and enable us to achieve.
Report has been sent to the CCG and the Safeguarding Lead.

CQC: Intelligent Monitoring

The 'elevated risk' is:
Whistleblowing (18-7-13 – 29-9-14)

The 'risks' are:
Composite indicator: In-hospital mortality - Cardiological conditions and procedures (01-May-13 to 30-Apr-14)
Composite indicator: In-hospital mortality - Haematological conditions (01-May-13 to 30-Apr-14)
NHS Staff Survey - KF10. The proportion of staff receiving health and safety training in last 12 months (01-Sep-13 to 31-Dec-13)

BOARD OF DIRECTORS

WHH/B/2015/ **009**

SUBJECT:	**Q3 Infection Prevention and Control**	
DATE OF MEETING:	28th January 2015	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Lesley McKay Associate Director of Infection Prevention and Control	
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance and OD Choose an item.	
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care SO2: To be the employer of choice for healthcare we deliver SO3: To give our patients the best possible experience	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.3 Failure to achieve infection control targets in accordance with the Risk Assessment Framework	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides a summary of infection control activity in quarter 3 (Q3), 2014 and highlights the Trust's progress year-to-date (YTD) against infection prevention and control key performance indicators. The Trust over trajectory for Clostridium difficile but has not exceeded the annual threshold. An MRSA bacteraemia case was identified in December 2014.	
RECOMMENDATION:	***The Board is asked to:-*** ***Note the* Q3 Infection Prevention and Control Report and** ***Support the request for increasing the Antibiotics Pharmacist hours***	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

Infection Prevention and Control Report

EXECUTIVE SUMMARY

This report provides a summary of infection control activity in quarter 3 (Q3), 2014 and highlights the Trust's progress year-to-date (YTD) against infection prevention and control key performance indicators.

The Trust over trajectory for Clostridium difficile but has not exceeded the annual threshold.

An MRSA bacteraemia case was identified in December.

CONTEXT

The Trust has developed healthcare associated infection (HCAI) reduction action plans for Clostridium difficile and MRSA & MSSA bacteraemias. These action plans are updated quarterly to ensure local and national priorities relating to HCAI are addressed and meet the requirements specified in the NHS Standard Contract for 2014/15.

Monitor uses Clostridium difficile infection rates as one of a number of metrics to assess Trust performance. Both avoidable and unavoidable cases of Clostridium difficile are taken into account for regulatory purposes. The *de minimis* limit for cases of C. difficile is set at 12. Monitor will assess the Trust for breaches of the Clostridium difficile objective (threshold of 26 cases for 2014/15) each quarter using a cumulative YTD trajectory. Monitor will consider whether the Trust is in breach of its licence if the Care Quality Commission reports serious concerns about Trust performance or third parties raise concerns about infection outbreaks.

HEALTHCARE ASSOCIATED INFECTIONS

CLOSTRIDIUM DIFFICILE

During Q3 the Trust reported 17 cases of *Clostridium difficile, 7* of which were hospital apportioned (appendix 1). As per mandatory reporting requirements, one case was reported following detection of pseudomembranous colitis during sigmoidoscopy in the absence of a toxin positive result.

Weekly surveillance is carried out to identify any periods of increased incidence (PIIs) [2 hospital apportioned cases within a 28 day period in a defined location]. The Infection Control Team includes PCR positive/toxin negative cases within this review. During October a PII was noted on ward B12 which included 1 toxin positive case and 2 PCR positive/toxin negative cases. It is not possible to confirm or rule out links with these cases as ribotyping of PCR positive/toxin negative cases is not performed by the reference laboratory.

Year to date (YTD) the Trust has reported 51 cases of *Clostridium difficile*, 23 of which are hospital apportioned against the financial year threshold of 26 cases. The Trust is 4 cases above planned trajectory at the end of Q3.

It should be noted that both community apportioned cases of Clostridium difficile (toxin positive) and all cases of Clostridium difficile PCR positive/toxin negative (local surveillance only) cared for within the Trust present a background incidence of cases and associated transmission risk.

Discussions are taking place with the CCG in relation to the review process for Clostridium difficile cases. The two cases submitted for review last year were not removed from contractual sanctions. The DIPC has requested further feedback and information on Terms of Reference used by the panel.

The last Antibiotic Point Prevalence Audit (October 2014) identified an overall increase in antibiotic usage and a decrease in prescribing compliance. The Infection Prevention and Control Team requested further support/increase in hours to the Antibiotics Pharmacist role to facilitate additional antibiotic ward rounds and to produce an antibiotic prescribing e-learning package. This was approved and supported by the Board however has not yet been implemented. The DIPC is addressing this with the Chief Pharmacist to support the Clostridium difficile reduction work streams.

BACTERAEMIAS

MRSA bacteraemia

During Q3 (December) the Trust reported 1 hospital apportioned MRSA bacteraemia from a patient on ICU. The post infection review did not identify any root causes. Some areas for improvement were noted which included:- use of chlorhexidine impregnated dressings to be introduced for all centrally placed access devices (currently only used for femoral sited devices or if known colonisation with MRSA or MSSA; review of IV device documentation forms to promote compliance with documenting the reason for IV device removal.

YTD the Trust has reported 4 MRSA bacteraemia cases, 3 of which are hospital apportioned against the threshold of zero avoidable infections.

MSSA bacteraemia

During Q3, the Trust reported 9 cases of MSSA bacteraemia, 4 of which were hospital apportioned. Post Infection reviews have been conducted into all cases with findings listed below:-

- Case 1 – urosepsis
- Case 2 – possible contaminant
- Case 3 – cellulitis (foot wound)
- Case 4 – repeated IV central line insertion

Cases 3 and 4 were both linked to ICU. Both patients were identified to be colonised with MSSA on admission to ICU. Suppression therapy was provided as per protocol and all other policies followed. Additional environmental audits have been undertaken with no significant findings. Input has been requested from the IV Therapy Team to support departmental training.

YTD the Trust has reported 23 MSSA bacteraemia cases, 7 of which are hospital apportioned. This is a positive position compared to the last financial year when the Trust flagged as an outlier both regionally and nationally for higher than average number of hospital apportioned cases.

E. coli bacteraemias

In Q3 a total of 42 cases were reported. The Medical Microbiologists review all cases of E. coli bacteraemia and the majority of cases are deemed unlikely to be associated with healthcare. YTD the Trust has reported 121 cases of E. coli bacteraemia.

OUTBREAKS/INCIDENTS/NEW DEVELOPMENTS

Viral Gastroenteritis

In Q3, 12 wards were under surveillance and part or fully closed due to symptoms of viral gastroenteritis. Two of these outbreaks were confirmed as norovirus. All the wards were re-opened as soon as it was safe to do so. The Microbiology laboratory is reviewing testing methodology with a view to providing in house testing for gastroenteritis viruses. This will provide more timely results to inform decision making.

Chickenpox incident

A chickenpox exposure incident occurred in the Antenatal Day Unit during November. Contact tracing identified significant exposure (>15 minutes) occurred to 3 adult contacts (2 in the late stages of pregnancy) and 1 neonate. The incident was managed with guidance from Public Health England. A patient notification exercise was undertaken. The adult contacts were confirmed immune following serology testing and the parent of the neonate was advised to seek medical advice if a rash develops. No secondary cases were identified in relation to the incident.

Ebola preparedness

The Infection Control Team is continuing work to prepare the Trust for managing suspected cases of Ebola and other viral haemorrhagic fever. Concerns have been raised with Public Health England in relation to the practical application of guidance published on donning and doffing of personal protective equipment.

A second suspect case attended the Trust in November 2014. An SBAR report on management of the case is included in appendix 3. Improvements were noted in how this case was managed compared to the first suspect case in August 2014.

Community Services Tender

The trust recently completed a tender application to provide Community Infection Prevention and Control services for Halton, St Helens and Warrington Boroughs. The Trust was shortlisted for interview however the tender remained with the incumbent organisation. Feedback on the tender has been received and will be utilised for any future bids.

Influenza

Public Health England have advised influenza A activity has increased to levels higher than the last 2 seasons and for most of the decade to 2009. There appears to have been a change (antigenic drift) in the A/H3N2 subtype meaning that the 2014 vaccine confers only partial immunity. Infections amongst those vaccinated appear in general to have attenuated rather than prevented the flu.

Modelling statistics for epidemics of influenza are not available. The Trust is proactively reviewing the Pandemic Influenza Plan and will adapt this accordingly.

NEXT STEPS

Further work is required to:-

- Ensure provision of Antibiotics Pharmacist Hours
- Ensure a robust plan is in place to meet an increased demand for admissions for respiratory type illness and segregation of patients suspected to have influenza
- Train staff in correct donning and doffing of personal protective equipment to prevent self-contamination when dealing with suspect cases of Ebola
- Review terms of reference for review of Clostridium difficile cases with the CCG

RECOMMENDATIONS

The Board is asked note the Report and support the requirement for additional Antibiotics Pharmacist Hours.

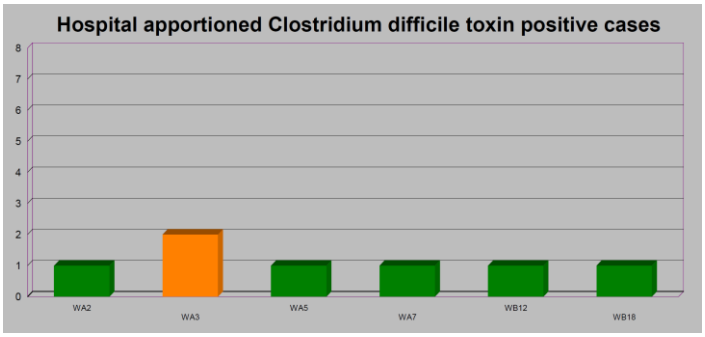
CONCLUSION

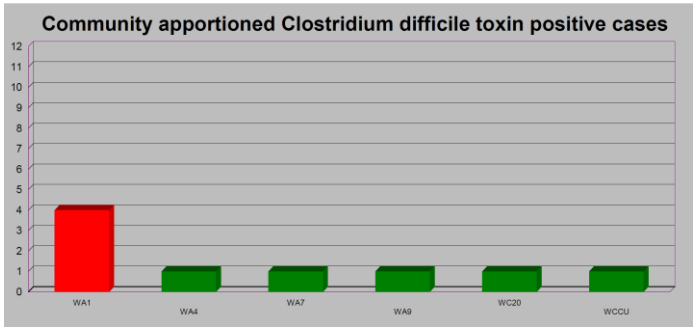
The Board is asked to note the contents of the report and the progress made.

Appendix 1 - HCAI Surveillance data April – September 2014

CLOSTRIDIUM DIFFICILE

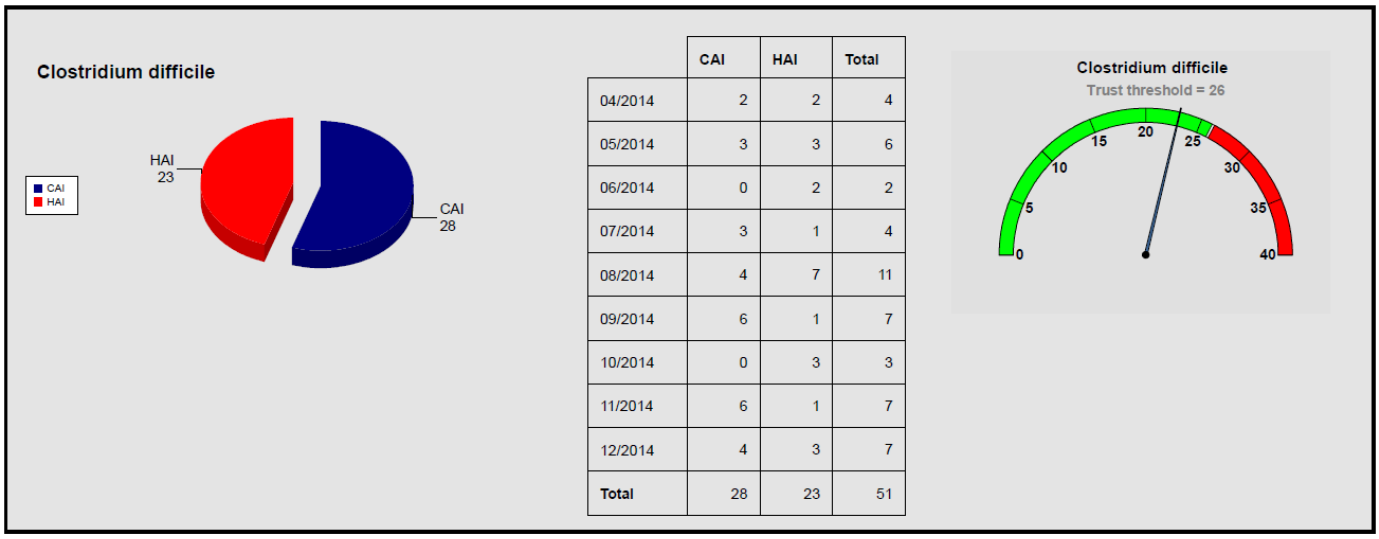
Q3 Clostridium difficile toxin positive* cases by location when detected





***B18 case reported following pseudomembranous colitis detection during sigmoidoscopy**

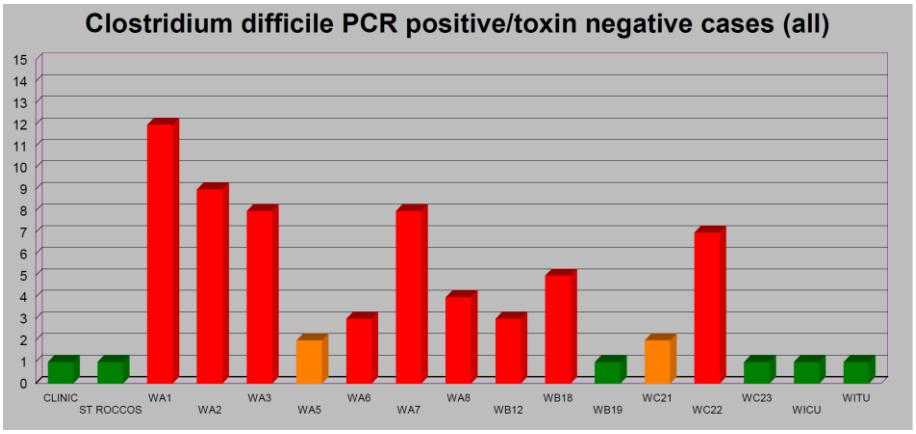
Clostridium difficile year to date position



	CAI	HAI	Total
04/2014	2	2	4
05/2014	3	3	6
06/2014	0	2	2
07/2014	3	1	4
08/2014	4	7	11
09/2014	6	1	7
10/2014	0	3	3
11/2014	6	1	7
12/2014	4	3	7
Total	28	23	51

Clostridium difficile PCR positive/toxin negative cases by location when detected

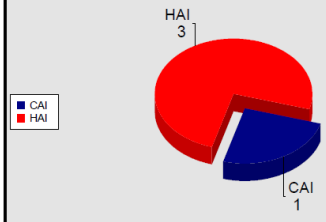
(Local surveillance only)



BACTERAEMIAS

MRSA bacteraemias

MRSA Blood Cultures

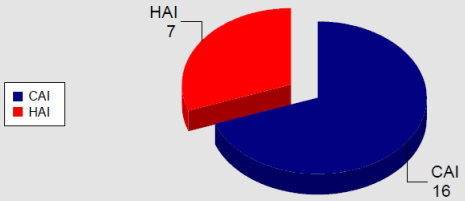


	BLOODSTREAM			Total
	CAI	HAI	Total	
05/2014	0	1	1	1
09/2014	1	1	2	2
12/2014	0	1	1	1
Total	1	3	4	4

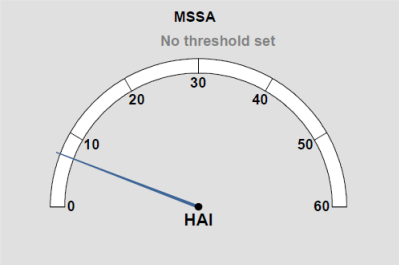
Annual Threshold

MSSA bacteraemia

MSSA blood cultures



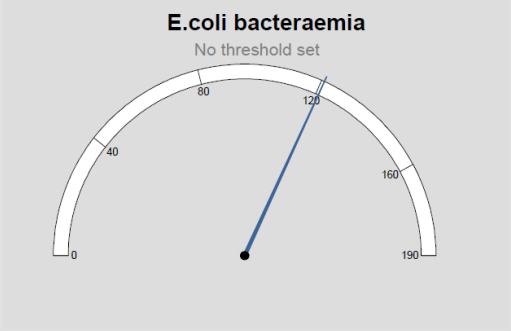
	CAI	HAI	Total
04/2014	4	1	5
05/2014	3	0	3
06/2014	0	1	1
07/2014	0	1	1
08/2014	3	0	3
09/2014	1	0	1
10/2014	2	1	3
11/2014	2	1	3
12/2014	1	2	3
Total	16	7	23



E Coli Bacteraemia

E Coli blood cultures

	Total
04/2014	16
05/2014	14
06/2014	10
07/2014	20
08/2014	18
09/2014	11
10/2014	11
11/2014	12
12/2014	9
Total	121



Appendix 2 - Antibiotic Point Prevalence Audit Results October 2014

The quarterly point prevalence audit of compliance with the Trust antibiotic formulary was carried out on 6th and 7th October 2014 across Warrington and Halton hospitals.

1. Number of patients audited

	Warrington hospital	**Halton hospital**	**Total**
% of inpatients seen on day of audit	94.5% (380/402)	83% (35/42)	94% (415/444)
% of inpatients prescribed antibiotics on day of audit	29.1% (117/402)	8.6% (3/35)	27% (120/444)
Number of antibiotics prescribed at time of audit	149	4	153

2. Overall antibiotic prescribing

27% of inpatients were prescribed at least one antibiotic when the study was conducted. As per previous audits a much higher percentage of patients were prescribed antibiotics at Warrington hospital than at Halton hospital. Overall use of antibiotics has increased from 26.1% last quarter (July 2014) to 27% this quarter. This is the same usage as that seen in October 2013, and lower than that seen in October 2012 (30%) and October 2011 (29%).

All patients had the allergy section of their prescription chart completed.

3. Compliance with the Formulary

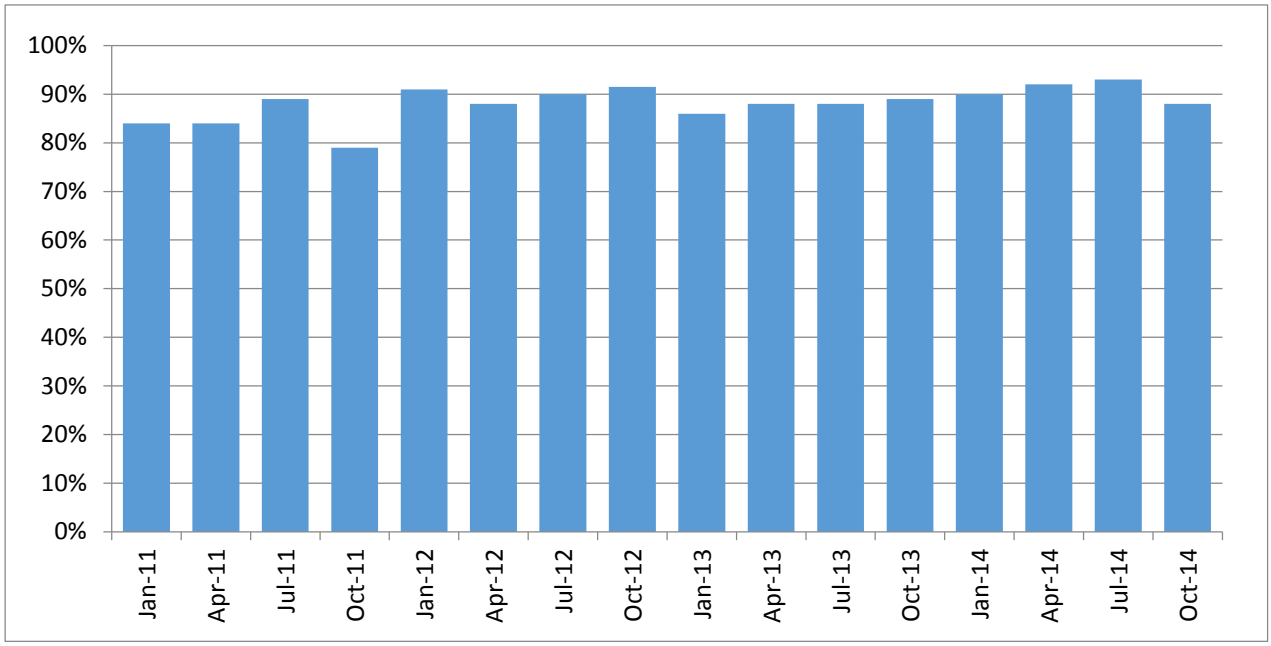
Overall compliance across both hospitals with the antibiotic formulary this quarter was 88.2%. This compares to compliance of 93% across the Trust last quarter.

Compliance at Warrington hospital was 89.3% this quarter. Compliance at Halton hospital was 50%, however only 4 antibiotics were prescribed at the time of the audit.

Overall there has been a significant reduction in compliance with the formulary in unscheduled care.

Compliance within unscheduled care was 86.9% (86/99), and within scheduled care compliance was 87% (47/54). This compares to 94% in unscheduled care last quarter and 89% in scheduled care last quarter.

Compliance with the formulary per quarter since January 2011



Compliance with the formulary was 100% in the last 6 months on all wards except for those detailed below.

Ward	Compliance (July 2014)	Compliance (Oct 2014)
A1	100%	85% (11/13)
A2	91% (10/11)	90% (9/10)
A3	80% (4/5)	60% (3/5)
A4	33% (1/3)	88% (7/8)
A5	100%	86% (12/14)
A6	83% (10/12)	84% (16/19)
A8	100%	86% (12/14)
B14	100%	83% (5/6)
C22	33% (1/3)	100%
CCU	100%	50% (1/2)
CMTC	67% (2/3)	0% (0/2)

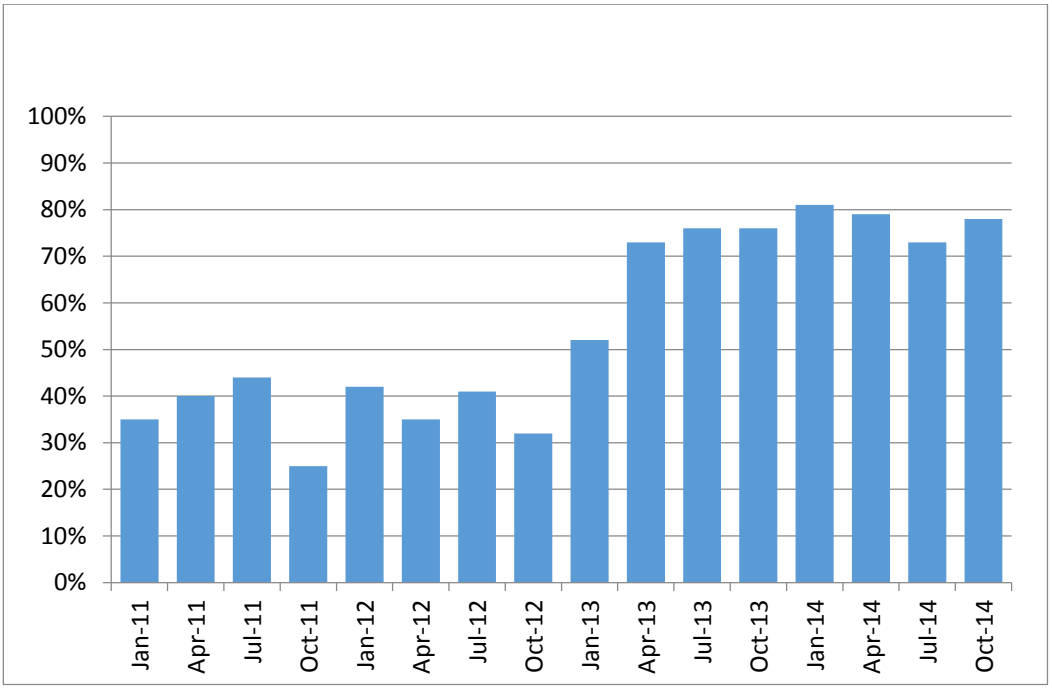
4. Documentation of indication for prescribing antibiotics

All patients prescribed antibiotics had an indication documented on either the medication chart or in the patient notes.

5. Documentation of review date or stop date

78% of antibiotics which were prescribed for over 24 hours had a documented stop or review date.

The graph below shows the steady improvement in this area following the introduction of the new drug charts in September 2012 until last quarter when review/stop date compliance decreased to 73%. This has improved to 78% this quarter.



Discussion

15 patients were given antibiotics which were not as per the Trust antibiotic formulary. 10 patients were under unscheduled care consultants and 5 patients were under scheduled care consultants.

Action Points

Results of this audit will be fed back to DIGG meetings and to the Antimicrobial Steering Group (AMSG). Letters to individual consultants will continue to be sent regarding specific areas of non-compliance. Ways to improve compliance will be discussed at the AMSG.

Microbiologist/Antibiotics Pharmacist ward rounds will continue in order to have an influence on prescribing at ward level.

Rachel Cameron

Antibiotics Pharmacist

Appendix 3 - SBAR report on the Management of a case of suspect VHF - November 2014

Situation

On Thursday 20th November 2014 at approximately 04:00hrs a patient attended the Accident and Emergency Department (AED) with a recent history of travel to Africa.

The viral haemorrhagic fever (VHF) risk assessment was followed and the patient was identified as low possibility of VHF.

Background

Currently there is a large scale Ebola outbreak affecting parts of Africa. Guidance has been published by the Department of Health on patient assessment and infection control requirements including personal protective equipment (PPE).

The Infection Control Team has revised the Trust's Policy for VHF and has been working with the Practice Educator in the AED to ensure staff understand the actions required in the event of a suspect case.

Assessment

Suspect cases of VHF are rare in the UK and therefore staff have limited experience in dealing with these cases.

