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Warrington and Halton Hospitals **NHS**  
NHS Foundation Trust

# WHH Board of Directors Meeting

**Wednesday 30<sup>th</sup> November 2016**  
**1:30pm – 4:00pm**  
**Trust Conference Room**



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## Warrington and Halton Hospital NHS Foundation Trust Agenda for a meeting of the Board of Directors held in public.

Wednesday 30<sup>th</sup> November 2016, time 13:30 -4.00pm

Trust Conference Room, Warrington Hospital

REF BM/16	ITEM	PRESENTER	PURPOSE	TIME	
	Presentation Dr Anne Robinson Stamford Work		Information	13:30	N/A
	Preseantation IM&T, Lorenzo 1 Year Anniverary		Information	14:00	N/A
/189	Welcome, Apologies & Declarations of Interest	Steve McGuirk, Chairman	N/A	14:10	Verbal
/190	Minutes of the previous meeting held on 26 <sup>th</sup> October	Steve McGuirk, Chairman	Decision	14:10	Encl
/191	Actions & Matters Arising	Steve McGuirk, Chairman	Assurance	14:15	Encl
/192	Chief Executive's Report	Mel Pickup, Chief Executive	Assurance	14:20	Verbal
/193	Chairman's Report	Steve McGuirk, Chairman	Information	14:35	Verbal

### Quality

/194	Integrated Performance Dashboard M8 2016-17 Including Key Issues Reports for October:  - Quality Governance Committee  - Finance & Sustainability Committee	All Executive Directors  Margaret Bamforth, Committee Chair Terry Atherton, Committee Chair	Assurance	14:40	Encl
/195	Adult Safeguarding Annual Report 2015-16	Kimberley Salmon-Jamieson Chief Nurse	Assurance	15:00	Encl

### People

/196	Board assurance on agency spend grip and control	Roger Wilson Director of H & OD	Assurance	15:10	Encl
/197	People Measures –Performance Improvement	Roger Wilson Director of H & OD	Assurance	15:20	Encl
/198	People Strategy	Roger Wilson Director of H & OD	Assurance	15:30	Encl
/199	Trust Engagement Dashboard	Pat McLaren, Director of Community Engagement	Assurance	15:45	Encl

### Sustainability

/200	Any Other Business	Steve McGuirk, Chairman	N/A	15:55	Verbal
	Date of next meeting: Wednesday 25 <sup>th</sup> January 2017				



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**Warrington and Halton Hospitals NHS Foundation Trust**  
**Minutes of the Board of Directors meeting held in public on Wednesday 27<sup>th</sup> October 2016**  
**Trust Conference Room, Warrington Hospital**

**Present:**

**BM/16/190**

Steve McGuirk	Chairman
Mel Pickup	Chief Executive
Terry Atherton	Non-Executive Director
Margaret Bamforth	Non-Executive Director
Prof Simon Constable	Medical Director & Deputy Chief Executive
Andrea Chadwick	Director of Finance & Commercial Development
Sharon Gilligan	Chief Operating Officer
Ian Jones	Non-Executive Director / Senior Independent Director
Lynne Lobley	Non-Executive Director & Deputy Chair
Anita Wainwright	Non-Executive Director

**In Attendance:**

Pat McLaren	Director of Community Engagement
Lucy Gardner	Director of Transformation
Jason DaCosta	Director of IM&T
Roger Wilson	Director of Human Resources and Organisational Development

**Apologies**

Kimberley Salmon- Jamieson	Chief Nurse
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Agenda Ref BM/	
	<p><b>The Board Meeting opened with two presentations:-</b>  <b>Digestive Diseases Clinical Business Unit with Tom Liversedge, CBU Manager, Guy Hanson, Theatre Manager and , Cathy Johnson, Matron,</b>                      The Chairman thanked the Digestive Diseases for their presentation and requested he go on the patient journey through theatres, the Associate Director of Operations for Surgery, Women’s and Children’s Division to arrange to meet with Chairman to discuss this.</p> <p><b>Quality Improvement Champions</b>                      The Chief Executive presented the Quality Improvement Champions present with Innovation Behaviour badges.</p>
16/177	<p><b>Welcome, Apologies &amp;Declarations of Interest</b>                      The Chair opened the meeting and welcomed those attending the meeting, including Governors.</p> <p>Apologies: Kimberley Salmon-Jamieson, Chief Nurse.</p> <p>Declarations of Interest: none declared.</p>
16/178	<p><b>Minutes of the Previous Meeting Held on 28<sup>th</sup> September 2016</b>                      The minutes of the previous meeting were approved as a true and accurate record of the meeting with the following amendments.</p>



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	<p>16/166 – Key Issues Report July Quality Committee - 6<sup>th</sup> bullet point should read ‘Complaints, Claims data report is an excellent report but the claims data itself demonstrates an opportunity to improve good record keeping standards.</p> <p>16/167 – Leadership Walkabouts – Action to be included in the Action Plan for the Chief Nurse to arrange for the walkabouts to be arranged.</p> <p>16/169 – Key Issues Report August Strategic People Committee – first bullet point should read Employee.</p>
16/179	<p><b>Action Plan&amp; Matters Arising</b></p> <p>All actions were reviewed and progress was noted, there were not matters arising for discussion.</p>
16/180	<p><b>Chief Executive Report</b></p> <p>The Chief Executive updated the Board on items that had occurred or progressed since the last meeting at the end of October:</p> <ul style="list-style-type: none"><li>• Two teams from the Trust the Forget-me-Not team, Patient Safety Award and Maternity Team for Lesson Learned have been shortlisted for the HSJ Awards and attended the judging panel in London at which they did extremely well. Staff from both teams will be attending the awards ceremony in London on 23<sup>rd</sup> November.</li><li>• Emergency Care Improvement Programme (ECIP) visited the Mid Mersey foot print from 10<sup>th</sup> October looking at how our systems deliver Urgent &amp; Emergency Care to our patients; this included the role of primary care, social care, community care and acute care. ECIP reviewed patients on the Warrington Hospital site on one of the days of their visit and found that patients with a stay of over 6 days of which there were (241) 58% of those were fit to leave hospital (139) 13% of those (18) were waiting for hospital services e.g. Diagnostic, Pharmacy and 66% (91) were waiting for an external agency, Local Authority or Community Care to do something either an assessment for intermediate care for home packages. Initial feedback was received on the 14<sup>th</sup> October a full report is to follow, in that feedback is was pleasing to note items of good practice at the Trust with the establishment of an Ambulatory Care Centre which has had a positive impact on the Trusts patient flow and patient experience. Areas where more work is required is to focus on developing alternatives to the hospital in the primary and social care settings and getting patients out of hospital and into a more appropriate environment when they are fit to do so.</li><li>• The STP has consumed a large proportion of the Executive Directors time to ensure our contribution at the STP and LDS Alliance level to set out a blue print to accelerate the implementation of Simon’s Stevens ‘5 Year Forward View’. The themes that feature within the STP are:-<ul style="list-style-type: none"><li>– Support for people to live better quality lives by promoting all the things we know have a positive impact on health and wellbeing and the</li></ul></li></ul>



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	<p>prevention of illness.</p> <ul style="list-style-type: none"><li>– Working even more closely than we already do with Local Authorities, Volunteer organisations and primary care to develop a joined up model of out of hospital care.</li><li>• Health &amp; Wellbeing Board the Medical Director attended both Warrington &amp; Halton Board usually the Chief Executive and the Medical Director alternative their attendance at these meetings. Warrington CCG presented a UM report which was critical of the Trust Urgent &amp; Emergency Care service. The Health and Warrington Scrutiny Committee request requested an independent report to be tabled.</li></ul> <p>Action: The Chief Executive to take the independent reports which is being undertaken by ECIP and the Urgent and Emergency Care Network to the Health &amp; Wellbeing Boards and the Health Scrutiny Committee.</p> <p>The Board noted the report.</p>
16/181	<p><b>Chairman's Report</b></p> <p>The Chairman gave the Board an update of events since the previous Board confirming:</p> <ul style="list-style-type: none"><li>• The Trust has appointed a Secretary to the Board, Julie Burke who is hoping to join the Trust late November.</li><li>• Lynne Lobley, Non-Executive Director leave the Trust at the end of November and the process has begun to recruit a new Non-Executive Director.</li><li>• Constitutional changes for Governors elections are:<ul style="list-style-type: none"><li>– South Mersey area will include the rest of England &amp; Wales constituency this will enable a broader field for the recruitment of the new Non-Executive Director.</li></ul></li></ul> <p>The Chairman thanked the Governors for the work on the constitutional changes.</p> <p>The Board noted the report.</p>
16/182	<p><b>Integrated Performance Dashboard M6 2016-17</b></p> <p>The Executive Directors each presented the performance metrics relating to their portfolios of responsibilities, which included workforce and quality KPIs, and the following points were highlighted:</p> <p><b>Quality</b></p> <p>The Medical Director took the Board through the highlights of the Dashboard:</p> <ul style="list-style-type: none"><li>• The Trust has had no cases of MRSA in September and none in the last 12 months which is an excellent achievement</li><li>• Clostridium Difficile 8 incidents year to date, 4 cases have been reviewed by the CCG and 3 cases removed.</li><li>• SUI's reported 3 in September with 7 open cases awaiting investigation panel review and may be downgraded as a result of the investigation.</li><li>• Sepsis work is ongoing ready for the Q1 report in November.</li></ul>



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- CQUIN for Pneumonia the Trust nearly at the threshold for achieving what can be done in a timely fashion
- Diabetes & Sepsis reporting coding correctly is a work in progress and there will be an added focus in the remaining months.
- Discharge Summaries as reported previously to the Board regarding the historical backlog 1600 which have been investigated and this is now virtually down to nothing just 25 which are with the Divisional team to bring patients back to clinic.

#### **Key Issues Report from October Quality Committee**

The report from Margaret Bamforth, Chair of the Quality Committee was taken as read but the following items were highlighted:

- The Chair of the Quality Committee brought to the Boards attention is the lack of an electronic surveillance system that can identify clusters of infection and this remains an item of high risk on the Trusts Risk Register, there are systems in place to mitigate the risk but this does require a high level of vigilance by the Infection Control Team.
- Chair of the Quality Committee brought to the Boards attention the issue of insufficient isolation facilities was raised and the use of side wards as admin areas. The Chief Operating Officer will investigate who is using the side wards and free up space.
- Anti-microbial stewardship was an important area discussed and which can improve patient outcomes; this is also linked to a CQUIN particularly the National Sepsis CQUIN and focuses on appropriate investigation and timely anti-biotic intervention. Lynne Loble, Non-Executive Director asked about Sepsis, Pneumonia, ITU and the administering antibiotics in a timely manner would a project for the Junior Doctors could undertake. The Medical Director explained that this tends to be the clinical decision making process and can mean prescribing antibiotics to quickly, more scope and focus is required on this issue. The Chief Executive suggested that Dr Anne Robinson attend the November Board meeting to present the work they have been doing with Stamford University.

**Action: The Chief Executive to ask Dr Robinson to present her work to the November Board.**

- Antimicrobial usage will be reviewed in a deeper dive and taken through the Quality Committee. The Medical Director agreed and would also pickup CQUIN and AQ through the Quality Committee.

**Action: Margaret Bamforth suggested a report be presented to the Private Board in November.**

The Board noted the report and the matters for escalation.

#### **Performance**

The Chief Operating Officer took the Board through the highlights of the Dashboard:

- The A&E four hour performance target in September was 94.75%; the team are to be congratulated.



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- The trajectory is where the Trust needs to be to continue to deliver all statutory targets.
- The Trust is will continue to focus on Ambulance handover times and compares favourably with other trusts in Cheshire & Merseyside. All Trusts have now signed up to the Ambulance handover concordat.
- 18 week RTT is good.

### People

The Director of Human Resources & Organisational Development took the Board through the highlights of the Dashboard:

- The sickness absence has not been recorded in a timely manner and therefore has meant that the previously reported figures were not correct. Managers will be reminded to record sickness in a timely manner. The figure that was reported in August was 3.9% reported actual 4.83%. September has dropped slightly to 4.7%
- Return to work compliance has edged upwards and the Trust is 70% compliant. Anita Wainwright, Non-Executive Director and Chair of the Strategic People Committee informed the Board that the workforce dashboard is presented to the Committee and allows the Committee to drill down to manager level this allows the HR Business Partners to reinforce positive good behaviours and show staff by undertaking return to work interviews that the Trust cares about their health and wellbeing. Also the attendance management policy has been reviewed and is now more robust.
- PDR target is 69% with the Trust target being 85%. The Chairman asked if the Trust has ever hit the 85% target and if not is that an indication that the target is too high and suggested looking at other Trusts and benchmarking the PDR targets against them.
- There will be a deep dive into the recruitment process and findings will be presented to the Strategic People Committee.

### Finance

The Director of Finance & Commercial Development took the Board through the highlights of the Dashboard:

- Month 6 the Trust has recorded a deficit of £0.7m which is on plan and a year to date deficit of £5.8m. The cash balance is £1.2m and the financial risk rating score is 2.
- The second half of the year is going to be incredibly challenging to keep on track. There is a planned Executive workshop on the 11<sup>th</sup> November to discuss the financial challenges facing the Trust and the risks in the second half of the year.
- The Trust has applied for a working capital loan of £7.9m in 2016/17 until this application has been approved the Trust has access to an interim revolving working capital facility, no loan was drawn down in September but year to date £6.5m has been drawn down.
- To date the planned savings targets have been delivered of £3.8m and £4.0m.



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### **Key Issues Report from the October Finance & Sustainability Committee**

The report from Terry Atherton, Chair of the Finance & Sustainability Committee was taken as read but the following items were highlighted:

- In September the A&E four hour target performance was 94.75% this is an excellent achievement for the team and this was against a trajectory of 91%. The month of October will prove challenging due to the acuity of patients being seen in the Trust.
- While Ambulance Turnaround times is challenging RTT remains strong all the remaining performance targets are close to plan.
- The Finance & Sustainability Committee will assume responsibility for the oversight of the Pay Bill which is to include Agency Locum expenditure.
- Cash remains very tight and daily intensive management is necessary.
- The Trust has met the criteria to enable the triggering of the Quarter 2 tranche of STP funding.
- An additional meeting of the Finance & Sustainability Committee in December has been arranged to cover both continued oversight of its areas of remit and also the requirements of the Planning Process for 2017/18 and 2018/19.

The Board noted the report and that there were no matters for escalation.

### **Key Issues Report from the October Audit Committee**

The report from Ian Jones, Chair of the Audit Committee was taken as read but the following items were highlighted:

- Counter Fraud report showed no significant problems at the Trust
- Internal Audit reports with regards to Clinical Coding and Dawes Quality Audits both received significant assurance.
- There has been steady progress to reduce the number of tender waivers.
- The process of appointment of the External Auditors for the next 3 years is reaching a conclusion and the Audit Committee will recommend Grant Thornton be appointment to the Council of Governors on 20<sup>th</sup> October.

The Board noted the report and that there were no matters for escalation.

### **Trust Engagement Dashboard**

The Director Community Engagement took the Board through the highlights of the Dashboard:

- Negative media around the mortality report, journalist sensationalised data which was from 2015. Lesson can be learned the Trust needs to be more aware and know when these report are due to ensure better briefings are available to the media.
- NHS Staff Survey has been sent out to all staff this year.
- NHS Choices the Trust needs to be more proactive and encourage patients to put positive comments on NHS Choices to balance out the negative ones this can be picked up at the Patient Experience Group. The Director of Community Engagement to discuss with the Chief Nurse.

**Action: Director of Community Engagement to discuss with Chief Nurse.**





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	<p>The Board noted the report.</p>
<p>16/183</p>	<p><b>Mortality Review Report October 2016</b></p> <p>The Medical Director presented the Mortality Review Report for October 2016 to the Board. This paper was written to provide the Board with the latest mortality data and provide local and national context and also to outline the actions in place to ensure robust oversight and monitoring to continue to reduce mortality in the Trust and the Trust mortality ratio figures.</p> <p>The Trust uses the Healthcare Evaluation Data system to assess the overall mortality data this allows the Trust to evaluate areas of concerns or trends.</p> <p>All deaths in the Trust have a screening review by a Consultant (who has not looked after the patient) this allows for an overview on the quality of care received. If a more in depth review is required this will be escalated to the Mortality Review Group.</p> <p>The Non-Executive Directors questioned the need to give clarity between different measures of mortality and also the need to ensure that the debate around measurement did not detract from ensuring the real issues are understood.</p> <p>The Medical Director suggested that the December Board Workshop is used to provide the Board and Governors who wish to attend a chance to understand HMSR, SHMI and Crude Mortality Rates, he explained this is a complex subject a workshop will greatly benefit the understanding of the issues and the investigation processes.</p> <p><b>Action: Medical Director to organise Mortality workshop on 14<sup>th</sup> December.</b></p>
<p>16/184</p>	<p><b>Paybill Growth / Agency Staffing</b></p> <p>The Director of Human Resources and Organisational Development presented the Paybill Growth / Agency Staffing paper to the Private Board this morning and the Board requested that a more detailed paper should be presented to the Board with a response checklist in November.</p> <p><b>Action: Director of Human Resources and Organisational Development to review and present an updated paper to the November Board.</b></p> <p>The Board noted the report.</p>
<p>16/185</p>	<p><b>Quarterly Corporate Risk Register</b></p> <p>The Medical Director presented the Trust Corporate Risk Register for noting.</p> <p>The Medical Director informed the Board of the risk of loss of vision due to lack of Ophthalmic failsafe for follow up appointments, no harm came to patients and lessons learned at table top meeting</p> <p>The Chairman said that he found the Risk Register a difficult document and complex and the Board does not do it justice reviewing it.</p> <p>The Director of Community Engagement suggested that this is an area which is reviewed at the same time that the Board Assurance Framework (BAF) is being reviewed and will liaise with the</p>



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	<p>Chief Nurse on the Trust Risk Register Review and arrange for a workshop early next year around the Risk Register and the BAF.</p> <p><b>Action: Director of Community Engagement to arrange Board Workshop to review the Trust Risk Register and the BAF.</b></p> <p>The Board noted the Trust Risk Register.</p>
16/186	<p><b>Quarterly Response to Lord Carter</b></p> <p>The Director of Finance &amp; Commercial Development explained that the quarterly responses to the Lord Carter Report were for information and to note progress by the Board.</p> <p>A discussion took place regarding the report and the Lord Carter national approach to making savings. The Trust is also exploring opportunities for additional income. The Single Oversight Framework Report will be presented to the Board in November and the Lord Carter metrics will inform this report.</p> <p>The Board noted the report.</p>
16/187	<p><b>Any Other Business</b></p> <p>The Director of IT informed the Board that there has been a significant Lorenzo upgrade undertaken and this has gone very well. It is also the one year anniversary of the implementation of the Lorenzo System. The Director of IT requested a 10minute presentation to the Board at the November Board meeting the Board agreed.</p> <p><b>Action: Director of IT to provide a 10 minute presentation on the one year anniversary of the Lorenzo implementation.</b></p> <p>There being no further business to discuss, the meeting closed at 16:00.</p> <p><b>Next Meeting:</b> Wednesday 30<sup>th</sup> November 2 016 in the Trust Conference Room</p>



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### BOARD OF DIRECTORS ACTION LOG

<b>AGENDA REFERENCE:</b>	<b>BM/191</b>	<b>SUBJECT:</b>	<b>TRUST BOARD ACTION LOG</b>	<b>DATE OF MEETING</b>	30th November 2016
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#### 1. ACTIONS ON AGENDA

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
16/167	26 <sup>th</sup> October	Leadership Walkabouts	Chief Nurse to arrange for the walkabouts	Chief Nurse	November 2016		Ongoing	

#### 2. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
16/180	26 <sup>th</sup> October 2016	CEO Report ECIP visit	ECIP report to be presented to Halton and Warrington HWBB	Chief Executive	November 2016	21 <sup>st</sup> November 2016	The ECIP report has been agended onto both HWBB for Janaury 2017	
16/182	26 <sup>th</sup> October 2016	CQUIN AQ	Paper to be presented to the Private Board in November	Medical Director/Chief Nurse	November 2016	30 <sup>th</sup> November 2016	CQUIN / AQ paper on the private board agenda	
16/182	26 <sup>th</sup> October 2016	Mortality Board Workshop	Workshop is a chance for Board & Governors to understand HMSR, SHMI and Crude Mortality Rates.	Medical Director	November 2016	1 <sup>st</sup> November 2016	Mortality Workshop arranged for 14 <sup>th</sup> December 2016	



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Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
16/182	26 <sup>th</sup> October 2016	Stamford Collaborative work	Dr Anne Robinson to present her work to the Board	Chief Executive	November 216	30 <sup>th</sup> November 2016		
16/184	26 <sup>th</sup> October 2016	Paybill Growth / Agency staffing	Updated paper to be presented to the November Board.	Director of HR & OD	November 2016	30 <sup>th</sup> November 2016	Revised paper on the Board agenda	
16/185	26 <sup>th</sup> October 2016	Review of BAF & Trust Risk Register	Board Workshop to be arranged to review BAF/ Trust Risk Register early 2017.	Director of Community Engagement	November 2016	30 <sup>th</sup> November 2016	Joint NED / Executive session to be used on 20 <sup>th</sup> January 2017	
16/187	26 <sup>th</sup> October 2016	Lorenzo 1 year Anniversary	Presentation to Board	Director of IT	November 2016	30 <sup>th</sup> November 2016	Presentation Trust Board Agenda	
16/137	29 <sup>th</sup> June 2016	Revised People Strategy	Revised People Strategy to August Board/ now November	Director of HR & OD	November 2016	30 <sup>th</sup> November 2016	Revised paper on the Board agenda	