The case was managed well with a couple of learning points and feedback identified as follows:-

- The patient was admitted by ambulance. Recent travel history to Africa was noted on arrival and the patient was isolated immediately in cubicle E
- The SOP for AED was followed and the relevant people contacted (Consultant Microbiologist; on-call person for Public Health England and the on-call Infection Control Nurse service)
- Restrictions of the number of staff coming into contact with the patient were put in place
- The patient was identified as low risk as travel was to an unaffected country (Ethiopia) in Africa
- Specimen containers for safe transport of the samples to the laboratory were available and used by staff in the AED department
- Effective liaison took place between AED medical staff and the Consultant Microbiologist. Liaison took place with the Microbiology and Haematology laboratories to supervise malaria antigen testing in the category three laboratory
- The specimens were transported by hand and not in the pneumatic tube as per the advice provided
- A VHF screen was not required but was taken to reduce the requirement for additional venepuncture. These samples should have been stored in the category three laboratory however, were sent by courier to be tested for VHF viruses. Once it was realised this had occurred the courier was recalled and the specimens were not tested
- Medical staff on duty in AED raised concerns about selection and correct use of PPE
- Due to the high profile nature of the suspected case, information was appropriately escalated to the DIPC
- The ICN attended AED and subsequently the admission ward (A1) to provide reassurance to staff
- A Datix report has been submitted indicating specimens were sent from AED in the correct containers to the laboratory however the request forms and specimen bottles were not labelled with danger of infection labels

- The patient was discharged on 23rd November 2014

Recommendations

- Further guidance (video images) on donning and removal of PPE is awaited from PHE and should be rolled out ensuring training records are maintained
- Samples taken for VHF screen should not be sent by courier to the reference laboratory until testing has been authorised by a Consultant Microbiologist
- AED staff to be reminded of the correct procedure for labelling specimen bottles and request forms with danger of infection stickers in suspect VHF cases

Please do not hesitate to contact me should you wish to discuss any of the content of this report or require any further advice.

Lesley McKay
Associate Director for Infection Prevention and Control
9th December 2014

BOARD OF DIRECTORS

WHH/B/2015/ **010**

SUBJECT:	**Complaints: Patient Experience Quarter 3 Report**
DATE OF MEETING:	28th January 2015
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	Michele Lord, Patient Experience Matron
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance and OD Choose an item.
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care SO3: To give our patients the best possible experience SO4: To provide sustainable local healthcare services
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework SO3/3.3 Failure to provide staff, public and regulators with assurances post Francis and Keogh review
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED:	None
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides an overview of complaints and other feedback received by the Trust in Quarter 3, October – December 2014. • The Trust received a total of 121 formal complaints between 1 October and 31 December 2014, which is an increase of 3 on the previous quarter. • One case has been closed by the PHSO in quarter 3. Seven cases are with the PHSO and they have requested the files of five cases for review. • 407 people contacted PALS in Quarter 3, this is 62 contacts less than previous quarter. • There is an overview of feedback left on *NHS Choices* • 13 formal compliment letters were sent to the Chief Executive. • Graphs demonstrate the top 5 subjects of complaints for the Trust and by division. • 99.30% of complaints were closed within agreed timescales. • Examples of learning from complaints from divisions provided
RECOMMENDATION:	***The Board is asked to:*** • Note progress in the management of complaints • Note improved information on subjects of complaints.

PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

EXECUTIVE SUMMARY

This is the third quarterly report providing an overview of complaints received by the Trust from 1 October to 31 December 2014. The report is written in accordance with the NHS Complaints Regulations (2009) and complements the patient experience annual report presented in May 2014.

In addition to numbers and categorisation of complaints received by the Trust, this report provides an opportunity to identify top 5 themes within divisions. In addition to the three divisions, this report also includes top 5 subjects for Accident & Emergency Department. This is a reflection of the relatively higher number of complaints and also to support the AED Survey (2014) action plan.

Background

In accordance with the *NHS Complaints Regulations* (2009), this report sets out a detailed analysis of the nature and number of formal complaints. The report also offers feedback from other sources, compliments, NHS Choices and PALS to provide a more rounded picture of the nature of feedback and to emphasise good and bad, with an emphasis on how clinicians and managers are supported by this intelligence in planning service improvement and to celebrate that which is positive and applauded.

The Trust is in a more assured place in terms of complaints handling than it was one year ago. Ongoing review by Mersey Internal Audit Complaints Management Review since the first report completed in April 2013 have identified improvements in the systems in place and recognised that the Trust has met the recommendations made in both reports.

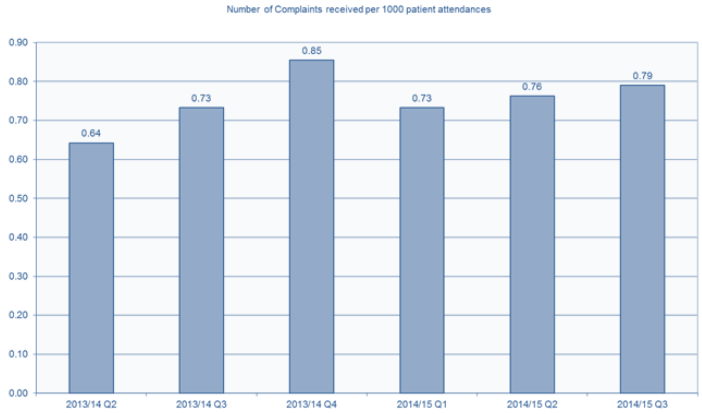
1. COMPLAINTS OVERVIEW

During Quarter 1 there were 153,562 attendances to our services. This makes the number of complaints received in Quarter 3 (121) just 0.078% of the total attendances.

Table 1: Trust activity 1 October – 31 December 2014

Activity	Type									
Month	DayCase	Inpatient	Non-Elective	New	Follow Up	A&E	MIU	Ward Attender	Outside Clinic Attendance	Grand Total
Oct	2,828	474	3,404	10,819	26,457	7,260	1,376	1,200	132	53,950
Nov	2,919	490	3,339	10,047	24,853	7,056	1,263	1,123	76	51,166
Dec	2,533	421	3,438	9,543	23,046	7,268	1,039	1,084	74	48,446
Grand Total	8,280	1,385	10,181	30,409	74,356	21,584	3,678	3,407	282	153,562

Figure 1: Complaints received per 1000 patient attendances for Quarter 2



The Trust received a total of 118 formal complaints between 1 June and 30 September 2014, which is a decrease of 11 on the previous quarter.

Table 2: Formal complaints received in Quarter 3

Quarter	Formal complaints received
Quarter 3, October – September 2014	121
Quarter 2, July – September 2014	118
Quarter 1, April – June 2014	108
Quarter 4, Jan – March 2014	128

Table 3: Risk rating of complaints, by quarter

	2013/14 Q4	2014/15 Q 1	2014/15 Q2	2014/15 Q3	Change from last Quarter
Complaints Received	**128**	**108**	**118**	**121**	↑
Low	54	31	46	48	↑
Moderate	60	39	62	58	↓
High	14	38	10	15	↑

All formal complaints were received in the English language with no requests made by a complainant (or enquirers) for the use of the Trust Interpreter Service. There were no formal complaints from or about the care of patients with a disability.

Parliamentary Health Service Ombudsman (PHSO)

During Quarter 3, one complaint was partly upheld by the PHSO with recommendations made. We complied within the required timescale and the ombudsman have reported that they are happy with the outcome and have closed the case. The recommendations included an updated action plan to demonstrate divisional learning from the complaint and a letter of apology from the Chief Executive to the complainant for failings in care and treatment.

There are seven cases with the PHSO. One of these has a response due, we are waiting for the PHSO report findings on five more and they have requested/been sent to us after they have requested records. One complaint is the subject of some discussion between the Trust and the PHSO.

Patient Advice and Liaison Service (PALS)

407 people contacted PALS in Quarter 3, compared to 469 in previous quarter. This is mainly due to a drop in the number of people contacting PALS during December 2014. Five PALS cases became formal complaints during Quarter 3.

The PALS Coordinator has been assisted by a temporary member of staff, which has enabled the service to continue during depleted team numbers due to a member of staff leaving and annual leave commitments. Now that the vacancy has been filled in the Patient Experience Team, the provision of support to PALS will be reviewed to ensure seamless service provision.

Plans to evaluate satisfaction with PALS are on track with the PALS Coordinator currently comparing tools and seeking examples of questionnaires used in other Trusts. We are considering a phone call following closure of the PALS to ask if outcome satisfactory.

Table 4: Examples of PALS contacts from Quarter 2

Q1	Contacts	Q2	Contacts	Q3	Contacts
April	137	July	154	October	175
May	181	August	140	November	126
June	137	September	175	December	106
Total	455	Total	469	Total	407

Table 5: Examples of the type of issues that have been raised with PALS

PALS Enquiry	Outcome
Service user's father passed away suddenly and the family were finding it very difficult to come to terms with their loss.	A meeting with the PALS officer had been arranged to establish the families concerns. Following on from this meeting a further meeting with the relevant professionals took place and all concerns were addressed. As the family member required bereavement support external organisation contact details were passed on.
The patient attended the PALS office because he felt he had not received relevant information about his condition and treatment plan. The patient was very agitated and expressed his concerns with the services provided.	The PALS officer passed on the patient's concerns to the consultant. The consultant clearly recalled having shared all necessary and relevant information with the patient during each consultation. It became clear that the patient had not retained the information, therefore a further consultation was arranged within 1 week. Following this, a letter from the consultant recapping the patient's condition and treatment plan was sent to the patient.
The patient passed away suddenly at a young age and the partner did not know what to do	The PALS officer accompanied the family member to the bereavement office and the

PALS Enquiry	Outcome
about the death certificate.	mortuary. The family member was extremely grateful to have received support during this very difficult time.

1.1 NHS Choices

Patients and visitors can post comments about their experience in our hospitals on the *NHS Choices* website. *NHS Choices* calculate a star rating for each site, based on the feedback, with 5 stars being the highest. Comments posted on this site are monitored by the Communications team and responses are passed to the appropriate service for action if needed.

Table 6: Number of patient comments left on *NHS Choices* for Quarter 3, by site

Star rating	Warrington	Halton	CMTC
★★★★★	12	9	5
★★★★	2	1	1
★★★	0	0	0
★★	1	0	0
★	5	0	0
Total for Q3	20	10	6

Table 7: Number of patient comments left on *NHS Choices* for Quarter 3, by ward/department

Ward/Department	Warrington	Halton	CMTC
Accident & Emergency	1	n/a	n/a
Children's & adolescent services	1	0	n/a
CMTC	n/a	n/a	6
ENT	1	0	n/a
Gastrointestinal & liver services	1	0	n/a
General surgery	1	5	n/a
Gynaecology	2	0	n/a
Haematology	2	0	n/a
Maternity	5	n/a	n/a
Minor injuries (Halton)	n/a	2	n/a
Ophthalmology	1	0	n/a
Orthopaedics	2	0	n/a
Pain management	0	1	n/a
Respiratory medicine	1	0	n/a
Vascular	0	1	n/a
Halton (unspecified)	n/a	1	n/a
Warrington (unspecified)	2	n/a	n/a

Comments received to the *NHS Choices* website

Warrington

Thank you.

I have just returned home after my 2nd visit to the Cardiac Catheter suite. I went in first for a T.O.E. and secondly for an Angiogram. The staff are kind caring and understood that I was nervous (although I ultimately realised that there was no reason to be).

From the medical professionals that carried out the procedures to the trainee nurses, everyone carried out their tasks efficiently, I couldn't ask for better care. They worked together well as a team and were very willing to go 'the extra mile' to ensure that my visit was as pleasant as it could be. Thank you for making what could have been scary in to what was almost a pleasant experience. If you have to have either or both of these procedures then this is the place to have them, you really don't need to worry.

Private health care...I don't think so!

Physiotherapist

Having being diagnosed with CFS and also having problems with my back and daily pain with my shoulder, I have been referred to the physiotherapy department in Warrington Hospital.

So after driving round for over half an hour trying to find a parking space and then paying £3 for the privilege, I finally got to my appointment. Where I was told off as I was not doing the exercises properly (well I do have a bad back!) and where they were more bothered about getting rid of me and chatting to her nurse friend on the reception. Made me feel like, what was the point? Plus my shoulder is now worse than before the appointment. There was no care, no consideration or compassion - I was just a temporary annoyance that was rushed through a pointless process to get me back out of the door. Beyond poor service.

Excellent care and very friendly staff

Got induced on the 15th Nov and had my little girl on the 17th and I have to say all the staff throughout my labour were amazing. Two midwives stood out, they made me feel so comfortable and at ease. I had a numerous of midwives due to shift changes but these 2 were amazing. I had complications towards the end and the whole team that came rushing in were quick and did a fantastic job of getting my little girl out safely. The lead doctor was fantastic.

The care on the anti natal ward afterwards was great. All staff were friendly and caring and don't have a bad word to say about my experience. I would like to personally thank the staff if I could get the midwives full names and send a letter of thanks.

Halton

Excellence at Day Care Centre

From the moment I entered the hospital I was efficiently directed to each individual department I needed to attend. The nurses and staff were smiley and friendly at all times. On arrival at the Day Care ward I was seen very quickly and even offered a cuppa. Everyone pertaining to the operation were very easy to understand and sort for my input as to what was about to happen. From the man who wheeled me into theatre to the theatre nurses and doctors, I was made to feel very comfortable and felt confident to be in their hands. In the recovery

room the same genuine care was administered and back in the ward. The nurses were brilliant!

Surgery for hernia

I was very impressed with the entire service that I received from the NHS, starting with a referral from my GP to the hospital. I was kept in the waiting room slightly longer than expected for my consultant's appointment, but otherwise this all went well.

I had a pre-op clinic scheduled, but this had to be rearranged twice. The first new date was OK, but the second was awkward for me. However, the hospital were able to change it back to the original date, but at Warrington Hospital. The pre-op all went smoothly.

The nurses and other staff in Halton Hospital were very caring, informative and helpful during my day-visit for surgery. They put me at ease. The surgery itself seemed to go well, and I was back home before too long. Very good service.

My experience of my operation and stay...

I had never been a surgery patient at Halton hospital and had, therefore, no idea of what to expect.....On entering the day case unit, I was greeted in a friendly manner and guided to my bed and asked to remove all clothing within the privacy of the curtain surrounding my bed. It was explained to me what procedure would follow prior to my visit to the operating theatre. This involved a visit by the anaesthetist to ask me questions about my health etc. And to explain to me briefly what the full anaesthetic would entail....Shortly afterwards I was visited by my urologist surgeon, who explained what he would do and asked me to sign the consent form. The ward manager asked me endless questions and filled in endless forms. In due course it was my turn to face the unknown.... I was wheeled by bed to a small room in front of the operating theatre doors and prepared with monitoring pads in different parts of my body and the needle inserted into the top of my hand for the drip etc. And then asked to breathe into an oxygen mask....Which administered a sedative gas to put me to sleep ready for the main anaesthetic. I knew nothing after that 'till a nurses voice called me by name...I woke up and said, where am I? She replied, in the recovery room. Shortly afterwards, I was wheeled on the bed to ward B4. I can truthfully say. I could not ask for better care and commitment by the staff of B4 ward, both day and night staff, and I was extremely pleased during my stay. Also the quality of food and drink was excellent as those men in my ward thought also...

CMTC

Rotator cuff repair and sub acromial decompression

First class! This is the second time I have attended the CMTC in the last two months for an operation and the care that I had is beyond compare. I was treated with the utmost dignity and respect, all the staff were friendly and could not do enough for me. I was not concerned about my operation because I was in a very safe pair of hands. My operation was a success and the theatre team were brilliant. The ward staff did a wonderful job of looking after me post op, who included a student nurse doing her ward training. I want to wish her all the very best for the future. I cannot thank all members of staff enough and a very big thank you goes to my surgeon. I will be coming back to the CMTC in the not too distant future for a further operation. I could almost say I am looking forward to it! Because the standard care is second to none and the thought of a further operation does not cause me any concern because I know that I am in a very safe pair of hands. My surgeon is second to none. I would like to pass on a very big thank you to everyone who was concerned with my care. Thank you.

If it was a holiday resort I would be back!

The doctor, thank you your care was faultless, kind and you looked after my every need. Nursing staff, nice and friendly, professional but very caring thank you. If it was a hotel I would go back the experience although not what I want to go through again they made it as nice as possible and the food was good!

Excellent from start to finish

All the staff were extremely friendly and professional and put me at ease right from the start. Only in as a day case for carpal tunnel surgery but nothing was too much trouble for anybody. Even got a hot meal after my operation; fish and chips and a big thanks for putting the salt and vinegar on! With me only having one hand in use. Overall I could not be happier with the day I was there. A massive thank you to you all

1.2 Compliments

The Trust received 13 formal compliments through letters sent directly to the Chief Executive. The new Trust website provides a new email address, Patient.ExperienceTeam@whh.nhs.uk for people wishing to make a complaint, comment or compliment. This has a less negative impression than the "complaints" inbox and people visiting the website are beginning to use this. Leaflets and posters are being updated to include new information for contacting the Patient Experience Team.

Table 8: Compliments by division, April – June 2014

Quarter 3	Letters received			
October	1	WCSS (1)		
November	3	WCSS (1)	Scheduled (1)	Trust (1)
December	2	Unscheduled (1)	Scheduled (1)	

Excerpts from compliment letters

I have been liaising with the Assistant Safeguarding Matron who has gone that extra mile to support not only the patient, but also staff involved in the process. The surgeon has been very helpful and understanding and also the care received from ward staff on C20 and the Assistant Safeguarding Matron has also helped with another patient again going the extra mile and I just wanted this to be recognised. The whole process and procedure could not have gone any better and the reasonable adjustments that have been offered from your services and professionals has been fantastic.

Member of Learning Disabilities Team

I would like to express our gratitude to the Ward Manager on ward A4 for her genuine compassion and concern for my elderly father who was admitted on Friday… she was the first person who showed this elderly gentleman respect and compassion. As a hospital you should be extremely grateful to have a nurse of such merit.

Please can you forward my appreciation to accident and emergency and the early pregnancy assessment unit? I am writing to express my thanks for the fantastic care I have received recently within the Trust. On Tuesday the 16th December I attended Accident and Emergency at approximately 19:20. The staff nurse was on duty was excellent. She was obviously under pressure,

however nothing was too much trouble; most of all she showed care and compassion.

2. FORMAL COMPLAINTS

2.1. Data collection and analysis

The ability to breakdown a more comprehensive list of complaints subjects into sub-sections provides more clarity to those studying themes, particularly in previously large sections such as care and treatment. The Patient Experience Team has been able to provide more custom reports on request, for example on medication issues, end of life care and falls. In this report there are top 5 breakdowns for Accident & Emergency and corporate areas.

2.2 *Formal complaints by division and by subject for Quarter 3*

Figure 2: Graph showing all complaints by subject

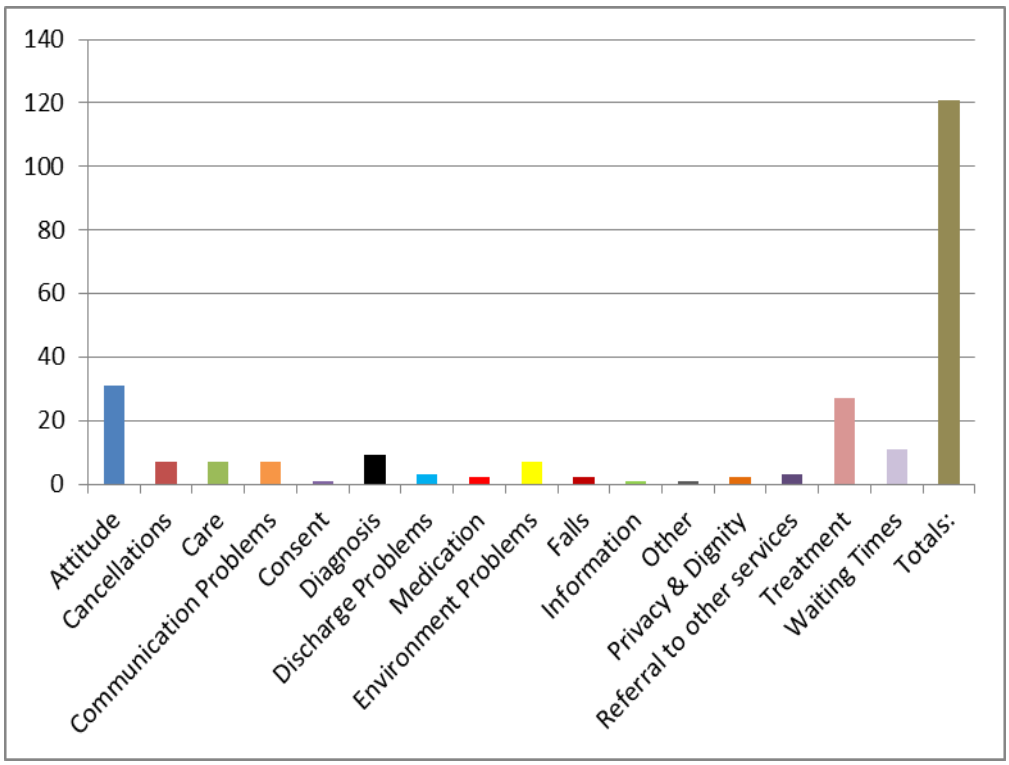


Figure 3: Graph showing top 5 subjects for Unscheduled Care, Quarter 3

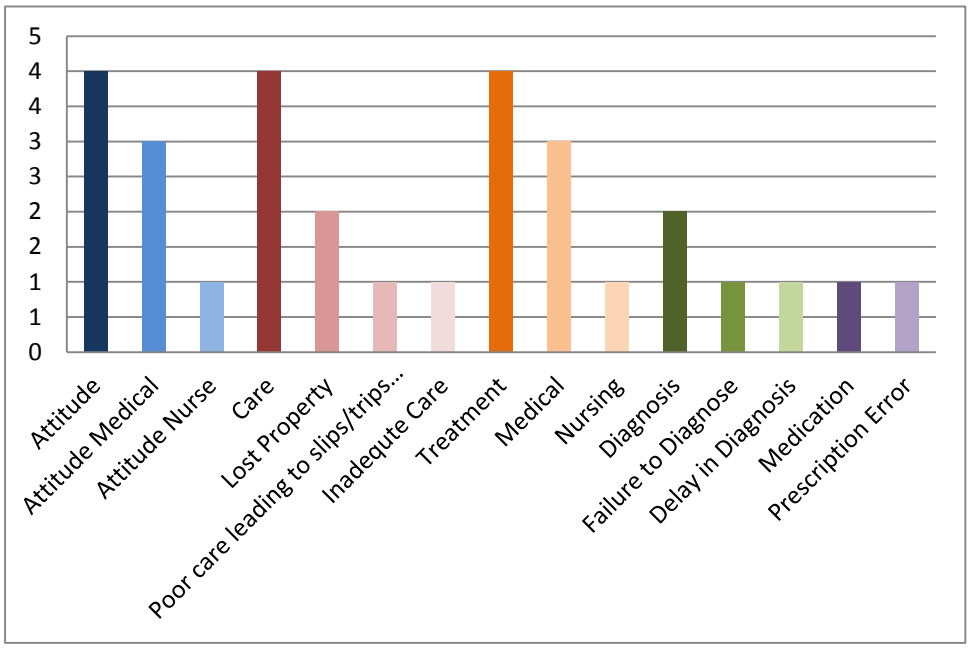


Figure 4: Graph showing top 5 subjects for Accident & Emergency

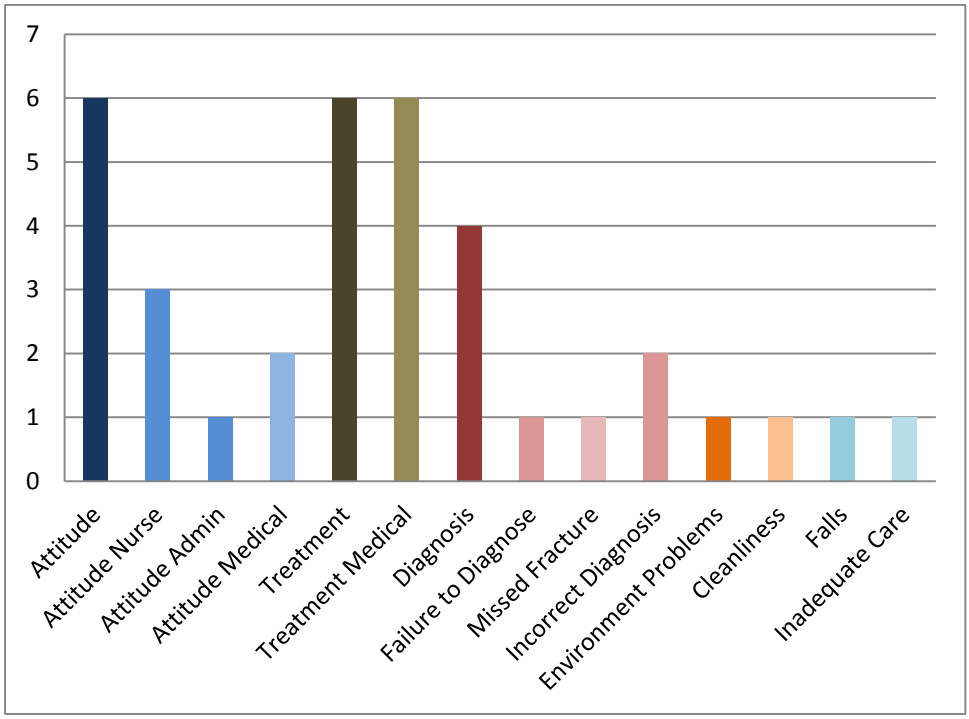


Figure 5: Graph showing top 5 subjects for Scheduled Care, Quarter 3

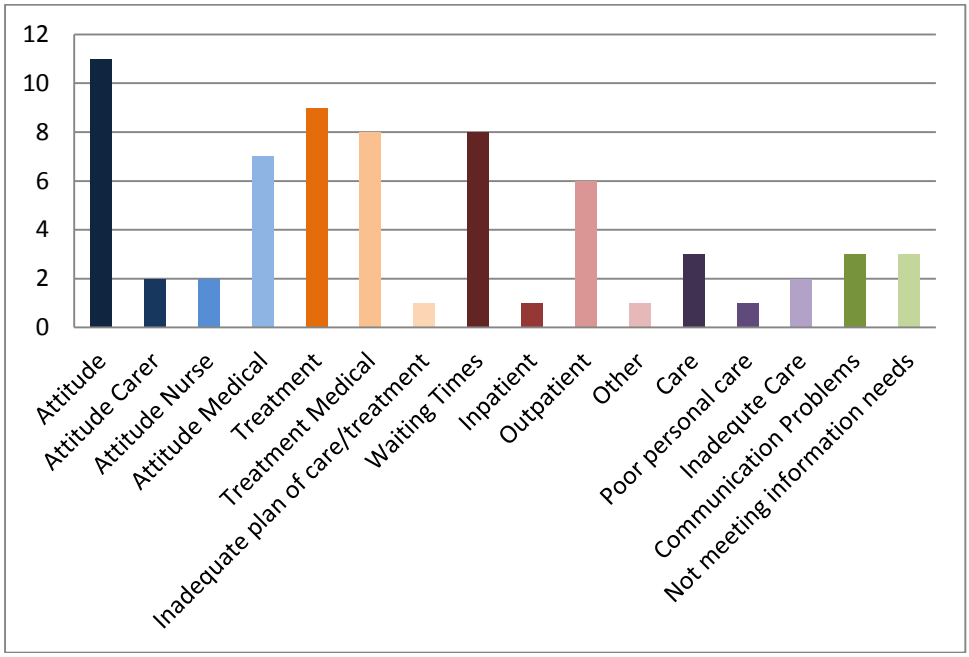


Figure 6: Graph showing top 5 subjects for WCSS, Quarter 3

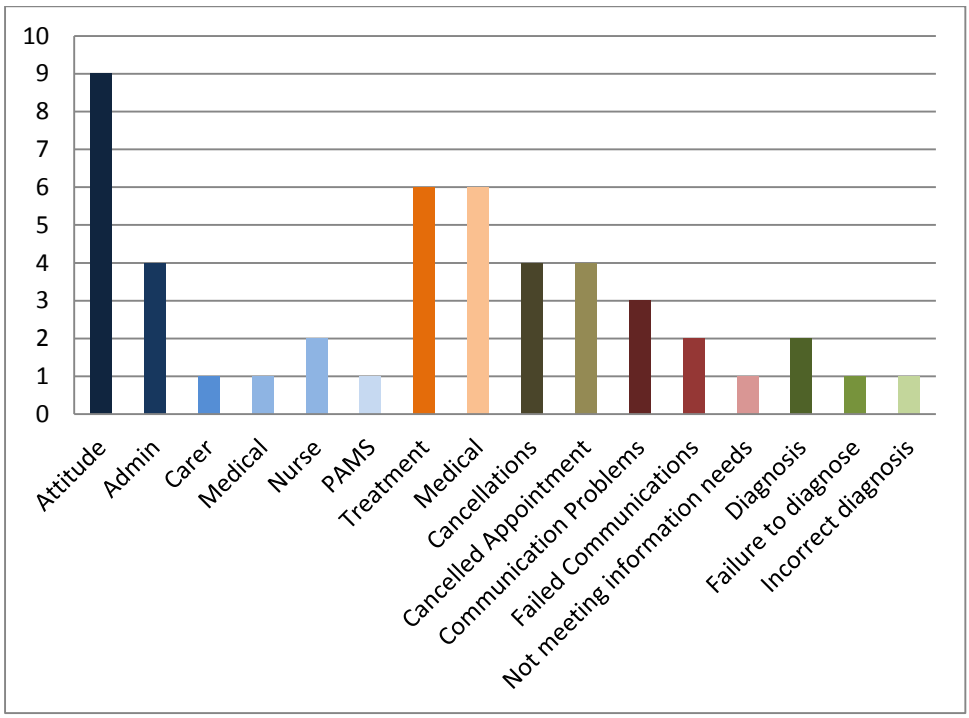
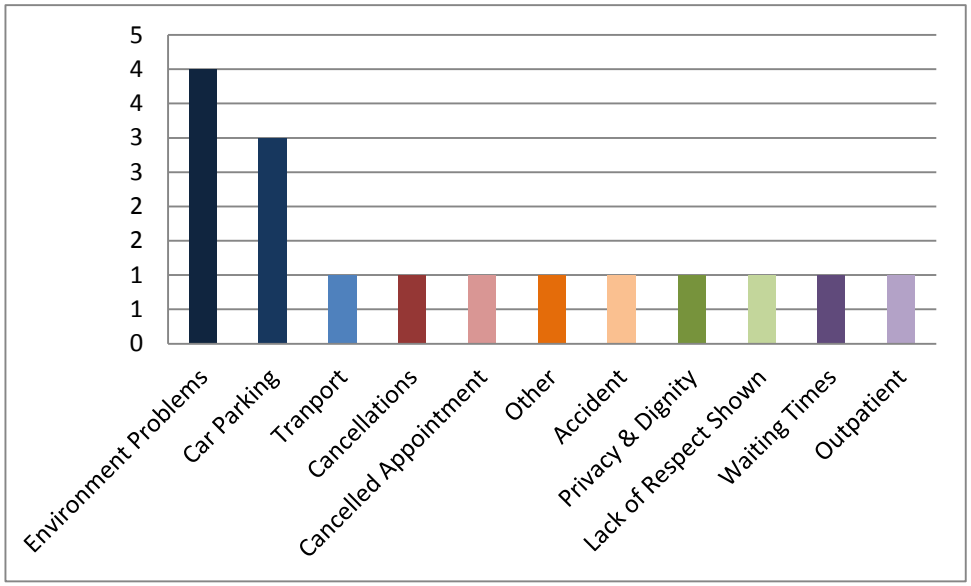


Figure 7: Graph showing top 5 subjects for corporate areas, Quarter 3



In light of recommendations made by Norman Lamb MP, following his review of the Liverpool Care Pathway, this report will henceforth contain a summary of those complaints made that raise concerns about any aspect of end of life care. Please note that in April 2014 this subject was added to the Datix system, so no complaints with EOL as a component from prior to that date could be reported. The lead executive for end of life care issues is the Director of Nursing, who has been notified of the two ongoing complaints. Patients will now be offered an independent advisor to any complaint made in relation to end of life care, and we will reflect this in our policy.

Table 9: Complaints made with end of life care concerns, after April 2014.

Summary of concerns regarding EOL care	Risk rating/ Date	Subject	Sub-subjects	Outcome
Patient admitted in March 2014. CT showed stroke. • Complainant felt the Liverpool Care Pathway (LCP) was a medical decision and not one she had a say in and wanted to know why. • Complainant wanted to know who made the decision to put her mother on the LCP and what were the reasons for this? • Complainant wanted to know what her mum was dying of. She survived for three weeks without any medication. • If her mum had been younger would the same things have been done and would she have been put on a LCP? • She wanted to know how her mum would have been treated before the LCP was introduced? • She wanted to know under the freedom of information act how much the Trust receives for putting	High July 2014	Treatment EOL Care	Inadequate plan of care Poor communication with family Inadequate care	Not upheld Part upheld Upheld

patients on the LCP?				
Complaint referred by 5BP. Complainant unhappy with care of mother at Hollins Park but a meeting also raised concerns about care at WHH. Issues: • Complainant believed that her mother was on the End of Life Pathway from the 20 June 2014. Wanted to know why she was not told about this and only informed that her mother had days to live. • The doctor took her mother off all her medications and then prescribed her injections. The complainant was not informed of this. She would like to know why and what the injections were. • On the Forget Me Not Ward the Mental Health Nurse reported that patient was trying to wake up, talk and say 'hello'. The day after the consultant took the drip away and let her die. Why? More issues raised through PALS: • Was patient over-sedated? • Did she die due to thirst • Why did patient not have food for 2 weeks?	Moderate	Treatment Transfer EOL EOL	Medical Unsafe transfer Poor communication with family Problems with LCP	Not Upheld Not Upheld Not Upheld Not Upheld
Daughter has complained about the care of both her mother and father, both inpatients and on different wards. Re. Father: • Father had COPD and was admitted to the Acute Medical Unit with Pneumonia. The doctor informed family that he had Pulmonary Fibrosis and that he had one to two days left to live. The Palliative Nurses attended. As mother was already in hospital family asked the ward manager if they could be placed somewhere together for the last few days and were told it was not possible. Complainant would like a full explanation of how this decision was made. • During the hours the family waited for their father to pass, they didn't have a private room to grieve and were shown a reception room, where people waited for appointments. There were no drinks machines, no privacy and when he did finally pass they were handed a leaflet. Complainant's brother even had to close the curtains and blinds out of respect. Patient was just left there	Moderate	Wait Care Drug Care Transfer EOL Privacy	Outside 4 hour target Inadequate care A2 Delay in administration Inadequate care Inadequate transfer Respect & Dignity Poor respect shown to family	Still under investigation

lifeless and the family stood outside the room with their mum in her wheelchair in tears, with nurses and doctors coming and going. Complainant felt they received no privacy, dignity or respect. The complainant said her father was a person, greatly loved by his family and deserved more than to see his wife exhausted and emotionally broken, with heart failure, struggling to be by his side on his death bed. Concerns raised about mother's care involved transfers and nursing care				
Granddaughter of lady who died on acute medical ward has made a complaint about her care. Issues: • Complainant's mother contacted the hospital and was told that patient had a comfortable night and informed of the visiting times. Her condition deteriorated around 2pm and your mother was informed immediately, she was there within ten minutes but sadly her mother had already passed away. • Complainant is very upset that her grandmother passed away on her own and felt that she should not have been put onto a ward with restricted visiting times. • Complainant found it very distressing that a black bag with her grandmother's name was left outside the cubicle whilst the family were with her. She assumed this was a body bag. She would like an explanation why this was placed there whilst the grieving family were there.	Low	EOL Privacy and Dignity	Poor communication with family Lack of dignity	Still under investigation

2.3 Concerns raised in Quarter 3

Some patients prefer to raise a concern rather than a formal complaint. Due to the way the Patient Experience Team now work, Patient Experience Officers provide cover for the PALS Officer. This has seen some "blurring" of PALS and concerns and lower numbers of concerns are reported. The team is establishing specific working definitions to ensure that concerns, complaints and PALS contacts are appropriately categorised and answered. Please note that since April 2014, any withdrawn complaints are re-categorised as concerns.

Figure 8: Concerns by division for Quarter 3

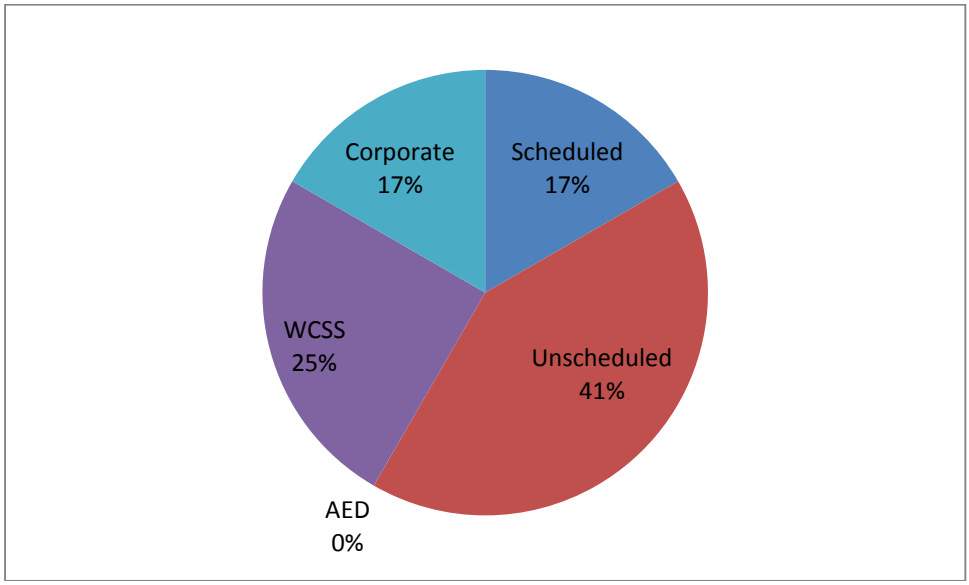


Table 10: Examples of the themes from concerns in Quarter 3

Attitude	1
Cancellations	2
Care	1
Diagnosis	1
Discharge Problems	1
Environment Problems	1
Treatment	3
Waiting Times	1
Totals:	11

2.4 Responding to people who want to tell us about their experience in a timely manner

In Quarter 3 we responded to 99.30% of our complaints within agreed timescales. Provision of high quality, well investigated and thorough responses is equally important to both patients and the Trust.

Table 11: Complaints closed in agreed timescales for Quarter 3

	October	November	December
Number of complaints closed in month, resolved within the required timescale	47	23	37
Number of complaints closed in month, not resolved within the required timescale	1	0	0
Number of complaints closed in the month	48	23	37
% complaints closed in month, resolved within required timescale	97.92%	100%	100%

2.5 Complaints withdrawn

During the period from October – December 2014 a total of 14 complaints were withdrawn. Examples of the reasons for withdrawal were:

- Patient decided to withdraw.
- Handled by PALS.
- Came from CCG but complainant had already complained directly to the Trust.
- Though the complaint was about the care of two patients, it was decided to respond as one.

2.6 Returned complaints

During Quarter 3, four people felt they were unhappy with their initial responses and wrote to/contacted us asking for further information, to meet with us, or to provide clarification. In total there are 16 return complaints being reviewed at present. Of these 16, one has a meeting arranged, three are in draft form and one is awaiting a response form GMC. Some of these are waiting for meetings to be arranged/held and they include some very sensitive and difficult cases that have needed additional support and input by senior managers and external agencies. In the last report we identified an internal target date of 30 working days to respond to returns. We are not meeting this and need to ensure that the Patient Experience Team follow up on returns and support the divisional staff in ensuring returns are answered in a timely manner.

Table 12: Returned complaints by division for Quarter 3 and outcome

Division	Not upheld	Partly upheld	Upheld
Unscheduled Care	3	2	2
Scheduled Care	3	1	0
WCSS	1	4	0
Corporate	0	0	0
Total	7	7	2

2.7 Complaints linked to serious untoward incidents

During Quarter 3, one complaint has been made that is the subject of a serious untoward incident investigation. A total of 8 complaints were linked to reported incidents that included falls and other patient safety incidents already reported and acted upon.

2.8 Formal meetings organised

There is enormous benefit in having appropriate staff meeting with complainants as soon as possible. Sometimes, people ring to make a complaint about the care of a friend or relative in our care. By contacting the matron or ward sister for the ward or department, we often are able to avoid a formal complaint.

During Quarter 3 a total of 16 meetings were held with complainants. Of these 8 were return meetings, i.e. the complainant has received a final response letter but is unhappy with it and asks for a meeting to discuss ongoing issues.

3. LESSONS LEARNED

The following table provides examples of closed complaints and actions taken by the divisions who are responsible for implementing and monitoring lessons learned. Each division has specific systems in place to feedback learning from complaints, firstly during/after the investigations and then through divisional groups, e.g. Divisional Integrated Governance Groups (DIGG, senior nurse/ward manager meetings.

Examples of complaints, action taken and learning

Description of Complaint	Actions	Learning
Scheduled Care: The foster mother of a lady with learning disabilities was very unhappy with the care provided. The patient was admitted through AED in July 2013. She had emergency surgery on the night of her admission and was later found to have an elevated blood sugar. She suffered a great deal of distress over the next few days when staff needed to take blood from her. Concerns raised: • Why couldn't her bloods have been taken while she was under anaesthetic? • Doctors and nurses did not talk to the patient to explain what they wanted to do. • Three doctors attempted to take one sample and the patient became extremely	Complainant attended a meeting to discuss her concerns with staff. The consultant was unable to attend on the day but a statement from him was fed back at the meeting. It was explained that blood sugars had not been high at the time patient went to theatre, so no blood had been drawn. The complainant was keen to ensure that other patients would not have the same experience as her foster daughter. The Matron for the ward, Patient Experience Matron and the Health Facilitator for 5BP (learning disabilities team) were able to identify actions that reassured the complainant that her concerns	Matron fed back to ward team to raise awareness of the need to: • Work with/involve carers in care and make an effort to adopt a communication style that will promote compliance. • Assess and make reasonable adjustments, i.e. time with patient. • Individual feedback to member of nursing team who complainant felt was insensitive and brusque. Health Facilitator presented at the "Grand Round" on 9th January 2015 to provide key messages for care of people with learning disabilities in acute hospitals. Patient Experience Matron participated in Grand Round presenting this story (with consent) as an ideal opportunity to reach a large audience of clinical

distressed. Complainant asked them to stop as they were ignoring her screams and protests. This upset other patients in the bay. • One doctor commented that "this has been a good experience for us", which the complainant felt was insensitive and inappropriate. • Patient was so affected by the experience she is terrified to come to hospital again.	were taken seriously. It was agreed that if patient is being readmitted (either electively or as an emergency) in the future, she would contact the PALS Officer to ensure that staff are aware of her anxieties and needs.	professionals. Short guidance document for staff who need to obtain blood tests from patients who have a fear or phobia being developed. This will include cues for possible solutions and escalation of problems. This will be included in the updated Learning Disabilities guidance available on policy/procedure pages of the Intranet.
Scheduled Care: Patient complained after being admitted for a breast procedure to ward C20. Shortly after her family left her, she was taken to ward A5 shortly after arrival and was left for a considerable amount of time in a waiting room. Having realised that A5 is a mixed sex ward, the patient rang her family to bring her a more suitable dressing gown. When her sister arrived with it the ward sister didn't know she was there. The patient was so upset she left the ward without having her surgery. Patient said she felt she was treated like trash and refused to come back in for her surgery.	Investigation showed that there were bed pressures on the day. Matron discussed patient's distress with patient flow team and ward team. Apologies made for this and for the fact that the patient had found it difficult to keep up with the Bed Manager when walking to A5 from C20. "Forward wait" area to be developed where elective patients can be admitted into a bed and prepared for theatre.	Matron discussed patient's experience with Bed Manager and a number of actions for her learning: • Asked to reflect on impact of these events on a patient awaiting serious surgery. • To ensure a wheelchair is offered if patient is to be transferred. • Better handover to ward staff about patients. The ward teams were asked to consider: • Ensure family members allowed to stay with patient if there is possibility of ward move.
Unscheduled Care: Patient's wife made a complaint about his care in WHH and the consultant from Clatterbridge. Issues for WHH concerned nurses' attitudes and poor communication with the patient and family. Complainant found staff unprofessional. The complainant raised concerns about telephone conversations where staff refused to provide updates, despite there being a password in order to facilitate better communication.	Clatterbridge Complaints department provided a response regarding the consultant's attitude and treatment. Care was reviewed by Consultant Nurse in Palliative Care and Matron. Concerns regarding A4 were reviewed and explanation made of nurse's conversation regarding moving and handling. Though information was correct the sister apologised for the manner in which it was communicated.	Issues fed back to teams in safety briefings and reviewed at team meeting – completed October 2014. This included: • Correct employment of password for close relatives to use to get more detailed updates when ringing the ward. • Accurate, timely and regular updates to family. • Documentation of all communication with family in case notes. • Discussion of appropriate and professional manner (including body language, tone of voice) to be used in communicating with

	Communication issues raised about A9 were investigated and an action plan drawn up. The Ward Manager monitored and evaluated to action plan.	patients and families. • Ward Manager to address individual issues in real time. • Time taken to answer nurse call. This was monitored by ward coordinator and raised with individuals when issues observed. • Reviewed at ward meetings.
Unscheduled Care: Patient's granddaughter complained about the care and communication provided. She was unhappy that no explanation was given as to why her grandfather became confused and no diagnosis was made. She was concerned that despite an IV infusion being started because of dehydration, her grandfather's jug and glass were out of his reach. Complainant was upset at the attitude of a nurse she asked for information and another said she was busy when family asked if patient could be taken to the toilet. She also highlighted examples of how her grandfather's dignity was undermined.	The complainant met the Matron for the ward and was pleased to have an opportunity to discuss all her concerns. Based on these issues, actions were agreed including feedback to all nursing staff about the concerns raised. The Matron provided the complainant with a copy of the care and compassion reflective workbook that she would be supervising the completion of with a member of staff. The Matron apologised for the distress caused to the patient and family.	Team learning through feedback of issues raised. Individual learning for staff nurse who reflected on her attitude and actions using the care and compassion booklet under supervision.
WCSS: Mother made a complaint following her attendance at AED with her five year old son, following a fall. She was very happy with reception staff, but not the attitude of a health care assistant. She felt the HCA was "frosty". She also felt upset that the HCA asked if social services were involved	Complaint was investigated by Assistant Matron for child health. The HCA was interviewed and apologised for any upset caused. Though it was explained that asking about social services involvement is part of information needed by staff, it was acknowledged that this is a sensitive subject and the manner of delivery may have been unhelpful when the mother was already upset. Assistant Matron to monitor the member of staff to ensure no repeats of this unfortunate incident.	HCA asked to complete the following actions/learning: • Reflect on her attitude and approach and to listen more to parents and children. • Complete care & compassion reflective workbook, under the supervision of a senior member of the team. • Always feedback her assessments to senior member of staff.
WCSS: Patient complained that he had two ENT appointments cancelled, one in July and one in August 2014. The reason for the cancellations:	Patient was seen 19 August 2014. Apologies were made and a new system to begin in November 2014 where patients are not given appointments several months	Review of new system will identify if it is providing a more satisfactory patient experience. Since November 2014, there has been one complaint concerning a

• The consultant was on leave. • No registrar for the clinic During Quarter 3 there were four formal complaints about cancelled clinics, three of which were upheld/partly upheld.	ahead. Instead, patients are contacted shortly before their appointment time to agree a mutually convenient time and date for their appointment. This is believed to help to ensure that patients are not booked onto clinics that are subsequently cancelled due to medical staff being on leave.	cancelled appointment. This concerned an ophthalmology clinic and is still being investigated.

4. ACTIONS

Following on from the annual complaints report in May 2014, the following identifies any progress on actions/improvements identified:

- Developing this skills and knowledge of the new Patient Experience Team.
  A recent vacancy in the team is filled and each member of the team has a competency framework to support their learning. Risk register has been amended to reflect improvements in systems and growing experience and skills of team.
- Developing a responsive, combined service – making it easy.
  The need for ongoing workshops to support staff in investigating complaints is recognised as key to improving performance in the investigation of, and response to, complaints. High clinical activity has affected the ability of staff to attend training. Opportunities to provide information and learning for staff can be *ad hoc.* The Grand Round on 10 October 2014 provided an opportunity to share good practice for complaint handling with 106, largely medical, staff. This presentation has been adapted as a workshop for a more in-depth study of complaints for a smaller audience. This will be trialled in February 2015.
- Monitoring and performance management in place.
- Policy audit completed. Will go to Clinical Governance, Quality & Audit Sub-committee in January 2015. We will include that we ensure to offer independent advisor to complainants when their complaint is about end of life care.
- Focus on return complaints to understand underlying root causes and better identification of outcome.
  The thirty day deadline for returns has been reviewed and shows some serious delays. More work to be undertaken in Quarter 4 to support divisions in responding in a timely manner.
- Improved complaints monitoring through updating complaint category information collected – making data meaningful.
  Progress in updating PALS module is slow due to capacity and activity of team. Will be carried over into Quarter 4.
- Updating the complaints information for patients and visitors, electronic as well as paper based.
  Posters and new leaflets being printed. Will be in place by end of January 2015. This will include easy read leaflets.
- Completion and assurance for action plans developed as a result of complaints.
  The CIRIS system provides a repository for governance, risk and compliance information and it was agreed that the action plans for complaints would be recorded on the system to facilitate reporting and monitoring of action plans generated by upheld and partially upheld complaints. The divisions have each identified clear processes for ensuring that all action

plans developed as a part of the investigation and response to a complaint are recorded on CIRIS and these will be reported locally within divisions, at the appropriate sub-committees and at Board.

5. RECOMMENDATIONS

The Board is asked to note the contents of this report, which describe the progress in the monitoring of complaints and to approve the actions as documented above.

BOARD OF DIRECTORS

WHH/B/2015/ **011**

SUBJECT:	**End of Life - presentation**
DATE OF MEETING:	28th January 2015
DIRECTOR:	Liz O'Brien, Palliative Care Consultant

BOARD OF DIRECTORS

WHH/B/2015/ **012**

SUBJECT:	**Patient Experience Strategy (2015 -2018) – Briefing paper**
DATE OF MEETING:	28th January 2015
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	Michele Lord, Patient Experience Matron
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance and OD Choose an item.
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care SO3: To give our patients the best possible experience SO4: To provide sustainable local healthcare services
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO2/2.1 Failure to engage and involve our workforce in the design and delivery of our services. SO3/3.2 Failure to develop a fit for purpose clinical and business information systems to support delivery of high quality patient care SO3/3.3 Failure to provide staff, public and regulators with assurances post Francis and Keogh review
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED:	None
EXECUTIVE SUMMARY (KEY ISSUES):	The aim of this paper is to identify the way forward for the effective collection of patient experience data and to improve the ways this information is used to demonstrate improvements made. The patient experience strategy will support the ideals of the Quality Strategy launched January 2015. Once the methodology and aspirations identified in this paper have been reviewed by the Board and agreed in principle the document will be shared widely for consultation across a range of staff, patient and governor groups and will form the bedrock of the new strategy to be launched in April 2015.
RECOMMENDATION:	***The Board is asked to:*** Agree in principle the methodology and aspirations of the proposed Patient Experience Strategy

Introduction

> *"The individual patient is the only witness to all his or her care experiences, making him or her essential source for information across services and care settings."*
>
> (King's Fund 2014)

Warrington and Halton Hospitals NHS Foundation Trust is committed to the delivery of care and treatment that fulfils the promise of our objectives:

- Ensure patients are safe in our care
- To be the employer of choice for health care we deliver
- To give our patients the best possible experience
- To provide sustainable local health care services

It is our sincere desire that all patients meet respect, compassion and safety in our care.

We acknowledge that to do this we must listen to what patients and families tell us to ensure that services are responsive to what we are told. In order to fully achieve this ambition, we must also ensure that we have robust and consistent processes in place to capture this information and all staff working for the Trust must be open to hearing what is said and using that intelligence in every aspect of their work.

This strategy is one of the three principles supporting our goal to be the trusted and preferred provider of in-patient and outpatient services to our community and to meet the needs of all our patients and their families. These are Safety, Quality and Patient Experience.

Francis (2013) tells us that,

> *"Patients must be the first priority in all that the NHS does. Within available resources, they must receive effective services from caring and committed staff, working within a common culture."*

The implementation of this strategy will provide a coordinated approach to how we listen, what we learn and how we work together to ensure a continuous cycle of improvement for things that can be improved and recognition of the good care patients tell us about every day in a variety of ways.

We know that patients are in a unique position at the centre of everything we do. They are expert witnesses to the care delivered by the Trust and must be enabled to tell us what they have witnessed so that the organisation can develop and learn.

As a busy acute care Trust it is vital that systems support the front line staff in order to ensure safe and effective care delivery and that identifies those areas in need of improvement, providing options and resources to make those improvements.

In 2011 our first patient experience strategy was written, defining what patient experience meant to the Trust and identifying eleven objectives for the first three years. This new strategy takes into the

next three years, building on what has been achieved and plotting our aspirations to broaden and improve our collective efforts and achievements.

Purpose of the Strategy
The aim of developing a patient experience strategy is to give people more say in decisions about their health and care and to ensure that services better reflect their needs and preferences.

This strategy provides a foundation for the work ahead in continually improving the way we listen to, and involve, patients in shaping the future development of services. This must be done against a background of increased clinical activity, planned changes in the physical environment and pressure on resources and under the aegis of local and national organisations and the challenge of meeting a range of targets, standards and indicators.

It is also important that we work with partner organisations in developing this area of work. This will provide opportunities for joint working, to share good ideas and practice and provide more seamless services across health and social care in the communities of Warrington and Halton. Everyone using health care services can provide feedback on their experiences and all services must work together in gathering this information in order to evaluate and understand the impact of what we do.