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### 3. ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
15/165	28 <sup>th</sup> September 2016	NHS Choices	Chief Nurse to liaise with the Director of Community Engagement regarding NHS Choices.	Chief Nurse	November 2016		Ongoing	
16/168	28 <sup>th</sup> September 2016	Champions Role Board Responsibilities for new Non-Executive Director	Chairman to meet with the Director of Community Engagement regarding gaps	Director of Community Engagement	October 2016		Ongoing	
16/136	29 <sup>th</sup> June 2016	Revised Nursing Strategy	Revised Nursing Strategy to be presented to Board	Chief Nurse	October 2016		To be presented to January Board 2017	

#### RAG Key

	Action overdue or no update provided
	Update provided but action incomplete
	Update provided and action complete



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## BOARD OF DIRECTORS

<b>AGENDA REFERENCE:</b>	<b>BM/16/194</b>
<b>SUBJECT:</b>	<b>Integrated Dashboard</b>
<b>DATE OF MEETING:</b>	30th November 2016
<b>ACTION REQUIRED</b>	<b>For Discussion</b>
<b>AUTHOR(S):</b>	Marie Garnett – Head of Contracts & Performance
<b>EXECUTIVE DIRECTOR SPONSOR:</b>	Andrea Chadwick, Director of Finance & Commercial Development / Sharon Gilligan, Chief Operating Officer
<b>LINK TO STRATEGIC OBJECTIVES:</b>	All
<b>LINK TO BOARD ASSURANCE FRAMEWORK (BAF):</b>	All
	Choose an item.
	Choose an item.
<b>STRATEGIC CONTEXT</b>	<p>To provide the Trust Board with assurance in relation to performance in the following areas:</p> <ul style="list-style-type: none"> <li>• Quality Improvement</li> <li>• Access &amp; Performance</li> <li>• Workforce</li> <li>• Finance</li> </ul>
<b>EXECUTIVE SUMMARY (KEY ISSUES):</b>	<p>Maintained zero tolerance for MRSA.</p> <ul style="list-style-type: none"> <li>• CQUIN performance for Sepsis achieved (AED screening partially compliant).</li> <li>• Achievement of STP access and performance trajectory.</li> <li>• Review of ambulance handover data ongoing with NWAS.</li> <li>• Trust levels of sickness absence improved in October.</li> <li>• Improvement of Return to work (RTW) interviews, work ongoing to achieve Trust target.</li> <li>• Cash balance below plan but compliant with conditions of working capital facility.</li> <li>• Cumulative Trust deficit is £0.1m below planned deficit.</li> <li>• CIP programme is £0.012m ahead of plan at end of month 7.</li> </ul>

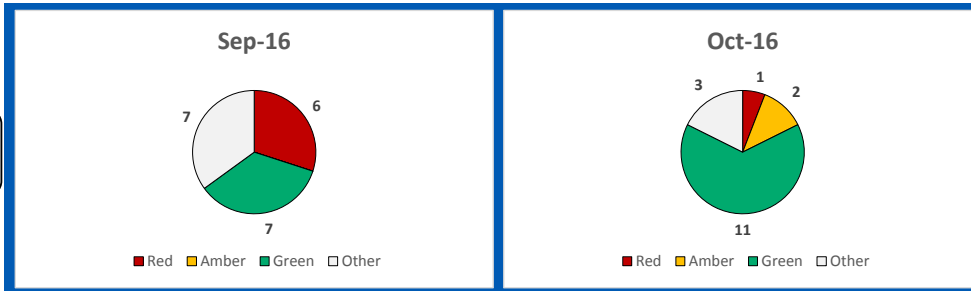


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<b>RECOMMENDATION:</b>	Trust board to note continued improvement in all areas of access and performance and to gain assurance that focus is on those issues which are ongoing.	
<b>PREVIOUSLY CONSIDERED BY:</b>	<b>Committee</b>	Choose an item.
	<b>Agenda Ref.</b>	
	<b>Date of meeting</b>	
	<b>Summary of Outcome</b>	
<b>FREEDOM OF INFORMATION STATUS (FOIA):</b>	Release Document in Full	
<b>FOIA EXEMPTIONS APPLIED:</b> <i>(if relevant)</i>	None	

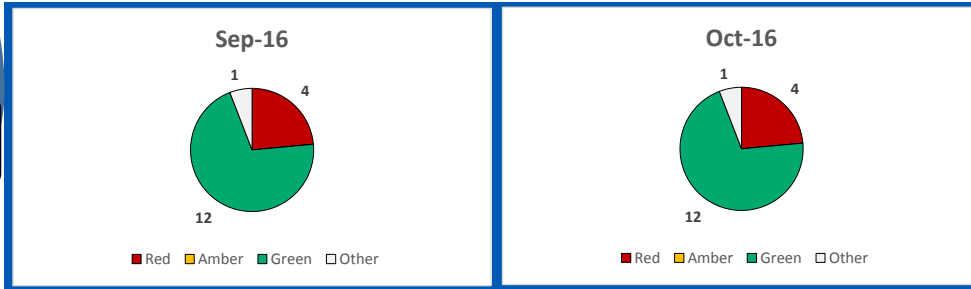
Key Points/Actions

Quality Improvement



Along with the 1 unapproved incident of major harm for October 2016, there are 7 on-going Incident Reviews from April - September 2016. The latest 12 month rolling HMSR has decreased to 107.6 amber status and the SHMI to 109.3. There were no cases of MRSA in October. Clostridium difficile YTD 8 cases of CDT have been reported. The CCG review panel for the 4 cases from Q2 has been deferred by the CCG until January 2017. The Safety Thermometer audit of inpatients reveals that <3% (based on new harms) had a fall, pressure ulcer, VTE or Catheter acquired infection in October 2016. Since April the Trust has reported 4 confirmed avoidable grade 3 pressure ulcers and 24 approved grade 2 pressure ulcers. The approved falls per 1000 BD for October is below the 5.6 threshold at 3.60. The Trust is compliant with SEPSIS National CQUIN Q2 with the exception of AED Screening which is deemed partially compliant. The AMR National CQUIN- awaiting outcome of discussions with the CCG regarding baseline for antibiotic reduction and Empiric Review Q2 is compliant at 86%. Following data cleansing of DATIX (Complaints system) currently taking place the number of "identified" returned complaints has increased from 6 to 18.

Access & Performance



The Trust continues to achieve all improvement trajectories agreed with NHSI.

Workforce



Overall three of the metrics have changed. Nursing Agency expenditure has changed from Red to Green, Turnover has changed from Red to Amber and RTW has changed from Red to Amber. There is no change with the other indicators. Sickness has decreased from the previous month and RTW rates have increased but only gradually. No change to recruitment times due to problems running NHS jobs reports. Non contracted pay remains high although agency expenditure has decreased. Medical Agency expenditure remains a key issue. Essential Training, Clinical Training and PDRs rates have all increased but only marginally. Two new metrics have been included relating to 'Top 20 agency staff earners over the last 12 months' and 'Agency staff who have worked for the Trust for the last 6 months'. This was a requirement from NHSI.

Finance



In October the Trust recorded a deficit of £0.4m which increases the year to date deficit to £6.1m which is £0.1m below the planned deficit of £6.2m. For the year to date period income is £1.3m above plan, expenses are £1.9m above plan and non operating expenses are £0.7m below plan. To date the capital programme planned spend is £2.8m and the actual spend is £1.9m. Due to the operating position the cash balance remains low and as at 31st October the cash balance is £1.2m. The performance against the Better Payment Practice Code is 29% in the month and 29% to date so is significantly lower than the 95% target. For the period the Trust has recorded a Use of Resources Rating of 3 which is in line with the planned rating. The Executive Team has reviewed the financial risk to the delivery of the control total and assessed a likely scenario of £12.9 deficit before mitigations. The risk has been shared with NHSI at the last Performance Review Meeting and at this stage the forecast delivery of £7.9m deficit has not been adjusted. It is vital that the mitigations are delivered to ensure the Trust remains on financial trajectory.



Quality Improvement

Description

Aggregate Position

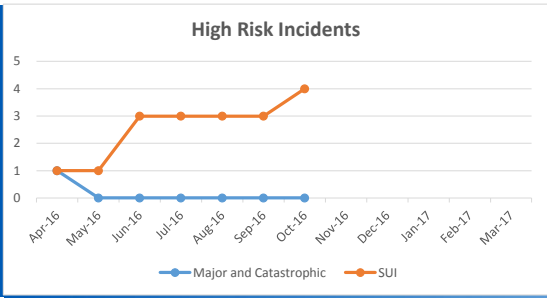
Trend

Variation

High Risk Incidents

Major and Catastrophic Incidents and Serious untoward incidents (SUIs) Level 3

The trust has reported 1 incident of Major Harm for October, but the investigation has not yet been completed so cannot be included as approved Major and Catastrophic Harm Incidents.



Along with the 1 unapproved incident of major harm for October 2016, there remain 7 Ongoing Incident Reviews from April - September (April = 1, June = 2, July = 2, August = 1, September = 2) currently graded as Major or Catastrophic Harm.

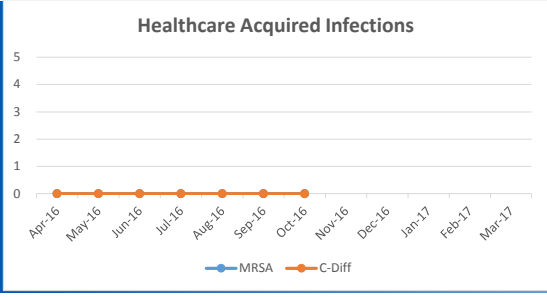
Healthcare Acquired Infections

MRSA  
Red: More than 5  
Amber: 1 to 5  
Green: 0

C-Difficile  
Red: More than 2  
Amber: 1 or 2  
Green: 27 or less per

MRSA - National objective is zero tolerance of avoidable MRSA bacteraemia. If breached a £10,000 penalty in respect of each incidence in the relevant month. CLOSTRIDIUM DIFFICILE (due to lapses in care) agreed threshold is <=27 cases per year.

The Trust has maintained its zero tolerance position for MRSA. Clostridium difficile YTD 8 cases of CDT have been reported. The CCG review panel for the 4 cases from Q2 has been deferred by the CCG until January.



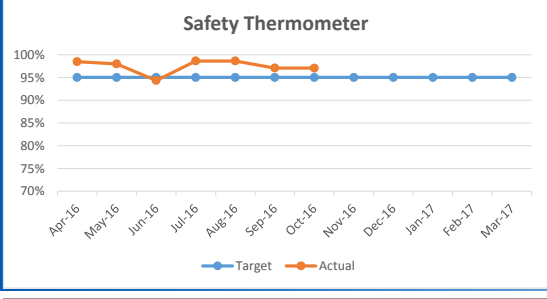
There were no cases of MRSA in October. CDT Nil returns were submitted for hospital apportioned cases in September and October

Safety Thermometer

Red: Less than 90%  
Amber: 90% to 94%  
Green: 95% or more

Measures % of patients who received "harm free care" defined by the absence of pressure ulcers, falls, catheter-acquired UTI's and VTE ( Safety Thermometer)

This measure only includes new harms. Based on monthly snapshot audit of all inpatients, just under 3% had a fall, pressure ulcer, VTE or Catheter acquired infection in October 2016.



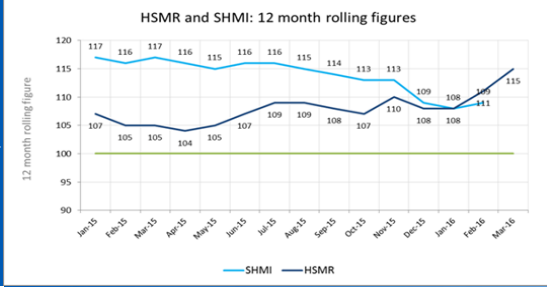
Mortality Ratios

Red: HSMR or SHMI higher than expected  
Amber: HSMR or SHMI over 100  
Green: HSMR and

Hospital Standardised Mortality Ratio (HSMR 12 month rolling) The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups.

The latest HSMR for August 2015 - July 2016 has decreased to 107.6 from the July 2015 - June 2016 HSMR of 113. We are a borderline national outlier - this result is not significant at 99.8% level but is significant at the 95% level, giving amber status. The SHMI for June 2015 - May 2016 is 109.3 showing a slight reduction against May 2015 - April 2016 of 109.9.

Summary Hospital-level Mortality Indicator (SHMI 12 month rolling) SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.



We have a higher weekend HSMR than weekday, and both weekend and weekday are above 100, but not statistically significant. Most peer trusts show the same variation between weekend and weekday. Looking at the 6 month rolling HSMR to get an overview of trends, suggests weekday HSMR is increasing and weekend HSMR may be slightly decreasing. The Trust is an outlier in three areas for the SHMI - UTI; Pneumonia and Diabetes with complications. Focused reviews have taken place into patients who have died with these diagnoses and the appropriate actions will be instigated once the findings have been aggregated.

Quality Improvement

Description

Aggregate Position

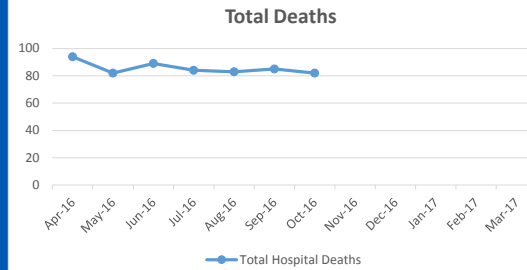
Trend

Variation

Total Deaths

Total Deaths in Hospital

The death rate was 2.8% for Q4 2015/ 16. It is 2.1% for 01/04/16 to 16/06/2016

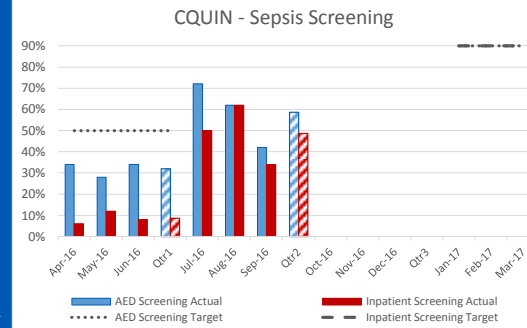


The Mortality Review Group is tasked with interpreting the data for the above and driving improvements

CQUIN - Sepsis  
AED Screening  
Red: Less than 50%  
Amber: 50% to 89.9%  
Green: 90% or more

Screening of all eligible patients - acute inpatients (\*to be validated). Screening of all eligible patients admitted to emergency areas (\*to be validated). Inpatient received treatments and empiric review within three days of prescribing antibiotics. Emergency patients received treatment and empiric review within three days of prescribing the antibiotics.

The four elements of the SEPSIS CQUIN are required to achieve the following thresholds in Q2- AED Screening is based on the national threshold and AED Antibiotic Review - 55%; Inpatient Screening - 10% and Inpatient Antibiotic Review - 20%.

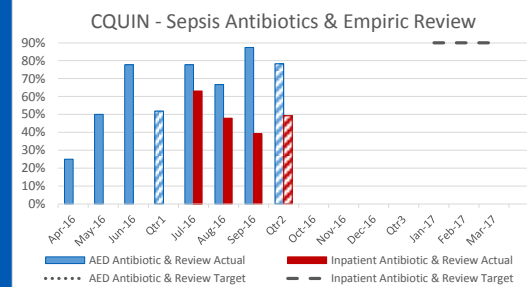


AED Screening achieved 58.67% against national threshold >=50% but less than 90%so deemed partially compliant. All other measures deemed compliant against Q2 thresholds - AED Antibiotic Review achieved 78.26% against threshold of 55%; Inpatient Screening achieved 48.67% against threshold of 10% and Inpatient Antibiotic Review achieved 49.23% against 20%. The thresholds for Q3 will need to be locally agreed with the CCG.

CQUIN - Sepsis  
Inpatient Screening At Qtr4  
Red: Less than 50%  
Amber: 50% to 89.9%

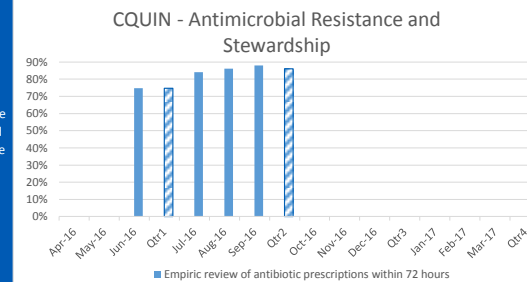
CQUIN - Sepsis  
AED Antibiotics & Review  
Trajectory yet to be agreed with CCG

CQUIN - Sepsis  
Inpatient Antibiotics & Review At Qtr4  
Red: Less than 50%  
Amber: 50% to 89.9%



Antimicrobial Resistance and Stewardship (AMR)  
National CQUIN  
AMR Reduction in antibiotic consumption per 1,000 admissions.  
AMR Empiric Review of antibiotic prescriptions within 72 hours

The Trust has submitted the baseline data for antibiotic consumption as required for 2013/2014 - 2015/2016 and the 2016/2017 Q1 usage report. In Q2 the Trust has performed an empiric review on 86% of prescriptions thus achieving the required threshold that at least 50% of cases in the sample are reviewed and is therefore compliant.



The pharmacist has been contacted to request quarterly reports on antibiotic consumption so that it can be included in this dashboard to evidence antibiotic usage against baseline

CQUIN -  
Antimicrobial  
Resistance and  
Stewardship

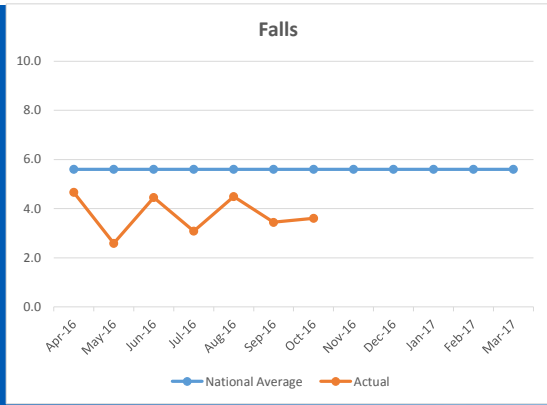
Quality Improvement

Description      Aggregate Position      Trend      Variation

Falls  
Red: More than 5.6  
Green: 5.6 or less

**Description**  
Approved falls / 1000 BD. This measure relates to the number of approved falls per 1000 bed days. The national threshold is 5.6.

**Aggregate Position**  
To date we are below the national average of 5.6 approved falls per 1000 bed days. Approved falls/1000 BD has been reported in the Quality Report / Account since 2014. If the Trust used all falls data would change as follows April - 5.53; May - 4.71; June - 5.71; July - 4.71 August 5.79, September 5.19 and October 4.31.

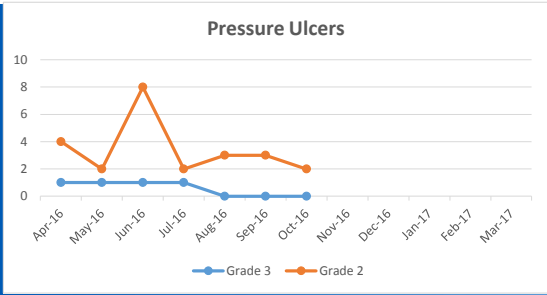


**Variation**  
The total number of falls per month is higher e.g. There were falls in October with 55 approved and requiring approval as such 3.60 reflects 55 approved falls per 1000 bed days.

Pressure Ulcers  
Grade 3  
Red: More than 3  
Green: 3 or less  
Grade 2  
Red: More than 82

**Description**  
Grade 3 hospital acquired (avoidable).  
Grade 2 hospital acquired (avoidable and unavoidable)

**Aggregate Position**  
To date we have 4 confirmed avoidable grade 3 pressure ulcers against an improvement priority threshold of >=3. There are 24 approved grade 2 pressure ulcers the grade 2 threshold of 82 for the year equates to 6 per month and 20.5 per quarter.

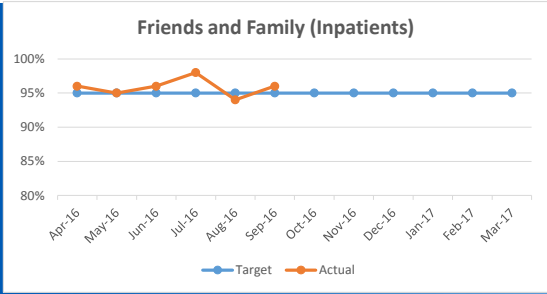


**Variation**  
There are 0 cases of Grade 3 pressure ulcers under review from April - October and 9 Grade 2 pressure ulcers under review.

Friends and Family (Inpatients)  
Red: Less than 95%  
Green: 95% or more

**Description**  
Percentage of Inpatients recommending the Trust. Patients are asked - How likely are you to recommend our ward to friends and family if they needed similar care or treatment?

**Aggregate Position**  
We had achieved the monthly target until August when it reduced below the threshold of 95%.

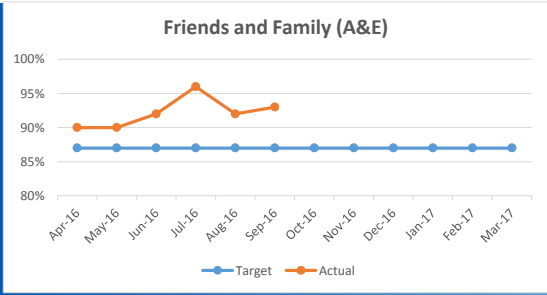


**Variation**  
This data is sourced from NHS England and is one month in arrears.

Friends and Family (A&E)  
Red: Less than 87%  
Green: 87% or more

**Description**  
Percentage of AED (Accident and Emergency Department) patients recommending the Trust : Patients are asked - How likely are you to recommend our AED to friends and family if they needed similar care or treatment?