We are committed to learning from experience. When patients tell us that things went wrong we first of all want to make it right (if possible) and then we want to ensure that the wider learning makes it less likely to happen in the future.

It is expected that this be a strategy that will be reviewed and shaped over time and in response to internal and external drivers. The Trust needs to be responsive to changes in policy, direction and/or priorities that will influence services and the way we evaluate them.

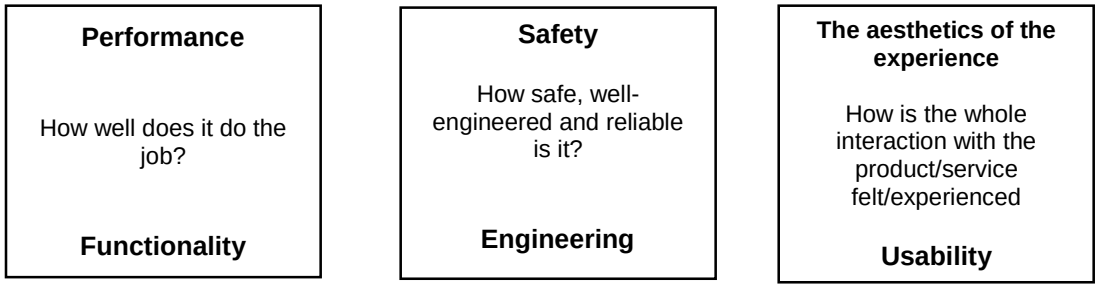
Defining Patient Experience
There are many definitions of what makes a "good" patient experience. The Department of Health (2009) define it as:

> *"Getting good treatment in a comfortable, caring and safe environment, delivered in a calm and reassuring way; having information to make choices, to feel confident and feel in control; being talked to and listened to as an equal and being treated with honesty, respect and dignity."*

What this strategy aims to do is to signpost the most effective ways that we can ensure patients tell us about their experience of care in a way that leads to growth and learning.

Why do we need to measure patient experience?
At the heart of all we do is the tenet that we strive for excellence in patient care. This strategy helps us to know what patients think is excellent care – and what isn't. It provides a direction of travel in how we develop our skills and approach to listening to patients and shaping our services in line with their vision.

Good service design comprises three elements. We have tended to focus on safety and performance and are now recognising the equal importance of patient experience as additional means of judging the overall success of our efforts, as perceived by the patients.



Source: NHS Institute of Innovation and Improvement (experience based design)

The quality of a patient's experience is fundamental to the Trust reputation and over time, its growth and success. The ability to demonstrate that we are listening and learning is vital in the development of the business of the Trust. Getting it right is always good for business.

Scope of the strategy

This strategy applies to all clinical and corporate services delivered by Warrington and Halton Hospitals NHS Foundation Trust and to all staff delivering those services.

Overall aims of the strategy

By collecting and responding to patient feedback we aim to embed a culture of learning and improvement that will lead to a better patient experience, recognise the efforts and dedication of staff and enhance the reputation of the Trust.

It is important that the Trust is able to compare performance across divisions and specialties and determine benchmarks for excellence, but also across health economies.

Key patient experience indicators and trends will continue to be reported shared and analysed at relevant groups and forums across the Trust. The systems and staff used to coordinate collection, analysis and reporting of patient feedback intelligence will develop in line with the service needs, seeking to improve the means, methods and skills employed to meet future needs. The methodologies used will provide assurance that all services are subject to regular and consistent feedback.

The strategy will be implemented from 1st April 2015 and will be reviewed in 2018.

Responsibilities

- The executive lead for patient experience is the Director of Nursing and Organisational Development.
- Development of the patient experience strategy will be directed by the Deputy Director of Nursing, Quality and Patient Experience.
- The lead for patient experience activities is Patient Experience Matron, working with the patient experience team and divisional staff, governors, volunteers, partner organisations and patient representative groups to ensure that appropriate feedback methodologies are in place, that the Trust is meeting nationally or locally agreed targets and that areas of concern are shared with the people who can most influence change.
- Divisional and service leads must ensure that appropriate action is taken in response to the information they receive and that any action plans are regularly reviewed and evaluated.

Suitable methods of sharing, reporting and storing patient experience information must be established and maintained.

- Patient experience is everybody's responsibility. From asking patients to complete a questionnaire, dealing with informal complaints to reviewing survey reports, investigating formal complaints and identifying learning and actions. Every member of staff needs to be committed to collecting or listening to feedback and in learning from what it tells us.

Model for the way forward

There are four components that, when embedded, will ensure we can truly value and learn from our patients' experience:

1. Capture the experience: using all available and appropriate tools to capture the experience of patients, families and staff.
2. Understand the experience: Identify the "touchpoints" of services. Learning **what** people feel when they experience our services and **when** they feel it.
3. Improve the experience: ensure that feedback is heard and understood by the relevant clinical teams and their managers. Receiving, analysing and sharing feedback and then involving patients and staff in developing practical and meaningful solutions.
4. Measure the improvement: by subjective outcomes (repeat surveys) or objective outcomes (reduced waiting times, fewer incidents, improved safety or performance etc). These may be applied across the Trust or specific to a specific service and require engagement of the staff delivering the services.

Source: Patient Experience Strategy, North Devon Healthcare NHS Trust

1. Capture

The real test of Trust performance are the views and experiences of the people who use our services. We need to ensure we find a range of ways to listen to the views and opinions of patients. We must also ensure the current ways we do this evolves to meet future needs.

Methods in use:

1. National surveys
    a. Inpatient — Yearly
    b. Outpatient — Every three years
    c. Accident & Emergency — Every three years
    d. Maternity — Every three years
    e. Children and young people — First time 2014
    f. Patient reported Outcome Measures (PROMs) are surveys that assess health outcomes and experience from four patient pathways. These are, hernia, hip replacement, knee replacement and varicose vein surgeries.

2. Local patient experience
    a. Patient experience tracker. A short survey providing basic experience metrics on patient satisfaction. This is employed on a rotational basis across wards.
    b. Privacy & dignity survey. 100 patients a month are asked about privacy and respect. This is a part of DSSA requirements.

c. Patient stories provide an in-depth insight into an individual's experience and provides learning for specific staff/teams.

3. Friends and Family Test (FFT). We have successfully implemented FFT in A&E, inpatient areas and maternity. Work on ensuring the next phase is rolled out continues in outpatient and day surgery areas.

4. NHS Choices. Feedback is followed by the Communications Department who alert individual managers to all feedback and posts appropriate responses.

5. Inspections and observations:

    a. DAWES assessments. This ward specific, comprehensive assessment of care includes a patient experience component that is fed back in real time to help teams to improve care.
    b. Governor's observations and walkabouts.

6. Feedback from partner organisations can be investigated and feedback provided to individuals, outside complaints processes. Patient feedback may come from:

    a. The two local Healthwatch organisations provide feedback and provide their own feedback from "enter & view" visits.
    b. The two CCG organisations.
    c. Local and community forums attended by representatives of the Trust, e.g. Carers Forum, Dignity Forum, local partnership boards etc.
    d. Local overview and scrutiny groups

7. Complaints/PALS. The data from the Patient Experience Team provides feedback on aspects of care and treatment that have not been as expected and required formal investigation and learning.

8. PLACE inspections are an annual opportunity to involve patient representatives in an exhaustive review of the care environment and facilities that leads to improvement plans that encompass estates and maintenance work, catering and cleaning services as well as ward teams.

Aspirations:

- Continue to refine and develop local surveys to improve the utility and to ensure the information gathered is useful and usable at the point of care. Ensure that local surveys provide
- Refine response and action in relation to national surveys. A more timely evaluation of results will provide more time to improve areas of concern before the next survey begins. Also, there is a need to triangulate local survey results with national survey reports to better track improvement between national surveys.
- Continue to maintain and improve FFT response rates in order to meet CQUIN.

- Upgrade the reporting contract for FFT to ensure the Trust can cope with increasing demand and further roll-out.
- Develop a score card to support teams/wards in local action in response to FFT feedback.
- Broaden the range of the existing Patient Experience Group (PEG) to provide a more dynamic and influential forum for the Trust to share patient experience feedback and initiatives with partners, patient representatives, third sector groups and service users.
- Over time, to develop a user friendly and useful patient experience dashboard.
- Improve the way staff can learn about patient experience by improving the Intranet community and development of an easily accessible and interesting newsletter for staff and partners.

2. Understand

As well as improving how and what information/feedback we collect, we need to better understand what we are being told and what implications this information may have. After capture we need to understand all the factors that affect the expectations of patients in order to identify appropriate actions and not to act reactively to every piece of feedback, be it contradictory or counterintuitive.

This area is where the culture of our workforce comes into play. We need all staff to be committed to seeking feedback and being equipped to objectively review and act. An excellent way to do this is to involve patients/patient representatives in looking at improvements. Use of methods like focus groups and ensuring participation of patient representatives on Trust groups is an excellent way to involve those who most benefit from improvements. This will also lead to less superficial solutions to issues and more sustainable change.

Benchmarking is another way that the Trust can improve understanding as it provides an excellent opportunity to learn from well performing areas and utilise ideas and innovations from within the Trust. Benchmarking also prevents duplication of effort in recognising solutions and methods that can be easily adopted in less well-performing areas.

The final aspect of understanding is the focus on trends and themes and what these suggest for service improvement.

Aspirations:

- Ensure resources are available to staff to provide the time and knowledge need to understand the feedback received and its implications for their service/practice. These would include provision of time out to engage in patient experience work, advice and support from appropriately skilled and knowledgeable colleagues and access to forums for sharing and benchmarking practice.
- Provision of work-based and online resources and training to be accessed by frontline and support staff to improve the organisations responsiveness and collective knowledge.
- Develop or adopt a patient experience toolkit that supports staff development.
- Identification of divisional and team processes for receiving and analysing feedback to provide assurance of action.

3. Improve

Gathering feedback is a waste of time unless what is gathered is constructively reviewed and improvements are both recognised and completed.

Every week there is the opportunity to gather meaningful and timely feedback from our patients and acting on this must lead to meaningful and timely improvement. Improvement is most meaningful when it is led and implemented by those closest to the patient providing the feedback. Timeliness of systems to needs to be improved so that there is a continuous cycle of improvement.

Clinical and support staff are generally extremely knowledgeable about their practice, the way their service works and what needs improving. These teams need to be empowered to act on what they know and what they learn from feedback so that they can lead change in their own areas. This includes specific training in analysing data, change and resource management and evaluating change. Senior staff must act as advisors, facilitators and supporters to help already busy staff/teams to value and embrace the opportunities offered from a range of feedback, including complaints and other negative information.

Aspirations:

- Strengthen divisional support to staff engaged in improvement work and develop the systems of monitoring and archiving these works.
- Training and development opportunities provided that skill staff in analysing patient experience intelligence and making informed decisions on what improvements are needed and the best way to achieve them.

Complaints handling training to be readily available and accessed by frontline staff.

4. Measure & Disseminate

It is vital to evaluate the success of all improvement plans to understand value and impact of change.

There are two ways to measure success:

1. Subjective outcomes. This can be seen through repeat surveys, questionnaires or focus groups to demonstrate an improvement on the areas previously identified as needing improvement.
2. Objective outcomes. Can be seen in performance against targets or previous performance, i.e. reduced waiting times or fewer incidents.

Communication of improvements can be done in a variety of ways:

- Ward/department news/messages using display boards.
- Monthly divisional performance reports.
- Presentations to divisional groups.
- Information posters and leaflets.
- Internal newsletters.
- Reports to corporate group meetings, including patient experience group and governor forums.
- External reports and presentations to commissioners, patient groups and partner organisations.
- Participation in public meetings and events to promote the Trust.
- Yearly Quality Report.

- Press releases
- Trust website and Intranet.

Aspirations:

- To refine and develop the systems to collate, report and share feedback for wards, departments and support services.
- Improve the ways that we share information on improvements with patients and partners and demonstrate ongoing improvement initiatives are enhancing care delivery.
- Improve reporting and sharing within divisional governance and specialty groups. Ensure all appropriate methods of communication are employed to reach the widest audience.
- More engagement of the wider team including all professions and support staff. Making patient experience work everybody's business.
- Develop benchmarks for services and once benchmarks are in place, develop key performance indicators (KPI) for each. This will provide a range of standards that will demonstrate excellence in care.
- Develop patient experience metrics in order to showcase Trust wide adherence to KPI. These can contribute to future CQUINs, providing the Trust with an opportunity to be proactive in the commissioning process.

Reference Material

The consultation exercise to be carried out will be informed by the following reference materials:

- Quality Strategy, Warrington and Halton Hospitals NHS Foundation Trust.
- NICE Quality Standards for Patient Experience.
- People in control of their own health and care, King's Fund.

Conclusion

This paper is the first step in developing a new patient experience strategy for Warrington and Halton Hospitals NHS Foundation Trust. It provides the baseline information needed and will be enhanced by the contributions of our governors, a number of partner organisations and other stakeholders to ensure that the very principles the new strategy promotes are in-built from its inception.

BOARD OF DIRECTORS

WHH/B/2015/ **013**

SUBJECT:	***AQUA Board to Board Action Plan***	
DATE OF MEETING:	28th January 2015	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Director of Nursing and Governance and OD	
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance and OD	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.2 Risk of harm through failure to comply with Care Quality Commission National core healthcare standards and maintain registration and failure to achieve minimum requirements for NHSLA Standards within maternity services and wider Trust.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	A Board to Board AQUA facilitated event took place on 13 October 2014 and actions arising from the event was agreed. The attached document sets out the agreed actions and their status.	
RECOMMENDATION:	***The Board is asked to:*** Note the AQUA Board to Board action plan and the status of the actions.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

ACTION PLANNING

Your Name: Karen Dawber **Email:** Karen.dawber@whh.nhs.uk

Your Organisation: Warrington and Halton FT

Event Name: Advanced Quality & Safety **Event Date:** 13/10/2014 – Update 31/12/14

Action	Who needs to be involved	Update	Date to Completion
Improve reporting from risk management systems to include individual action detailing what actions have been taken and learning	• Director of Nursing	• Individuals reporting incidents on to the system receive an automated reply. In addition to this when on the system staff is told how to escalate immediately if concerned and who will be notified of the incident.	• Completed November 2014
	• Director of Nursing	• Speak out safely and professional forum information pages available on the Hub for all staff to use	• Completed November 2014
	• Associate Director of Governance	• Governance report reviewed and divisional dashboards developed to enable targeted discussion at Bilateral meetings	• Completed December 2014
	• Associate Director of Governance	• Plans to evaluate the risk management system against other providers in 2015/16, this will include functionality, ease of use and cost.	• To review progress via risk management and report back to Governance September 2015
Further develop the executive safety walkabouts	• Associate Director of Governance	• Provide information / briefing packs prior to walkabouts	• Completed November 2014
	• Associate Director of Governance / Deputy Director of Nursing	• All wards to have own dashboard with a range of HR / Quality metrics	• Completed January 2014

ACTION PLANNING

Board directed audit of policies and procedures to test action plans in place and working on areas of potential significant harm	• **Board/Executive Team** • **Chair of Governance and Associate Director of Governance** • **Director of Nursing / Director of Finance**	• **All policies and procedures have audit requirements as per NHSLA / good practice.** • **Policy to be reviewed at Governance committee as part of standing agenda – MB to provide criteria and policies to be reviewed** • **Agree with MIAA a selection of policies to be audited over 2015/16 and report back via audit committee**	• **Completed November 2014** • **March 2015** • **Q4 14/15**
Improve the ability of middle manager to make decisions that would reduce the level of potential harm (NB use of global trigger tool)	• **Trust Board** • **Medical Director** • **Medical Director / Associate Director of Education**	• **Quality strategy revised to include three specific reporting strands: Effectiveness; Experience and Safety – New structures to be implemented over Q4 14/15** • **Effectiveness committee to focus on the enhancement of mortality reviews including the use of the Global Trigger Tool routinely** • **Divisional leadership development programme in place, to look at the potential to develop more bespoke leadership development for clinical leaders**	• **Completed November 2014** • **January 2015** • **March 2015**
Review all shifts handovers with a view to reducing the level of harm by review of compliance with checklist, follow up by action 2	• **Medical Director / Deputy Director of Nursing**	• **Initial discussions held with the clinical directors, reluctance to use more checklists but potential to utilise the ibleep technology to schedule tasks / reviews** • **Hand over from AED to ward transfer document has been agreed, ward transfer**	• **March 2015** • **January 2015**

ACTION PLANNING

		checklist being reviewed. • Handover period reduced to twice daily (from 3) further review of effectiveness planned (12 months on)	• April / May 2015
Celebrate successes and learning and evaluate the Board meeting	• All Board meeting	• Patient story included routinely as part of the Board • Staff stories / service improvement now included and staff asked to present to Board • Chair to ask members to evaluate meeting	• Completed • Completed November 2014 • Completed November 2014
Follow Up meeting with AQUA Monday 9th February	• Board Members / Trust Board Secretary	• On site discussion with Jamie Orlikoff – Board members and senior managers to attend if available • Further exploration re effectiveness agenda and "plotting the dots" reducing variation • Discussion re data what is assurance and what does that mean, how do we link the clinical audit programme to the Board Assurance Framework • NED development day 11th of February	• February 2015

BOARD OF DIRECTORS

WHH/B/2015/ **014**

SUBJECT:	**December 2014 CQC Intelligent Monitoring**
DATE OF MEETING:	28th January 2015
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	Millie Bradshaw, Associate Director of Governance
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance and OD
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.2 Risk of harm through failure to comply with Care Quality Commission National core healthcare standards and maintain registration and failure to achieve minimum requirements for NHSLA Standards within maternity services and wider Trust.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED:	None
EXECUTIVE SUMMARY (KEY ISSUES):	The overall assessment by the CQC places WHHFT at Band 5 (highest rating Band 6). Please see Figure 1 below. The Trust summary report shows a demonstrable increase from the previous IM which was Band 3 in July 2014
PREVIOUSLY CONSIDERED BY:	**Committee** Quality Committee Agenda item QGC/ 15/011 **Date of meeting** 13th January 2015 **Summary of Outcome** Recommended for Approval

Care Quality Committee Intelligent Monitoring (IM) as at December 2014

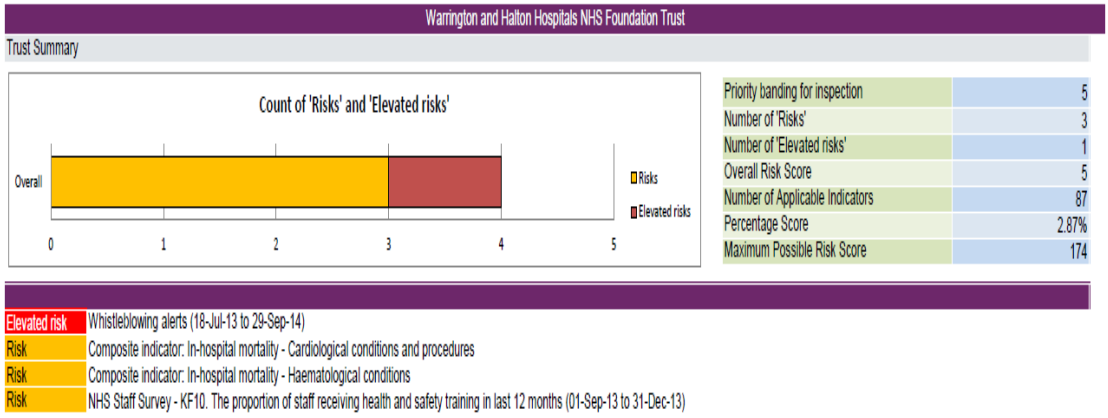
EXECUTIVE SUMMARY

The CQC published in December 2014 the Intelligent Monitoring (IM) on the applicable 87 indicators for the Trust. There is an ' Elevated Risk' of Whistleblowing Alerts which has already been reported to the Board of Directors by the Director of Nursing. An Action Plan is in place and monitored via the Strategic Peoples Committee. The December Report shows one new risk named 'in house cardiological conditions and procedures'.

ASSESSMENT

The overall assessment by the CQC places WHHFT at Band 5 (highest rating Band 6). Please see Figure 1 below. The Trust summary report shows a demonstrable increase from the previous IM which was Band 3 in July 2014

Figure 1



In Hospital Mortality – Haematology: There were 4 deaths in this category in the period in question. The diagnoses for 2 of the 4 patients were incorrectly coded. It is unlikely that we would have triggered as a risk, with just 2 deaths in this category.

In Hospital Mortality – Cardiological conditions: The Trust has flagged as a risk on this aggregate measure, with no risks identified for the 13 individual diagnoses which make up the aggregate e.g. Acute Myocardial Infarction (AMI). The Intelligent Monitoring indicators have not yet been replicated by the HED team; they intend to do this once the methodology used by the CQC is permanently agreed. Until then, it is difficult to identify the detail behind this risk. To attempt to do this, the Clinical Effectiveness Team have looked at the relative risk mortality (RRM) for each of the diagnoses. There are 5 diagnoses with more than 1 death and a RRM over 100. Only one of these is statistically significant; Acute Myocardial Infarction, with a RRM of 156 and 41 deaths against 26 expected. A review into the care of these patients has been conducted with no concerns about the quality of care at this time; 1 case has been identified for some further review to ensure that we fully understand the patient's experience. A report will be written and circulated by the end of February 2015.

RECOMMENDATION:

1. For the Board of Directors to receive and note the IM document

CONCLUSION

The Board to be assured that as part of the ongoing Risk and Quality Strategies to the review and monitoring of the relevant data sources to ensure safe, effective, caring, responsive and a well led organisation with good systems of Governance.

Intelligent Monitoring Report

Report on

Warrington and Halton Hospitals NHS Foundation Trust

December 2014

To view the most recent inspection report please visit the link below.

http://www.cqc.org.uk/Provider/RWW

CQC has developed a new model for monitoring a range of key indicators about NHS acute and specialist hospitals. These indicators relate to the five key questions we will ask of all services – are they safe, effective, caring, responsive and well-led? The indicators will be used to raise questions about the quality of care. They will not be used on their own to make judgements. Our judgements will always be based on the result of an inspection, which will take into account our Intelligent Monitoring analysis alongside local information from the public, the trust and other organisations.

What does this report contain?

This report presents CQC's analysis of the key indicators (which we call 'tier one indicators') for Warrington and Halton Hospitals NHS Foundation Trust. We have analysed each indicator to identify two possible levels of risk.

We have used a number of tests to determine where the thresholds of "risk" and "elevated risk" sit for each indicator, based on our judgement of which statistical tests are most appropriate. These tests include CUSUM and z-scoring techniques. Where an indicator has 'no evidence of risk' this refers to where our statistical analysis has not deemed there to be a "risk" or "elevated risk". For some data sources these thresholds are determined by a rules-based approach - for example concerns raised by staff to CQC (and validated by CQC) are always flagged in the model.

NHS Trusts that have had an inspection at the time of producing this update of Intelligent Monitoring have not been assigned a banding; all other indicator analysis results are shown in their report. "Recently inspected" is stated for these trusts. This is to reflect the fact that CQC's new comprehensive inspections will provide its definitive judgements for each organisation.

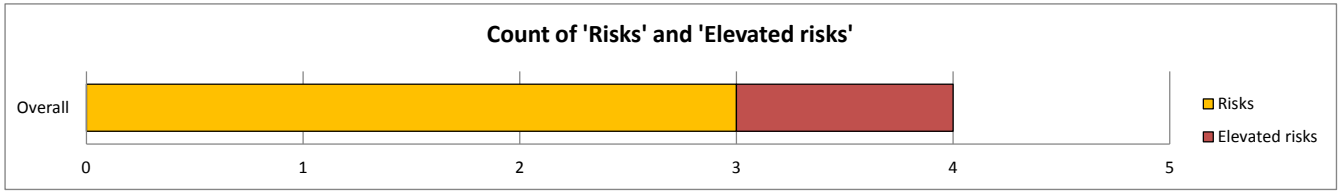
Further details of the analysis applied are explained in the accompanying guidance document.

What guidance is available?