**Aggregate Position**  
We have exceeded the monthly threshold 87% to date for 2016.



**Variation**  
This data is sourced from NHS England and is one month in arrears.

Quality Improvement

Description

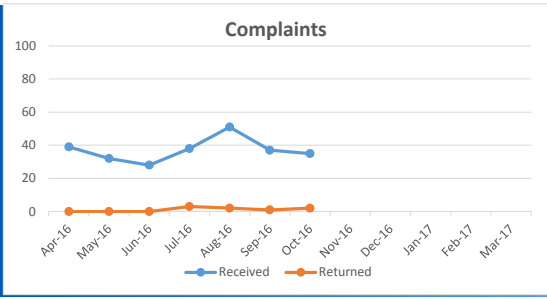
Aggregate Position

Trend

Variation

Complaints

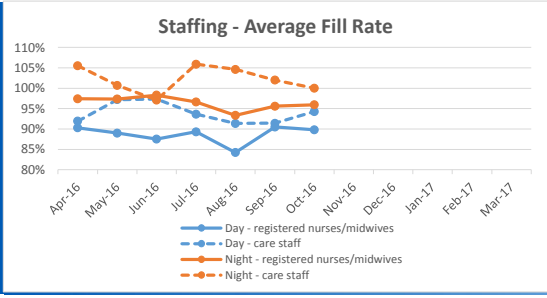
Total complaints received. Total returned complaints  
Year to date the Trust has received 260 complaints and 18 returned complaints.



A data cleansing of DATIX (Complaints system) is currently taking place and the number of "identified" returned complaints has increased from 6 to 18. (NB This data collection started in May 2016).

Staffing - Average Fill Rate

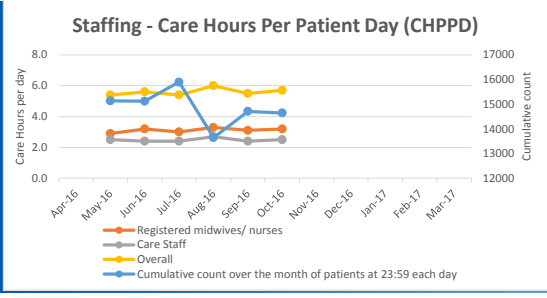
Percentage of planned verses actual for registered and non registered staff by day and night  
We continue to move staff around areas/wards that are short to ensure patient safety at all times. WHH Trust is currently working with Allocate to implement a robust electronic Acuity Tool to monitor staffing levels live. The system will be completed by April 2017.



When numbers are greater than 100% this is usually due to specialising. The Trust is aiming for a 90% fill rate (national average)

Staffing - Care Hours Per Patient Day (CHPPD)

Care Hours Per Patient Day (CHPPD) =  $\frac{\text{Hours of registered nurses} + \text{Hours of healthcare support workers}}{\text{Total number of inpatients}}$   
Trusts to be benchmarked against each other and tolerance agreed by NHSI



Analysis of data from over 1,000 wards, in the pilot stage, found a wide variation in the care hours provided per patient day - ranging from 6.33 to 15.48 hours with an average of 9.1 hours. The data produced excludes CCU, ITU and Paediatrics.

Mandatory Standards - Access & Performance

Description	Aggregate Position	Trend	Variation																																																			
<p><b>Diagnostic Waiting Times 6 Weeks</b></p> <p>All diagnostic tests need to be carried out within 6 weeks of the request for the test being made. The national target is 99% or over within 6 weeks.</p> <p>This metric also forms part of the Trust's Sustainability and Transformation Plan (STP) Improvement trajectory.</p> <p>The national target of 99% for Diagnostic waiting times has been achieved with actual performance at 99.96%. The Trust has also met the STP Improvement trajectory.</p> <p>The proposed tolerance levels applied to the improvement trajectories are also illustrated.</p>	<p><b>Diagnostic Waiting Times 6 Weeks</b></p> <table border="1"> <caption>Diagnostic Waiting Times 6 Weeks Data</caption> <thead> <tr> <th>Month</th> <th>Target</th> <th>Actual</th> <th>Target with Tolerance</th> </tr> </thead> <tbody> <tr><td>Apr-16</td><td>99%</td><td>99.96%</td><td>99%</td></tr> <tr><td>May-16</td><td>99%</td><td>99.96%</td><td>99%</td></tr> <tr><td>Jun-16</td><td>99%</td><td>99.96%</td><td>99%</td></tr> <tr><td>Jul-16</td><td>99%</td><td>99.96%</td><td>99%</td></tr> <tr><td>Aug-16</td><td>99%</td><td>99.96%</td><td>99%</td></tr> <tr><td>Sep-16</td><td>99%</td><td>99.96%</td><td>99%</td></tr> <tr><td>Oct-16</td><td>99%</td><td>99.96%</td><td>99%</td></tr> <tr><td>Nov-16</td><td>99%</td><td>99.96%</td><td>99%</td></tr> <tr><td>Dec-16</td><td>99%</td><td>99.96%</td><td>99%</td></tr> <tr><td>Jan-17</td><td>99%</td><td>99.96%</td><td>99%</td></tr> <tr><td>Feb-17</td><td>99%</td><td>99.96%</td><td>99%</td></tr> <tr><td>Mar-17</td><td>99%</td><td>99.96%</td><td>99%</td></tr> </tbody> </table>	Month	Target	Actual	Target with Tolerance	Apr-16	99%	99.96%	99%	May-16	99%	99.96%	99%	Jun-16	99%	99.96%	99%	Jul-16	99%	99.96%	99%	Aug-16	99%	99.96%	99%	Sep-16	99%	99.96%	99%	Oct-16	99%	99.96%	99%	Nov-16	99%	99.96%	99%	Dec-16	99%	99.96%	99%	Jan-17	99%	99.96%	99%	Feb-17	99%	99.96%	99%	Mar-17	99%	99.96%	99%	<p>2 breaches of the 6 week standard in Cardiology echocardiography</p>
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<p><b>Referral to treatment Open Pathways</b></p> <p>Percentage of incomplete pathways waiting within 18 weeks. The national target is 92%</p> <p>This metric also forms part of the Trust's STP Improvement trajectory.</p> <p>Open pathways continue to perform above the 92% target. The Trust has also met the STP improvement trajectory.</p> <p>The proposed tolerance levels applied to the improvement trajectories are also illustrated.</p>	<p><b>Referral to treatment Open Pathways</b></p> <table border="1"> <caption>Referral to treatment Open Pathways Data</caption> <thead> <tr> <th>Month</th> <th>Target</th> <th>Actual</th> <th>Target with Tolerance</th> </tr> </thead> <tbody> <tr><td>Apr-16</td><td>92%</td><td>92.5%</td><td>92%</td></tr> <tr><td>May-16</td><td>92%</td><td>93.0%</td><td>92%</td></tr> <tr><td>Jun-16</td><td>92%</td><td>93.0%</td><td>92%</td></tr> <tr><td>Jul-16</td><td>92%</td><td>93.5%</td><td>92%</td></tr> <tr><td>Aug-16</td><td>92%</td><td>94.0%</td><td>92%</td></tr> <tr><td>Sep-16</td><td>92%</td><td>93.5%</td><td>92%</td></tr> <tr><td>Oct-16</td><td>92%</td><td>93.5%</td><td>92%</td></tr> <tr><td>Nov-16</td><td>92%</td><td>92.0%</td><td>92%</td></tr> <tr><td>Dec-16</td><td>92%</td><td>92.0%</td><td>92%</td></tr> <tr><td>Jan-17</td><td>92%</td><td>92.0%</td><td>92%</td></tr> <tr><td>Feb-17</td><td>92%</td><td>92.0%</td><td>92%</td></tr> <tr><td>Mar-17</td><td>92%</td><td>92.0%</td><td>92%</td></tr> </tbody> </table>	Month	Target	Actual	Target with Tolerance	Apr-16	92%	92.5%	92%	May-16	92%	93.0%	92%	Jun-16	92%	93.0%	92%	Jul-16	92%	93.5%	92%	Aug-16	92%	94.0%	92%	Sep-16	92%	93.5%	92%	Oct-16	92%	93.5%	92%	Nov-16	92%	92.0%	92%	Dec-16	92%	92.0%	92%	Jan-17	92%	92.0%	92%	Feb-17	92%	92.0%	92%	Mar-17	92%	92.0%	92%	<p>The only specialities not to achieve the target are:</p> <ul style="list-style-type: none"> <li>• Urology – 90.86%</li> <li>• T&amp;O – 87.47%</li> </ul>
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<p><b>A&amp;E Waiting Times - National Target</b></p> <p>All patients who attend A&amp;E should wait no more than 4 hours from arrival to admission, transfer or discharge. The national target is 95%</p> <p>This metric also forms part of the Trust's STP improvement trajectory.</p> <p>The Trust is not achieving the 95% national 4 hour target. However the Trust is achieving against the STP improvement trajectory.</p> <p>The proposed tolerance levels applied to the improvement trajectories are also illustrated.</p>	<p><b>A&amp;E Waiting Times - 4hr target</b></p> <table border="1"> <caption>A&amp;E Waiting Times - 4hr target Data</caption> <thead> <tr> <th>Month</th> <th>Improvement Trajectory</th> <th>Actual</th> <th>Improvement Trajectory with Tolerance</th> </tr> </thead> <tbody> <tr><td>Apr-16</td><td>95%</td><td>90.5%</td><td>95%</td></tr> <tr><td>May-16</td><td>95%</td><td>92.5%</td><td>95%</td></tr> <tr><td>Jun-16</td><td>95%</td><td>94.0%</td><td>95%</td></tr> <tr><td>Jul-16</td><td>95%</td><td>93.0%</td><td>95%</td></tr> <tr><td>Aug-16</td><td>95%</td><td>93.5%</td><td>95%</td></tr> <tr><td>Sep-16</td><td>95%</td><td>95.0%</td><td>95%</td></tr> <tr><td>Oct-16</td><td>95%</td><td>92.0%</td><td>95%</td></tr> <tr><td>Nov-16</td><td>95%</td><td>90.0%</td><td>95%</td></tr> <tr><td>Dec-16</td><td>95%</td><td>90.0%</td><td>95%</td></tr> <tr><td>Jan-17</td><td>95%</td><td>90.0%</td><td>95%</td></tr> <tr><td>Feb-17</td><td>95%</td><td>90.0%</td><td>95%</td></tr> <tr><td>Mar-17</td><td>95%</td><td>90.0%</td><td>95%</td></tr> </tbody> </table>	Month	Improvement Trajectory	Actual	Improvement Trajectory with Tolerance	Apr-16	95%	90.5%	95%	May-16	95%	92.5%	95%	Jun-16	95%	94.0%	95%	Jul-16	95%	93.0%	95%	Aug-16	95%	93.5%	95%	Sep-16	95%	95.0%	95%	Oct-16	95%	92.0%	95%	Nov-16	95%	90.0%	95%	Dec-16	95%	90.0%	95%	Jan-17	95%	90.0%	95%	Feb-17	95%	90.0%	95%	Mar-17	95%	90.0%	95%	<p>Whilst the Trust is not achieving the 95% national target improvement in performance continues with the Trust achieving 92.05% in October and meeting the STP Improvement trajectory.</p>
Month	Improvement Trajectory	Actual	Improvement Trajectory with Tolerance																																																			
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Diagnostic Waiting Times 6 Weeks  
Red: Less than 99%  
Green: 99% or above

Referral to treatment Open Pathways  
Red: Less than 92%  
Green: 92% or above

RTT - Number of patients waiting 52+ weeks  
Green = 0, otherwise Red

A&E Waiting Times - National Target  
Red: Less than 95%  
Green: 95% or above

A&E Waiting Times - STP Trajectory  
Red: Less than trajectory  
Green: Trajectory or above

Mandatory Standards - Access & Performance

Description

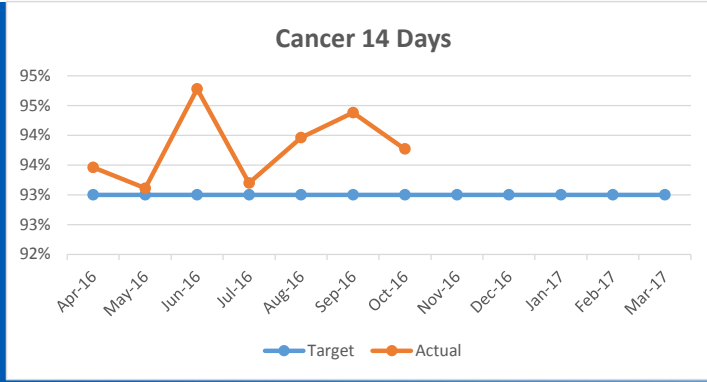
Aggregate Position

Trend

Variation

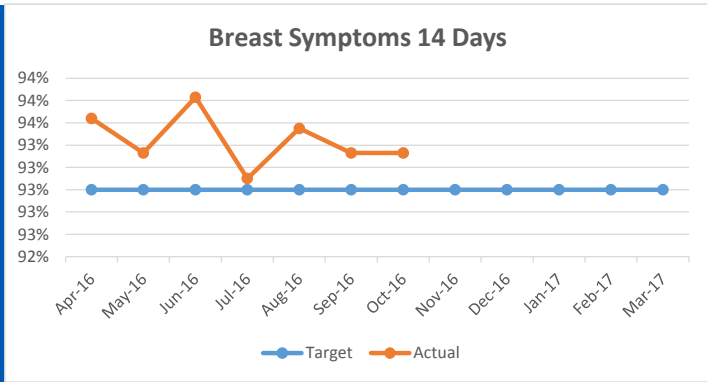
Cancer 14 Days  
 Red: Less than 93%  
 Green: 93% or above

All patients need to receive first appointment for cancer within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis.



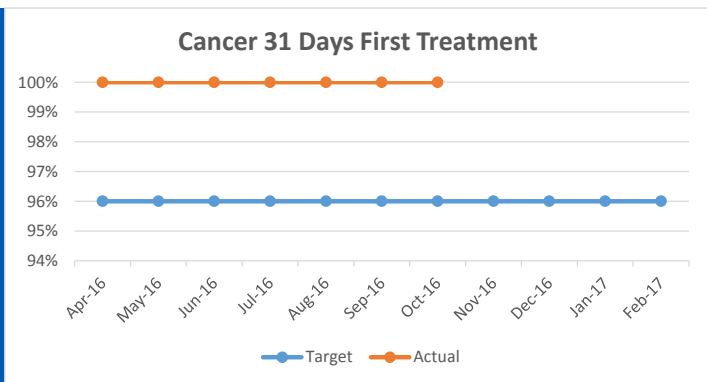
Breast Symptoms 14 Days  
 Red: Less than 93%  
 Green: 93% or above

All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis.



Cancer 31 Days First Treatment  
 Red: Less than 96%  
 Green: 96% or above

All patients to receive first treatment for cancer within 31 days of decision to treat. This national target is 96%. This target is measured and reported on a quarterly basis.



Mandatory Standards - Access & Performance

Description

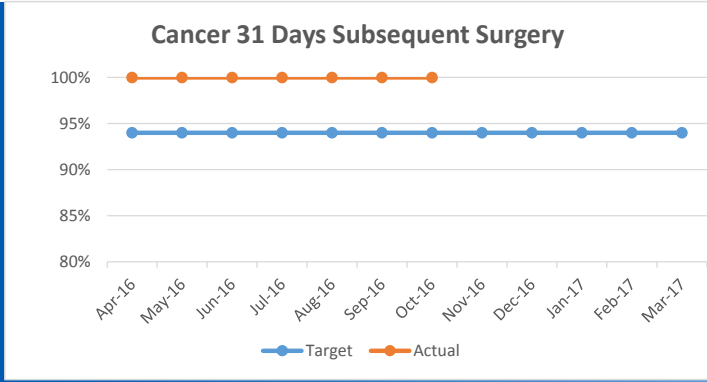
Aggregate Position

Trend

Variation

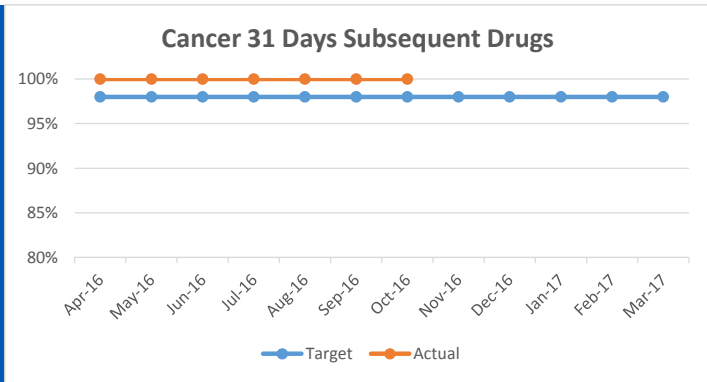
Cancer 31 Days Subsequent Surgery  
Red: Less than 94%  
Green: 94% or above

All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat/surgery. The national target is 94%. This target is measured and reported on a quarterly basis.



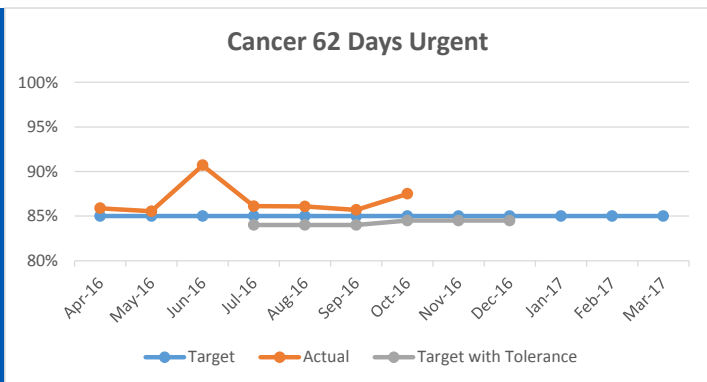
Cancer 31 Days Subsequent Drug  
Red: Less than 98%  
Green: 98% or above

All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat – anti cancer drug treatments. The national target is 98%. This target is measured and reported on a quarterly basis.



Cancer 62 Days Urgent  
Red: Less than 85%  
Green: 85% or above

All patients to receive first treatment for cancer within 62 days of urgent referral. The national target is 85%.  
This metric also forms part of the Trust's STP Improvement trajectory.  
The proposed tolerance levels applied to the improvement trajectories are also illustrated.

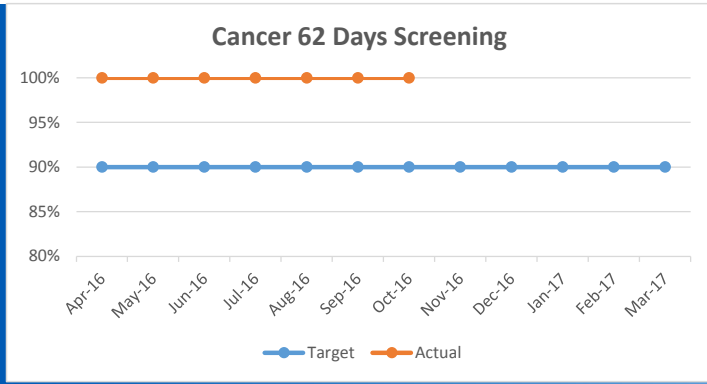


Mandatory Standards - Access & Performance

Description      Aggregate Position      Trend      Variation

Cancer 62 Days Screening  
Red: Less than 90%  
Green: 90% or above

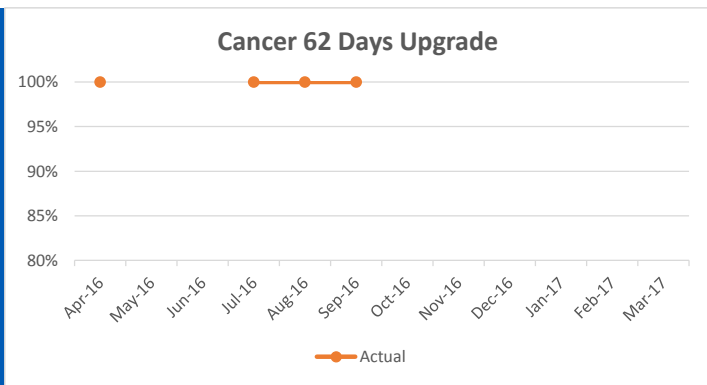
**Description**  
All patients must wait no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers. The national target is 90%. This target is measured and reported on a quarterly basis



**Variation**

Cancer 62 Days Upgrade

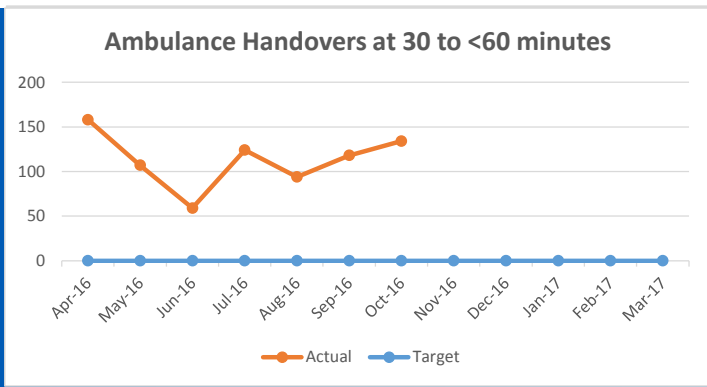
**Description**  
62 day upgrade



**Variation**

Ambulance Handovers 30 to <60 minutes  
Red: More than 0  
Green: 0

**Description**  
Number of ambulance handovers that took 30 to <60 minutes (based on the data record on the HAS system)



The A & E delivery board has signed an ambulance concordat to ensure the whole system focuses on this key measure. The Trust is working closely with NAWAS colleagues to review processes involved in handover to ensure that they are as robust as possible. There is a region wide patient safety summit on 25/11/16 around ambulance handovers which the Trust will be attending.



Mandatory Standards - Access & Performance

Description	Aggregate Position	Trend	Variation																																																				
<p><b>Ambulance Handovers at 60 minutes or more</b></p> <p>Red: More than 0 Green: 0</p>	<p>Number of ambulance handovers that took 60 minutes or more (based on the data record on the HAS system)</p>	<p><b>Ambulance Handovers at 60+ minutes</b></p> <table border="1"> <caption>Ambulance Handovers at 60+ minutes</caption> <thead> <tr> <th>Month</th> <th>Actual</th> <th>Target</th> </tr> </thead> <tbody> <tr><td>Apr-16</td><td>105</td><td>0</td></tr> <tr><td>May-16</td><td>40</td><td>0</td></tr> <tr><td>Jun-16</td><td>10</td><td>0</td></tr> <tr><td>Jul-16</td><td>30</td><td>0</td></tr> <tr><td>Aug-16</td><td>45</td><td>0</td></tr> <tr><td>Sep-16</td><td>25</td><td>0</td></tr> <tr><td>Oct-16</td><td>40</td><td>0</td></tr> <tr><td>Nov-16</td><td>0</td><td>0</td></tr> <tr><td>Dec-16</td><td>0</td><td>0</td></tr> <tr><td>Jan-17</td><td>0</td><td>0</td></tr> <tr><td>Feb-17</td><td>0</td><td>0</td></tr> <tr><td>Mar-17</td><td>0</td><td>0</td></tr> </tbody> </table>	Month	Actual	Target	Apr-16	105	0	May-16	40	0	Jun-16	10	0	Jul-16	30	0	Aug-16	45	0	Sep-16	25	0	Oct-16	40	0	Nov-16	0	0	Dec-16	0	0	Jan-17	0	0	Feb-17	0	0	Mar-17	0	0	<p>There has been an improvement in the position in quarter 2 when there was 105 patients who waited over 60 minutes, compared to 156 in quarter 1, however focus remains on this key measure of patient experience.</p>													
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Mar-17	0	0																																																					
<p><b>Discharge Summaries - % sent within 24hrs</b></p> <p>Red: Less than 95% Green: 95% or above</p>	<p>The Trust is required to issue and send electronically a fully contractually compliant Discharge Summary within 24 hrs of the patients discharge</p>	<p><b>Discharge Summaries - % sent within 24hrs</b></p> <table border="1"> <caption>Discharge Summaries - % sent within 24hrs</caption> <thead> <tr> <th>Month</th> <th>Actual</th> <th>Target</th> </tr> </thead> <tbody> <tr><td>Apr-16</td><td>68%</td><td>95%</td></tr> <tr><td>May-16</td><td>70%</td><td>95%</td></tr> <tr><td>Jun-16</td><td>80%</td><td>95%</td></tr> <tr><td>Jul-16</td><td>80%</td><td>95%</td></tr> <tr><td>Aug-16</td><td>88%</td><td>95%</td></tr> <tr><td>Sep-16</td><td>90%</td><td>95%</td></tr> <tr><td>Oct-16</td><td>90%</td><td>95%</td></tr> <tr><td>Nov-16</td><td>95%</td><td>95%</td></tr> <tr><td>Dec-16</td><td>95%</td><td>95%</td></tr> <tr><td>Jan-17</td><td>95%</td><td>95%</td></tr> <tr><td>Feb-17</td><td>95%</td><td>95%</td></tr> <tr><td>Mar-17</td><td>95%</td><td>95%</td></tr> </tbody> </table>	Month	Actual	Target	Apr-16	68%	95%	May-16	70%	95%	Jun-16	80%	95%	Jul-16	80%	95%	Aug-16	88%	95%	Sep-16	90%	95%	Oct-16	90%	95%	Nov-16	95%	95%	Dec-16	95%	95%	Jan-17	95%	95%	Feb-17	95%	95%	Mar-17	95%	95%	<p>Since Lorenzo go live the way we send discharge summaries has changed, which should support more accurate summaries. However we have seen a reduction in performance since November. We have therefore set up new report enabling each area can measure their performance against the target, and there is also an escalation process in place. We are seeing the impact and improvements have been made in the last month.</p> <p>We are currently investigating an SUI related to a delay in discharge summaries being sent to GPs, the issue was raised through the quality contract meeting and a full investigation is taking place.</p>													
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<p><b>Discharge Summaries - Number NOT sent within 7 days</b></p> <p>Red: Above 0 Green: 0</p>	<p>If the Trust does not send 95% of discharge summaries within 24hrs, the Trust is then required to send the difference between the actual performance and the 95% required standard within 7 days of the patients discharge</p>	<p><b>Discharge Summaries - Number NOT sent within 7 days</b></p> <table border="1"> <caption>Discharge Summaries - Number NOT sent within 7 days</caption> <thead> <tr> <th>Month</th> <th>Number not sent within 24hrs that resulted in &lt;95%</th> <th>Of the number required to hit 95% how many not sent within 7 days</th> <th>Target</th> </tr> </thead> <tbody> <tr><td>Apr-16</td><td>1600</td><td>1600</td><td>0</td></tr> <tr><td>May-16</td><td>1700</td><td>500</td><td>0</td></tr> <tr><td>Jun-16</td><td>1000</td><td>200</td><td>0</td></tr> <tr><td>Jul-16</td><td>1000</td><td>100</td><td>0</td></tr> <tr><td>Aug-16</td><td>500</td><td>100</td><td>0</td></tr> <tr><td>Sep-16</td><td>500</td><td>100</td><td>0</td></tr> <tr><td>Oct-16</td><td>500</td><td>100</td><td>0</td></tr> <tr><td>Nov-16</td><td>0</td><td>0</td><td>0</td></tr> <tr><td>Dec-16</td><td>0</td><td>0</td><td>0</td></tr> <tr><td>Jan-17</td><td>0</td><td>0</td><td>0</td></tr> <tr><td>Feb-17</td><td>0</td><td>0</td><td>0</td></tr> <tr><td>Mar-17</td><td>0</td><td>0</td><td>0</td></tr> </tbody> </table>	Month	Number not sent within 24hrs that resulted in <95%	Of the number required to hit 95% how many not sent within 7 days	Target	Apr-16	1600	1600	0	May-16	1700	500	0	Jun-16	1000	200	0	Jul-16	1000	100	0	Aug-16	500	100	0	Sep-16	500	100	0	Oct-16	500	100	0	Nov-16	0	0	0	Dec-16	0	0	0	Jan-17	0	0	0	Feb-17	0	0	0	Mar-17	0	0	0	
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Workforce

Description

Aggregate Position

Trend

Variation

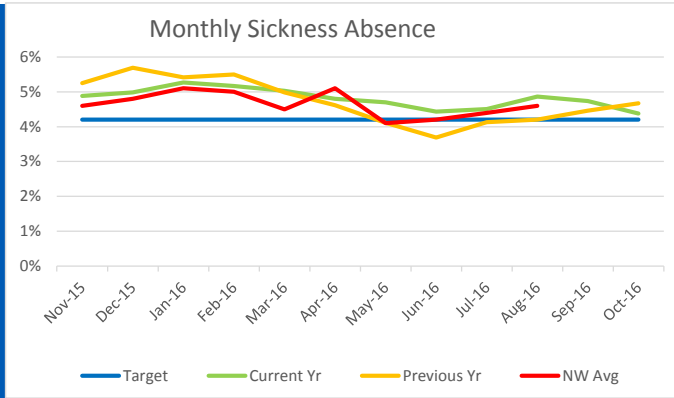
**Sickness Absence**  
Red: Above 4.5%  
Amber: 4.2% to 4.5%  
Green: Below 4.2%

Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year, and North West average

Sickness absence for October 2016 improved and was 4.38%.

The latest figure(August) for the North West absence performance are 4.6% (WHH was 4.86%)

The YTD sickness has marginally increased to 4.67% against a target of 4.2%



Managers have been reminded about the need for absence being input in a timely manner so the figures for this month should be accurate. The monthly figure of 4.38% for October is the lowest for over 12 months which is encouraging, especially at this time of year. WHH continues to be slightly above the North West Average.

Sickness for the Divisions is as follows:  
ACS - Oct-16 = 4.53%, YTD = 4.95%  
SWC - Oct-16 = 4.02%, YTD = 4.74%  
Corp - Oct-16 = 5.0%, YTD = 3.98%

The revised Attendance Management policy will be implemented from 1.12.16.

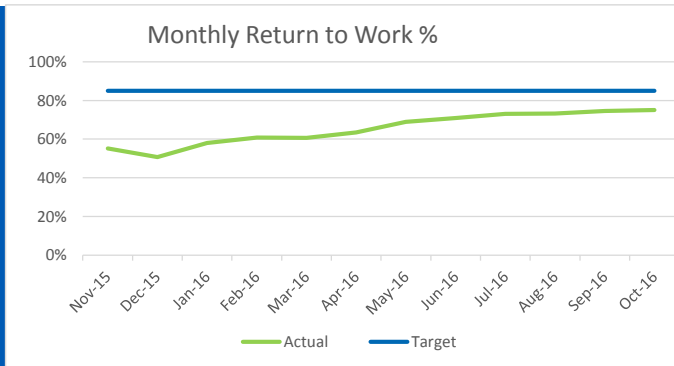
Stress remains the number one reason for absence with 24% of all sickness absence due to stress.

**Return to Work**  
Red: Below 75%  
Amber: 75% to 85%  
Green: Above 85%

A review of the completed monthly Return to Work Interviews

RTW compliance was 75% for October which was an improvement but continues to be below the Trust Target. However, the trend is generally upward and from April the increase is over 12%.

The YTD RTW rate is 67% an increase of 5% from the previous month.



Completion of RTWs is considered key to good sickness management and this has been reinforced at Divisional review meetings conducted by the Director of HR & OD in November. Audits undertaken by HRBPs of RTWs showed that on the whole these are being completed but in some instances they were being undertaken but not recorded on ESR. HRBPs continue to support their managers to increase compliance.

**Recruitment**  
Red: Above Target  
Green: On or Below Target

A measurement of the average number of days it is taking to recruit into posts.

It also shows the average number of days between the advert closing and the interview (target 10) to measure if we are taking too long to complete shortlisting and also highlights the number of days for which it takes successful candidates to complete their pre-employment checks

There is no change to the recruitment times from the previous month as there have been problems in running reports off NHS Jobs. This will be rectified for next month. Therefore, the overall total of 68 days remains the same.



No Change

Workforce

Description

Aggregate Position

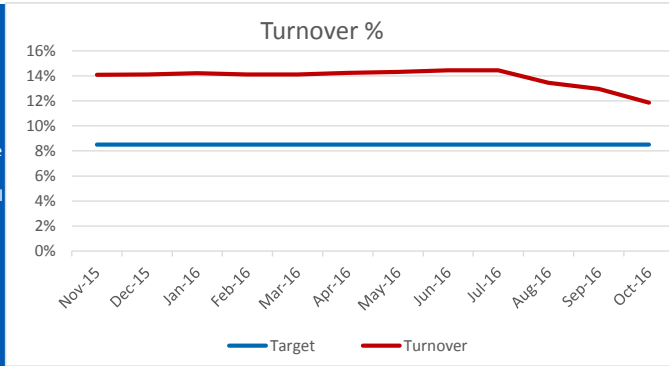
Trend

Variation

**Turnover**  
Red: Below 5%  
Above 12%  
Amber: 5% to 7% or  
10% to 12%

A review of the turnover percentage over the last 12 months

Turnover has reduced again for the fourth consecutive month to 11.86% and is the lowest for over 12 months. The status is now 'amber'. However this is still above the Trust target of 7 - 10%.



October was an excellent month for new starters with 81.3 wte commencing and only 31.4 wte staff leaving. Overall there continues to be more starters (43.8 wte) than leavers (37.6 wte)

The main reasons people are leaving WHH is for an improved 'Work Life Balance' (119 people in the last 12 months) which is almost twice the second reason given as 'Relocation' (67).

Work continues within the CBUs to address this.

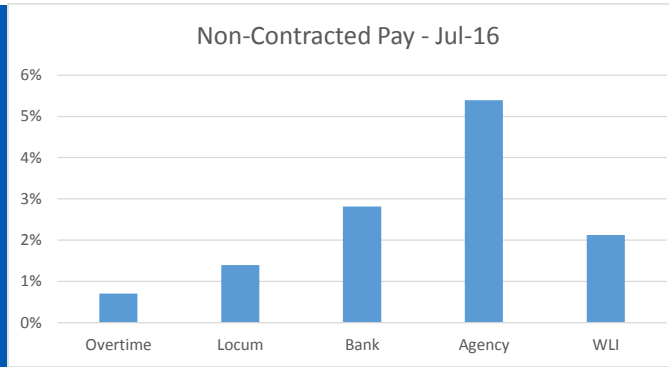
**Non Contracted Pay**

A review of the Non-Contracted pay as a percentage of the overall pay bill year to date

Agency spend remains the highest element of Non-Contracted pay, accounting for 5.39% of the Trusts overall pay bill year to date but better than the position at April of 5.93%.

Bank spend is 2.81% followed closely by WLI spend at 2.13% of the pay bill.

Overall Non-Contracted pay now makes up 12.43% of the pay bill compared to 13.02% in April.



Work continues on implementing the action plan developed alongside E&Y.

WLI payments reduced on a phased basis wef 17 October 2016.

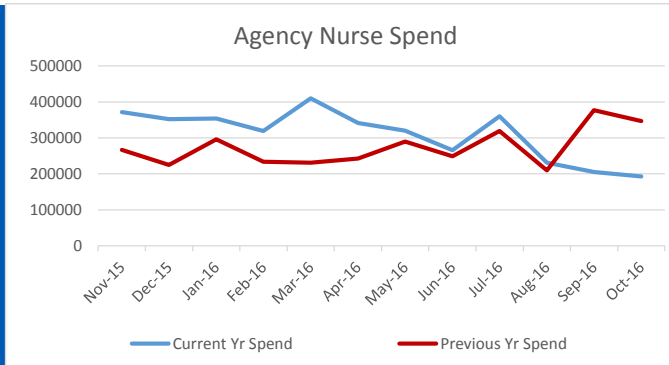
On 8 November an event was held at Aintree for all of the trusts in Cheshire and Mersey specifically relating to agency expenditure which was supported by NHSI.

NHSI has issued new reporting arrangements relating to 'Strengthening financial performance & accountability in 2016/17' much of which covers agency expenditure. This is why some additional metrics have been added to this report.

**Agency Nurse Spend**  
Red: Greater than  
Previous Yr  
Green: Less than  
Previous Yr

A review of the monthly spend on Agency Nurses

Agency Nurse spend continues to decrease and October was the lowest level this financial year at £193k. Expenditure is now less than in 2015/16 for the same period.



On-going work continues to reduce the reliance of Agency Nurses and this is reflected in the reduction over the last three months.

As above, on 8 November an event was held at Aintree for all of the trusts in Cheshire and Mersey specifically relating to agency expenditure which was supported by NHSI.

Workforce

Description

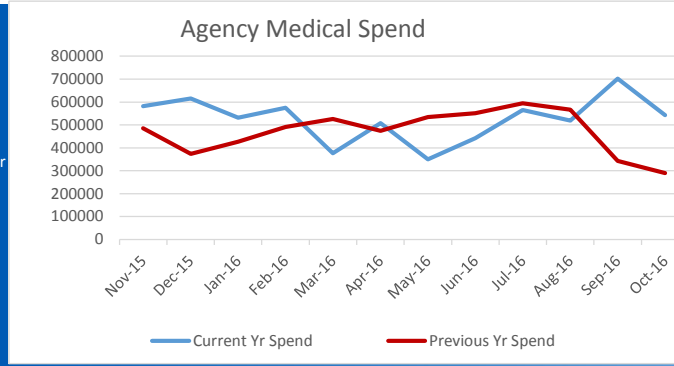
Aggregate Position

Trend

Variation

Agency Medical Spend  
Red: Greater than Previous Yr  
Green: Less then

A review of the monthly spend on Agency Locums  
Agency Medical spend significantly reduced in October by £159k to £543k but was considerably more than the same period last year (£290k).



There has been increased grip and control during October which has resulted in reduced expenditure. This focus will remain and be reviewed by the Director of HR & OD on a regular basis.  
Enforcing the Price Cap rules is continuing to prove difficult and the majority of our shifts worked each week breach the Price Cap.  
The trust has engaged Gatenby Sanderson to try and fill long term medical vacancies.

Essential Training  
Red: Below 70%  
Amber: 70% to 85%  
Green: Above 85%

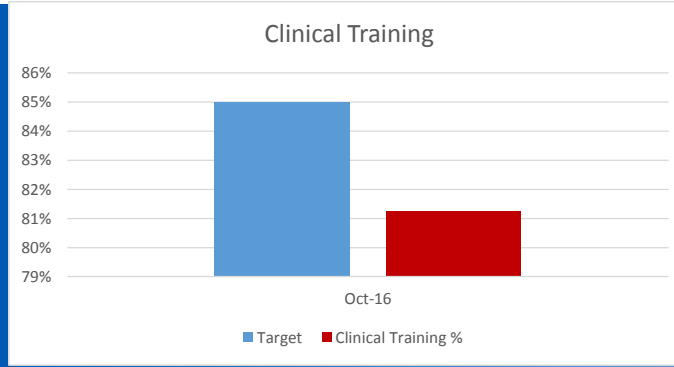
A summary of the Essential Mandatory Training Compliance, this includes:  
Corporate Induction  
Dementia Awareness,  
Fire Safety  
Health and Safety  
Moving and Handling  
The current compliance for October is 85.64% which is marginally above the trust target of 85%



Grouping the Mandatory Training in this method is new way of reporting compliance. The October rate was a very slight increase from the previous month and shows an upwards trend which has been sustained for 5 consecutive months.  
Divisional progress is as follows:  
ACS October = 84.36% Amber  
SWC October = 84.99% Amber  
Corp October = 89.80% Green

Clinical Training  
Red: Below 70%  
Amber: 70% to 85%  
Green: Above 85%

A summary of the Clinical Mandatory Training Compliance, this includes:  
Infection Control  
Resus  
Safeguarding Procedures (Adults) - Level 1  
Safeguarding Procedures (Adults) - Level 2  
Safeguarding Procedures (Children) - Level 1  
Safeguarding Procedures (Children) - Level 2  
Safeguarding Procedures (Children) - Level 3  
SEMA  
The current compliance for October is 81.25% but is below the trust target of 85%.



Grouping the Mandatory Training in this method is new way of reporting compliance. The October rate was a very slight decrease from the previous month.  
Divisional progress is as follows:  
ACS October = 77.55% Amber  
SWC October = 81.02% Amber  
Corp October = 88.92% Green

Workforce

Description

Aggregate Position

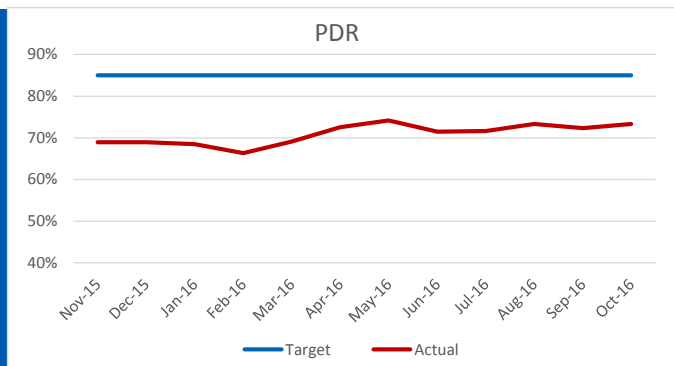
Trend

Variation

**PDR**  
Red: Below 70%  
Amber: 70% to 85%  
Green: Above 85%

A summary of the PDR Compliance rate

The PDR compliance rate for October is 73.34% but this is still below the Trust target of 85%.



The HR team are offering further support to managers who are struggling with their PDR Compliance.

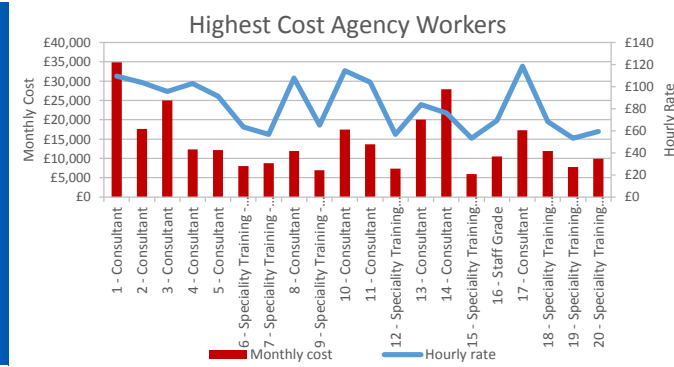
The Director of HR & OD met again with the Divisions during November to emphasise the importance of PDR rates increasing. Rates are increasing but only marginally and the Divisions have been asked to give this more focus.

Divisional progress is as follows:  
ACS October = 68.40% Red  
SWC October = 72.16% Amber  
Corp October = 81.31% Amber

**Highest Cost Agency Workers**

A summary of the Top 20 highest agency earners over the last 12 months

It is important to note that although the table shows the Top 20 highest agency staff over the last 12 months, 7 of these agency workers are no longer working through an agency at this rate. Some have left the trust completely and others are working directly for the trust at a lower rate.



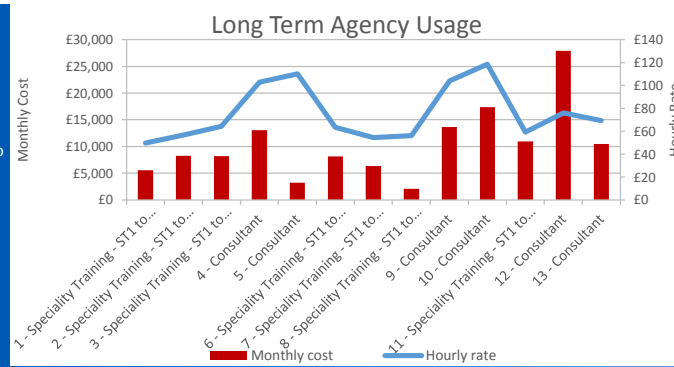
In addition to the 7 agency workers who are no longer working through an agency, 2 more are planning to transfer to be employed directly at the trust on a lower rate and one more terminates their appointment at the end of November 2016.

Efforts are continuing to try and reduce the rates for the remaining agency workers.

**Long Term Agency Usage**

A summary of agency workers who have been working at the trust every month for over 6 months

The table shows that there are 13 agency doctors who have worked for the trust for over 6 months. The red columns show the total monthly cost for each doctor and the blue line shows the hourly rate.