We have published a document setting out the definition and full methodology for each indicator. If you have any queries or need more information, please email enquiries@cqc.org.uk or use the contact details at www.cqc.org.uk/contact-us

Warrington and Halton Hospitals NHS Foundation Trust

Trust Summary



Priority banding for inspection	5
Number of 'Risks'	3
Number of 'Elevated risks'	1
Overall Risk Score	5
Number of Applicable Indicators	95
Percentage Score	2.63%
Maximum Possible Risk Score	190

Elevated risk	Whistleblowing alerts (18-Jul-13 to 29-Sep-14)
Risk	Composite indicator: In-hospital mortality - Cardiological conditions and procedures
Risk	Composite indicator: In-hospital mortality - Haematological conditions
Risk	NHS Staff Survey - KF10. The proportion of staff receiving health and safety training in last 12 months (01-Sep-13 to 31-Dec-13)

Tier One Indicators

Section	ID	Indicators	Observed	Expected	Risk?
Never Events	STEISNE	Never Event incidence (01-Sep-13 to 31-Aug-14)	1	-	No evidence of risk
Avoidable infections	CDIFF	Incidence of Clostridium difficile (C.difficile) (01-Aug-13 to 31-Jul-14)	27	27	No evidence of risk
	MRSA	Incidence of Meticillin-resistant Staphylococcus aureus (MRSA) (01-Aug-13 to 31-Jul-14)	3	2.08	No evidence of risk
Deaths in low risk diagnosis groups	MORTLOWR	Dr Foster Intelligence: Mortality rates for conditions normally associated with a very low rate of mortality (01-Apr-13 to 31-Mar-14)	Within expected range	-	No evidence of risk
Patient safety incidents	NRLSL03	Proportion of reported patient safety incidents that are harmful (01-Jun-13 to 31-May-14)	0.38	0.28	No evidence of risk
	NRLSL04	Potential under-reporting of patient safety incidents resulting in death or severe harm (01-Jun-13 to 31-May-14)	20	31.61	No evidence of risk
	NRLSL05	Potential under-reporting of patient safety incidents (01-Jun-13 to 31-May-14)	7166	5720.38	No evidence of risk
Central Alerting System	COM_CASIM	Composite of Central Alerting System (CAS) safety alerts indicators (01-Apr-04 to 31-Aug-14)	-	-	No evidence of risk
	CASIM01A01	*The number of alerts which CAS stipulated should have been closed by trusts during the preceding 12 months, but which were still open on the date CQC extracted data from the CAS system (01-Sep-13 to 31-Aug-14)*	*0 alerts still open*	-	*No evidence of risk*
	CASIM01B01	*The number of alerts which CAS stipulated should have been closed by trusts more than 12 months before, but which were still open on the date CQC extracted data from the CAS system (01-Apr-04 to 31-Aug-13)*	*0 alerts still open*	-	*No evidence of risk*
	CASIM01C01	*Percentage of CAS alerts with closing dates during the preceding 12 months which the trust has closed late (01-Sep-13 to 31-Aug-14)*	*< 25% of alerts closed late*	-	*No evidence of risk*
Venous Thromboembolism	VTERA03	Proportion of patients risk assessed for Venous Thromboembolism (VTE) (01-Apr-14 to 30-Jun-14)	0.96	0.95	No evidence of risk
Mortality: Trust Level	SHMI01	Summary Hospital-level Mortality Indicator (01-Apr-13 to 31-Mar-14)	Trust's mortality rate is 'As Expected'	-	No evidence of risk
	COM_HSMR	Dr Foster Intelligence: Composite of Hospital Standardised Mortality Ratio indicators (01-Apr-13 to 31-Mar-14)	-	-	No evidence of risk
	HSMR	*Dr Foster Intelligence: Hospital Standardised Mortality Ratio (01-Apr-13 to 31-Mar-14)*	*Within expected range*	-	*No evidence of risk*
	HSMRWKDAY	*Dr Foster Intelligence: Hospital Standardised Mortality Ratio (Weekday) (01-Apr-13 to 31-Mar-14)*	*Within expected range*	-	*No evidence of risk*
	HSMRWKEND	*Dr Foster Intelligence: Hospital Standardised Mortality Ratio (Weekend) (01-Apr-13 to 31-Mar-14)*	*Within expected range*	-	*No evidence of risk*

Indicators displaying * represent a suppressed value between 1 and 5

Section	ID	Indicators	Observed	Expected	Risk?
	COM_CARDI	Composite indicator: In-hospital mortality - Cardiological conditions and procedures	-	-	Risk
	HESMORT24CU	*In-hospital mortality: Cardiological conditions (01-May-13 to 30-Apr-14)*	-	-	*Risk*
	MORTAMI	*Mortality outlier alert: Acute myocardial infarction (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTARRES	*Mortality outlier alert: Cardiac arrest and ventricular fibrillation (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTCABGI	*Mortality outlier alert: CABG (isolated first time) (case status as at 19-Nov-14)*	*Not included*	*Not included*	*Not included*
	MORTCABGO	*Mortality outlier alert: CABG (other) (case status as at 19-Nov-14)*	*Not included*	*Not included*	*Not included*
	MORTCASUR	*Mortality outlier alert: Adult cardiac surgery (case status as at 19-Nov-14)*	*Not included*	*Not included*	*Not included*
	MORTCATH	*Mortality outlier alert: Coronary atherosclerosis and other heart disease (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTCHF	*Mortality outlier alert: Congestive heart failure; nonhypertensive (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTDYSRH	*Mortality outlier alert: Cardiac dysrhythmias (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTHVD	*Mortality outlier alert: Heart valve disorders (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTPHD	*Mortality outlier alert: Pulmonary heart disease (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	COM_CEREB	Composite indicator: In-hospital mortality - Cerebrovascular conditions	-	-	No evidence of risk
	HESMORT21CU	*In-hospital mortality: Cerebrovascular conditions (01-May-13 to 30-Apr-14)*	-	-	*No evidence of risk*
	MORTACD	*Mortality outlier alert: Acute cerebrovascular disease (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	COM_DERMA	Composite indicator: In-hospital mortality - Dermatological conditions	-	-	No evidence of risk
	HESMORT35CU	*In-hospital mortality: Dermatological conditions (01-May-13 to 30-Apr-14)*	-	-	*No evidence of risk*
	MORTSKINF	*Mortality outlier alert: Skin and subcutaneous tissue infections (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTSKULC	*Mortality outlier alert: Chronic ulcer of skin (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	COM_ENDOC	Composite indicator: In-hospital mortality - Endocrinological conditions	-	-	No evidence of risk
	HESMORT29CU	*In-hospital mortality: Endocrinological conditions (01-May-13 to 30-Apr-14)*	-	-	*No evidence of risk*
	MORTDIABWC	*Mortality outlier alert: Diabetes mellitus with complications (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTDIABWOC	*Mortality outlier alert: Diabetes mellitus without complications (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTFLUID	*Mortality outlier alert: Fluid and electrolyte disorders (case status as at 19-Nov-14)*	-	-	*No evidence of risk*

Section	ID	Indicators	Observed	Expected	Risk?
Mortality	COM_GASTR	Composite indicator: In-hospital mortality - Gastroenterological and hepatological conditions and procedures	-	-	No evidence of risk
	HESMORT27CU	*In-hospital mortality: Gastroenterological and hepatological conditions (01-May-13 to 30-Apr-14)*	-	-	*No evidence of risk*
	MORTALCLIV	*Mortality outlier alert: Liver disease, alcohol-related (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTBILIA	*Mortality outlier alert: Biliary tract disease (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTGASHAE	*Mortality outlier alert: Gastrointestinal haemorrhage (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTGASN	*Mortality outlier alert: Noninfectious gastroenteritis (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTINTOBS	*Mortality outlier alert: Intestinal obstruction without hernia (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTOGAS	*Mortality outlier alert: Other gastrointestinal disorders (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTOLIV	*Mortality outlier alert: Other liver diseases (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTOPJEJ	*Mortality outlier alert: Operations on jejunum (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTPERI	*Mortality outlier alert: Peritonitis and intestinal abscess (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTTEPBI	*Mortality outlier alert: Therapeutic endoscopic procedures on biliary tract (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTTEPLGI	*Mortality outlier alert: Therapeutic endoscopic procedures on lower GI tract (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTTEPUGI	*Mortality outlier alert: Therapeutic endoscopic procedures on upper GI tract (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTTOJI	*Mortality outlier alert: Therapeutic operations on jejunum and ileum (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	COM_GENIT	Composite indicator: In-hospital mortality - Genito-urinary conditions	-	-	No evidence of risk
	HESMORT31CU	*In-hospital mortality: Genito-urinary conditions (01-May-13 to 30-Apr-14)*	-	-	*No evidence of risk*
	MORTUTI	*Mortality outlier alert: Urinary tract infections (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	COM_HAEMA	Composite indicator: In-hospital mortality - Haematological conditions	-	-	Risk
	HESMORT28CU	*In-hospital mortality: Haematological conditions (01-May-13 to 30-Apr-14)*	-	-	*Risk*
	MORTDEFI	*Mortality outlier alert: Deficiency and other anaemia (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	COM_INFEC	Composite indicator: In-hospital mortality - Infectious diseases	-	-	No evidence of risk
	HESMORT26CU	*In-hospital mortality: Infectious diseases (01-May-13 to 30-Apr-14)*	-	-	*No evidence of risk*
	MORTSEPT	*Mortality outlier alert: Septicaemia (except in labour) (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	COM_MENTA	Composite indicator: In-hospital mortality - Conditions associated with Mental health	-	-	No evidence of risk
	HESMORT33CU	*In-hospital mortality: Conditions associated with Mental health (01-May-13 to 30-Apr-14)*	-	-	*No evidence of risk*
	MORTSENI	*Mortality outlier alert: Senility and organic mental disorders (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	COM_MUSCU	Composite indicator: In-hospital mortality - Musculoskeletal conditions	-	-	No evidence of risk
	HESMORT36CU	*In-hospital mortality: Musculoskeletal conditions (01-May-13 to 30-Apr-14)*	-	-	*No evidence of risk*
	MORTPATH	*Mortality outlier alert: Pathological fracture (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	COM_NEPHR	Composite indicator: In-hospital mortality - Nephrological conditions	-	-	No evidence of risk
	HESMORT30CU	*In-hospital mortality: Nephrological conditions (01-May-13 to 30-Apr-14)*	-	-	*No evidence of risk*
	MORTRENA	*Mortality outlier alert: Acute and unspecified renal failure (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTRENC	*Mortality outlier alert: Chronic renal failure (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	COM_NEURO	Composite indicator: In-hospital mortality - Neurological conditions	-	-	No evidence of risk
	HESMORT34CU	*In-hospital mortality: Neurological conditions (01-May-13 to 30-Apr-14)*	-	-	*No evidence of risk*
	MORTEPIL	*Mortality outlier alert: Epilepsy, convulsions (case status as at 19-Nov-14)*	-	-	*No evidence of risk*

Section	ID	Indicators	Observed	Expected	Risk?
	COM_PAEDI	Composite indicator: In-hospital mortality - Paediatric and congenital disorders and perinatal mortality	-	-	No evidence of risk
	HESMORT32CU	*In-hospital mortality: Paediatric and congenital disorders (01-May-13 to 30-Apr-14)*	-	-	*No evidence of risk*
	MATPERIMOR	*Maternity outlier alert: Perinatal mortality (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	COM_RESPI	Composite indicator: In-hospital mortality - Respiratory conditions	-	-	No evidence of risk
	HESMORT25CU	*In-hospital mortality: Respiratory conditions (01-May-13 to 30-Apr-14)*	-	-	*No evidence of risk*
	MORTASTHM	*Mortality outlier alert: Asthma (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTBRONC	*Mortality outlier alert: Acute bronchitis (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTCOPD	*Mortality outlier alert: Chronic obstructive pulmonary disease and bronchiectasis (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTPLEU	*Mortality outlier alert: Pleurisy, pneumothorax, pulmonary collapse (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTPNEU	*Mortality outlier alert: Pneumonia (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	COM_TRAUM	Composite indicator: In-hospital mortality - Trauma and orthopaedic conditions and procedures	-	-	No evidence of risk
	HESMORT37CU	*In-hospital mortality: Trauma and orthopaedic conditions (01-May-13 to 30-Apr-14)*	-	-	*No evidence of risk*
	MORTCRAN	*Mortality outlier alert: Craniotomy for trauma (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTFNOF	*Mortality outlier alert: Fracture of neck of femur (hip) (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTHFREP	*Mortality outlier alert: Head of femur replacement (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTHIPREP	*Mortality outlier alert: Hip replacement (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTINTINJ	*Mortality outlier alert: Intracranial injury (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTOFRA	*Mortality outlier alert: Other fractures (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTREDFB	*Mortality outlier alert: Reduction of fracture of bone (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTREDFBL	*Mortality outlier alert: Reduction of fracture of bone (upper/lower limb) (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTREDFNOF	*Mortality outlier alert: Reduction of fracture of neck of femur (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTSHUN	*Mortality outlier alert: Shunting for hydrocephalus (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	COM_VASCU	Composite indicator: In-hospital mortality - Vascular conditions and procedures	-	-	No evidence of risk
	HESMORT23CU	*In-hospital mortality: Vascular conditions (01-May-13 to 30-Apr-14)*	-	-	*No evidence of risk*
	MORTAMPUT	*Mortality outlier alert: Amputation of leg (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTANEUR	*Mortality outlier alert: Aortic, peripheral, and visceral artery aneurysms (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTCLIP	*Mortality outlier alert: Clip and coil aneurysms (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTOFB	*Mortality outlier alert: Other femoral bypass (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTPVA	*Mortality outlier alert: Peripheral and visceral atherosclerosis (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTREPAAA	*Mortality outlier alert: Repair of abdominal aortic aneurysm (AAA) (case status as at 19-Nov-14)*	-	-	*No evidence of risk*
	MORTTOFA	*Mortality outlier alert: Transluminal operations on the femoral artery (case status as at 19-Nov-14)*	-	-	*No evidence of risk*

Section	ID	Indicators	Observed	Expected	Risk?
Maternity and women's health	MATELECCS	Maternity outlier alert: Elective Caesarean section (case status as at 19-Nov-14)	-	-	No evidence of risk
	MATEMERCS	Maternity outlier alert: Emergency Caesarean section (case status as at 19-Nov-14)	-	-	No evidence of risk
	MATSEPSIS	Maternity outlier alert: Puerperal sepsis and other puerperal infections (case status as at 19-Nov-14)	-	-	No evidence of risk
Re-admissions	MATMATRE	Maternity outlier alert: Maternal readmissions (case status as at 19-Nov-14)	-	-	No evidence of risk
	MATNEORE	Maternity outlier alert: Neonatal readmissions (case status as at 19-Nov-14)	-	-	No evidence of risk
	COM_ELRE_ON	Composite indicator: Emergency readmissions with an overnight stay following an elective admission (01-Apr-13 to 31-Mar-14)	-	-	No evidence of risk
	HESELRE_ON	*Emergency readmissions with an overnight stay following an elective admission (Cross sectional) (01-Apr-13 to 31-Mar-14)*	*469*	*467.06*	*No evidence of risk*
	HESELRECU_ON	*Emergency readmissions with an overnight stay following an elective admission (CUSUM) (01-Jan-14 to 31-Mar-14)*	*-*	*-*	*No evidence of risk*
	COM_EMRE_ON	Composite indicator: Emergency readmissions with an overnight stay following an emergency admission (01-Apr-13 to 31-Mar-14)	-	-	No evidence of risk
	HESEMRE_ON	*Emergency readmissions with an overnight stay following an emergency admission (Cross sectional) (01-Apr-13 to 31-Mar-14)*	*2549*	*2684.35*	*No evidence of risk*
	HESEMRECU_ON	*Emergency readmissions with an overnight stay following an emergency admission (CUSUM) (01-Jan-14 to 31-Mar-14)*	*-*	*-*	*No evidence of risk*
PROMs	PROMS52	PROMs EQ-5D score: Groin Hernia Surgery (01-Apr-13 to 31-Mar-14)	0.06	0.09	No evidence of risk
	PROMS_HIP	Composite of hip related PROMS indicators (01-Apr-13 to 31-Mar-14)	-	-	No evidence of risk
	PROMS53	*PROMs EQ-5D score: Hip Replacement (PRIMARY) (01-Apr-13 to 31-Mar-14)*	*0.41*	*0.44*	*No evidence of risk*
	PROMS54	*PROMs Oxford score: Hip Replacement (PRIMARY) (01-Apr-13 to 31-Mar-14)*	*20.44*	*21.29*	*No evidence of risk*
	PROMS_KNEE	Composite of knee related PROMS indicators (01-Apr-13 to 31-Mar-14)	-	-	No evidence of risk
	PROMS55	*PROMs EQ-5D score: Knee Replacement (PRIMARY) (01-Apr-13 to 31-Mar-14)*	*0.34*	*0.32*	*No evidence of risk*
	PROMS56	*PROMs Oxford score: Knee Replacement (PRIMARY) (01-Apr-13 to 31-Mar-14)*	*16.53*	*16.24*	*No evidence of risk*
Audit	NHFD01	The proportion of cases assessed as achieving compliance with all nine standards of care measured within the National Hip Fracture Database. (01-Jan-13 to 31-Dec-13)	0.4	0.6	No evidence of risk
	SSNAPD02	SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator (01-Apr-14 to 30-Jun-14)	Level C	-	No evidence of risk

Section	ID	Indicators	Observed	Expected	Risk?
Compassionate care	IPSURTALKWOR	Inpatient Survey Q34 "Did you find someone on the hospital staff to talk to about your worries and fears?" (Score out of 10) (01-Jun-13 to 31-Aug-13)	5.86	-	No evidence of risk
	IPSURSUPEMOT	Inpatient Survey Q35 "Do you feel you got enough emotional support from hospital staff during your stay?" (Score out of 10) (01-Jun-13 to 31-Aug-13)	7.07	-	No evidence of risk
Meeting physical needs	IPSURHELPEAT	Inpatient Survey Q23 "Did you get enough help from staff to eat your meals?" (Score out of 10) (01-Jun-13 to 31-Aug-13)	7.26	-	No evidence of risk
	IPSURINVDECI	Inpatient Survey Q32 "Were you involved as much as you wanted to be in decisions about your care and treatment?" (Score out of 10) (01-Jun-13 to 31-Aug-13)	7.39	-	No evidence of risk
	IPSURCNTPAIN	Inpatient Survey Q39 "Do you think the hospital staff did everything they could to help control your pain?" (Score out of 10) (01-Jun-13 to 31-Aug-13)	7.78	-	No evidence of risk
Overall experience	IPSUROVERALL	Inpatient Survey Q68 "Overall…" (I had a very poor/good experience) (Score out of 10) (01-Jun-13 to 31-Aug-13)	7.8	-	No evidence of risk
	FFTNHSESCORE	NHS England inpatients score from Friends and Family Test (% change) (01-Aug-13 to 31-Jul-14)	-2% Short Term - 0.1% Long Term	-	No evidence of risk
Treatment with dignity and respect	IPSURRSPDIGN	Inpatient Survey Q67 "Overall, did you feel you were treated with respect and dignity while you were in the hospital?" (Score out of 10) (01-Jun-13 to 31-Aug-13)	8.47	-	No evidence of risk
Trusting relationships	IPSURCONFDOC	Inpatient Survey Q25 "Did you have confidence and trust in the doctors treating you?" (Score out of 10) (01-Jun-13 to 31-Aug-13)	8.85	-	No evidence of risk
	IPSURCONFNUR	Inpatient Survey Q28 "Did you have confidence and trust in the nurses treating you?" (Score out of 10) (01-Jun-13 to 31-Aug-13)	8.73	-	No evidence of risk
A&E Survey	AESURWAIT	A&E Survey Q7: From the time you first arrived at the A&E Department, how long did you wait before being examined by a doctor or nurse? (01-Jan-14 to 31-Mar-14)	6.27	-	No evidence of risk
	AESURCONFID	A&E Survey Q14: Did you have confidence and trust in the doctors and nurses examining and treating you? (01-Jan-14 to 31-Mar-14)	8.51	-	No evidence of risk
	AESURPRIV	A&E Survey Q18: Were you given enough privacy when being examined or treated? (01-Jan-14 to 31-Mar-14)	8.86	-	No evidence of risk
	AESURATTENT	A&E Survey Q19: If you needed attention, were you able to get a member of medical or nursing staff to help you? (01-Jan-14 to 31-Mar-14)	7.68	-	No evidence of risk
	AESURREASS	A&E Survey Q22: If you were feeling distressed while you were in the A&E Department, did a member of staff help to reassure you? (01-Jan-14 to 31-Mar-14)	6.37	-	No evidence of risk
	AESURPAIN	A&E Survey Q30: Do you think the hospital staff did everything they could to help control your pain? (01-Jan-14 to 31-Mar-14)	7.34	-	No evidence of risk
	AESURCONT	A&E Survey Q41: Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the A&E Department? (01-Jan-14 to 31-Mar-14)	6.8	-	No evidence of risk
	AESURDIGRES	A&E Survey Q42: Overall, did you feel you were treated with respect and dignity while you were in the A&E Department? (01-Jan-14 to 31-Mar-14)	8.77	-	No evidence of risk

Section	ID	Indicators	Observed	Expected	Risk?
Access measures	COM_AD_A&E	Composite indicator: A&E waiting times more than 4 hours (01-Jul-14 to 30-Sep-14)	-	-	No evidence of risk
	AD_A&E13	*Proportion of patients spending more than 4 hours in Type 1 only A&E departments from arrival to discharge, transfer or admission (01-Jul-14 to 30-Sep-14)*	*0.09*	*0.05*	*No evidence of risk*
	AD_A&E14	*Proportion of patients spending more than 4 hours in Type 2 only A&E departments from arrival to discharge, transfer or admission (01-Jul-14 to 30-Sep-14)*	*Not included*	*Not included*	*Not included*
	AD_A&E15	*Proportion of patients spending more than 4 hours in Type 3 only A&E departments from arrival to discharge, transfer or admission (01-Jul-14 to 30-Sep-14)*	*0*	*0.05*	*No evidence of risk*
	COM_RTT	Composite indicator: Referral to treatment (01-Jul-14 to 31-Jul-14)	-	-	No evidence of risk
	RTT_01	*Monthly Referral to Treatment (RTT) waiting times for completed admitted pathways (on an adjusted basis): percentage within 18 weeks (01-Jul-14 to 31-Jul-14)*	*90.7%*	*88.4%*	*No evidence of risk*
	RTT_02	*Monthly Referral to Treatment (RTT) waiting times for completed non-admitted pathways: percentage within 18 weeks (01-Jul-14 to 31-Jul-14)*	*97.8%*	*95.8%*	*No evidence of risk*
	RTT_03	*Monthly Referral to Treatment (RTT) waiting times for incomplete pathways: percentage within 18 weeks (01-Jul-14 to 31-Jul-14)*	*94.9%*	*93.2%*	*No evidence of risk*
	DIAG6WK01	Diagnostics waiting times: patients waiting over 6 weeks for a diagnostic test (01-Jul-14 to 31-Jul-14)	0	0.017	No evidence of risk
	WT_CAN26	All cancers: 62 day wait for first treatment from urgent GP referral (01-Apr-14 to 30-Jun-14)	0.88	0.85	No evidence of risk
	WT_CAN27	All cancers: 62 day wait for first treatment from NHS cancer screening referral (01-Apr-14 to 30-Jun-14)	1	0.9	No evidence of risk
	WT_CAN22	All cancers: 31 day wait from diagnosis (01-Apr-14 to 30-Jun-14)	1	0.96	No evidence of risk
	CND_OPS02	The proportion of patients whose operation was cancelled (01-Apr-14 to 30-Jun-14)	0.013	0.008	No evidence of risk
	CND_OPS01	The number of patients not treated within 28 days of last minute cancellation due to non-clinical reason (01-Apr-14 to 30-Jun-14)	0	0.051	No evidence of risk
	AMBTURN06	Proportion of ambulance journeys where the ambulance vehicle remained at hospital for more than 60 minutes (01-Apr-14 to 30-Apr-14)	0.009	0.024	No evidence of risk
Discharge and Integration	DTC40	Ratio of the total number of days delay in transfer from hospital to the total number of occupied beds (01-Apr-14 to 30-Jun-14)	0.032	0.023	No evidence of risk
Patient-led assessments of the care environment	COM_PLACE	Composite of PLACE indicators (29-Jan-14 to 17-Jun-14)	-	-	No evidence of risk
	PLACE01	*PLACE score for cleanliness of environment (29-Jan-14 to 17-Jun-14)*	*0.99*	*0.97*	*No evidence of risk*
	PLACE02	*PLACE score for food (29-Jan-14 to 17-Jun-14)*	*0.89*	*0.89*	*No evidence of risk*
	PLACE03	*PLACE score for privacy, dignity and well being (29-Jan-14 to 17-Jun-14)*	*0.9*	*0.87*	*No evidence of risk*
	PLACE04	*PLACE score for facilities (29-Jan-14 to 17-Jun-14)*	*0.95*	*0.92*	*No evidence of risk*

Indicators displaying * represent a suppressed value between 1 and 5

Section	ID	Indicators	Observed	Expected	Risk?
Reporting culture	NRLSL08	Consistency of reporting to the National Reporting and Learning System (NRLS) (01-Oct-13 to 31-Mar-14)	6 months of reporting	-	No evidence of risk
	COM_SUSDQ	Data quality of trust returns to the HSCIC (01-Apr-14 to 30-Jun-14)	-	-	No evidence of risk
	SUSA&E02	*Percentage of Secondary Uses Service (SUS) records for Accident and Emergency care with valid entries in mandatory fields. (01-Apr-14 to 30-Jun-14)*	*99.7%*	*96.7%*	*No evidence of risk*
	SUSAPC02	*Percentage of Secondary Uses Service (SUS) records for inpatient care with correct entries in mandatory fields. (01-Apr-14 to 30-Jun-14)*	*99.7%*	*97.3%*	*No evidence of risk*
	SUSOP02	*Percentage of Secondary Uses Service (SUS) records for outpatient care with valid entries in mandatory fields. (01-Apr-14 to 30-Jun-14)*	*100.0%*	*97.3%*	*No evidence of risk*
	FFTRESP02	Inpatients response percentage rate from NHS England Friends and Family Test (01-Aug-13 to 31-Jul-14)	29.8%	32.9%	No evidence of risk
Partners	MONITOR01	Monitor - Governance risk rating (09-Sep-14 to 09-Sep-14)	Monitor risk rating: No evident concerns	-	No evidence of risk
	MONITOR02	Monitor - Continuity of service rating (09-Sep-14 to 09-Sep-14)	3: emerging or minor concern	-	No evidence of risk
	TDA03	TDA - Escalation score (01-Jun-14 to 30-Jun-14)	Not included	Not included	Not included
	NTS12	GMC National Training Survey – trainee's overall satisfaction (26-Mar-14 to 08-May-14)	Within the middle quartile (Q2/IQR)	-	No evidence of risk
Staff survey	STASURBG01	NHS Staff Survey - The proportion of staff who would recommend the trust as a place to work or receive treatment (01-Sep-13 to 31-Dec-13)	0.67	0.65	No evidence of risk
	NHSSTAFF04	NHS Staff Survey - KF7. The proportion of staff who were appraised in last 12 months (01-Sep-13 to 31-Dec-13)	0.88	0.83	No evidence of risk
	NHSSTAFF06	NHS Staff Survey - KF9. The proportion of staff reported receiving support from immediate managers (01-Sep-13 to 31-Dec-13)	0.70	0.65	No evidence of risk
	NHSSTAFF07	NHS Staff Survey - KF10. The proportion of staff receiving health and safety training in last 12 months (01-Sep-13 to 31-Dec-13)	0.60	0.75	Risk
	NHSSTAFF11	NHS Staff Survey - KF15. The proportion of staff who stated that the incident reporting procedure was fair and effective (01-Sep-13 to 31-Dec-13)	0.66	0.62	No evidence of risk
	NHSSTAFF16	NHS Staff Survey - KF21. The proportion of staff reporting good communication between senior management and staff (01-Sep-13 to 31-Dec-13)	0.30	0.29	No evidence of risk