The highest hourly rate is for consultant 10 on c£120 per hour and the highest cost per month is consultant 12 on c£28k.

It should be noted that some doctors only work on an infrequent basis but at least once per month and are included on the table.

Efforts have been made to persuade some agency doctors to work directly for the trust and this has been met with some success. This work continues.

Safely Reducing Costs & Mandatory Standards - Finance

Description

Aggregate Position

Trend

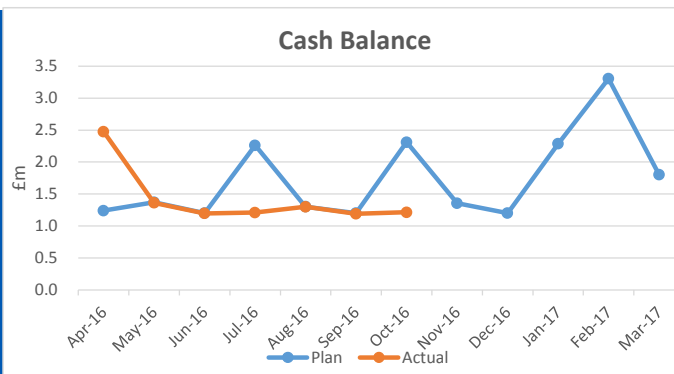
Variation

Cash Balance

Red: Less than 90% or below minimum cash balance per NHSI  
Amber: Between 90% and 100% of planned cash balance  
Green: On or better than plan

Cash balance at month end compared to plan

Under the terms and conditions of the working capital loan the Trust is required to have a minimum cash balance during the month of £1.2m.  
The current cash balance of £1.2m equates to circa 2 days operational cash.



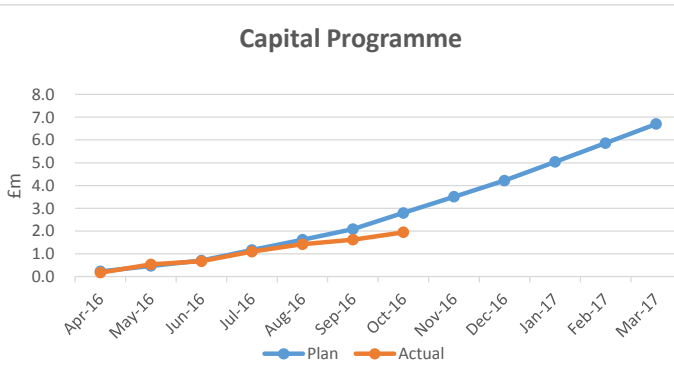
The current cash balance of £1.2m is £1.1m below the planned cash balance of £2.3m however it was necessary to have a cash balance of £1.2m at the end of the month in order to comply with the terms and conditions of the working capital facility.

Capital Programme

Red: Off plan <80% - >110%  
Amber: Off plan 80-90% or 101-110%  
Green: On plan 90%-100%

Year to date capital expenditure compared to plan

The actual capital spend in the month is £0.3m which increases the year to date spend to £1.9m.



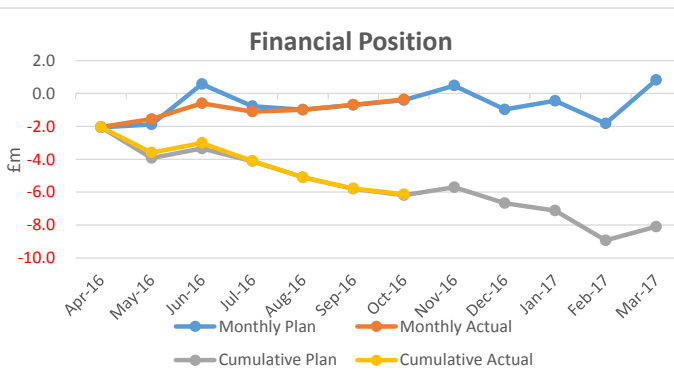
The cumulative capital spend of £1.9m is £0.9m below the planned spend of £2.8m.

Financial Position

Red: Deficit Position  
Amber: Actual on or better than planned but still in deficit  
Green: Surplus

Year to date surplus or deficit compared to plan.

The actual deficit in the month is £0.4m which increases the cumulative deficit to £6.1m.



The cumulative deficit of £6.1m is £0.1m below the planned deficit of £6.2m.

Safely Reducing Costs & Mandatory Standards - Finance

Description

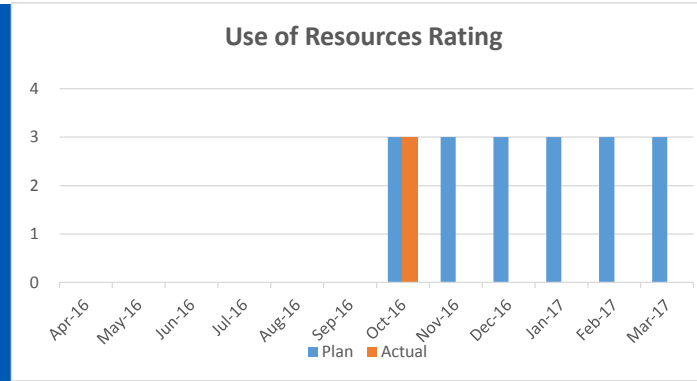
Aggregate Position

Trend

Variation

Year to date Use of Resources Rating compared to plan

The current Use of Resources Rating is 3. Capital Servicing Capacity, Liquidity and I&E margin are all scored at 4 (lowest), agency ceiling is scored at 2 and Variance from plan is scored at 1 (highest).



The current Use of Resources Rating of 3 is in line with the planned rating of 3.

Planned improvements in productivity and efficiency.

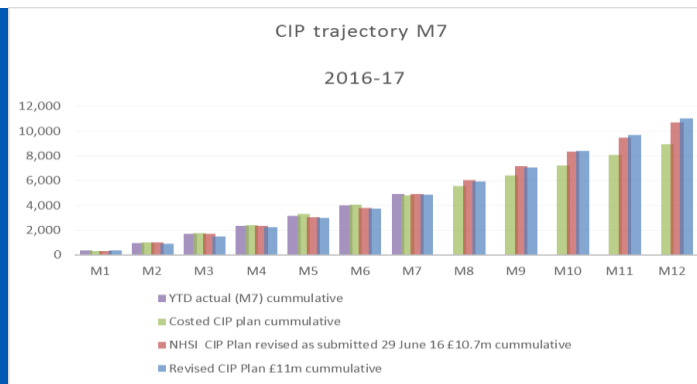
The Trust has a CIP target of £11m and delivery of £10.7m is currently assumed in the reforecast financial plan. To date the Trust has developed schemes worth £8.953m in year (£9.579m recurrently).

Clinical Business Units / Corporate Support area	CIP Internal Target £11m £000s	CIP costed PYE £000s	CIP costed FYE £000s	% of £11m target costed PYE %
Surgery and Women's and Children's	4,161	2,989	3,815	72%
Acute Care Services	4,516	3,594	3,699	80%
Schemes not allocated to CBUs	0	484	474	-
Controls	277	0	0	0%
Outpatients	121	121	182	100%
Corporate support areas	1,925	1,765	1,409	92%
<b>Total Trust</b>	<b>11,000</b>	<b>8,953</b>	<b>9,579</b>	<b>81%</b>

The part year effect of costed schemes is £8.953m which is £1.747m below plan. This is offset by £1.852m part year effect of cost avoidance schemes. The full year effect of costed schemes £9.579 m which is £1.121m below plan, again this is offset by £3.072m FYE of cost avoidance schemes.

Year to date cost savings delivered compared to plan.

The savings delivered in month are £0.887m which increases the cumulative savings delivered to £4.916m.



The cumulative savings of £4.916m are £0.012m ahead of the planned savings of £4.904m at the end of month 7.

As stated in the "Cost Improvement Programme - plans in progress" section, the total value of costed schemes in year as at month 7 is £8.953m against a plan of £10.7m.

Use of Resources Rating

Red: Use of Resources Rating 4  
Amber: Use of Resources Rating 3  
Green: Use of Resources Rating 1

Cost Improvement Programme - Plans in Progress

Red: Plan is less than 50% of annual plan  
Amber: Plan is between 51% and 89% of annual plan  
Green: Plan is over 90% of annual plan

Cost Improvement Programme - Performance to date

Red: Cumulative savings less than 90% of planned savings  
Amber: Cumulative savings between 90% and 100% of planned savings  
Green: On or above plan

Safely Reducing Costs & Mandatory Standards - Finance

Description

Aggregate Position

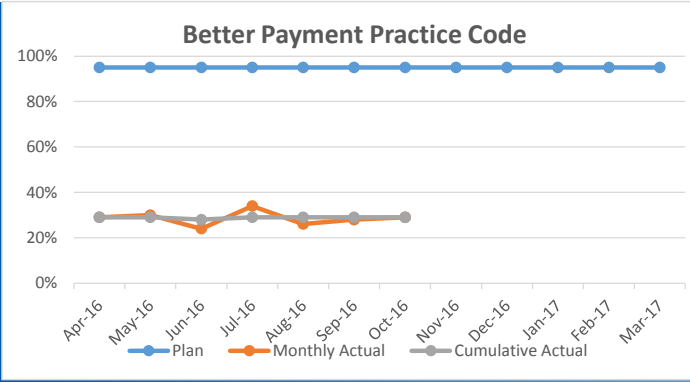
Trend

Variation

**Better Payment Practice Code**

Red: Cumulative performance below 85%  
Amber: Cumulative performance between 85% and 95%  
Green: Cumulative performance 95% or better

Payment of non NHS trade invoices within 30 days of invoice date compared to target. In month the Trust has paid 29% of suppliers within 30 days which maintains the year to date performance at 29%.

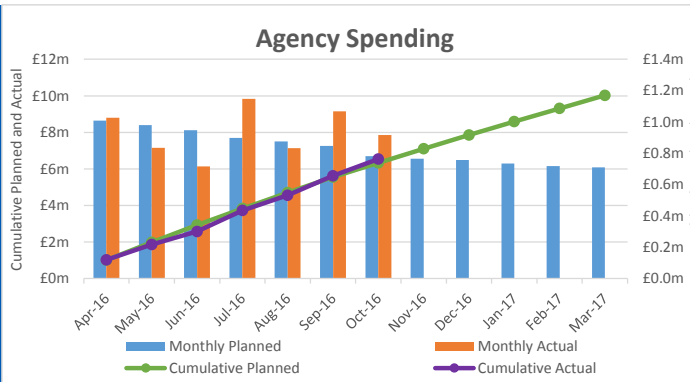


The cumulative position of 29% is 66% below the national standard of 95%, this is due to the low cash balance and the need to manage cash very closely.

**Agency Spending**

Red: More than 105% of ceiling  
Amber: Over 100% but below 105% of ceiling  
Green: Equal to or less than agency ceiling.

Year to date agency spend compared to agency ceiling. The actual agency spend in the month is £0.9m which increases the year to date spend to £6.5m.



The cumulative agency spend of £6.5m is £0.2m above the agency ceiling of £6.3m.



We are WHH

**BOARD OF DIRECTORS**

<b>AGENDA REFERENCE:</b>	<b>BM/16/194a</b>	
<b>SUBJECT:</b>	<b>Key Issues Report from the Quality Committee 1<sup>st</sup> November 2016</b>	
<b>DATE OF MEETING:</b>	30th November 2016	
<b>ACTION REQUIRED</b>	<b>For Assurance</b>	
<b>AUTHOR(S):</b>	Margaret Bamforth, Committee Chair	
<b>DIRECTOR SPONSOR:</b>		
<b>LINK TO STRATEGIC OBJECTIVES:</b>	All	
<b>LINK TO BOARD ASSURANCE FRAMEWORK (BAF):</b>	BAF1.1: CQC Compliance for Quality	
	BAF1.2: Health & Safety	
	BAF2.2: Nurse Staffing	
<b>FREEDOM OF INFORMATION STATUS (FOIA):</b>	Release Document in Full	
<b>FOIA EXEMPTIONS APPLIED: (if relevant)</b>	None	
<b>EXECUTIVE SUMMARY (KEY ISSUES):</b>	This report provides a high level summary of business at the September meeting.	
<b>RECOMMENDATION:</b>	<p><b>The Board note the report and that there are no matters arising for escalation.</b></p> <p><b>The Board satisfies itself that the revised Terms of Reference will ensure the Committee delivers the assurance It requires and either makes amendments or ratifies accordingly.</b></p>	
<b>PREVIOUSLY CONSIDERED BY:</b>	<b>Committee</b>	Not Applicable
	<b>Agenda Ref.</b>	
	<b>Date of meeting</b>	
	<b>Summary of Outcome</b>	

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## KEY ISSUES REPORT QUALITY COMMITTEE

<b>Date of meeting:</b>	1 <sup>st</sup> November 2016
<b>Standing Agenda Items</b>	None
<b>Formal Business</b>	<p>Quality Improvement Champions</p> <p>The Committee received a report outlining the work of the first cohort of Quality Improvement Champions. The second cohort is currently undertaking the training programme. The work of the Quality Champions has already been presented to the October Trust Board and the enthusiasm and quality of the projects was evident on that occasion. Dr Anne Robinson, Associate Medical Director Quality Improvement, wanted to draw the Quality Committee's attention to three particular projects that have had a significant impact.</p> <ul style="list-style-type: none"> <li>• A Urinary Catheter Passport has been developed by Rachel Birley, which facilitates improved communication regarding the care of catheters at home and supports improved self-care by patients.</li> <li>• Dr Shilpa Patel has been involved in a project reviewing clinical venues for patients referred to ENT post trauma. She is so impressed with the QI methodology and new skills that she has acquired that she wanted to share her learning. So, she is supporting F1s to develop QI skills and will be acting as a mentor to them.</li> <li>• Erin Wilson, Specialist Orthoptist is now involved in a national project to introduce bedside sight testing to identify those at risk of falls.</li> </ul> <p>The long-term vision is to mentor and support staff and share experiences via the extranet to create a culture of quality improvement. The project is being carried out through a partnership between AQuA and the Trust. A bespoke training programme has been developed through this partnership.</p> <p>More details can be found on the extranet.</p> <p><a href="https://extranet.whh.nhs.uk/workspaces/whh-innovation/quality-improvement-champions">https://extranet.whh.nhs.uk/workspaces/whh-innovation/quality-improvement-champions</a></p> <p>Quality Dashboard</p> <p>The committee went through the Quality Dashboard. The Trust has been unable to meet the target for VTE risk assessment and prophylaxis. There appears to be a number of issues underlying this and opportunities for</p>

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	<p>improving compliance are being explored at several different levels. Recording appears to be a significant factor and moving to electronic recording has possibly compromised the quality of the data captured. Work is underway with the Matrons to improve the data quality.</p> <p>There was a lengthy discussion about the Advancing Quality CQUINs, which include diabetes, pneumonia and COPD. Again the issues are complex and, although there is progress against the thresholds, it is proving difficult to meet the required level. Discussion with the CCG is in progress to look at how this can be managed going forward. Other ways of presenting the data so that progress could be more visible was also discussed. The need to build in additional support as part of the planning process for CQUINs was also highlighted.</p> <p>Many of the same issues apply to the Sepsis measures. The minimum thresholds are not being met for inpatient and ED screening and the picture for antibiotic administration is mixed. Some of the issues also relate to data collection and auditing.</p> <p>The Committee discussed producing a paper for presentation to the Board which would review all the CQINs in more depth and look at the underlying issues which are currently resulting in the failure to meet the required thresholds.</p> <p>There is to be a review of the complaints process that will include PALS.</p> <p>Quality Impact Assessment Process</p> <p>A paper was presented to the Quality Committee for discussion and consideration. The oversight for CIP Quality Impact Assessment process is via the FSC. The paper presented to Quality Committee outlined the process from an initial idea to implementation. The paper included a flow diagram which sets out the process, the method of risk assessment and the sign off by the Chief Nurse and Medical Director. The Committee agreed that the process was robust. The role of the Quality Committee in quality impact assessment was discussed. Although, it was not considered necessary for the Quality Impact Assessments to come to the Committee, it was felt that there is a need for some level of oversight from a quality perspective. What would be useful, and provide additional assurance, is a review following implementation of a project to look at the actual quality impact incurred and whether the original risk assessment was a realistic valuation.</p> <p>CQC Inspection</p> <p>The Quality Committee recognises the need to ensure a state of</p>
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	<p>preparedness for a CQC visit. Three papers were presented. These included, a paper outlining the development of a CQC Operational Board, the CQC document, 'What our strategy means for the health and social care services we regulate', and the action plan from the CQC visit in January 2015. The CQC Operational Board will oversee the gathering of evidence, the mapping of the Key Lines of Inquiry, as well as identifying and overseeing the related work streams. Although, none of these papers were looked at in any detail, they generated discussion about the new methodology the CQC will be using and the need to gather evidence to demonstrate a change in practice in those areas identified by the CQC as needing improvement. Regular reports will come to the Quality Committee from the CQC Operational Board from January.</p> <p>The Risk Register was reviewed and the need to be clear about the impact of mitigation on the initial risk rating was highlighted.</p>
<p><b>Local Policies and Guidance Approved:</b></p>	<p>None</p>
<p><b>Any Learning and Improvement identified from within the meeting:</b></p>	<p>Trainee Doctors – lessons learned. Action plan developed following feedback from trainee doctors to ensure they receive information re lessons learned from incidents and other safety issues.</p>
<p><b>Any other relevant items the Committee wishes to escalate?</b></p>	<p>None.</p>



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## BOARD OF DIRECTORS

<b>AGENDA REFERENCE:</b>	<b>BM/16/194b</b>	
<b>SUBJECT:</b>	<b>Key Issues Report form the Finance &amp; Sustainability Committee October 2016</b>	
<b>DATE OF MEETING:</b>	30th November 2016	
<b>ACTION REQUIRED</b>	<b>For Assurance</b>	
<b>AUTHOR(S):</b>	Terry Atherton, Committee Chair	
<b>EXECUTIVE DIRECTOR SPONSOR:</b>		
<b>LINK TO STRATEGIC OBJECTIVES:</b>	All	
<b>LINK TO BOARD ASSURANCE FRAMEWORK (BAF):</b>	BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management	
	BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management	
	BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management	
<b>FREEDOM OF INFORMATION STATUS (FOIA):</b>	Release Document in Full	
<b>FOIA EXEMPTIONS APPLIED: (if relevant)</b>	None	
<b>EXECUTIVE SUMMARY (KEY ISSUES):</b>	This report provides a high level summary of business at the November meeting.	
<b>RECOMMENDATION:</b>	The Board is asked to note the contents of the discussions and that there is one matter for escalation.	
<b>PREVIOUSLY CONSIDERED BY:</b>	<b>Committee</b>	Not Applicable
	<b>Agenda Ref.</b>	
	<b>Date of meeting</b>	
	<b>Summary of Outcome</b>	



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## KEY ISSUES REPORT NOVEMBER FINANCE AND SUSTAINABILITY COMMITTEE

<b>Date of meeting:</b>	<b>Wednesday 23<sup>rd</sup> November 2016</b>
<b>Reports <i>not</i> received as agreed in the annual work plan:</b>	All reports were received.
<b>Action taken:</b>	N/A
<b>Any areas of risk identified:</b>	<p>The meeting was quorate (indeed 3 Non-Executive Directors were present, in addition to the Chair).</p> <p>The minutes of the meeting of 19<sup>th</sup> October were approved as a correct record.</p> <p>In line with the authority of the Board the Finance and Sustainability Committee reviewed and approved the final Draft Version 3 of the Draft Operation Plan 2017/18 and 2018/19 which needed to be submitted by midday on 24<sup>th</sup> November. A number of enhancements were identified in respect of the narratives of both Quality and Workforce Planning.</p> <p>The Control Totals advised by NHS Improvement pose a challenge to the Trust. There is the capacity for committee members to give further feedback on the final draft ahead of the December submission date.</p> <p>The October meeting KIR indicated that Finance and Sustainability Committee would on behalf of the Board assume the responsibility for the oversight of the Pay Bill in its widest sense. The Director of HR and OD had joined the meeting for this item and following a presentation and a wide ranging discussion the Finance and Sustainability Committee agreed the information requirements, including benchmarking data and performance measures that are required to fulfil this role. It was understood that this is not just to satisfy the requirements of NHS Improvement; this is what the Trust requires.</p> <p>Finance and Sustainability Committee will commence this role from the December meeting as a specific agenda item and the Medical Director, Chief Nurse and Director of HR and OD will be present for this agenda item.</p> <p>The Finance Report for Month 7 was reviewed. For the month of October a deficit of £0.4m was incurred, which was on plan. The year to date loss of £6.1m is marginally better than plan.</p> <p>The usual variances in both income and expenditure were reviewed together with ongoing service pressures.</p> <p>Cash remains tight and due to delays in receiving Q2 Sustainability and</p>



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	<p>Transformational funding, the Trust has now drawn in full the interim revolving working capital loan of £7.9m.</p> <p>Finance and Sustainability Committee received the minutes of the Capital Planning Group of 28<sup>th</sup> October. An update will be provided to the December meeting as to the review of current approval levels in respect of Capital Expenditure.</p> <p>Finance and Sustainability Committee received a presentation around the emerging pressures concerning the ability to achieve the 2016/17 Control Total and the consequent impact on cash flow. A very lengthy discussion ensued around these pressures and the scenario planning that has taken place. Whilst the Finance and Sustainability Committee will receive monthly updates including negotiations with Commissioners and Regulators and the Mitigations underway, it was agreed that the position should be escalated to the Private part of the next Trust Board meeting on 30<sup>th</sup> November.</p> <p>At the end of Month 7, the Trust has delivered £4.916m in actual CIP, some £12k ahead of plan for the Months 8-12 CIP delivery becomes more challenging. Total CIP and cost avoidance/income recovery schemes have been developed to the value of £10.806m PYE and £12.651m FYE.</p> <p>The 2016/17 CIP Target remains at £10.7m.</p> <p>The Committee received a paper and presentation which outlined the Transformation and Cost Improvement Governance arrangements in a very comprehensive and reassuring manner.</p> <p>The draft minutes of the Innovation and Cost Improvement Committee of 27<sup>th</sup> October were received.</p> <p>For the month of October, the A&amp;E four hour performance was a very creditable 92.05% against the agreed trajectory of 91%. This gives a year to date performance of 92.67%. Feedback has been received following the ECIP visit and the final report is awaited.</p> <p>Ambulance handover times remain a challenge for the Trust.</p> <p>Achievement of the 18 week RTT remains strong.</p> <p>All remaining performance targets are at or close to plan despite the increasing seasonal pressures.</p> <p>Finance and Sustainability Committee received a comprehensive update in respect of IM&amp;T matters noting that Lorenzo has now been operational for 12 months. Committee members were especially keen to receive updates in the areas of communication in respect of both appointments and discharge letters.</p> <p>A number of sub committee minutes were received and noted by the Finance and Sustainability Committee in respect of IM&amp;T related matters.</p>
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	The Finance and Sustainability Committee will next meet on 20 <sup>th</sup> December 2016, 2 pm in the Executive Meeting Room.
<b>Action taken:</b>	
<b>Local Policies and Guidance Approved:</b>	
<b>Any Learning and Improvement identified from within the meeting:</b>	
<b>Any other relevant items the Committee wishes to escalate?</b>	As above.





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## BOARD OF DIRECTORS

<b>AGENDA REFERENCE:</b>	<b>BM/16/195</b>
<b>SUBJECT:</b>	<b>Adult Safeguarding Annual Report 2015/16</b>
<b>DATE OF MEETING:</b>	30th November 2016
<b>ACTION REQUIRED</b>	<b>For Assurance</b>
<b>AUTHOR(S):</b>	Wendy Turner
<b>EXECUTIVE DIRECTOR SPONSOR:</b>	Kimberley Salmon-Jamieson, Chief Nurse
<b>LINK TO STRATEGIC OBJECTIVES:</b>	SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience
<b>LINK TO BOARD ASSURANCE FRAMEWORK (BAF):</b>	BAF1.1: CQC Compliance for Quality
<b>STRATEGIC CONTEXT</b>	This report provides information about Trust Adult Safeguarding activity between 1st April 2015 and 31st March 2016. The report is to provide assurance to the Board of Directors around Adult Safeguarding during this period.
<b>EXECUTIVE SUMMARY (KEY ISSUES):</b>	<p>The report highlights areas of priority for the Trust;</p> <ol style="list-style-type: none"> <li>1. To ensure that Trust policy reflects the changes in The Care Act (1) including the new categories of abuse. Ensure that we are compliant with CQC regulation outcome 7.(2)</li> <li>2. All training resources should be in line with the Bournemouth Model and should reflect changes in the Care Act and compliance with CQC regulation outcome 7.</li> <li>3. To put a structure in place to monitor and capture the numbers of patients we have detained under DoLS. (3)</li> <li>4. To be able to work with relevant partner agencies in ensuring complaint DoLS provision.</li> <li>5. To continue to work in partnership with the Trust Children's Safeguarding team to provide domestic abuse/violence policy and guidance to Trust teams.</li> <li>6. Facilitate Wrap and Prevent training to all clinical facing staff.</li> <li>7. Learning Disability service provision required review.</li> <li>8. Review shared policies with links to adult safeguarding.</li> </ol>



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<b>RECOMMENDATION:</b>	The Board is asked to note the contents of this report	
<b>PREVIOUSLY CONSIDERED BY:</b>	<b>Committee</b>	Quality Committee
	<b>Agenda Ref.</b>	W&HHFT/QC/16/166
	<b>Date of meeting</b>	4 <sup>th</sup> October 2016
	<b>Summary of Outcome</b>	Approved
<b>FREEDOM OF INFORMATION STATUS (FOIA):</b>	Release Document in Full	
<b>FOIA EXEMPTIONS APPLIED:</b> <i>(if relevant)</i>	None	



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<b>SUBJECT</b>	<b>Adult Safeguarding Annual report 2015/16</b>	<b>AGENDA REF:</b>	<b>16/195</b>
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## 1. BACKGROUND/CONTEXT

This report provides information about the Adult Safeguarding activity between 1 April 2015 and 31 March 2016. The report will provide the Board of Directors with a view of all areas encompassed within Adult Safeguarding during this time to provide assurance that the necessary safeguarding frame work is in place.

Safety from harm and exploitation is one of our most basic needs; everyone has a right to be safe. The Trust has a statutory duty and obligation to meet national/local legislation and policies; as such the Trust is required to develop robust measurable safeguarding systems and processes in order to protect vulnerable groups and service users within the organisation from harm and exploitation. Safeguarding encompasses a range of activities aimed at upholding a person's fundamental right to be safe whilst at the same time protecting peoples' rights to make choices and decisions.

## 2. KEY ELEMENTS

Changes in The Care Act including new categories of abuse:

- DoLS (Deprivation of Liberty Safeguards)
- Domestic abuse
- Training
- Prevent/WRAP
- Learning Disability provision

## 3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

- Adult Safeguarding Lead Nurse to ensure that the Adult Safeguarding policy is updated to include changes in The Care Act including the new categories of abuse.
- Adult Safeguarding Lead Nurse to continue to work closely with the children's safeguarding team in the provision of domestic abuse support and education across the trust.
- Adult Safeguarding Lead Nurse to ensure that there is a system in place to monitor all patients with in the Trust who may be detained under DoLS.
- Adult Safeguarding Lead Nurse to ensure that training provision is reviewed and access to training is improved. Also to make sure that training information has been updated to include changes in The Care Act including the new categories of abuse.



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- Adult Safeguarding Lead Nurse to ensure that a WRAP program of training is introduced at the Trust and that regular Prevent updates are provided in the regular training program for all clinical staff.
- Currently the provision of learning disability support for the Trust now sits with the safeguarding team, following a reorganisation of services at the Trust. However for the period that this report covers this provision was the responsibility of the former Patient Experience Matron. Going forward learning disability performance data will be included with all other adult safeguarding performance reporting. The Mazar report recommendations will be incorporated into the Trust Safeguarding Framework.

## 4. IMPACT ON QPS?

### Q

All elements of safeguarding service provision, training material, policies and procedures must reflect our statutory obligations and meet our regulatory requirements in order to provide the tools to ensure that our staff are able to recognise and act on safeguarding concerns. It's of paramount importance that our teams have the right policies, training and knowledge in place in order to recognise adults at risk. Not observing this element would mean that there could be a potential risk of missed referrals.

### P

People are the most important element of safeguarding. We need to ensure that the message from The Care Act is delivered and understood by the ward teams and that processes are in place to enable our staff to provide the level of support required by vulnerable people. We need to equip staff with the knowledge of how to do this well and to ensure when needed they know where and when to request specialist knowledge. This will ensure that every potential safeguarding alert/concern is investigated where and when required.

### S

All policies and procedures in place are required to meet statutory and legal requirements and are subject to scrutiny and review by external agencies.

## 5. MEASUREMENTS/EVALUATIONS

The Adult Safeguarding Service is measured and evaluated on a quarterly and annual basis.

The data for last year regarding referrals and contacts across the Trust is incomplete due to inconsistencies in the data collection. The following areas are measured quarterly and collated at year end:

- The volume of referral/concern activity, including internal ICE referrals, external local authority referrals and interface incidents.



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- DATIX systems are in place to alert the adult safeguarding team to incidents and complaints. Details of comparisons for 2014/15 and 2015/16 can be found at Appendix 1.
- Staff Training Compliance.
- The themes and trends within the referral, complaint or incident (pertaining to categories of abuse) can then be evaluated and reported on.

## 6. TRAJECTORIES/OBJECTIVES AGREED

- Continue to report quarterly and annually on service performance.
- To collate meaningful data and evidence in order to measure and audit the current years' performance making comparisons at the end of each quarter against the previous quarter.
- To ensure that safeguarding policies are kept up to date.
- To maintain training programmes.
- To ensure DoLS and LD agendas continue to be supported throughout the Trust
- To ensure that we comply with The Care Act and that we reflect essential standards in relation to Outcome 7.

## 7. MONITORING/REPORTING ROUTES

- The following reporting routes are in place;
- Quarterly reports to Warrington CCG (copy to contracts, chief nurse and deputy chief nurse)
- Quarterly reports to the Clinical Quality Focus Group.
- Bi-annual reports to the Patient Safety Committee
- Annual report to Warrington and Halton Hospital Trust Board, Warrington Safeguarding Adults Board and all sub groups, Halton Safeguarding Adults Board and all sub groups.

## 8. ASSURANCE COMMITTEE

Annual reporting to the Quality Committee.

## 9. TIMELINES

Continue to provide evidence through reporting into patient safety and clinical quality groups



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**Appendix one;**

**Incidents by category and numbers reported**

	14/15	15/16	Total
<b>Totals:</b>	193	286	479
<b>Safeguarding Adults</b>	34	28	62
<b>Security Issue</b>	28	39	67
<b>Pressure Ulcer</b>	23	87	110
<b>Unexpected events</b>	21	38	59
<b>Medicines</b>	13	13	26
<b>Physical Assault to Other eg Patient Visitor</b>	12	8	20
<b>Verbal Assault/Threatening Behaviour</b>	9	2	11
<b>Assault non physical</b>	5	7	12
<b>Communications Issue (verbal, electronic and paper)</b>	5	4	9
<b>Treatment</b>	5	2	7
<b>Domestic Abuse</b>	4	1	5
<b>Consent &amp; Mental Capacity Act</b>	4	2	6
<b>Bed management</b>	3	2	5
<b>Dietetics / Nutrition</b>	3	0	3
<b>Mental Health Act</b>	3	7	10
<b>Patient Slips, Trips &amp; Falls</b>	3	20	23
<b>Fire</b>	2	2	4
<b>Discharge</b>	2	6	8
<b>Emergency Medicine</b>	2	0	2
<b>Patient Choice</b>	2	1	3



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<b>Administrative</b>	1	0	1
<b>Community Midwives (Pick List)</b>	1	1	2
<b>Gynaecology (Pick List)</b>	1	0	1
<b>Breach of confidentiality and potential data loss - Internal Issue (verbal, electronic and paper)</b>	1	0	1
<b>Manual handling - Patient involved</b>	1	1	2
<b>Obstetric (Pick List)</b>	1	1	2
<b>Paediatric (Pick List)</b>	1	0	1
<b>Patient Transfer</b>	1	3	4
<b>Safeguarding Children</b>	1	2	3
<b>Trauma</b>	1	0	1
<b>Recognising Risk in Deteriorating Patient</b>	0	1	1
<b>Diagnosis</b>	0	1	1
<b>Disruption of services</b>	0	1	1
<b>Property Related</b>	0	1	1
<b>Other Information Governance Issue</b>	0	1	1
<b>Resuscitation / Cardiac Arrest</b>	0	1	1
<b>Staffing</b>	0	3	3

References;

1. The Care Act 2014, updated with new categories of abuse 2015
2. CQC regulation 7 March 2010, updated with essential standards 2016
3. DoLS (Deprivation of Liberty Safeguards) MCA 2005



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# Safeguarding Vulnerable Adults

## Annual Report 2015/2016







Produced By Wendy Turner Lead Nurse Adult Safeguarding

## Contents

<b>Section one</b>	<b>Page</b>
Introduction and definition of an “Adult at Risk”	3
National context	4
Executive summary	7
<b>Section two</b>	
Duties, Roles and Responsibilities	10
Reporting Arrangements	10
Policy, Procedures and Guidance	12
Safeguarding Adults Training	13
Safeguarding referrals and alerts to safeguarding team	14
Mental Capacity Act 2005 and Deprivation of Liberty Safeguards	15
Deprivation of Liberty Safeguards	15
Domestic Violence	16
Learning Disabilities	17
Service Users	18
Work Plan for 2016/2017	19
<b>Section three</b>	
Appendices:	20
Appendix 1- WASB – Memorandum of Understanding	
Appendix 2. Steering groups Terms of reference	
Appendix 3 Induction training- summary of feedback	
Appendix 4 Trust training figures for adult safeguarding	
Appendix 5 Datix Risk Management System reviews by location	

## Section One

### Introduction

Following the recent review and reconfiguration of the trusts management structure, we now have Clinical Business Units in place with new triumvirate management structures. Following the completion of the process the adult safeguarding team now has a lead Nurse (formerly the matron post) and a matron (formerly the assistant matron post). The new appointees are Wendy Turner, Lead Nurse and Jim Eatwell, Matron. As services are still under review following the recent restructure plans are currently being considered for Learning disabilities (LD) to also sit within the adult safeguarding team. We have taken the opportunity to review the current service and to take stock of our priorities; as a result have new and exciting ideas that will be rolled out over the coming year that will help support the trust in delivering the adult safeguarding service, and I look forward to reporting on them in 2016/2017 report.

For this year though we are proud to present the sixth annual report for Adult Safeguarding for Warrington and Halton Hospitals NHS Foundation Trust however it must be said that as I have been in post since 1 April 2016 much of the information here has been sourced retrospectively in the absence of the former post holder.

Safety from harm and exploitation is one of our most basic needs and everyone has a right to be safe. As adults, we constantly weigh up the balance of risks and benefits in what we do and the choices we make. 'Safeguarding' is a range of activity aimed at upholding the fundamental right to be safe, at the same time as respecting people's right to make choices. Safeguarding involves six principals; Partnership, prevention, protection, accountability, proportionality and empowerment.

This annual report and audit of compliance describes the systems, processes, training and accountability arrangements for Safeguarding Adults at the Trust. The report is divided into three sections. Section one provides an overview of national updates and an Executive Summary, section two is a more detailed account of specific areas of safeguarding and section three provides the quantitative and qualitative data to support the body of the report.

#### **Changes to the Term Vulnerable Adult**

In the past we referred to *The Vulnerable Adult*, this term has been changed to the term *Adult at Risk*. This is because 'vulnerable adult' may wrongly imply that some of the fault for the abuse lies with the adult being abused. Therefore 'adult at risk' is used as an exact replacement for 'vulnerable adult'.

#### **Definition of an 'Adult at Risk'**

An adult at risk is defined as any person aged 18 years and over who is or may be in need of community care services by reason of mental health issues, learning or physical disability, sensory impairment, age or illness and who is or may be unable to take care of him/herself or unable to protect him/herself against significant harm or serious exploitation. (*The Care Act 2014*)



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Abuse is defined widely and includes domestic and financial abuse. The other crucial difference from the previous definition is that the duties apply regardless of whether the adult lacks mental capacity.

The Care Act 2014 states; Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.

The Care Act 2014 outlines the key principles in safeguarding adults as:-

- **Empowerment** - The presumption of person led decisions and informed consent. Adults should be in charge of their care. Self-determination can involve risk and making sure that such risk is recognised and understood by all concerned, and minimised whenever possible.
- **Protection** - Patients should be offered the support necessary for them to protect themselves.
- **Prevention** - prevention of harm or abuse is the primary goal
- **Proportionality** - Safeguarding responses should be proportional to the nature and seriousness of the concern
- **Partnership** - Safeguarding adults is most effective where individuals professionals and communities work together to prevent ,detect and respond to harm and abuse
- **Accountability** - That there is accountability and transparency in delivering safeguarding, with agencies recognising that it may be necessary to share confidential information, but that any disclosure should be compliant with relevant legislation.

## National Context

### The Care Act 2014

This is a landmark piece of legislation that places care and support law into a single, modern statute for the first time. It aims to:-

- Promote people's wellbeing
- Enable people to prevent and postpone the need for care and support
- Put people in control of their lives so they can pursue opportunities to realise their potential

**The Act introduces the first statutory framework for protecting adults from abuse and neglect and includes:**

- A new duty for a local authority to carry out enquiries (or cause others to) where it suspects an adult is at risk of abuse or neglect
- A requirement for all areas to establish a Safeguarding Adults Board to bring together Local Authority, NHS and the Police to coordinate activity to protect adults from abuse and neglect



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- A requirement for Safeguarding Adults Board's to carry out safeguarding adults reviews into cases where someone who is experiencing abuse or neglect dies or there is concern about how authorities acted, to ensure lessons are learned
- Safeguarding Adults Boards can require information sharing from other partners to support reviews or other functions

### **Making Safeguarding personal**

In response to feedback from people using safeguarding services, stakeholders and practitioners that the focus of safeguarding work was on process and procedure. People using safeguarding services wanted a focus on a resolution of their circumstances, with more engagement and control. The Care Act instructs partner agencies to engage closely with the victims to establish their needs and what they want to happen?

Provider agencies should produce for their staff a set of *internal guidelines* which relate clearly to the Safeguarding Boards multiagency policy, which set out the responsibilities of all staff to operate within it. These should include guidance on:

1. identifying adults who are particularly at risk;
2. recognising risk from different sources and in different situations and recognising abusive behaviour from other service users, colleagues, and family members;
3. routes for making a referral and channels of communication within and beyond the agency;
4. assurances of protection for whistle blowers;
5. working within best practice as specified in contracts;
6. working within and co-operating with regulatory mechanisms;
7. working within agreed operational guidelines to maintain best practice in relation to: challenging behaviour
  - i. Personal and intimate care;
  - ii. control and restraint;
  - iii. gender identity and sexual orientation;
  - iv. medication;
  - v. handling of people's money;
  - vi. risk assessment and management.

### **DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS)**

On 19<sup>th</sup> March 2014, a Supreme Court judgement changed the criteria for assessing whether a person with limited mental capacity is being "deprived of their liberty" in a care home, hospital or other 24 hour care setting.

The Supreme Court provided guidance on what is regarded as a deprivation of liberty. The judgement stated:

A person may be deprived of their liberty if:

They do not have the **capacity** to consent to their care and treatment



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**AND**

- They are under continuous supervision and control

**AND**

- The person is not free to leave

This is known as the acid test, and is applied when deciding if a patient has had their liberties deprived. This has placed a huge pressure on the service that grants DoLS (or not). There have been calls to make radical changes to how we manage this process.

Previous to this judgement a DoLS assessment was only required for patients that lacked capacity and wished to leave the place of safety. The change in legislation has seen a unprecedented increase in workload for not only the hospital teams but the local authority who are required to assess all request for DoLS made by the hospital and care homes. Notwithstanding the cost burden of £180 for a psychiatrist to review each assessment, (met by local authority).

At the Government's request, the Law Commission has now published an 'interim statement' the finished review is due to be published by the end of 2016. The Law Commission reaffirms the "compelling case" for replacing DoLS and the scale of workloads and pressure on resources mean that the commission feels that it is not sustainable in its current form.

The same financial and resource pressures in the current economic climate mean that the grand scale of the initial proposals is unrealistic, and simply too costly to implement at the moment. This has clearly driven their response, which accepts that reform must "demonstrably reduce the administrative burden", and provides "maximum benefit for the minimum cost".

As a result, the proposals will now be for a more straightforward, streamlined and flexible scheme focused solely on authorising deprivation of liberty, and going no further, although Some amendments to the MCA may be proposed. The proposal that has been put forward is that the responsibility for establishing the case for a DoLS should be shifted from the provider to the care commissioner (usually the local authority or CCG) where possible the same assessments that are already in place will continue to be used.

Furthermore it has been suggested that an amendment to the Coroners and Justice Act 2009 should be made to explicitly remove the proposed scheme from the definition of 'state detention', which triggers the need for an inquest, in some cases with a jury. It is also proposed that a tribunal to replace the Court of Protection jurisdiction should be considered but this remains in the balance, and a final decision on this has not yet been reached.

The Safeguarding Adult team here at the trust has continued with its commitment to support local agencies and the DoLS process. However in the past we have not always been able to monitor the process



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happening at trust level. Therefore an action taken by the new lead was to correct this and with the new matron has implemented a DOLs data base. This is reviewed weekly meaning frequent and close liaison between the safeguarding team and the wards, and the safeguarding team and local authority. Due to an increased awareness by the safeguarding team of how many DOLs we have and the constant reviewing causing more frequent contact with the wards compliance in the process is improving as we are constantly educating staff through our contact. The data base has been built in line with the CQC notification document and will provide us with excellent audit information going forward. This will in turn inform current teaching packages hence supporting practice improvements through out the trust.

### **New categories of abuse**

- In addition to the two new categories added in 2014/15, ***Human Trafficking/Modern Slavery and Exploitation by radicalisers who promote violence***, a further category has now been added which is self neglect.

The Department of Health have recognised the increase in occurrence and severity of Human Trafficking and identified the need to support victims. They have produced a publication which provides guidance and sets out actions for healthcare staff who suspect that their patient may be a victim of human trafficking. This publication is relevant to all kinds of healthcare settings, including Accident and Emergency, Primary Care, Sexual Health Services and Genito-Urinary Medicine (GUM) clinics.

For more information, please [click here](#)

The Department of Health also announced that the Government, Local Authorities and other partners have entered into a shared commitment to take specific steps to support a more coordinated and joined up health and community care service by 2018.

Similarly to human trafficking exploitation by radicalisers has been placed into the wider scope of Adult Safeguarding and the Department of Health has ensured that this becomes a priority for Trust by ensuring the local Clinical Commissioning Groups (CCG's) include the Prevent Strategy as part of the yearly Quality Contract. As a result the safeguarding adults lead is also the prevent lead for the trust. The prevent lead is responsible for attending regional meetings, dissemination of information and learning, working closely with event planning and security to ensure policies and processes are in place to support the trust with this agenda.

### **SELF NEGLECT**

Self neglect is a new category of abuse. This is a difficult area as those who have capacity to make their own decisions may have made life choices which have resulted in their neglected state and this is in deed how



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they have chosen to live their life. However we have a duty to empower our patients and assist them to make life choices that are healthy and that are conducive to healthy life style. The warrington safeguarding adults board has held a self neglect and hoarding training event earlier this year. This high lighted the problems and issues associated with this form of abuse. A new assessment tool was written and circulated for comment. It was discussed and subsequent meetings and received good reviews. The tool is to be trialed by our hospital OT's and I look forward to reprotog the outcome in next years report.