Section	ID	Indicators	Observed	Expected	Risk?
Staffing	ESRSIC	Composite risk rating of ESR items relating to staff sickness rates (01-Aug-13 to 31-Jul-14)	-	-	No evidence of risk
	ESRSIC01	*Proportion of days sick due to back problems in the last 12 months (01-Aug-13 to 31-Jul-14)*	*0.003*	*0.003*	*No evidence of risk*
	ESRSIC02	*Proportion of days sick due to stress in the last 12 months (01-Aug-13 to 31-Jul-14)*	*0.01*	*0.007*	*No evidence of risk*
	ESRSIC03	*Proportion of days sick in the last 12 months for Medical and Dental staff (01-Aug-13 to 31-Jul-14)*	*0.02*	*0.035*	*No evidence of risk*
	ESRSIC04	*Proportion of days sick in the last 12 months for Nursing and Midwifery staff (01-Aug-13 to 31-Jul-14)*	*0.048*	*0.042*	*No evidence of risk*
	ESRSIC05	*Proportion of days sick in the last 12 months for other clinical staff (01-Aug-13 to 31-Jul-14)*	*0.045*	*0.046*	*No evidence of risk*
	ESRSIC06	*Proportion of days sick in the last 12 months for non-clinical staff (01-Aug-13 to 31-Jul-14)*	*0.037*	*0.039*	*No evidence of risk*
	ESRReg	Composite risk rating of ESR items relating to staff registration (31-Jul-14 to 31-Jul-14)	-	-	No evidence of risk
	ESRREG01	*Proportion of Medical and Dental staff that hold an active professional registration (31-Jul-14 to 31-Jul-14)*	*1*	*0.99*	*No evidence of risk*
	ESRREG02	*Proportion of Nursing and Midwifery staff that hold an active professional registration (31-Jul-14 to 31-Jul-14)*	*1*	*0.99*	*No evidence of risk*
	ESRTO	Composite risk rating of ESR items relating to staff turnover (01-Aug-13 to 31-Jul-14)	-	-	No evidence of risk
	ESRTUR01	*Turnover rate (leavers) for Medical and Dental staff (01-Aug-13 to 31-Jul-14)*	*0.12*	*0.1*	*No evidence of risk*
	ESRTUR02	*Turnover rate (leavers) for Nursing and Midwifery staff (01-Aug-13 to 31-Jul-14)*	*0.11*	*0.12*	*No evidence of risk*
	ESRTUR03	*Turnover rate (leavers) for other clinical staff (01-Aug-13 to 31-Jul-14)*	*0.11*	*0.12*	*No evidence of risk*
	ESRTUR04	*Turnover rate (leavers) for all other staff (01-Aug-13 to 31-Jul-14)*	*0.08*	*0.11*	*No evidence of risk*
	ESRSTAB	Composite risk rating of ESR items relating to staff stability (01-Aug-13 to 31-Jul-14)	-	-	No evidence of risk
	ESRSTA01	*Stability Index for Medical and Dental staff (01-Aug-13 to 31-Jul-14)*	*0.93*	*0.94*	*No evidence of risk*
	ESRSTA02	*Stability Index for Nursing and Midwifery staff (01-Aug-13 to 31-Jul-14)*	*0.9*	*0.9*	*No evidence of risk*
	ESRSTA03	*Stability Index for other clinical staff (01-Aug-13 to 31-Jul-14)*	*0.91*	*0.9*	*No evidence of risk*
	ESRSTA04	*Stability Index for non clinical staff (01-Aug-13 to 31-Jul-14)*	*0.93*	*0.91*	*No evidence of risk*
	ESRSUP	Composite risk rating of ESR items relating to staff support/ supervision (01-Aug-13 to 31-Jul-14)	-	-	No evidence of risk
	ESRSUP01	*Ratio of Band 6 Nurses to Band 5 Nurses (01-Aug-13 to 31-Jul-14)*	*0.35*	*0.4*	*No evidence of risk*
	ESRSUP02	*Ratio of Charge Nurse/ Ward Sister (Band 7) to Band 5/6 Nurses (01-Aug-13 to 31-Jul-14)*	*0.23*	*0.18*	*No evidence of risk*
	ESRSUP03	*Proportion of all ward staff who are registered nurses (01-Aug-13 to 31-Jul-14)*	*0.64*	*0.68*	*No evidence of risk*
	ESRSUP04	*Ratio of consultant doctors to non-consultant doctors (01-Aug-13 to 31-Jul-14)*	*0.59*	*0.66*	*No evidence of risk*
	ESRSUP05	*Ratio of band 7 Midwives to band 5/6 Midwives (01-Aug-13 to 31-Jul-14)*	*0.25*	*0.26*	*No evidence of risk*
	ESRSTAFF	Composite risk rating of ESR items relating to ratio: Staff vs bed occupancy (01-Aug-13 to 31-Jul-14)	-	-	No evidence of risk
	ESRRAT01	*Ratio of all medical and dental staff to occupied beds (number of beds per staff) (01-Aug-13 to 31-Jul-14)*	*6.44*	*4.6*	*No evidence of risk*
	ESRRAT02	*Ratio of all nursing staff to occupied beds (number of beds per staff) (01-Aug-13 to 31-Jul-14)*	*2.86*	*2.23*	*No evidence of risk*
	ESRRAT03	*Ratio of all other clinical staff to occupied beds (number of beds per staff) (01-Aug-13 to 31-Jul-14)*	*2.26*	*2.07*	*No evidence of risk*
	ESRRAT04	*Ratio of all midwifery staff to births (number of births per staff) (01-Aug-13 to 31-Jul-14)*	*31.42*	*28.23*	*No evidence of risk*
	FLUVAC01	Healthcare Worker Flu vaccination uptake (01-Sep-13 to 31-Jan-14)	0.77	0.59	No evidence of risk

Section	ID	Indicators	Observed	Expected	Risk?
Qualitative intelligence	WHISTLEBLOW	Whistleblowing alerts (18-Jul-13 to 29-Sep-14)	1 or more	-	Elevated risk
	GMC	GMC - Enhanced monitoring (01-Mar-09 to 22-Jul-14)	-	-	No evidence of risk
	SAFEGUARDING	Safeguarding concerns (23-Sep-13 to 22-Sep-14)	-	-	No evidence of risk
	SYE	CQC Share Your Experience - the number of negative comments is high relative to positive comments (09-Sep-13 to 08-Sep-14)	8	8.65	No evidence of risk
	NHSCHOICES	NHS Choices - the number of negative comments is high relative to positive comments (01-May-13 to 30-Apr-14)	11	19.07	No evidence of risk
	P_OPINION	Patient Opinion - the number of negative comments is high relative to positive comments (28-May-13 to 27-May-14)	4	3.88	No evidence of risk
	CQC_COM	CQC complaints (23-Sep-13 to 22-Sep-14)	20	26.89	No evidence of risk
	PROV_COM	Provider complaints (01-Apr-13 to 31-Mar-14)	422	426.65	No evidence of risk

Indicators displaying * represent a suppressed value between 1 and 5

BOARD OF DIRECTORS

WHH/B/2015/ **015**

SUBJECT:	**Verbal Report from the Chair of the Strategic People Committee**
DATE OF MEETING:	28th January 2015
DIRECTOR:	Lynne Lobley

BOARD OF DIRECTORS

WHH/B/2015/ **016**

SUBJECT:	Human Resources / Education & Development Key Performance Indicators (KPIs) Report	
DATE OF MEETING:	28th January 2015	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Mick Curwen, Associate Director of HR	
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance and OD	
LINK TO STRATEGIC OBJECTIVES:	SO2: To be the employer of choice for healthcare we deliver	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	• Very little change in Mandatory Training and PDR rates • Another 11 doctors recommended for revalidation • Sickness rates continue to rise • Turnover and Vacancy rate have increased. Headcount has increased to its highest rate since April • Reduction in temporary staffing expenditure • High number of medical staff vacancies • All main Equality and Diversity targets achieved for 2014 and slight increase in training rate	
RECOMMENDATION:	***The Board is asked to:*** Note progress on the achievement of the KPIs and the action being taken to try and address shortfalls where appropriate.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Not Applicable

Appendix 1

Human Resources / Education & Development
Key Performance Indicators Report January 2015

1.0 Introduction

This report focuses on the KPIs which are felt to give a good indication on progress with the main workforce and governance performance areas within Human Resources and Education and Development.

Some KPIs lend themselves to monthly monitoring whilst others are bi-monthly, quarterly, bi-annually or annually and this is indicated on the 'dashboard' attached. With all of the KPIs the performance is shown under the traffic light system of Red, Amber or Green against the target and the threshold criteria. This should enable Board members to see at a glance the progress being made and to allow a greater focus on those areas which are red or amber. This 'dashboard' is part of a wider number of KPIs which are monitored at the Strategic People Committee and their links to CQC/NHSLA compliance.

The dashboard attached to this report shows the progress on KPIs, focussing on the position at December 2015, where applicable.

2.0 HR and E&D Trust Workforce Standards KPIs Overview

2.1 Mandatory Training

The target for all mandatory training is 85%.

There has been very little change to the mandatory training rates with Health and Safety and Fire remaining the same and a slight decrease for Manual Handling. The trend in recent months of little change has therefore continued. However, individually, some Divisions/areas are meeting the trust target for some parts of the mandatory training.

Completion rates for the Divisions are as follows (figures in brackets denotes the month of November 2014):

Division	Fire Safety	Health & Safety	Manual Handling
Scheduled Care	70% (68%) (Amber)	92% (92%) (Green)	66% (66%) (Red)
Unscheduled Care	68% (70%) (Amber)	88% (88%) (Green)	61% (62%) (Red)
Women's & Children's	74% (75%) (Amber)	90% (91%) (Green)	75% (76%) (Amber)
Estates	78% (87%) (Green)	100% (100%) (Green)	97% (97%) (Green)
Facilities	84% (84%) (Green)	81% (81%) (Amber)	81% (82%) (Amber)
Corporate Areas	82% (84%) (Green)	98% (99%) (Green)	82% (85%) (Amber)

None of the areas are achieving all of the targets. Most areas remained similar to the previous month with only Estates showing a marked reduction.

At a Corporate level the arrangements introduced in September 2012 for Corporate Induction continue to work well and an impressive 98% of staff attended corporate induction during December 2014.

2.1.1 Health & Safety (Green)

There has been no change from the previous month and the rate remains at 90% and green. The target for 2014/15 is being achieved.

2.1.2 Fire Safety (Amber)

There has been no change from the previous month and the rate is 74% and amber.

2.1.3 Manual Handling – Patient / Non-Patient Combined (Amber)
There was a slight decrease of 1% from the previous month and the rate is 72% and the status is amber.

2.1.3.1 Manual Handling Patient Training Only (Red)
There was a slight decrease of 1% from the previous month and the rate is 66% and red.

2.1.3.2 Manual Handling Non-Patient Training Only (Amber)
There was no change from the previous month and the rate is 81% and amber.

2.2 Staff Appraisals
The target for completed PDRs is 85%.

During December there was no change for both Non-Medical and Medical and Dental staff.

Completion rates for the Divisions for non-medical staff are as follows (figures in brackets denotes the month of November 2014):

Division	PDR Rate
Scheduled Care	68% (68%) (Red)
Unscheduled Care	65% (65%) (Red)
Women's and Children's	73% (73%) (Amber)
Estates	70% (72%) (Amber)
Facilities	85% (88%) (Green)
Corporate Areas	76% (73%) (Amber)

Only Facilities are meeting the target and the only area to show an increase was the corporate areas but they are still amber.

2.2.1 Non-Medical Staff (Amber)
For the period up to December 2014 the percentage of non-medical staff having had an appraisal did not change at 72% and the status is amber.

2.2.2 Medical & Dental Staff (Green)
The combined rate for Consultant staff and Middle Grade doctors, up to December 2014 did not change and remained at 86%. The rate for Consultants and other M&D also remained the same at 91% and 75% respectively.

This means that the target of 85% was achieved and the status is green.

Divisions have been reminded at the bi-lateral meetings that priority must still be given to appraisal rates despite the financial position and these are regularly reviewed. The Director of Nursing and Governance also met with Divisional Managers at the beginning of January to personally remind managers of the importance of undertaking PDRs and is expecting all staff to have dates diarised for their PDRs. Progress will be monitored.

2.3 Revalidation for Medical and Dental Staff (Green)
The Revalidation Decision Making Group met on 20 January 2015 although the Medical Director was not present. The Panel have recommended to the Medical Director that 11 more doctors are submitted for revalidation to GMC which would increase the total approved to 102 with 18 doctors deferred. This would make the rate as 85%.

The next meeting of the Decision Making Group has provisionally been arranged for 10.3.15.

2.4 Sickness Absence

2.4.1 Sickness Absence Rates (Amber)
The new sickness absence target for 2014/15 is 3.75%.

Sickness absence for December 2014 was at its highest for a number of years at 5.35% which was an increase of 0.53% from the previous month. Consequently the cumulative rate for April – December 2014 increased to 4.48%.

This is largely explained by the under-reporting within the nursing wards/areas and a genuine increase in staff displaying flu like symptoms.

Sickness absence continues to be closely monitored and managed in all areas in the Trust in line with the Attendance at Work Policy. The number of staff being managed either through the Short Term Absence or Long Term Absence Sections of the policy, remains high at over 250 staff.

2.4.2 Return to Work Interviews (RTW) (Red)
The target for this KPI is 85% and is only reported on a quarterly basis. The rate for Q3 was disappointing at 53% which was a reduction of 6% from Q2.

At training sessions and when completing eSVLs, managers are reminded of the need to undertake RTW interviews and record these on ESR. It is still believed that more RTW interviews are actually taking place but managers are failing to record this on ESR.

2.5 Turnover Rate (Amber)
The target for this KPI is min 8% or max 9%. This is designed to reflect that both a high and a low figure could be detrimental to the interests of the trust. A high figure could indicate dissatisfaction with the trust and lead to increased recruitment and training costs. A low figure could indicate a 'stagnant' workforce with potential lack of new ideas and inspiration.

The rate for the previous 12 months up to December 2014 showed a slight increase of 0.1% to 10.16% and the status is amber. After a brief 2 month stability period, the previous trend since April continues to increase and is of some concern. This is most notable within Unscheduled Care (11.82%) and Scheduled Care (11.61%) who are showing quite high rates. Both of these Divisions are undertaking further analysis of leavers by personal interviews to understand in more detail why staff are leaving.

2.6 Funded Establishment / Staff In-Post / Vacancies (Green)
The Trust FE FTE was 3717 and staff in post 3409 FTE. This means the vacancies FTE has slightly increased to 8.28% and the status remains as 'green'. The number of vacancies has increased by 10 to 308.

The headcount of 4182 was an increase of 20 from the previous month and is at its highest level since April 2014.

2.7 Expenditure on NHSP Bank/Agency/Medical Locum (Red)
The threshold for this KPI is 4.5% of total pay bill. Total spend in December 2014 decreased significantly by £208k and was £967k, which represents 7.49% of the pay bill for the month and cumulatively for April – December 2014 the rate is 7.47%. Against the agreed threshold for 2014/15 of 4.5% the status, therefore, is 'Red' and was not achieved.

Details of the main areas of expenditure for December are as follows:
Nurse Bank and Agency Nursing - £398k (£479k for October)
Agency (exc Medical & Nursing Agency) - £195k (£210k for October)

Medical Locums and Medical Agency - £374k (£486k for October)

All three areas show a decrease as follows: Nurse Bank/Agency by £81k; Agency by £15k and Medical Locums /Agency by £112k.

Total expenditure for the period April – December 2014 is £8.6m broken down as follows:
Nurse Bank and Agency Nursing - £3.7m
Agency (exc Medical and Nursing Agency) - £1.7m
Medical Locums and Medical Agency - £3.2m

NB In order to staff the additional intermediate care beds which were opened earlier this year the trust had to recruit staff predominantly from agencies and some of these staff have continued to be needed to meet additional staffing pressures. The total additional expenditure which is being met externally from Warrington CCG is now £373k which is included in the above amounts. However, the CCG have now indicated that funding for therapy staff can be made permanent and the Therapy Departments are in the process of making appointments on AfC contracts but do not expect to have staff in post until Feb/March 2015.

The main focus of attention remains on Nurse Bank/Agency and Medical Locum/Agency expenditure.

The main 'Hot Spot' areas of expenditure during December were as follows:

Nurse Bank and Agency Nursing
Elderly and Stroke - £132k (£56k on agency) (£155k in Nov)
A&E - £99k (£87k on agency) (£81k in Nov)
Critical Care - £56k (£50k in Nov)
Acute Medicine – £42k (£56k on agency) (£78k in Nov)
Specialty Medicine - £27k (£21k in Nov)
Women's - £20k
Surgery - £18k (£44k in Nov)
T&O - £16k (£43k in Nov)

Agency
Therapies - £61k (£70k in Nov)
Pharmacy - £33k (£38k in Nov)
PMO – £32k (£43k in Nov)

Medical Locums/Agency
Elderly and Stroke - £127k (£208k in Nov)
T&O - £77k (£92k in Nov)
Surgery - £37k (£62k in Nov)
Specialty Medicine - £37k (£36k in Nov)
A&E - £36k (£34k in Nov)

There are a number of workforce initiatives designed to reduce the time taken to recruit staff and reduce temporary staffing expenditure. Progress is as follows:

Nursing Recruitment
Rolling adverts are in place in Unscheduled Care and Scheduled Care with an emphasis on AMU and Theatres. This has been very successful with many qualified nurses being appointed and vacancy levels against establishment being much closer.

International Recruitment

The trust is working with an agency called Globalmedirec to recruit Consultant Radiologists. From the first round of interviews one doctor accepted an offer of employment and commenced on 10.11.14. Skype interviews for 2 applicants were held on 10.12.14 but unfortunately neither candidate was suitable.

Unscheduled care have identified 6 consultant posts suitable for international recruitment and a campaign will commence at the end of January with an advert appearing in the BMJ. An advert will also appear in the local Indian press.

Recruitment Process

The trust is working on a number of initiatives to streamline the recruitment process and the first phase has been implemented and publicised in key Divisions. The second phase involves putting in place a revised ECF process using Share Point. DBS checks are now being undertaken electronically and most are being received within 5 working days.

De Poel

Work is continuing with De Poel on a pilot to focus on Medical Locums and the control over the rates we pay by using their system. It is hoped that this can be launched on 2.3.15.

During December there has been significant pressure on beds which has led to many areas being escalated which are not funded.

Work is continuing on the Medical Productivity work stream. A new Job Planning Policy for Consultants has been agreed and the trust is working with Allocate on a pilot in Anaesthetics to implement job plans in line with the new policy. This has been completed and it has been agreed that the pilot will be extended to a more complex area and this will be A&E.

The number of Medical and Dental vacancies is currently contributing to the expenditure on Medical Locum/Agency and a summary is shown below:

Unscheduled Care

Medicine

1 Consultant Gastroenterologist
1 Consultant Interventional Cardiologist
1 Consultant Cardiologist (for 12 months due to Sabbatical unable to fill position)
1 Consultant Stroke
1 Consultant Elderly Care
1 Consultant Elderly Care/Dementia
1 Consultant Elderly Medicine/Acute
1 Consultant Orthogeriatric
1 Consultant Respiratory
1 Consultant AMU

A&E

4 Specialty Doctors

Scheduled Care

1 Specialty Doctor in Anaesthetics (locum appointment to commence in Feb 2015)
1 Specialty Trainee in Anaesthetics
1 Specialty Doctor in Ophthalmology
3 LAS posts in Trauma & Orthopaedics
1 Core Trainee in Urology (appointment made and to commence in Feb 2015)
1 Locum consultant in Spinal Surgery (appointment made and to commence in Feb 2015)

Women's and Children's

Radiology

4x Consultant Radiologists

Women's

1 GPST1/2 vacancy
1 Part-time Consultant – Locum in post
1 Whole time Consultant (currently advertised)

Discussions and monitoring of progress continue on all of the above issues at the bi-lateral divisional review meetings.

2.8 Equality & Diversity

2.8.1 E&D Specialist in place (Green)
A new SLA for an E&D Specialist Adviser SLA with the Countess of Chester Hospital Trust has now been agreed from June 2014 for a period of 2 years.

2.8.2 Annual Workforce Equality Analysis Report published (Green)
This was achieved for 2014 with the Report published on the Trust Website. Therefore, the status is 'green'.

2.8.3 Annual Equality Duty Assurance report published (Green)
This was achieved for 2014 with the Report published on the Trust Website. Therefore, the status is 'green'.

2.8.4 Annual Equality Objectives published (Green)
This was achieved for 2014 and the status is 'green'.

2.8.5 Annual Equality Strategy published (Green)
This was achieved for 2014 and the status is 'green'

2.8.6 Staff have access to E&D information and resources (Green)
Trust staff do have access to E&D information and resources.

2.8.7 Staff have undertaken E&D Mandatory Training (Red)
There has been an increase of 1% from Q2 to 64% at Q3.

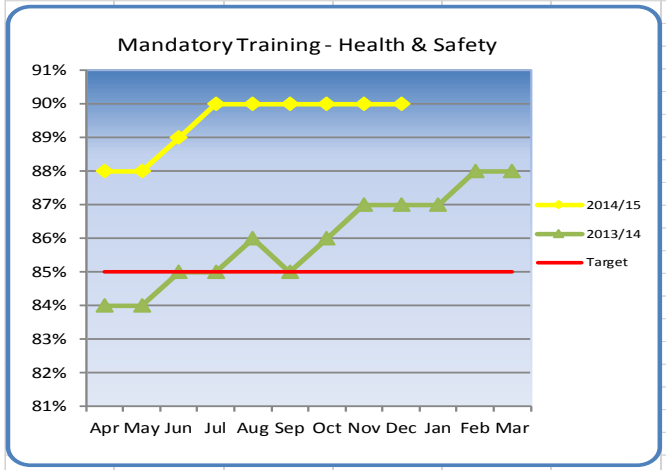
Warrington and Halton Hospitals NHS Foundation Trust

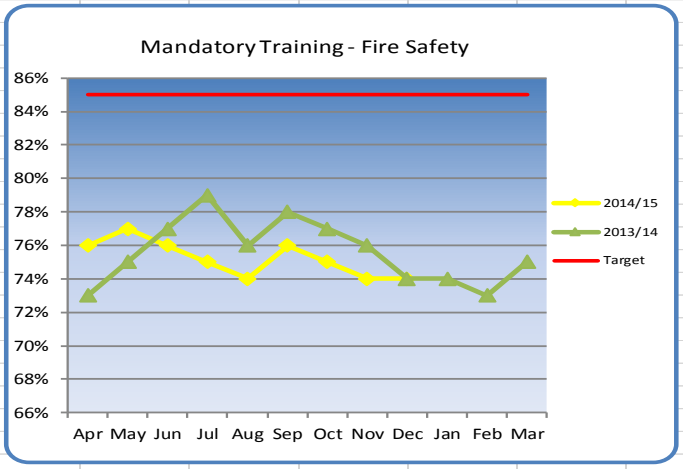
Governance & Workforce Division

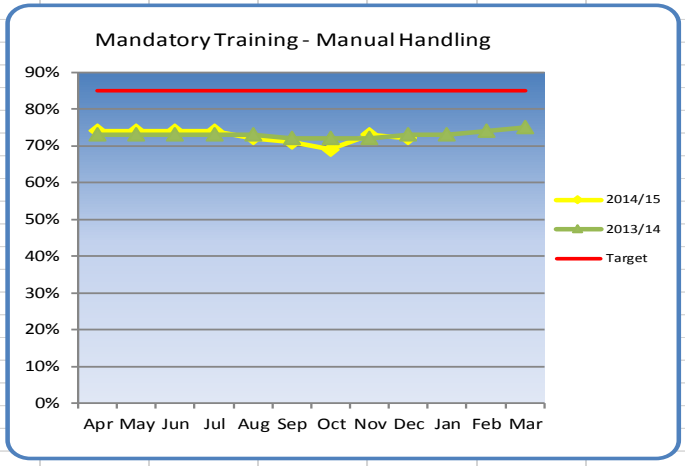
Human Resources / Education & Development Workforce Key Performance Indicators

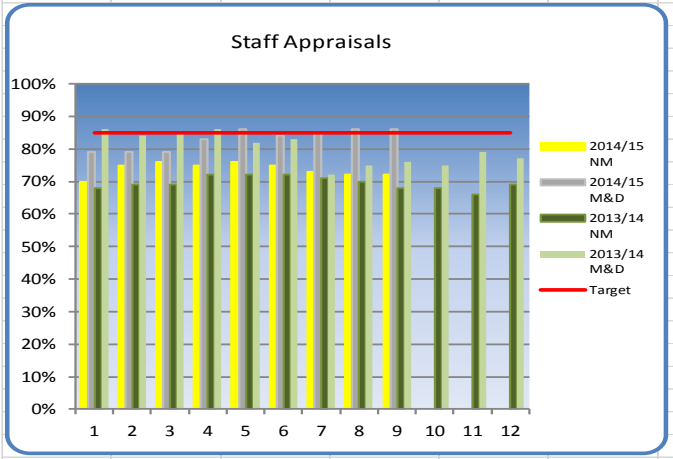
2014/15			Target / Threshold	Frequency	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year to Date	Criteria for RAG Status: Green	Amber	Red
Training & Development	Mandatory Training	Heallth & Safety	85% staff trained in last 3 years	Monthly	88%	88%	89%	90%	90%	90%	90%	90%	90%				**90%**	85 - 100%	70 - 84%	< 70%
		Fire Safety	85% staff trained in last 12 months	Monthly	76%	77%	76%	75%	74%	76%	75%	74%	74%				**74%**	85 - 100%	70 - 84%	< 70%
		Manual Handling - Patient	85% staff trained in last 2 years	Monthly	67%	67%	67%	68%	65%	64%	65%	67%	66%				**66%**	85 - 100%	70 - 84%	< 70%
		Manual Handling - Non-Patient			86%	85%	85%	83%	82%	80%	76%	81%	81%				**81%**			
		Manual Handling - Total			74%	74%	74%	74%	72%	71%	69%	73%	72%				**72%**			
	Staff Appraisals	Non Medical	85% staff received appraisal in last 12 months	Monthly	70%	75%	76%	75%	76%	75%	73%	72%	72%				**72%**	85 - 100%	70 - 84%	< 70%
		Medical & Dental - consultants & career grades, (exc Jnr Drs)			79%	79%	79%	83%	86%	84%	85%	86%	86%				**86%**			
	Revalidation for Medical & Dental Staff		85% of eligible M& D Staff revalidated	Monthly	81%	81%	82%	82%	82%	82%	84%	84%	85%				**85%**	85 - 100%	70 - 84%	< 70%
Sickness Absence	Sickness Absence Rates		4%	Monthly	4.18%	3.99%	3.98%	3.94%	3.70%	4.31%	4.90%	4.82%	5.35%				**4.48%**	3.75%	3.76-4.49%	> 4.50%
	Return to work interviews (wef 2013/14)		85%	Quarterly			53%			59%			53%				**53%**	85 - 100%	70 - 84%	< 70%
Workforce	Turnover (Leavers)		Min 8% or Max 9%	Monthly	9.0%	9.1%	9.3%	9.3%	9.7%	9.4%	9.4%	10.1%	10.2%				**10.2%**	8 - 9%	5 - 7.9% / 9.1 - 12%	< 5% / > 12%
	Establishment / SIP	Funded WTE (see NB 1 below)	Min 6.5% or Max 10% FE / SIP gap	Monthly	3686	3676	3682	3674	3695	3700	3696	3706	3717				**3717**	6.5 - 10%	5 - 6.4% / 10.1 - 12%	< 5% / > 12%
		Staff in Post WTE (see NB 1 below)			3392	3391	3371	3375	3424	3382	3399	3408	3409				**3409**			
		Staff in Post Headcount (see NB 2 below)			4171	4155	4134	4143	4156	4152	4172	4162	4182				**4182**			
		Vacancies WTE (see NB 1 below)			294	285	311	299	271	318	297	298	308				**308**			
		Vacancies %			7.97%	7.75%	8.44%	8.13%	7.33%	8.59%	8.03%	8.04%	8.28%				**8.28%**			
	Flexible Labour Expenditure (% of total paybill)	Bank / Agency / Medical Locums Total	4.5%	Monthly	6.6%	6.7%	7.6%	6.7%	7.9%	7.3%	7.3%	9.1%	7.5%				**7.5%**	4.5%	4.6 - 5.0%	> 5.0%
	Equality & Diversity	E&D Specialist in place	Achieved	6-monthly						Achieved							**Achieved**	Achieved	Work in progress	No progress
		Annual Workforce Equality Analysis report published	Achieved	Annual													**Achieved**	Achieved	Work in progress	No progress
		Annual Equality Duty Assurance report published	Achieved	Annual													**Achieved**	Achieved	Work in progress	No progress
		Annual Equality Objectives published	Achieved	Annual													**Achieved**	Achieved	Work in progress	No progress
		Annual Equality Strategy published	Achieved	Annual													**Achieved**	Achieved	Work in progress	No progress
		Staff have access to E&D information and resources	Achieved	6-monthly						Achieved							**Achieved**	Achieved	Work in progress	No progress
		Staff have undertaken E&D training	85% staff trained	6-monthly			62%			63%			64%				63%	85 - 100%	70 - 84%	< 70%

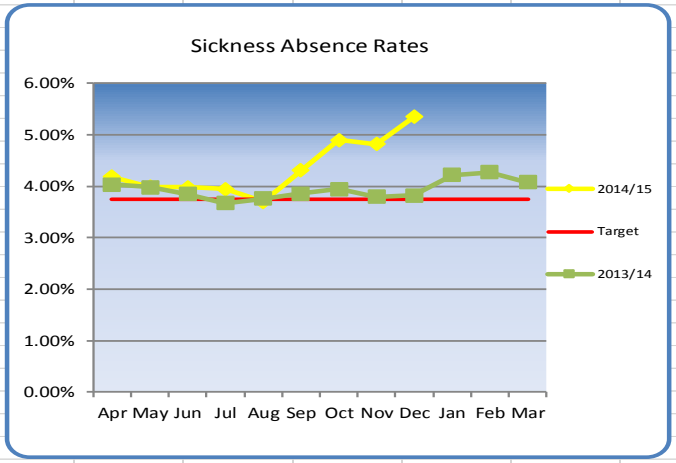
NB 1 Figures from Finance Ledger					**R**	**Red**		**A**	**Amber**		**G**	**Green**								
NB 2 Figures from HR ESR																				

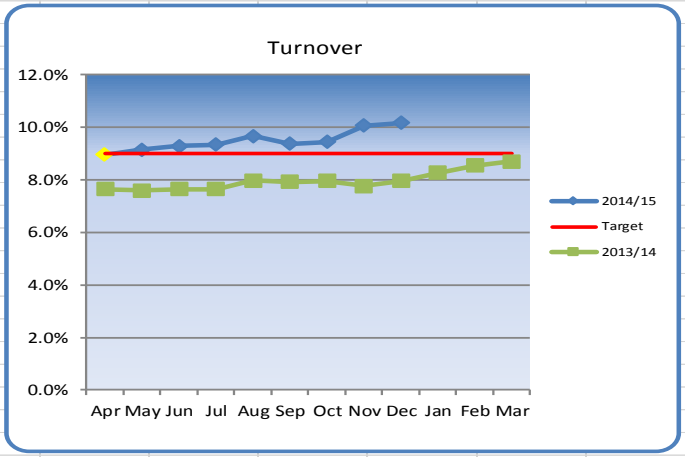

Mandatory Training - Health & Safety
91%
90%
89%
88%
87%
86%
85%
84%
83%
82%
81%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
2013/14
Target

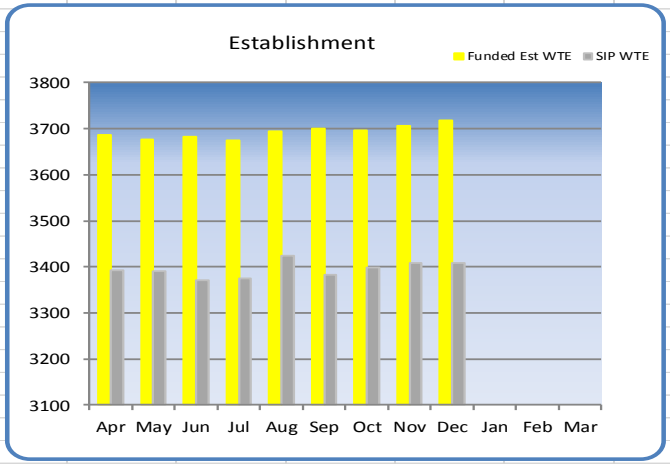

Mandatory Training - Fire Safety
86%
84%
82%
80%
78%
76%
74%
72%
70%
68%
66%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
2013/14
Target

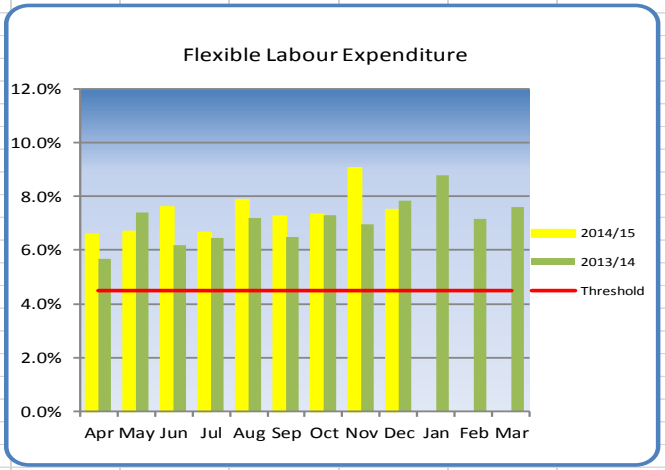

Mandatory Training - Manual Handling
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
2013/14
Target


Staff Appraisals
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
1 2 3 4 5 6 7 8 9 10 11 12
2014/15 NM
2014/15 M&D
2013/14 NM
2013/14 M&D
Target


Sickness Absence Rates
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
Target
2013/14


Turnover
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
Target
2013/14


Establishment
Funded Est WTE
SIP WTE
3800
3700
3600
3500
3400
3300
3200
3100
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar


Flexible Labour Expenditure
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
2013/14
Threshold

BOARD OF DIRECTORS

WHH/B/2015/ **017**

SUBJECT:	**Equality Duty Assurance Report**	
DATE OF MEETING:	28th January 2015	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Sophie Hunter, Equality and Diversity Specialist	
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance	
LINK TO STRATEGIC OBJECTIVES:	SO2: To be the employer of choice for healthcare we deliver	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	To provide an update on how Warrington and Halton Hospitals NHS Foundation Trust (WHH) is meeting its statutory obligations under the Equality Act (2010). A summary of the key equality achievements is shown at pages 13 & 14 of this report	
RECOMMENDATION:	***The Board is asked to:*** Note the equality achievements and approve the report for publication on the trust website	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Not Applicable

Equality Act 2010

Equality adherence briefing, January 2015

Purpose:

To provide an update on how Warrington and Halton Hospitals NHS Foundation Trust (WHH) is meeting its statutory obligations under the Equality Act (2010).

Background:

The public sector single equality duty (PSED) identified as the *General Duty* (Section 149) of the Equality Act 2010 came into force on 1st of April 2011. In September 2011, S*pecific Duties* were published to outline how public authorities are to meet the general duty to:

- *Eliminate* unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- *Advance equality of opportunity* between people who share a protected characteristic and those who do not
- *Foster good relations* between people who hare a protected characteristic and those who do not

Below are the Specific Duties of the Equality Act 2010 with a response on how the Trust is working to meet its equality duty:

'Publish Information outlining how they (public authorities) will comply with the general duty by 31/1/2012' (Thereafter annually)

WHH has formulated its annual Equality Duty Assurance Report (2015) to outline how it is working to meet its statutory obligations to the Equality Act (2010). The specific duties direct that any information that is published should be provided in an accessible format so the Equality Duty Assurance Report (2015) is presented in a clear and simple format (see appendix 1). It will be presented to the Equality & Diversity Sub-Committee.

Publish data on its workforce, which should reflect relevance to the local population by 31/1/2012' (Thereafter annually)

The Trust has published a 2013 Workforce Equality Analysis Report (WEAR) in 2014 and will publish a 2014 report by 31st of January 2015. The WEAR provides a breakdown of the Trust's workforce and across the protected characteristics, as well as a recruitment profile and other workforce activity around formal procedures in Human Resources. It compares the workforce data against the local population demographics.

Over the past few years, changes have been made to reporting mechanisms in ESR and this has resulted in a more robust and detailed report to be published in 2015. The report will be presented to the Strategic People Committee. Data from the WEAR will also underpin evidence in certain sections of the NHS Equality Delivery System (EDS2).

'Undertake a revised equality screening process to replace equality impact assessments (EIAs) called an Equality Analysis, in functions, services, policies, strategy and decisions, from 6/4/2011 onwards'

The Trust has introduced Equality Analysis and undertakes this on key strategies, policies and service changes. There is no longer a requirement in law to publish an equality analysis, as there was for EIAs. However, a public authority must provide evidence if challenged on how a decision has been made or with whom any consultation may have taken place. Going forward from 2015, EIAs will also feature as part of the approval for Cost Improvement Process ideas.

'Publish equality objectives by 5th of April 2012. Publish an equality strategy outlining how they (public authority) will achieve their equality objectives by 5th of April 2013 '

The Trust meets this criterion fully. In 2012 four equality objectives were published, clearly identifying the steps the Trust needed to take, in order to improve its equality assurance and to further demonstrate how it aims to meet the equality duty.

In April 2013, the Equality Strategy was published, which incorporated the Equality Objectives, which were reviewed and amended prior to the equality strategy publication.

'All information published on how they will meet the equality duty must be presented in such a manner that it is accessible to the public'

All published information in 2012, 2013, 2014 and planned 2015 adheres to this directive.

Other work around equality duty assurance

The Trust implemented the NHS Equality Delivery System (EDS2) in 2013. It was rated as *Achieving* in 10 of the 18 individual EDS2 outcomes and *Developing* in the remainder. This was positive rating in the first year of its assessment. In 2014, the Trust has rated 12 of the 18 as Achieving, so progress can clearly be seen.

In May 2013 the Trust set up a Disability Equality Group, which has membership from Staff, Governors, Carers, Patients and 3rd Sector disability organisations. This group focuses on working on improved accessibility for disabled Patients and Staff. It reports into the main Equality and Diversity Sub-Committee, which meets quarterly.

Equality Duty Assurance Report (2015)

High Quality, Safe Healthcare

Quality People Sustainability

Contents

1. Introduction

Background

Public Sector organisations have been required to demonstrate how they are actively working to reduce health inequalities by promoting equality and working to eliminate discrimination, whilst maintaining a commitment to respect human rights. Moreover, they need to demonstrate the outcomes of this work, in particular, showing how they have assessed the impact of policies, strategies and action plans on the local population and its workforce.

Aims of the Equality Duty Assurance Report (EDAR)

In formulating this Equality Duty Assurance Report (EDAR), Warrington and Halton Hospitals Hospital NHS Foundation Trust (WHH) is not only aiming to ensure that it is meeting the legal duties to promote equality and challenge unlawful discrimination, but also to ensure that consideration of equality and human rights issues is incorporated into day-to-day practice across the organisation. Intended outcomes will be equal access to services for all groups and reduced health inequalities and improved health outcomes for patients. Safeguarding employees across the protected characteristics and a commitment to advance equality of opportunity across the organisation are also key components.

This document aims to provide reassurance that the strategic direction of WHH for promoting equality and eliminating discrimination since April 2011 underpins its adherence to the general duty of the Equality Act (2010) and binding specific duties of the equality duty. Moreover, it may serve as a stepping stone towards formulating strategies and actions that build upon the previous achievements made under Equality Delivery System (EDS2) and related equality action plans.

Scope of the Equality Duty Assurance Report (EDAR)

This Equality Duty Assurance Report sets out the commitment of Warrington and Halton Hospitals NHS Foundation Trust (WHH) in how it will endeavour to adhere to statutory obligations, building upon progress achieved under previous equality schemes and directives.

2. The Public Sector Equality Duty

Legislation overview

In April 2010, the Equality Act received Royal assent. The act identified the phased implementation of legislative requirements, to bring into effect measures to promote equality and eliminate discrimination, which were built upon nine previous pieces of equality law. The initial phase came into force in October 2010. The second phase

came into effect from 5th of April 2011. This took the form of the creation of a single equality duty for public sector bodies. The third phase came forward from 1st of October 2012 and this extended *Age equality* from only employment protection to include the duty with regard to the provision of goods and services

The Act now includes all the protected characteristics. The only part of the general duty that applies to *civil partnership and marriage* is the responsibility to eliminate discrimination and prohibited conduct.

The full list of protected characteristics is:

- age
- disability
- gender reassignment
- civil partnership and marriage
- pregnancy and maternity
- race
- religion or belief
- sex (formerly referred to as gender)
- sexual orientation

Warrington and Halton Hospitals NHS Foundation Trust (WHH) has been working towards eliminating discrimination across many of these protected characteristics (PC) for some time. Equality impact assessments and other areas of equality analysis included taking almost all the newly defined PCs into consideration before the single equality duty came into effect in April 2011.

Preparations to adhere to wider considerations around engagement under the new general duty have been undertaken. These include the development and maintenance of a comprehensive engagement framework, involving many seldom heard or considered communities, in order to build capacity for involvement and consultation in staff, patients and other stakeholders.

The amendment to previous equality legislation does not therefore necessitate significant changes to our strategy, governance or direction of travel. However, the Act does introduce new specific duties, which came into effect from the 10th of September 2011.

The general duty is as follows:

- **Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.**
-
- **Advance equality of opportunity between people who share a protected characteristic and those who do not.**

- **Foster good relations between people who share a protected characteristic and those who do not.**

The following are the public sector specific duties which came into force on 10th of September 2011. To meet the specific duties, public sector bodies should:

- **Publish Information outlining how they will comply with the general duty by 31/1/2012 (**Annually thereafter**).**

- **Publish details on their workforce breakdown and the local population by various equality denominations e.g. age, race etc., by 31/1/2012 (**Annually thereafter**).**

- **Undertake a revised equality screening process to replace equality impact assessments called an *Equality Analysis*, in functions, services and policies.**

- **Formulate one objective for each protected characteristic, by 5th of April 2012.**

- **Publish an equality strategy by 5th April 2013.**

- **All information published on how they will meet the equality duty must be presented in such a manner that it is accessible to the public.**

Amendments to previous obligations

There is no longer a requirement to produce a single equality scheme (SES). The Warrington and Halton Hospitals NHS Foundation Trust (WHH) SES ended on 31st of March 2014.

WHH introduced equality analysis to replace equality impact assessments, with regard to assessing potential differential impacts against protected characteristics and Human Rights Articles. The Trust has adopted an approach that the scope of equality duty should also refrain from equality analysis which is not proportionate or deemed relevant.

The Government Equalities Office indicates strongly that there should be less bureaucracy within the equality and human rights agenda. Emphasis now focuses on equality outcomes and productivity, rather than process. This follows some of the key outcomes of the White Paper 'Liberating the NHS: Equity and excellence':

- **Putting Patients & Public First**

- **Autonomy, Accountability and democratic legitimacy**

- **Improving Healthcare outcomes**

- **Cutting bureaucracy & improving efficiency**

WHH will continue its commitment to adhere to the revised equality duties and build upon the significant progress of work already undertaken with regard to race, disability and gender and all other protected characteristics. This equality duty assurance report is clear and provides the means to demonstrate adherence to the general duty are indicated within this document.

To meet the specific duty to "*Publish Information outlining how they* (WHH) *will comply with the general duty by 31/1/2012",* and every 12 months thereafter. In January 2014 WHH published its Single Duty Assurance Report which outlines how the trust will strive to meet its equality duty obligations. It also published a revised and improved Workforce Equality Analysis Report for the year ending 2013, in late January 2014, in order to meet a further specific duty requirement of the equality Act (2010).

The work that was implemented by the Trust to demonstrate its equality performance in the NHS Equality Delivery System (EDS2), led to an assessment rating in 12 of the 18 individual EDS2 outcomes of *Achieving* compared to 10 out of 18 in the previous year. This was a very good result to demonstrate the Trust progression and commitment to Equality and Diversity.

The assessment of the 18 individual EDS2 outcomes can only be done by internal and external stakeholders, who reflect the spectrum of the protected characteristics and represent their respective interests and collective insight. So the grades provide robust assurance that the Trust's functions, services, policies and strategies are working towards reducing equality and health inequalities across the whole organisation.

3. Meeting the equality duties

Providing evidence of how we are meeting our duty

Through this EDAR and the Workforce Equality Analysis (2014) which will also be published by 31st of January 2015, WHH aims to demonstrate how it is paying due regard to the general duty. This assurance report has been published, to fall in line with the requirements of the specific duties of the single equality duty.

The EDAR outlines the equality governance framework of the organisation, which underpins equality and human rights activity across all functions, policies and services within the organisation.

The Equality & Diversity Sub Committee (EDSC) reports to the Strategic People Committee, which in turn reports to the Board of Directors and advises and endorses a range of initiatives, reports and actions. The EDSC is the steering group for a specialist sub group which focuses on disability matters and improving access for disabled people.

The Disability Equality Group (DEG) has internal and external stakeholder membership, with active involvement from patient representatives and members of third sector bodies, these include:

- Warrington Deaf Club,
- Halton Disability Partnership
- Warrington Carers (WIRED)
- The British Red Cross
- Warrington Health Watch
- Knowsley and St Helens Deafness Resource Centre, Warrington Disability Partnership
- Halton Health Watch
- Halton Carers
- DIAL House Chester
- Action on Sight Loss and Halton Carers Centre
- Elected Governors are active members of the EDSC and DEG.

In 2014 WHH have liaised extensively with additional external stakeholders to increase awareness and understanding of equality issues, these include:

- Warrington The Crime Prevention Group
- Cheshire Travellers
- Cheshire Equality Leads Forum
- Warrington Homeless (YMCA)
- The Council of Faiths

As in previous years, WHH can provide its strategic documents in varied formats. Although it is not a legal requirement to publish equality analysis and engagement undertakings, WHH will continue to be transparent and inclusive, in demonstrating how it is meeting its equality duty and working in partnership with others.

Consultation and involvement of staff and service users

WHH is committed to ensuring that staff and service users are involved in shaping the equality and human rights work stream and have opportunities to influence health service planning and delivery. The Trust has invested some years ago in a Staff

Engagement and Wellbeing lead post, in order to engage and support its workforce. There is a Staff Engagement and Wellbeing group, which directs its associated action plan for 2013-2015.

WHH has a strong emphasis on engagement in its equality action plans, in order to facilitate '*autonomy, accountability and democratic legitimacy'* with regard to how it discharges undertakings under the general duty of the equality Act (2010). Only by working in partnership with people and our staff can we develop services that meet local need and are utilised effectively.

Equality Monitoring

Good quality data underpins all equality and diversity work from identifying priorities to measuring the effectiveness of our actions. The quality of data collection and analysis needs to be improved in order that we may effectively understand our local population and who is using local services. We will formulate actions into the equality strategy to improve the capture of data, especially with regards to protected characteristics, where the profile is incomplete or requires more impetus.

Equality Analysis

A commitment to undertaking equality analysis ensures that our policies, strategies, functions and any services we deliver endeavour not to lead to an unfavourable effects on different people and help to identify any positive action we can take to promote equality of opportunity and access. By ensuring we have effective processes for undertaking Equality Analysis, WHH aims to ensure the services it provides meet the needs of patients and thereby increases public confidence.

Creating accessible information

Barriers to information can prevent people from effectively accessing health services and may affect health outcomes for some people. It is important that local people are involved in helping us to identify these needs and agree solutions. This is an important element of how WHH actively works with its internal and external stakeholders.

A prime is example is the Disability Equality group, which has membership including disabled individuals, patients, carers and disability organisations. This group continues to collaborate to try to make improvements to the experiences of disabled patients and to work on solutions to surmount any barriers they may face, including communications and related matters. WHH will ensure that information is available in a range of formats and languages, exploring greater use of new technologies to assist with this. The Trust has enhanced its translation service which is a benefit to patient care.

Improving Patient experience and quality

WHH builds upon what it has learned from its previous equality schemes for race, disability and gender respectively and the single equality scheme (2011-2014), with a view to improving services and patient experience. The Trust received accreditation and recognition from the Care Quality Commission (CQC) with regard to all its essential outcomes in 2013 and has a positive record on Patient safety.

The Trust works toward engaging with local people from all communities and the Health Watch teams from Halton and Warrington. It also collaborates with partner organisations in the statutory sector, in order to gain greater understanding of the local picture and to work to address potential health inequalities.

Promoting equality among the workforce

WHH aims to have a workforce that reflects the demographic make-up of the local population. It will do this through positive and targeted recruitment policies and procedures. In addition it will ensure that the workforce is supported to promote equality of opportunity and challenge discrimination.

WHH will maintain an annual commitment to produce a full workforce equality analysis, in order to support future planning and development options. The 2014 workforce equality analysis will be published in January 2015, to fall in line with the directive of the specific duties.

Working on Health Inequality

In line with the NHS England Equality and Health Inequality Strategy 2013-2015, the Trusts will collaborate with partner agencies in both statutory and the third sector, to work on improving accessibility to services and the patient experience of patients from seldom heard groups in the community, who have been shown in Joint Strategic Needs Assessments and epidemiology studies to be disproportionately prevalent in poor health outcomes, morbidity and low access to both primary and secondary care services and resources.

Action planning

In line with the single equality duty, WHH will utilise its growing engagement network and links to local 3rd sector organisations, to gain the perspectives and ascertain the needs of both its workforce and the public that it serves.

Equality and Human Rights links to priorities and functions

Supporting the strategic vision

Effective application of the actions relating to the equality duty will complement and support the organisation's strategic vision. An increase in knowledge and understanding of local patients and their needs will enable the more effective and efficient use of resources and as a consequence, help improve patient experience, quality and minimise potential for inequalities or discrimination. The strategic vision of the Warrington and Halton Hospitals NHS Foundation Trust is the QPS:

The three elements of QPS are:

Excellence for our patients – Includes safety, effectiveness and experience

Caring for our staff – About our workforce, how we engage with you and how we develop leadership and help enhance your careers and use your skills

Here for our community – A focus on good governance, financial viability, the profile and perception of the trust and growth.

Each area has a remit of work, backed by targets and improvements we want to see. For example, **quality** is underpinned by real improvements like reductions in infection, pressure ulcers and falls; **people** by improvements in how our staff perceive us and reductions in sickness; and **sustainability** by improvements in our role in the community, governance standards and stable finances.

Progress and achievements so far

With the background of the of the three year period of Single Equality Scheme (2011-2014) and through the Equality and Diversity Sub-Committee (EDSC) and related work

streams, significant progress has been made to ensure that WHH remains compliant with legislation and that equality issues are considered as part of mainstream planning.

Summary of key equality achievements:

- Published single equality scheme for the period 2011-2014 – Though this is no longer required this action was fulfilled to ensure compliance during this time.
- Published workforce equality analysis report for year ending 2012 on 31/1/13, and continuously for 2013 on 31/1/2014, and will be published for 2014 on 31/1/2015.
- Attained an achieving grade in 12 of 18 EDS2 outcomes in 2014 assessments.
- Established a new Disability Equality Group in 2013 with extensive disability group stakeholder membership and Health Watch involvement
- Published the inaugural four year equality strategy for 2013-2017
- Developed a new Equality Analysis toolkit to replace the equality impact assessment tool
- Secured a DH Capital bid to set up a dementia ward and related services, Dementia Ward opened in May 2014.
- Formulated a Dementia strategy and affiliated work groups, projects and *Forget Me Not* wristband identification programme and NCFE Dementia qualification for all staff
- Formulated the inaugural Carers Strategy in partnership with the two borough Carer organisations *WIRED* and *Halton Carers Centre* and have initiated a single point learning training programme in all clinical areas, to raise staff awareness and promote Carer inclusivity at all stages of the care pathway along with the introduction of Carer Champions and various initiative's to ensure Carer support is accessible from stakeholder charities
- Put Carers firmly on the staff agenda by the introduction of 'Carer Champions' on wards to give information and make referrals to Carer Support organisations.
- Continuous interpretation and translation service to support minority communities and disabled patients
- Developed a standard operating policy in partnership with two local Deaf associations, to improve access to British Sign Language interpretation provision in outpatient and unscheduled care

- Participated in Warrington LGBT Pride events in 2012, 2013 and 2014 as well as supplying advertisement and promotion for the event through the hospitals intranet

- Promoted World AIDS Day and national HIV testing week through engagement activities and promotional media

- Annual participation in the international Disability Awareness Day event in Warrington

- Faith and Culture guide formulated to support staff knowledge in Inpatient care and details added to the hospital bedside booklet to inform patients on the services of the Spiritual Care Team

- Initiatives to improve the patient experience of the homeless including the introduction of a clothing bank for use at patient discharge

4. Accountability

Responsibilities and Accountability

The Board of Directors have overall responsibility to ensure that the organisation adheres to the statutory obligations contained within section 149 of the Equality Act (2010) known as the public sector single equality duty (PSED).

The Director of Nursing and Organisational Development chairs the quarterly Equality and Diversity Sub-Committee (EDSC) which reports into the Strategic People Committee, which is a sub-committee of the Board.

Foundation Trust Governors sit in the EDSC and Disability Equality Sub Groups and are involved in many committees, projects and steering groups to promote inclusivity, improved patient and staff experience.

Warrington and Halton Hospitals NHS Foundation Trust (WHH) as a whole needs to work together to ensure that it builds upon the significant progress that has been made so far, in meeting the equality duties and embedding the fundamentals of equality analysis and engagement in its functions, services, strategies and organisational undertakings.