### **Further to the saville enquirey**

The common themes and issues that have emerged from the investigations' findings which we see as relevant to the wider NHS today can be grouped under the following general headings:

- Security and access arrangements, including celebrity and VIP access;
- The role and management of volunteers;
- Safeguarding;
- Raising complaints and concerns (by staff and patients);
- Fundraising and charity governance; and
- Observance of due process and good governance.

Volunteer recruitment, essential DBS checks and dedicated safeguarding staff that deliver training to all levels of staff are essential to good governance.

The Trust has a working action plan (on CIRIS) covering all recommendations contained within the report which is Monitored by the Director of HR and OD via the Strategic Peoples Committee reporting to the Board of Directors.

### **Executive Summary**

The Trust's dedication to Adult Safeguarding is evidenced through our frontline staff's work with other agencies to protect 'Adults at risk' from abuse. The adult Safeguarding Team's work to improve processes that protect people and improve early help and identification for those at risk. Safeguarding is truly everyone's business across the Trust. The importance of ensuring that safeguarding is at the heart of our organisation is evident from the reports that have been brought into the spotlight over the past year with national reports and media reports which highlight poor practice and offer lessons to learn. We need to remain vigilant in ensuring we apply the lessons learnt by other organisations to our own. The following information describes some of the key changes, reviews and improvements undertaken by the Trust to achieve the aim of ensuring patients are safe in our care.



### **Warrington Adults Safeguarding Board. (WASB) Halton Adults Safeguarding Board. (HSAB)**

Both the WASB and HSAB have an independent chair that is also the independent chair for the children's board. This has allowed for closer accountability and scrutiny of the work jointly undertaken by both boards. A memorandum of understanding (MOU appendix one) has been agreed with partner agencies and signed by all representatives of the board.

During 2014/15 significant developments have taken place in agreeing a Multi- Partnership Safeguarding Policy for all Partner agencies to sign up to. This agreement continues to be developed to further improve partnership working.

Contained within the guidance is advice for staff with regard to self-neglect and hoarding assessment of risk which is to be further reviewed this year. This is a complex area and there has been limited advice available from the department of health but following the Care Act this has now been included as a category for neglect.

### **Warrington Clinical Commissioning Group (CCG)**

The CCG and the trust work very closely together in ensuring that our patients receive safe health care of a high standard. The safeguarding lead is required to send quarterly assurance reports on the trusts status in relation to the contractually agreed targets. The CCG lead safeguarding nurse works very closely with the trust lead nurse in-between reporting periods to ensure that work plans remain and key indicators on track. There is live consultation on policy updates and action plans. There is collaborative working in all areas of safeguarding to ensure that we have met our required target areas. In the interests of engagement, clarity and transparency, there is a monthly meeting with the CCG Safeguarding lead nurse and the trust adult safeguarding team now takes place to support all processes detailed above. Staff who are required to use restrictive physical interventions have received specialist training to ensure that the use of restraint is always appropriate, reasonable, proportionate and justifiable to that individual.

### **Training figures**

To achieve the CCG standard on adult safeguarding training the Trust needs to achieve 85% compliance. Data from ESR for training compliance at year end (31/3/16 Appendix 3) for adult safeguarding show level 1 at 75.61(non-clinical) and Level 2 at 62.15(clinical).

Staff training figures continue to be a challenging area to achieve the contractual standard. The release of front line staff to attend training remains an obstacle due to the operational demands. A breakdown of the training figures indicate that it is the 3 yearly updates that are out of date and not new staff starting at the Trust as all staff receive safeguarding training at induction. There can be a degree of confidence that all staff have at some point had awareness training and are aware of what to do if they have a safeguarding concern. This is supported by the DAWES audits where safeguarding is a component of the assessment I have not had any concerns highlighted to me from any of the DAWES that have been conducted this year. If the assessors have a concern with a particular individual or team they will be referred to the safeguarding



team for additional training and support. Work on using less traditional methods of delivering training are being explored for example workbooks.

The Safeguarding Team has whenever possible adapted and changed training programs to deliver training to small groups in clinical areas. These sessions have been well received but delivery to smaller groups can reduce the overall compliance for training and can be time consuming for the Team.

### **Delivering the *Prevent* agenda (Counterterrorism)**

NHS North west has disseminated responsibility to local CCG to ensure Trust deliver on the Department of Health Prevent Agenda. This is now a requirement of the NHS Standard Contract. Included is a requirement for the Trust to include in its policies and procedures the principles of the *Prevent* agenda and to ensure that it has a program to deliver Health WRAP. The Policy for the Trust was ratified in October 2014 and training commenced and is subject to regular updates. The focus of Prevent training is the ability of staff to identify vulnerable at risk adults and children who are susceptible to exploitation and to provide a forum and process of referral for their concern. In principle it is identifying staff, patients or others in what is termed the pre-criminal phase. It is the responsibility of the trust prevent lead to attend quarterly regional prevent forum meetings, sharing information from this and other regular communications with the wider trust.

The Safeguarding Adults team currently include prevent training in their level two safeguarding delivery, however, education for specific high risk staff groups who need to engage in a more detail, there is a program known as WRAP. We have developed our key working relations with Partner agencies and the regional Channel lead (Police). To date we have received 2 enquires to be investigated by the team but both of these were prior to this report, there have been no enquiries/referrals in this reporting year.

### **Safeguarding Policy reviews**

The Safeguarding Adults Policy remains a working document that is updated as and when new guidance becomes available.

Key changes and additional sections that have been included in the policy are guidance on:-

- Self Neglect
- The Care Act 2015
- Mental Capacity Act and DOLS
- Human trafficking
- Modern slavery

### **Domestic Violence**



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In February 2014 the following Nice Guidance was published: - Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively. This strategy was implemented during 2014/15. Focus was placed on ensuring that we developed an increasing awareness of front line staff to undertake the nationally recognised risk assessment “Domestic Abuse, Stalking and Harassment” (DASH) and then action appropriately. The adults and children’s teams continue to attend the MARAC meeting completing any actions requested by the group and feeding results back to them.

In 2014/15 the Trust welcomed the appointment of an Independent Domestic Violent Advocate who works at the Trust two days per week to provide training and support to ward staff to assist in undertaking assessments. This service has proved invaluable and the support and education for staff throughout the last year has enhanced the delivery of the strategy.

However, this area of our practice still needs further education and support as we can see from referrals we receive across the trust, not all staff are confident in the completion of DASH. This is supported and evidenced from the reduction we have seen in referrals from 189 in 2014/15 to 178 in 2015/16. Both children’s and Adults safeguarding teams are currently providing bespoke sessions and regular monthly training for adult and Children’s safeguarding at level one and two, this training includes domestic abuse. The Independent Domestic Violence Advocate has also provided training opportunities for trust staff.

### **Snap shot of weekly specific Adult Safeguarding activities in 2015/2016**

- Electronic referrals via ICE
- Datix reviews
- Pressure ulcer Datix reviews
- Falls Datix reviews
- Domestic Violence reviews ( no children)
- Local Governing Safeguarding Patient strategy reviews
- IMCA referrals
- Deprivation of Liberty Safeguard request (Warrington only)
- Best interest strategy meetings
- High level investigation (include level 1, 2 and Multi Agency Reviews)
- Prevent reviews

Unfortunately I do not have a whole year’s data for some of the above actions and so cannot accurately report the numbers against the activities; however this will be addressed in next year’s report.

### **Service users and their family**

At the centre of the Trusts safeguarding work are the patients themselves. Information in the form of leaflets and posters is provided around the trust to advise the general public on what to do if they have a



concern or if they are a victim of abuse. The aim is to raise awareness with the general public and to signpost them to the appropriate agencies. This has included participation in this years' World Elder Abuse Day, Learning Disability Week and Carer Week.

The Safeguarding team remains highly motivated and committed to achieving the highest possible standard for all adults who attend the trust and are deemed 'at risk'.

## **Section 2**

The next section of the report will provide more specific details of the processes and functioning of the Adult Safeguarding Team for 2015/2016

### **Duties, Roles and Responsibilities**

#### **Director of Nursing and Governance**

The Director of Nursing is the executive accountable to the Board of Directors for ensuring compliance with all safeguarding adult procedures within the Trust. The Deputy Director of Nursing, Quality and Patient Experience is the delegated lead for Safeguarding Adults.

#### **Operational Leads**

The Operational Lead is the Lead Nurse for Adult Safeguarding, supported by the Matron for Adult Safeguarding.

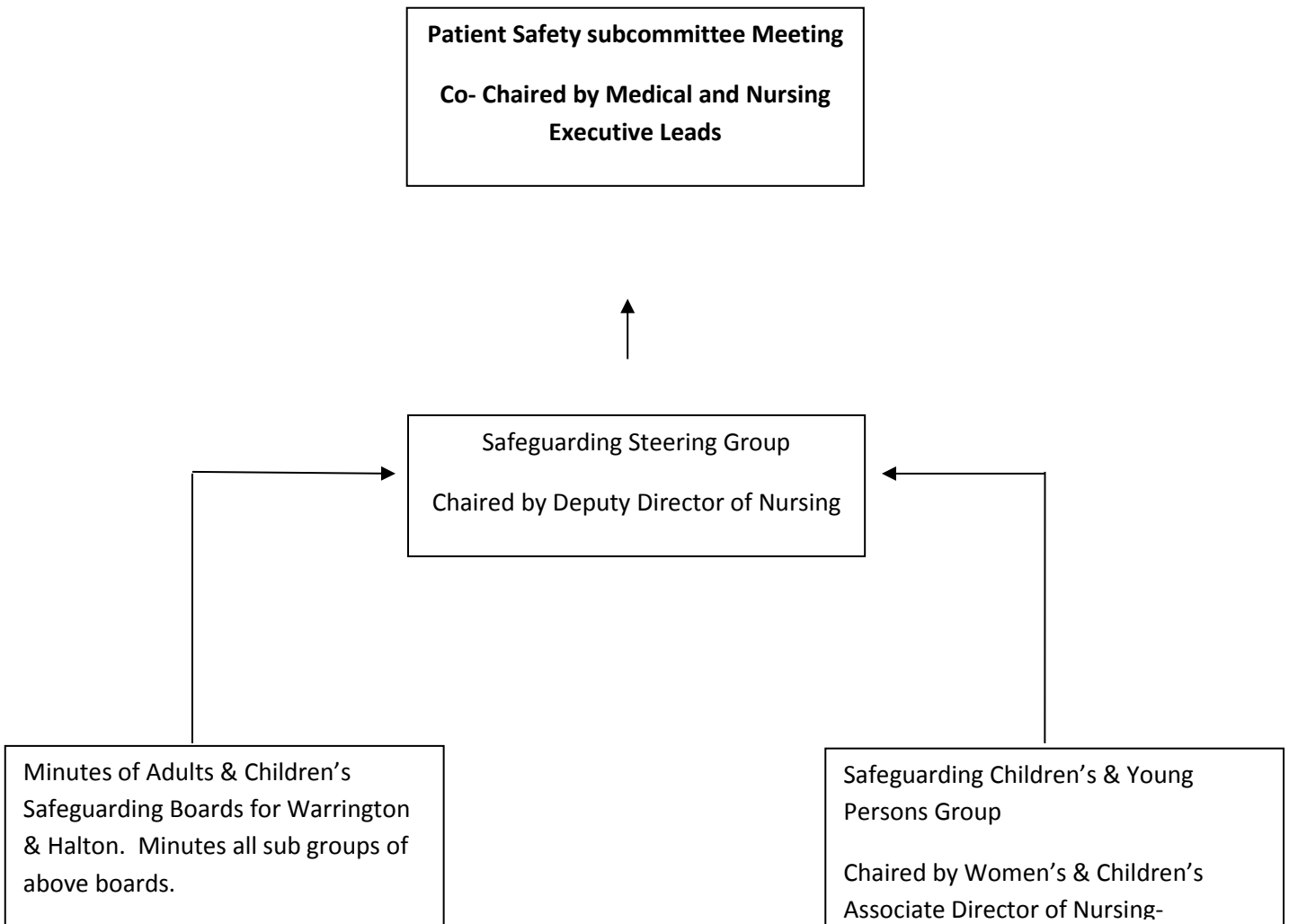
#### **Associate Divisional Directors (ADD)**

The ADD have responsibility for ensuring that eligible staff have undergone awareness training and have access to all documentation and information required for successful implementation and compliance of this policy.

#### **Trust reporting arrangements, the reporting system is detailed below**



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### **Warrington and Halton Adults Safeguarding Boards – Partnership working**

The Trust has a seat on both Safeguarding Boards and has representation at all sub groups of the Boards which include:-

- Serious Case Review
- Quality intelligence safeguarding meeting
- Policy & Procedure
- Training & Development
- Safer work force and development

There are five additional partner agency forums which the safeguarding team attend and work collaboratively with.

- Safeguarding Adults Partnership Forum
- Mental Capacity Act Forum



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- Warrington Domestic Abuse Partnership Forum (WDAPF)
- No second night out ( Homeless Strategy)
- Prevent Forum

All groups meet quarterly and the key actions from these meetings are presented and discussed at the six weekly meetings of the Trusts Safeguarding Adults Strategy Group.

In addition to the above the safeguarding team is represented on the following internal Trust forums to disseminate key safeguarding messages:-

- Nursing & Midwifery Advisory Committee (NMAC)
- Mental Health Forum
- Forget me not group
- Equality and Diversity Committee
- Currently the present learning disability arrangements for attendance to meetings are under review and updated information will follow this report.

### **Safeguarding Steering Group**

The Safeguarding Strategy group is chaired by the Deputy Director of Nursing and Governance and meets on a six weekly basis. Appendix 2 shows the group membership and terms of reference

### **Membership of the Safeguarding Steering Group:-**

- Deputy Director of Nursing- Chair
- Lead Nurse Safeguarding Adults - Deputy Chair
- Matron for Safeguarding
- Learning Disability Nurse
- Lead nurses from the following CBU's; (or their deputies)

Digestive Diseases

Musculoskeletal Care

Specialist Surgery

Urgent and Emergency Care

Airway, Breathing and Circulation

- Specialist Medicine
- Associate Director of Governance
- Out Patient Manager
- Learning Disability Nurse
- Therapy representative



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- Regional IMCA Representative
- Older persons specialist nurse
- Lead Nurse for children's safeguarding
- Clinical Commissioning Group (CCG)- Lead nurse for adults

#### **Standard Agenda items include:-**

- Strategic update
- Policy Review, Guidance and Standard Operational Procedures
- Training strategy
- Governance – (Datix Incidents, Ice referrals, MAR Action Plan)
- Actions from Safeguarding Adults Board and sub groups
- Matron report and lesson's to be learnt
- Learning disability
- DOLs
- Children's Safeguarding
- Domestic Violence
- Mental Capacity Act
- IMCA

The Safeguarding Matron produces a quarterly report that is provided to the CCG, a bi-annual trust patient safety and effectiveness Committee report and an Annual Report is provided to the Board. Annual reports are provided to both the Halton Adult Safeguarding Board and for each of their sub groups along with the same for Warrington Adult Safeguarding Board.

#### **Policy, Procedures and Guidance**

##### **The Safeguarding Adults Policy**

This remains a working document and is updated as and when local and national guidance is release that affects the process of managing adult safeguarding. It is currently under review as there are additions to be made in line with the care act.

The previous key changes and additional sections that have been included in the policy were guidance on:-

- Human Trafficking and Modern slavery
- Exploitation by radicalisers who promote violence (The Prevent Strategy)
- Celebrities and VIP visits to hospital ( Savile enquiry)
- The Care Act 2014

## Prevent Policy

Prevent sits with safeguarding, it is not seen as an additional role but part of it. We alert people in training sessions of the problems surrounding the radicalisation of vulnerable people. The Lead Nurse is also the prevent lead for the trust and has undergone (along with the matron) WRAP training in order to facilitate the requirement for wrap training for front line staff. The lead nurse has a seat at Channel Panel.

The intention of this policy is to identify how staff will be supported to develop an understanding of the Department of Health 'Prevent Strategy' and how they can utilise their existing knowledge and skills to recognise that someone may have been or is being radicalized. The policy will build on existing safeguarding policies and procedures already in place within the Trust. In addition to the prevent requirements,

The Prevent Key Objectives are:

1. Challenge the ideology that supports terrorism and those who promote it.
2. Prevent vulnerable individuals from being drawn into terrorism and ensure that they are given appropriate advice and support.
3. Work with sectors and institutions where there are risks or radicalisation.

Health sectors are expected to be involved in delivering objectives 2 and 3 only. Through education and training staff are provided with the tools to help identify vulnerable people who may be influenced or exploited into becoming radicalized. The Training demonstrates when to be concerned, who and how to report their concerns to and what occurs after a referral has been made.

The Prevent Strategy is now part of the yearly Quality Contract that the trust needs to deliver on. This is monitored via a quarterly DASH return to the CCG.

## Safeguarding Adults Training

### Level 1 & 2 training

Training and development provides a basis for ensuring that vulnerable people are effectively safeguarded. The safeguarding training and development plan aim to provide for a skilled, informed workforce (of both clinical and non-clinical staff) that recognises abuse and its signs. The training delivered enables staff to appropriately respond and prevent abuse where possible, know what to do when abuse happens or raise a concern.

Training is delivered by:

- Trust Induction ( clinical and non- clinical- level 1)
- E-Learning Programme- level 2
- Specific monthly clinical group sessions- level 2
- Work Book ( level 1)
- Clinical supervision
- Warrington & Halton Borough Councils



We receive positive feedback from staff about the training programme who stated that the information provided is appropriate and at the level they require.

Data from ESR for training compliance up to march 2016 for staff groups (excluding Junior Medical and dental) are:-

- Level 1 75.61%
- Level 2 62.15%

Training figures for safeguarding need to be 85% compliant to achieve the CCG standard. Due to clinical demand it has been particularly difficult to release staff to attend training sessions particularly during the winter months. The Safeguarding Team has adapted and changed training programs to deliver bespoke sessions in small groups on clinical areas and at meetings. These have been well received but overall attendance numbers are reduced when training is delivered by this method

Divisional breakdown of training and feedback summaries of training are detailed in appendix 4

We have worked collaboratively with the Learning & Development Team to produce a work plan to assist in achieving the 85% target.

During the year additional safeguarding training sessions have been completed to ensure that the message of 'safeguarding is everybody's business' and what to do if you have concerns have been arranged to supplement the ESR formal training figures.

The team has delivered monthly face to face level 1 and level 2 training and in addition to this has a permanent session on Volunteers Induction.

#### **Additional training that supports safeguarding assessments**

Consent and Mental capacity training is an essential requirement for clinical staff to ensure that appropriate assessment are undertaken when assessing any safeguarding concerns.

The trust figure for consent to treatment as of March 2016 were recorded as 63.3% and for Conflict resolution 70.27%

#### **Safeguarding Alerts and referrals to the trust safeguarding team**

All staff can seek advice and direction from the safeguarding team by either: -

- Service Order on ICE
- E-mail
- Telephone contact.
- Bleep





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Over the past twelve months the team has been very busy dealing with all forms of contacts and referrals unfortunately I do not have the data to compare 2015/16 to the previous year 2014/15 however this information will be provided next year on 2015/16 activity.

Once an alert has been received by the safeguarding team they contact the referrer and work alongside them to determine if a formal safeguarding referral is required to the local authority to formally investigate the allegation as an external lead. Depending on the reason for referral this may also result in a referral to the Public Protection Unit (PPU-Police). The Police will lead on all cases if a potential or possible criminal act has taken place.

### **Datix Referrals to the Safeguarding Adult Team**

The clinical incident reporting system supports next working day review in that the Clinical Governance Team will ensure that incidents relating to safeguarding concerns reported on Datix will be alerted to the Safeguarding Team for review.

Datix incidents referred to the adult safeguarding team are reviewed by the matron and lead nurse who will categorise the incident by either-

- Confirming that the appropriate action was taken;
- Advise that additional information is required; or
- Decide that incident needs further investigation or referral to social care

The team then work alongside the lead investigator to ensure that all areas of safeguarding are addressed and actioned appropriately.

In addition to (and using the same screening method), the above Datix incidents; the safeguarding team also screen Datix reports related to community and hospital acquired pressure ulcers. The focus is to scrutinize grade 3 and 4 pressure ulcers with the Tissue Viability Nurse Specialist to identify any concerns. The team also screens all Datix reports relating to falls in the trust there were harm occurs.

Appendix 5 shows a summary of the categories of safeguarding reviews for the year 2015/2016

A breakdown of the Datix incidents (excluding pressure ulcers) show the following top 5 categories selected for safeguarding concerns were:

- Security Issue (including missing patients)
- Community acquired pressure ulcers
- Unexpected events
- Safeguarding concern
- Mental Health Act

## High level investigations

This category of referral also involves the Adult Safeguarding team; they are required to be part of the teams that review high level investigations which include Sudden Unnatural Incident's (SUI's), Level 1's and Safeguarding Boards Multi- Agency Reviews.

## Mental Capacity Act

The Mental Capacity Act covers and empowers children aged 16 and 17. Once 18, the young person is an adult. When issues about a child's upbringing, or their money or property, are considered by a court, statute makes it clear that "the child's welfare shall be the court's paramount consideration"<sup>3</sup>. Known widely as the "paramountcy principle", this has a far-reaching effect on children's social care practice, emphasising to all what a court would need to see in order to approve arrangements.

Adults have a legal right to make their own decisions, even if they are unwise, as long as they have capacity to make that decision and are free from coercion or undue influence. However decision-making power relating to children lies with those who have parental responsibility for the child. As a child grows in maturity and understanding, the law gives the child a greater say in decisions. Once a child understands fully the choice to be made and its consequences, the child's view prevails<sup>2</sup>, at least as regards consent, though on occasions the courts have been prepared to override a capable child's refusal of life-saving treatment.

## Court of Protection

The court of protection will make decisions about a persons' best interests with regards to care and treatment delivery.