BOARD OF DIRECTORS

WHH/B/2015/ **018**

SUBJECT:	**Staffing Exceptions Report**
DATE OF MEETING:	28th January 2015
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	Alison Lynch, Deputy Director of Nursing
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance and OD Choose an item.
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care SO3: To give our patients the best possible experience SO4: To provide sustainable local healthcare services
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework SO3/3.3 Failure to provide staff, public and regulators with assurances post Francis and Keogh review SO1/1.2 Risk of harm through failure to comply with Care Quality Commission National core healthcare standards and maintain registration and failure to achieve minimum requirements for NHSLA Standards within maternity services and wider Trust.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED:	None
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides an overview of nurse staffing for December 2014. Links to the Safety Thermometer are also included to assist in triangulation of incidents with staffing levels. Additional points to note are: • The National Institute for Clinical Excellence have outline draft A&E departrments ensure there are enough nursing staff available to provide safe care at all times to patients. We are taking part in the national consultation of this guidance. • Additionally, we have also expressed interest in being one of the first hospitals outside the Shelford group to trial the AED staffing tool designed specifically for AED staffing levels.
RECOMMENDATION:	***The Board is asked to:*** • Note the contents of this report, which describe the progress in the monitoring of complaints and to approve the actions as

	documented. • Approve the staffing exemption Report	
PREVIOUSLY CONSIDERED BY:	**Committee** **NA**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Staffing Levels

Dec-14

The columns in bold contain the figures that are submitted to the DoH via the Unify portal (A&E figures excluded)

This column will automatically calculate the number of shifts

									Day					Night													
									Registered midwives/nurses			Care Staff		Registered midwives/nurses			Care Staff										
Division	Ward	Non-escalation Beds	Budgeted Registered staff	Vacancies including maternity leave	Posts appointed to but not yet started	Budgeted Unregistered staff	Vacancies including maternity leave	Sickness & Absence for Nov-14	Agreed nurse to patient ratios	**Total monthly planned staff hours**	**Total monthly actual staff hours**	**Total monthly planned staff hours**	**Total monthly actual staff hours**	Agreed nurse to patient ratios	**Total monthly planned staff hours**	**Total monthly actual staff hours**	**Total monthly planned staff hours**	**Total monthly actual staff hours**	Number of hours above or below planned	Length of a shift in hours	Number of shifts above or below planned	Variance	Falls	Hospital acquired pressure ulcers	Catheter associated UTIs	New VTEs	Associate Director of Nursing/Matrons Assurance Statement
Scheduled Care	W-A4 - Ward A4	28	10.90	0.00	0.00	8.60	0.0	3.86%	1:8	1782.1	1770.6	713.0	713.0	1:8	713.0	713.0	356.5	356.5	-11.5	11.5	-1.0	-0.32%	0	1	0	0	
	W-A5 - Ward A5	28	17.20	2.00	0.00	12.90	0.0	9.20%	1:7	1426.0	1414.5	1069.5	1023.5	1:9	1069.5	1023.5	713.0	701.5	-115.0	11.5	-10.0	-2.69%	1	0	0	0	
	W-A6 - Ward A6	28	16.60	4.40	1.00	13.60	0.0	2.50%	1:7	1426.0	1400.5	1069.5	1069.5	1:9	1069.5	989.0	713.0	713.0	-106.0	11.5	-9.2	-2.48%	0	2	0	1	
	W-A9 - Ward A9	28	17.80	2.80	2.00	15.50	1.0	11.22%	1:7	1426.0	1227.0	1426.0	1403.0	1:9	1069.5	966.0	713.0	713.0	-325.5	11.5	-28.3	-7.02%	2	0	1	0	
	W-B19 - Ward B19	18	14.30	2.60	1.60	13.90	0.0	4.70%	1:6	1069.5	1039.0	1069.5	1004.5	1:6	713.0	713.0	713.0	713.0	-95.5	11.5	-8.3	-2.68%	1	0	0	0	
	W-B4-H - Ward B4 - Halton	27	12.20	1.27	0.00	6.00	0.00	14.23%	1:9	874.0	829.0	552.0	533.0	13.5 :1	552.0	529.0	322.0	299.0	-110.0	11.5	-9.6	-4.78%	0	0	0	0	When the ward closed over xmas and new year staff were moved to support the wards at Warington.(Not included in these figures) .
	W-CM1-H - Ward 1 - CMTC Treatment Centre	30	26.60	5.38	0.00	14.00	1.80	7.43%	1:5.5	1482.5	1475.0	839.0	839.0	10 : 1	667.0	632.5	425.0	379.5	-87.5	11.5	-7.6	-2.56%	0	0	0	0	due to chirstmas no lists ovet this time, staff sent ot warrington to cover
	W-ICU - Intensive Care Unit	18	76.74	4.50	4.50	12.52	1.00	11.01%	1:1 Level 3 1:2 Level 2	4991.0	3984.8	1069.5	833.8	1:1 Level 3 1:2 Level 2	4991.0	3864.0	713.0	437.0	-2644.9	11.5	-230.0	-22.48%	0	0	1	0	18 beds funded but used flexibly depending on dependency of patients (ie. can be at full capacity at 16 beds if 10 Level 3 and 6 Level 2) 14 Q nurses required per shift but sickness and maternity leave mean a reduced level of qualified. Nurses still provide agreed nurse:patient ratios. Unit Occupancy for December 2014 was 99% in relation to staffing levels and patient dependancy
Total		205	192.34			97.02		8.32%											-3495.9		-304.0						
Unscheduled Care	AED			4.70	1.00	13.02	2.99	7.27		4320.0	3940.0	1125.0	784.0		3101.7	3168.6	837.6	486.6	-1005.1	12.5	-80.4	-10.71%	0	0	0	0	Shifts underfilled with added pressure of esccalation areas opened and nil staff to cover. filled over 600 hrs of trainined and untrained staff sickness in Dec .
	W-A1A - Ward A1 Asst	29	41.40	13.44	0.00	22.10	4.40	4.69	5.5	2712.5	2473.0	1550.0	1436.5	0.0	1953.0	1902.0	651.0	640.5	-414.5	12.5	-33.2	-6.04%	0	0	0	5	
	W-A2A - Ward A2 Admission	28	18.83	3.00	0.00	12.90	2.00	4.02	5.6	1426.0	1368.0	1069.5	1097.0	9.3	1069.5	961.0	713.0	701.0	-151.0	11.5	-13.1	-3.53%	0	0	0	0	
	W-A3OPAL - Ward A3 Opal	34	18.83	2.90	3.00	15.50	1.00	3.55	8.5:1	1426.0	1330.5	1426.0	1397.5	0.0	1069.5	1000.5	1000.5	874.0	-319.5	11.5	-27.8	-6.49%	1	0	0	0	
	W-A7 - Ward A7	33	18.80	0.40	0.00	15.50	0.29	1.57	8.3:1	1656.0	1410.0	1426.0	1368.5	0.0	1311.0	1104.0	713.0	690.0	-533.5	11.5	-46.4	-10.45%	0	0	0	1	
	W-A8 - Ward A8	34	18.80	1.40	0.00	15.50	1.40	12.81	8.5:1	1472.0	1412.0	1426.0	1386.0	0.0	1092.0	1058.0	793.5	747.0	-180.5	11.5	-15.7	-3.77%	0	0	0	1	322 hrs required for 1:1 care support, 110 not filled, not altered within set hours
	W-B12 - Ward B12 (Forget-me-not)	21	13.68	1.00	0.00	15.50	4.85	3.50%	7.0:1	1069.5	1047.0	1426.0	1403.5	0.0	713.0	690.0	713.0	874.0	93.0	11.5	8.1	2.37%	1	0	0	0	needed extra staff during most of December with 1:1 and dependency of patients at night
	W-B14 - Ward B14	24	18.80	3.00	0.00	12.90	2.20	9.78%	6.0:1	1426.0	1274.0	1069.5	922.0	8.0	1069.5	851.0	713.0	632.5	-598.5	11.5	-52.0	-13.99%	2	0	0	0	
	W-B18 - Ward B18	24	18.80	1.41	2.63	18.00	2.55	11.20%	6.0:1	1426.0	1195.5	1426.0	1359.0	0.0	1069.5	1000.5	1069.5	838.0	-598.0	11.5	-52.0	-11.98%	1	0	0	1	Daily review (Monday to Friday) of staffing levels for next 24 - 48 hours with Divisional Matron team to assess risk and gain assurance that sub-optimal staffing does not significantly compromise care Opportunity to flex levels depending on cohort bed capacity
	W-C21 - Ward C21	24	13.68	1.0	1.0	11.30	2.05	4.19%	8.0:1	1069.5	989.0	816.5	655.0	0.1	713.0	713.0	839.5	632.5	-449.0	11.5	-39.0	-13.06%	0	0	0	1	Daily review (Monday to Friday) of staffing levels for next 24 - 48 hours with Divisional Matron team to assess risk and gain assurance that sub-optimal staffing does not significantly compromise care
	W-C22 - Ward C22	21	13.68	0.80	1.60	12.90	0.00	7.58%	7.0:1	1069.5	1069.5	1069.5	987.0	0.1	713.0	705.0	713.0	713.0	-90.5	11.5	-7.9	-2.54%	1	0	0	0	Daily review (Monday to Friday) of staffing levels for next 24 - 48 hours with Divisional Matron team to assess risk and gain assurance that sub-optimal staffing does not significantly compromise care
	W-CCU - Coronary Care Unit	8	21.2	9.0	0.0	2.6	1.0	1.91%	2.0:1	1426.0	1379.5	356.5	270.5	0.0	1069.5	1058.0	0.0	0.0	-144.0	11.5	-12.5	-5.05%	0	0	0	0	
Total		280	216.47			167.73		6.15%											-4391.1		-372.0						
WCSS	W-B11B/W-B11C - Ward B11	24	29.50	3.60	2.00	15.92	2.00	3.26%	1:1 level3 1:2 Level2	2100.0	2072.5	840.0	805.0	0.0	1488.2	1479.0	0.0	0.0	-71.7	7.5 day 10.63 night		-1.62%	0	0	0	0	stafing levels reduced on Chrstmas day to reflect activity
	W-NHDU/W-NITU/W-NSC - Neonatal Unit	18	24.38	4.00	4.00	6.52	0.00	6.77%	7.5:18	1092.0	1078.0	798.0	798.0	7.5:18	942.8	932.6	240.0	231.0	-33.2			-1.08%	0	0	0	0	adhoc sickness covered by nurse specialist on call
	W-C20 - Ward C20	12	12.63	2.40	2.40	5.00	0.00	9.50%	1:4	1050.0	1042.5	900.0	735.0	1:6	600.8	600.8	0.0	48.5	-124.0			-4.86%	0	0	0	1	
	W-C23 - Ward C23	22	97.92	4.60	4.60	10.70	11.60		1:7.33	1348.5	1342.8	930.0	840.0	1:11	600.8	523.3	300.9	281.0	-193.1			-6.07%	0	0	0	0	
Total		76	164.43	14.60	13.00	38.14	13.60	5.44%											-422.0		0.0		0	0	0	1	
Grand Total		561	573.24	14.60	13.00	302.89	13.60	0.20											-8309.0		-676.0		0	0	0	1	

BOARD OF DIRECTORS

WHH/B/2015/ **019**

SUBJECT:	**QPS Behaviours Framework draft**	
DATE OF MEETING:	28th January 2015	
ACTION REQUIRED	**For Decision**	
AUTHOR(S):	Suzanne Douglas, Organisational Development Manager	
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance Choose an item.	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO2/2.2 Risk that the Trust does not have the right people with the right skills ie workforce is not competent and cannot deliver as commissioned. SO2/2.1 Failure to engage and involve our workforce in the design and delivery of our services.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	The QPS behaviours framework details the behaviours and attitudes required by all employees and it supports the delivery of our business plan and organisational strategy, values and culture.	
RECOMMENDATION:	***The Board is asked to:*** ***Approve the QPS behaviours framework***	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable Or type here if not on list:
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

QPS Behavioural Framework

Guidance Document

Contents

Organisational Vision and Values

Our vision is to be the most clinically and financially successful integrated healthcare provider in the mid-Mersey region.

In order to achieve our vision we believe we need to focus on the **QUALITY** of our services, on the **PEOPLE** who deliver them and on ensuring our organisation's **SUSTAINABILITY**, within the wider Local Health Economy in which we operate.

This triple aim is what we call our '**QPS'** framework – it is the underpinning strategic framework for everything that we do and provides our core strategic aims:

- **QUALITY:** Delivering excellence for our patients.
- **PEOPLE:** Committed to and caring for our staff
- **SUSTAINABILITY:** Being here for our communities, now and going forward

Our triple aim is supported by nine strategic objectives and a series of detailed enabling strategies that set out the specific steps we will take to achieve each aspect, and by when.

Strategic Aim	Objectives
Quality Delivering excellence for our patients	1. We will reduce harm and focus on having no avoidable deaths by managing and reducing clinical and operational risks. 2. We will improve outcomes, based on evidence and are deliver care in the right place, first time, every time 3. We will focus on the patient and their experience, adopting 'no decision about me without me' as a way of life and that we get the basics right so our patients will be warm, safe, clean, well fed and well cared for
PEOPLE Committed to and caring for our staff	4. We will ensure that our teams are competent, available in the right numbers to deliver our services and fit and well in work so that we improve their working lives. 5. We will communicate openly with our teams and expect the same from them in return. We expect staff to take accountability and will support them to do so. We want to be an employer of choice and we encourage loyalty from our staff and recognise their discretionary efforts. 6. We will reward talent, supporting the development of leaders as role models within the organisation and invest in the education, training and development of our teams.
SUSTAINABILITY Being here for our communities, now and going forward	7. We will ensure we have effective leadership and provide robust assurance to our Board of Directors ensuring compliance across all areas of regulation and develop and encourage our governors and members. 8. We will ensure we have robust contracts for services provided and develop service line management so that we understand how effectively we use our resources, invest in IM&T and look for opportunities to collaborate on services for reciprocal benefit. 9. We will be recognised as a good corporate citizen, market our services effectively and develop and diversify our business whilst also pursuing the collection of charitable funds.

QPS Behaviours framework will bring together values, expectations and competency. This will lead to a set of behaviours focused around our QPS triple aim, enabling us to fully link our overall strategic aims with every single individual within the organisation.

What is the behaviours framework?

The behaviours framework is a set of core behaviours which define 'how' we are expected to approach our work and sits alongside what we do, as outlined in each of our job descriptions.

The framework details the behaviours and attitudes required by all employees and it supports the delivery of our business plan and organisational strategy, values and culture.

What do we mean by behaviour?

Behaviours demonstrate the attitudes and approach we take to work, they are:

- How we do things
- How we treat others
- What we say and how we say it
- How we expect to be treated

The behaviours framework will help us to celebrate achievements, talk about our aspirations and express how we would like to develop.

How did we develop the framework and what are the behaviours?

The QPS behaviours campaign used a range of methods to derive key words to shape the future behavioural framework:

- 'We need a word' – 1,035 words returned to help to capture our future behaviours
- QPS Behaviour Focus Groups
- QPS Behaviours Survey (integrated as part of Quarter 2 Staff Friends and Family Test)

Table 1 provides the top 2 words identified for each element of QPS.

Table 1: Top behaviours linked to QPS

Quality	People	Sustainability
Responsible	Enthusiastic	Resourceful
Efficient	Supportive	Adaptable

The six key words are incorporated within a set of five behaviours. These behaviours are applicable for every member of staff regardless of their role or band. All behaviours have individual descriptions which clarify how they relate to the way we work.

The QPS behaviours have been linked to the NHS Constitution values, please see appendix 1 for a visual representation.

Model 1: QPS Behavioural Framework

Where and how are the behaviours supported?

The behaviours are supported by the following processes:

Recruitment
Applicants are interviewed and selected following behavioural based interviewing for cultural fit as well as job fit. See appendix 2 for a sample of values based interview questions.

Awards
Staff demonstrating outstanding behaviour and being an advocate for the behaviours are recognised and awarded through the awards scheme. See appendix 3 for a template to record evidence of meeting the behaviours (Mapping Stories against the QPS Behaviours Framework).

Performance management
Staff are managed, supervised and appraised for their work performance and behaviours.

Partnership working and transformation
The way in which we work with our partners is key to delivering the business plan and organisational strategy; the behaviours framework is central to the success of this and to the development of relationships with our partners.

Policy
The behaviours are fully supported by the policies, processes and guidance designed to support the workforce.

Wellbeing initiatives
We recognise that an individual's well-being can be affected by negative behaviour and we will ensure support is available.

QPS Behaviour Framework

Quality – Delivering excellence for our patients

Excellence

With enthusiasm you work responsibly to deliver a high quality efficient service. You pursue a 'can-do' attitude in all of the work you deliver.

Our required behaviours	When 'excellence' is not demonstrated
• Demonstrate a positive professional attitude • Take pride in your own work and that of your team • Understand who your customers are and why they matter • Willing to go the extra mile for customers and act upon their feedback	• Unwilling to be exposed to change • Not delivering what is expected of you • Show a lack of concern in the quality of your work • Show a negative attitude towards colleagues and customers • Focus on the problems and not the solutions

People – Committed to and caring for our staff

Working Together

You work with others enthusiastically to reach a common goal; sharing information, supporting colleagues and searching out solutions from relevant partners and the community we serve.

Our required behaviours	When 'working together' is not demonstrated
• Work together with colleagues and customers, and take the time to build effective working relationships. • Celebrate team successes and create a positive team spirit. • Work well with people who have different ideas, perspectives and backgrounds. • Share skills and knowledge, and encourage and support others in applying their ideas to work. • Encourage working together for the benefit of the customer.	• Show little sign of co-operating within your team or working in partnership. • Close down others by being judgemental, interrupting or talking over them. • Don't ask others for opinions or ideas. • Choose not to work as a team by pursing your own agenda.

People – Committed to and caring for our staff

Managing self (responsibility)

You take ownership of your work and use your initiative to deliver. You are accountable for your own performance and development, and take responsibility for your actions and decisions.

Our required behaviours	When 'managing self' is not demonstrated
• Are trustworthy and reliable. • Seek to learn from your colleagues. • Review your own performance and ask for feedback to learn and improve. • Work safely to maintain the health of both yourself and others. • Use your initiative to solve problems and inform others when you are aware of potential issues. • Acknowledge when you make mistakes and take responsibility for addressing and correcting them. • Appropriately challenge assumptions and unhelpful behaviour.	• Blames the system or others; demonstrating an unwillingness to take reasonable action to do things differently. • Do not take responsibility for your actions, admit you are wrong or recognise how our actions affect others. • Ignore problems and don't use your initiative. • Dismiss alterative ideas and discourage colleagues from suggesting new ways of doing things. • Manage your time poorly and do not deliver what is expected of you. • Behave in a way that might put others at risk.

Quality – Committed to and caring for our staff

Leadership (role modelling)

You lead by example through your behaviours and professional approach to work; inspiring your colleagues and driving for results.

Our required behaviours	When 'leadership' is not demonstrated
• Are driven to achieve results and you show courage when things don't go to plan. • Are compassionate, caring and empathetic to both colleagues and customers. • Engage and seek guidance from others.	• Don't listen to, research or question information for a better understanding. • Choose to ignore adverse criticism, seeing it as a personal attack rather than a way to develop yourself or your performance. • Are self-interested and fail to acknowledge colleague and customers perspectives. • Refuse to share information to maintain advance over others.

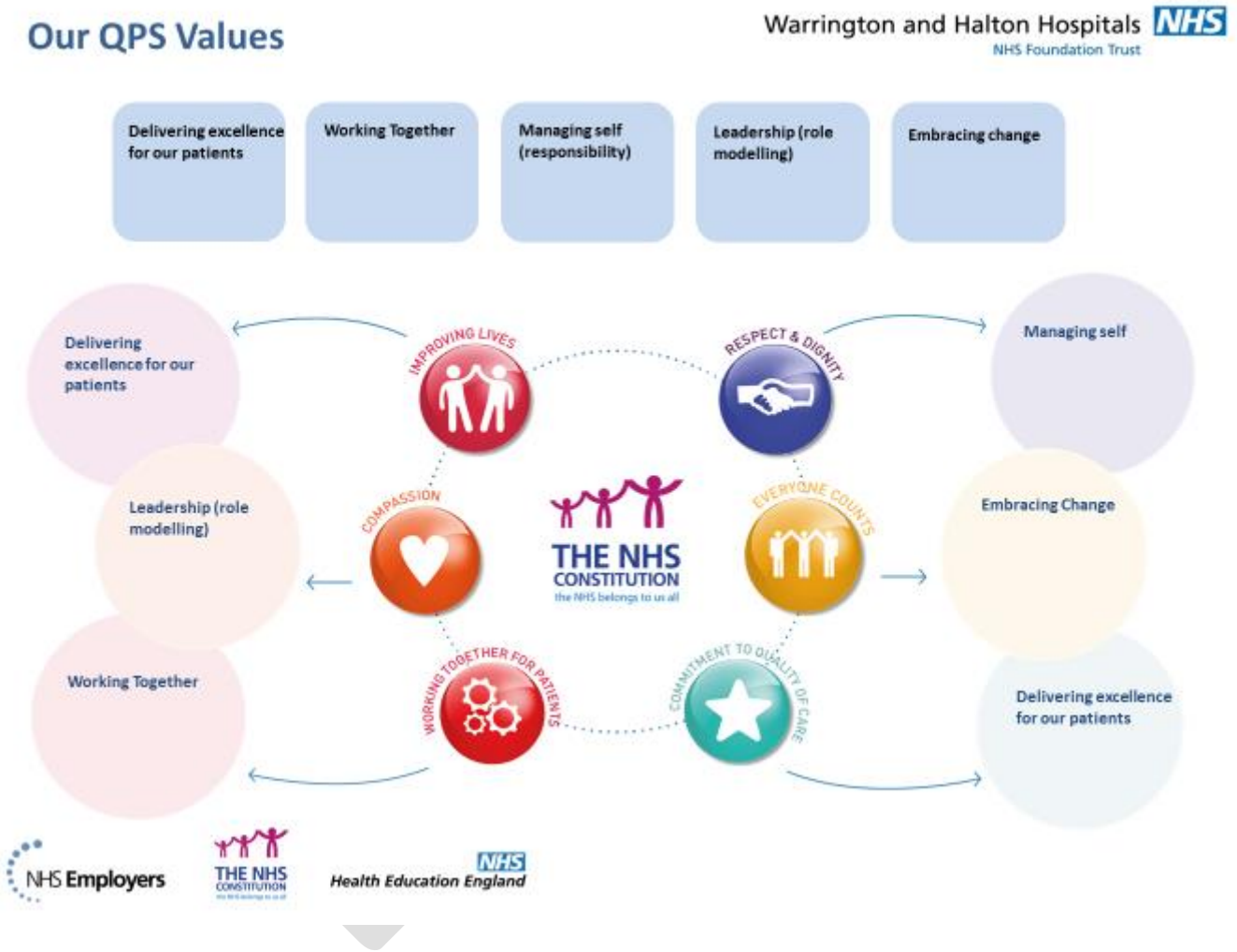
Sustainability – Being here for communities, now and going forward

Embracing change

Energise and engage self and others and mobilise action to embed change.

Our required behaviours	When 'embracing change' is not demonstrated
• Receptive to new ideas and different ways of working. • Responds positively when asked to make changes or when ones sees change is needed. • Makes the best of a new and/ or difficult situation. • Deals with the ambiguity that sometimes comes with change.	• Does not accept change and creates barriers to impede new ways if working. • Undermines new ways of doing things. • Fails to take on board new methods of delivering the service to accommodate different teams. • Openly discussed issues in a negative way.

Appendix 1 – Links to the NHS Constitution Values



Values in the NHS Constitution

WORKING TOGETHER FOR PATIENTS

Patients come first in everything we do. We fully involve patients, staff, families, carers, communities, and professionals inside and outside the NHS. We put the needs of patients and communities before organisational boundaries. We speak up when things go wrong.

RESPECT AND DIGNITY

We value every person – whether patient, their families or carers, or staff – as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest and open about our point of view and what we can and cannot do.

EVERYONE COUNTS

We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind. We accept that some people need more help, that difficult decisions have to be taken – and that when we waste resources we waste opportunities for others.

COMMITMENT TO QUALITY OF CARE

We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time. We encourage and welcome feedback from patients, families, carers, staff and the public. We use this to improve the care we provide and build on our successes.

COMPASSION

We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for patients, their families and carers, as well as those we work alongside. We do not wait to be asked, because we care.

IMPROVING LIVES

We strive to improve health and wellbeing and people's experiences of the NHS. We cherish excellence and professionalism wherever we find it – in the everyday things that make people's lives better as much as in clinical practice, service improvements and innovation. We recognise that all have a part to play in making ourselves, patients and our communities healthier.

Appendix 2 – QPS behavioural based interview questions

QPS behaviours	Sample Interview Questions
Excellence	• Describe a time when you made a decision in order to solve a recurring problem. What was the problem? What did you do? What was the outcome? Were you satisfied with the outcome, why or why not? • Tell us about a time when you did not have enough information to make a decision. What was the situation? How did the lack of information impact the situation? What action did you take to mitigate the possible damage?
Working Together	• Tell me about a time when you worked successfully as a member of a team. What did you do that was effective? How could you have been more effective? • Describe a situation where you were successful in getting people to work together effectively. What did you do that was effective? How could you have been more effective? • Describe the most difficult working relationship you've had with an individual. What specific actions did you take to improve the relationship? How could you have been more effective? • Describe a situation in which you identified and resolved a conflict in a team. How did you go about identifying the conflict? What actions did you take to resolve the conflict? What was the outcome? • Describe an instance when you kept a commitment to others even to your own detriment. What was the instance? What did you do? Do you feel you did the right thing, why or why not? • Describe the way you handled a specific problem that involved others from a variety of levels with differing values, ideas and beliefs. What was the problem? How did you handle it? What was the result?
Managing Self	• Tell me about a time when you acted over and above the expectations of your role. • Tell me about a time when you set and achieved a goal. What did you do that was effective? How could you have been more effective? • Describe something you have done to improve the performance of your service. What did you do that was effective? How could you have been more effective? • Describe a time you had to meet a scheduled deadline while your work was being interrupted continuously. What was most difficult about this and how did you handle it?
Leadership (role modelling)	• Tell us about a time when you took responsibility for an error and were held personally accountable. What was the situation? What did you do? What was the outcome?

Embracing Change	• Tell me about a time you had to quickly adjust your work priorities to meet changing demands? What did you do that was effective? How could you have been more effective? • Tell me about a time when you had to change your point of view or your plans to take into account new information or changing priorities. What did you do that was effective? How could you have been more effective? • Tell me about a time a significant change was made within your company or organization. How did the change affect you? How did you manage the change? • Tell me about a situation where you had to quickly adjust to a change in your department or team priorities. How did this change affect you?

Appendix 3 – Mapping Stories against the QPS Behaviours Framework

Aim:
Use stories to clearly present demonstrated behaviours in the workplace as supporting evidence of your performance discussion/review.

Instructions:
With reference to your Goals & Objectives, consider your work over the year to date and pick out 3 key examples, which '*tell a story*'. **Choose 3 different examples/stories** that can assist you to demonstrate how you behave in your workplace whilst achieving your G & O's (whether that is with patients, customers, other healthcare providers, employees or colleagues). Those chosen stories (examples) should be able to directly relate and link to one or more of the Trust's 5 QPS Behaviours.

Steps:

1. Choose a story linked to how you have achieved at least one of your Goals and Objectives. (*It should be a story fairly significant, current and observable by others*)
2. Give the story a headline (*Topic*), name its characters (*people involved*), and write a brief summary of the story
3. Link your story to any of the 5 QPS Behaviours. *(A story can link to more than 1 Behaviour)*
4. Include own reflections/learning and suggested future behaviour changes.

Step 1 – Choose a story

Story Headline: (Step 2*)*
Story Characters: (Step 2.*Who were the people involved)*
Story Plot and Content: (Step 2.*Write a brief summary of how you did it as a story (about* 10 lines)
Linked Behaviours *(*Step 3)
Summary of story. (Step 4: *Reflect on your own learning from the event. Suggest any planned future behavioural changes that have emerged from this reflection*)