## Mental Capacity Act 2005 (MCA) & Deprivation of Liberty Safeguards (DOLS)

In April 2014 the House of Lords published its findings to the: House of Commons Select Committee on the implication and impact of the Mental Capacity Act. The committee's overall finding was that while the MCA is a 'visionary piece of legislation', the Act has 'suffered from a lack of awareness and a lack of understanding'. In total, the report made 39 recommendations. The two key recommendations were that:-

- an independent body is given responsibility for oversight of the Act in order to drive forward vital changes in practice
- they found that the Deprivation of Liberty Safeguards (DoLS), inserted into the Mental Capacity Act in 2007 by the Mental Health Act, are not fit for purpose. The Committee is recommending that the DoLS be replaced with legislation that is in keeping with the language and ethos of the Mental Capacity Act as a whole



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In adult safeguarding the assessment of a patient's capacity is a key element in determining a 'best interest' decision or appropriate action to take when a patient lacks capacity to determine their own care plan.

The Trust Lead for MCA is the Associate Director of Governance (ADG) this includes responsibility for consent and mental capacity training for staff. The ADG audits the Trust documentation for MCA on a monthly basis and reports the findings at the quarterly Safeguarding Steering group.

Whilst the audits have shown that increase awareness of capacity assessments are being undertaken there remains confusion amongst the front line staff on key issues such as who can undertake a capacity assessment and who should be involved. The primary area of concern is that staff do not record the involvement of family and friends in the assessment and/or if consideration of an IMCA is required.

Education and direct clinical supervision is undertaken by the safeguarding team but similar to the House of Lords findings the Trust still has a way to go to be confident that this piece of legislation is embedded in day to day practice.

### **Deprivation of Liberty Safeguards (DoLS)**

DoLS is a process of assessment and actions that result in depriving a patient of their liberty or their choice in order to keep them safe from harm. For example a dementia patient that wishes to leave the ward and does not have the capacity to understand that if allowed to leave the ward it would put them in direct danger for example of being knocked down by a passing car. The ward therefore has to put in place a number of significant restrictions to stop the patient from leaving the ward. This may include sedation, 1 to 1 nursing, cot sides and in some instances full restraint.

The staff complete an urgent request to be assessed for a standard authorisation which if granted allow the staff to work within a legal framework to impose restrictions on patients to keep them safe and deliver appropriate care

The Trust has seen an increase in DoLS assessments over the past twelve months working closely with Warrington Borough Council MCA Coordinator to improve referral pathways and assessments, which has demonstrated increased awareness and understanding of this important assessment process.

In March 2014 the Supreme Court delivered a verdict known as the 'Cheshire West verdict' that has fundamentally changed the way acute trusts and care homes assess patients for DoLS. The Trust has been asked to review the judgment and to look at the implication and to co-ordinate a response in coordination with the Local Safeguarding Boards. The key change from the judgment is that a patients compliance will



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no longer be relevant to the decisions made, for example if a patient without capacity is assessed as requiring one to one care for their risk of falls and do not object, appear willing to have a member of staff sitting with them constantly, cannot consent and are not free to leave must undergo assessment and application of a DoLS. The revised test will be that all patients who lack capacity and is under continuous supervision and control and is not free to leave, and cannot consent to these arrangements will require an assessment and application of a DoLS.

In view of the above judgement the trust has been working to implement the changes in key areas like the Forget Me Not Unit and cohort ward. The safeguarding team had previously delivered an agreed programme of education planned to meet this requirement throughout 2015/16. The DoLS training is now included in level 2 safeguarding adults training.

### Independent Mental Capacity Advocate (IMCA) referrals

The Trust continues to work with the 'Together' IMCA services that support the Trust in upholding the rights of some of the most vulnerable members of our society. A referral to IMCA services is a statutory requirement for patients who lack capacity, are un-befriended (have no family or friends), are over 18 years of age and are unable to participate in serious medical decisions or have a change to accommodation after 28 days, this includes remaining in hospital.



HKWS IMCA 2015  
Q4 Report.pdf

### IMCA

There were a total of 92 referrals made in quarters three and four in 2014-15. The breakdown of referral types is below

#### IMCA Referral Type

IMCA Referral Type	Numbers of Referrals
Serious Medical Treatment	16; a reduction on last year Q3 & 4
Change of Residence	16; an increase on last year's Q3 & 4
Adult Safeguarding	3; an increase on last year's Q3 & 4
Care Review	3; an increase on last year's Q3 & 4
Inappropriate Referral	10; an increase on last year's Q3 & 4
Other	44
<b>TOTAL</b>	<b>92</b>



## **Domestic Violence (DV)**

The lead for Domestic Violence is the Trust Safeguarding Children's team Named Nurse and detailed data on all aspects related to DV are contained with their annual report. The Safeguarding Adult team work collaboratively with the Children's team to deliver the agreed strategy that is produced by the Warrington & Halton Domestic Abuse Partnership (WDAPF).

The Independent Domestic Violence Advocate (IDVA) continues to work at the trust for two days a week, alongside frontline staff to educate and assess patients that are disclosing DV. Training and support is the key area of focus so that staff can assess correctly and action and signpost as required.

## **Home office -Domestic Homicide Review – (DHR)**

The trust is expected to engage and support DHR by submitting reports and providing information for the investigations.

## **Learning Disabilities (LD)**

It is recognised that the Trust has limited assurance around learning disabilities, due the absence of a learning disabilities hospital liaison nurse. This has been risk assessed and actions are in place to mitigate the risk. The operational lead for learning disabilities is the Patient Experience Matron, who is tasked with liaison and links with partners and other organisations in the interest of ensuring equality in healthcare. In addition, the Assistant matron for Safeguarding supports the Patient Experience Matron with queries and requests for support by the learning disabilities teams of Warrington and Halton, Trust staff and other providers. This issue has been discussed with commissioners and there are tentative plans to develop this role.

The learning disabilities pathways group is to re launched in the Autumn of 2016 following the departure of the previous post holder, a new appointment will be in place by the end of summer 2016. The group will provide an opportunity to review issues, share good and poor practice and identify development work needed. The group will continue to meet bi-monthly and members include divisional, carer and provider representatives.

Staff can find advice and information on the Learning Disabilities Community on *The Hub* (Intranet) and there is a guidance document providing a consistent approach to care of this population. This document is currently under review to ensure information is updated, realistic and evidence based.



## **Example of good practice showing when staff have ensured reasonable adjustments were made for care delivered.**

### **Case one;**

We have a patient who is a frequent service user to our trust, from an establishment near by. The patient has some mental health issues and issues, has the capacity to make decisions about their care and lives in a mental health care setting. The choice not to comply with treatment for leg ulcers or attend to their personal hygiene is often made and on occasion the patient has arrived at the trust in an unkempt and dishevelled state prompting a rash of referrals out to the care setting.

There have been a number of inter agency meetings about and with RS the outcome was as follows.

The needs and preferences of the patient were listened to, and a recognition of their behavioural issues were noted. The aim was not to remove autonomy, it was to empower the patient's independence and support different choices so that treatment and care needs could be facilitated.

A pass port was written instructing staff of what the patient likes and dislikes were, what upset or worried them and what made them happy. The document explained how the patient sometimes did not want to wash or change their clothes and how they preferred to use the toilet. The explanations helped staff understand the needs of the patient and supported partnership working, helping to prevent inappropriate safeguarding referrals. The patient was less anxious about coming to hospital and became more settled as a result. A rule that the safeguarding team were to be informed of admission meant that we are able to prepare wards and depts about how to care for and support the patient helping to educate and support staff to support the patient. This meant that staff approached the care needs differently.

The patient still often refuses to wash and change clothes however, there is now less anxiety about this as when the patient arrives staff are not so alarmed about the appearance of the patient.

### **Case two;**

The following case study describes the care given to a patient who accessed our maternity services. The patient had particularly complex needs as she was psychotic and pregnant and also suffered from diabetes. She required a wide range of support from a number of health providers. The outcome of her pregnancy was that her child was to be removed at birth and this required an extremely sensitive and measured approach in order to support her and reduce the stress and trauma of this event as far as we possibly could. This process required partnership working with the Trust adult and children's safeguarding teams, the diabetes team, the consultant obstetrician and anaesthetist, the psychiatric teams and the Child Protection teams from the area to which the baby was to be transferred to at birth.

The plan going forward was to allow the patient access her children when her mental state improved. The patient's capacity was absent at the start of the process but with improved compliance with her medication and treatment this appeared to improve at times over the weeks this process was planned. There were many visits by the adult and children's safeguarding teams along with the named midwife for safeguarding and the consultant obstetrician who led and planned this patient's care. Case conferences were held and there were meetings with the teams and the patient in order to support her anxiety. There were arranged visits to the dept. at the trust and many conversations about what was required in her best interests.



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Provision was made for staffing to be in place to support her needs on admission and a room on labour ward was used for the whole of her stay to support a calm and familiar environment for her. Her delivery was carefully planned and every step of the way was explained to her, ensuring that we considered her care needs altering them in line with the management of her progress and improvement of her mental health status. Consideration was given at all times to make this process as least restrictive as possible and as flexible as possible to allow for fluctuations in her mental state. Opportunity was provided for the patient to voice her concerns and choices about how she wanted to be cared for as far as her condition would allow. There were frequent explanations at all times and her care plan was carefully maintained. We sought her opinion on what she wanted her child to be dressed in once it was born and constantly reinforced the reason why this process was necessary. Her opinion and preferences were sought and she was included in the whole process as much as her condition and mental state would allow, in the decision making processes and there were constant temperature checks about her understanding.

The birth was a success and with the patient's agreement by caesarean section, the patient was allowed to hold her baby and have photographs and the staff involved held a celebration of the child's birth with gifts for the baby and a cake in order to make this as positive an experience as it possibly could be. The patient knew that once she was well enough she would be able to have supervised visits with her children.

### **Service Users and outcome for patients**

One of the highest priorities that we have at the Trust is to safeguarding our patients and to show that in doing so a positive outcome can be reached.

To achieve this the Trust needs to identify the patients who require assistance or are vulnerable by the following:-

- Identifying any one at risk
- Delivering on a timely and appropriate response.
- Ensuring robust protections and support for the individuals at risk.
- Providing information that they have a right to receive and explanation of the process.
- Ensuring they or their family are included whenever possible in decisions about their care

Information is provided around the Trust for patients to access this is in the form of leaflets and posters which direct the general public on what to do if they have a concern or are a victim of abuse.

A number of promotional days have taken place throughout the year specifically aimed at raising awareness with the general public and signposting them to the appropriate agencies. These are as follows:



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Directed to	Promotion	Venue	Date
General Public	World Elder Abuse Day	Main Entrance of hospital	15/6/16
General Public	Learning Disability week	Main Entrance of hospital	Week commencing 2/7/16
General Public	Safeguarding Awareness	Main Entrance of hospital	15/6/16

### Work Plan for 2016/17

The key objectives for the Trust will be to continue to promote awareness of vulnerable adults and their right to be safe and to safeguard and promote the welfare and dignity of vulnerable adults and to take the appropriate steps to reduce abuse. It will ensure referral to the correct agencies as necessary and includes:

- Implementation of WASB- Partnership Safeguarding Guidance and Procedure Policy
- Implementation of level 3 Prevent training (WRAP)
- Review and update of the Trust Restraint Policy and Mental Capacity Act Policy to ensure they are Care Act compliant
- Quarterly review of the Trust Clinical Commissioning Groups (CCG's) contract report ensuring supportive evidence is provided to meet the requirements
- A review of training strategy to further identify training needs within the acute hospital workforce. Working collaboratively with the Halton and Warrington Borough Councils
- To monitor and manage the capacity and workload of the safeguarding team in ensure continuous improvement in achieving the 'Cheshire West Judgements'
- To improve on existing audit processes to monitor effectiveness of lessons learned upon safeguarding practice and outcomes for people who use our service





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## Section Three

warrington  
**[safeguarding]**  
adults board



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## Appendix 1

This Memorandum of Agreement has been drawn up in relation to the roles and responsibilities of member organisations to the Safeguarding adults Board agreed on the 27.7.2013

The signing of this memorandum constitutes the acceptance and agreement of to the following:

As my organisation's representative on the Warrington SAB I agree to:

- Maintain regular attendance at the SAB and its sub groups
- Make an active contribution to the planning, development and implementation of strategic objectives including contribution to sub groups, workshops and task and finish groups including where required a chairing role
- Support the delivery of Development Plan priorities including the co-ordination, delivery and reporting of actions assigned to me personally or as a representative of my organisation
- Provide an effective link between the SAB and organisation to disseminate strategic and operational priorities and ensure that these are met
- To act as a safeguarding adults voice and to take the lead on behalf of SAB, within my own organisations networks and any relevant committees which I also attend
- On behalf of my organisation, promote and support information sharing with other agencies in order to protect vulnerable adults
- Alert the Board to any safeguarding issues that arise in my organisation and to provide information and updates as requested including on profile and serious issues/cases.
- Promote and coordinate staff engagement in relevant WSAB activities and initiatives, including training and awareness raising
- Secure and co-ordinate my organisation's participation as appropriate in multiagency reviews and IMRs
- Provide regular feedback to the Board, on my organisation's safeguarding work including an annual submission to the business plan report

Signed by:


Full Name:

Date:



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## Appendix 2 Safeguarding Adults Steering Group Terms of Reference

<b>Title:</b> Safeguarding Adults Steering Group Terms of Reference		Warrington and Halton Hospitals  NHS Foundation Trust	
<b>Authors Name:</b> Associate Director of Nursing/ Safeguarding Lead Nurse			
<b>Scope:</b> N/A		<b>Classification:</b> N/A	
<b>Replaces:</b> Vulnerable Adults Steering Group			
<b>To be read in conjunction with the following documents:</b> N/A			
<b>Unique Identifier:</b>	<b>Review Date:</b> June 2017  <b>This document is no longer authorised for use after this date</b>		
	<b>Issue No.</b> 1	<b>Issue Date:</b> June 2016	
<b>Approved by:</b>	<b>Ratification Date:</b>		
<b>Document for Public Display:</b> Yes			

### 1. Purpose



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- The Safeguarding Adults Steering Group will oversee the Trust's policies, strategies and procedures relating to the Trust's objectives on all matters related to Safeguarding of Adults.
- The Safeguarding Steering Group will be a conduit for safeguarding information; sharing this information with CBU leads in order for them to disseminate this to their respective teams and through their quality governance forums. The agreed policies and guidelines of both Warrington and Halton Local Safeguarding Adults Boards will be shared at this group.

Close liaison will be maintained with the Safeguarding Children's steering Group and all information from the adult steering group will be fed through to the Patient Safety and Effectiveness Sub Committee with the purpose of providing assurance to the Trust Board on the management of risks relating to the safeguarding of vulnerable adults, the Deprivation of Liberty Safeguards and Prevent. An annual report will be submitted as part of the assurance process.

## **2. Accountability Terms of Reference**

- 2.1** The Safeguarding Adults Steering Group will be a formally constituted group within the Trust and it will report directly to Patient Safety and Effectiveness Subcommittee chaired by the Deputy Director of Nursing
- 2.2** The Chairman of the Safeguarding Steering Group will be the Associate Director of Nursing.
- 2.3** The terms of reference will be reviewed annually by the Steering group.

## **1. Main Areas of Work of the Committee**

- The principle areas of focus will be the scrutiny of performance against National and Local standards aligned to the Care Quality Commission Fundamental Standards.
- The Steering Group will review Safeguarding Policies and ensure their effective implementation. Audit schedules for each policy will be agreed on an annual basis.
- The Steering Group will receive summary performance reports in respect of staff training compliance.



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- The Steering Group will monitor all untoward complaints and incidents related to vulnerable adults. Taking an active role in 72 hour, level one and two investigations where required, also ensuring that effective root cause analysis is undertaken in all unexpected and unexplained deaths. The Steering Group will make any necessary recommendations to the Executive Team if there is evidence of system or individual failure assist in identifying areas for improvement.
- The Steering Group will link closely to the work on Elder Abuse in the Trust to ensure that vulnerable adults who are actually or potentially involved are identified appropriately.

#### **4. Membership**

The membership of the Safeguarding Adults Steering Group shall be;

- Deputy Director of Nursing- Chair
- Trust Lead Nurse Safeguarding Adults - Deputy Chair
- Matron for Safeguarding
- Attendance from lead nurses from the following CBU's is required;  
Digestive Diseases  
  
Musculoskeletal Care  
  
Specialist Surgery  
  
Urgent and Emergency Care  
  
Airway, Breathing and Circulation  
  
Specialist Medicine
- Associate Director of Governance
- Out Patient Manager
- Trust lead for Learning Disability
- Therapy representative
- Regional IMCA Representative
- Older persons specialist nurse

Nominated Deputy to attend in situations of absence.

#### **5. Frequency of Meetings and Quorum**



The Steering Group shall meet every 6 weeks.

The group will be considered quorate with at least 4 members from the above list present (excluding safeguarding Lead Nurse and Matron).

## **6. Delegated Powers**

The Group will be delegated policy development and implementation responsibilities for policies and guidelines related to Safeguarding. Ratification on behalf of the Trust Board will be undertaken by the Safeguarding Steering Group

## **Reporting Arrangements**

The Safeguarding Adults Steering Group meetings will produce action notes for the Patient Safety and Effectiveness committee.

## **7. Review**

The Safeguarding Adults Steering Group will undertake a review of its Terms of Reference and membership, including the role of any Working Groups annually.

## **8. Managing Effectiveness**

The Group will have formal action notes and these will be submitted to the Patient Safety and Effectiveness Sub Committee. The Chairman will draw the attention to the Executive Team, any issues that require disclosure to the full Board or those requiring Executive action via a high level briefing paper.

The agenda and minutes of this meeting may be made available to public and persons outside Warrington & Halton Hospitals NHS Foundation Trust as part of the Trust's compliance with the Freedom of Information Act 2000.



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## 9. Conduct of the group

The group will conduct its meeting in accordance with any national guidance; they will respect each other and commit to taking forward any developments

Members of the group have a responsibility to:

- a) attend at least 75% of meetings;
- b) act as 'champions', disseminating information and good practice as appropriate;
- c) identify agenda items or forward papers/ information relating to Safeguarding to the chair prior to the meeting



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Appendix 3 Training  
figures by division

	Safeguarding Procedures (Adults) - Level 1 1st March 2013 - 31st March 2016			Safeguarding Procedures (Adults) - Level 2 1st March 2013 - 31st March 2016		
	Heads	Number Completed	% Completed	Heads	Number Completed	% Completed
<b>CORPORATE SERVICES</b>						
370 Finance RWW208	69	68	98.55%	0	0	
370 FIN FSD RWW340	7	7	100.00%	0	0	
370 Finance & Supplies RWW339	62	61	98.39%	0	0	
370 HR & OD RWW210	115	105	91.30%	24	17	70.83%
370 HR & Payroll RWW334	53	48	90.57%	3	2	66.67%
370 ODG Education RWW331	62	57	91.94%	21	15	71.43%
370 IT RWW213	74	67	90.54%	1	0	0.00%
370 IT RWW3	74	67	90.54%	1	0	0.00%
370 Nursing & Governance RWW209	68	61	89.71%	44	34	77.27%
370 Governance RWW333	17	17	100.00%	3	3	100.00%
370 Nursing RWW341	51	44	86.27%	41	31	75.61%
370 Research & Development RWW314	9	5	55.56%	8	2	25.00%
370 R&D RWW414	9	5	55.56%	8	2	25.00%
370 Strategy Partnerships & Communications RWW307	9	9	100.00%	0	0	
370 SPC RWW407	9	9	100.00%	0	0	
370 Trust Execs RWW211	24	17	70.83%	4	2	50.00%
370 Trust Executives RWW314	24	17	70.83%	4	2	50.00%
<b>OPERATIONS</b>						
370 CHARITABLE FUNDS RWW106	1	1	100.00%	0	0	
370 Charity Development Fund	1	1	100.00%	0	0	
370 Estates RWW326	61	59	96.72%	0	0	
370 Estates RWW4	61	59	96.72%	0	0	
370 Facilities RWW327	380	315	82.89%	0	0	
370 Facilities RWW4	380	315	82.89%	0	0	
370 OPS Central Operations RWW337	6	3	50.00%	0	0	
370 OPS Central Operations RWW418	6	3	50.00%	0	0	
370 Scheduled Care RWW323	858	639	74.48%	715	482	67.41%
370 Critical Care RWW405	313	266	84.98%	291	221	75.95%
370 General Surgery RWW406	224	146	65.18%	161	100	62.11%
370 Scheduled Care Divisional Management RWW404	17	14	82.35%	10	7	70.00%
370 Special Surgery RWW422	124	99	79.84%	107	83	77.57%
370 Trauma Orthopaedics & Cancer RWW407	180	114	63.33%	146	71	48.63%
370 Unscheduled Care RWW324	881	550	62.43%	725	393	54.21%
370 Acute Medicine RWW428	110	50	45.45%	86	39	45.35%
370 Discharge & Palliative Care RWW429	16	10	62.50%	14	5	35.71%
370 Emergency Care RWW416	162	99	61.11%	122	76	62.30%
370 Medicine, Elderly & Stroke RWW417	304	197	64.80%	283	162	57.24%
370 Specialty Medicine RWW423	227	142	62.56%	213	106	49.77%
370 Unscheduled Care Divisional Management RWW424	62	52	83.87%	7	5	71.43%
370 Womens, Childrens & Supporting Services RWW325	1360	1061	78.01%	875	559	63.89%
370 Audiology RWW415	22	19	86.36%	19	12	63.16%
370 Child Health RWW409	132	103	78.03%	125	69	55.20%
370 Pathology RWW419	145	120	82.76%	50	19	38.00%
370 Pharmacy RWW421	141	124	87.94%	2	2	100.00%
370 Radiology RWW420	181	155	85.64%	141	109	77.30%
370 Therapies RWW413	291	255	87.63%	270	218	80.74%
370 WCSS Divisional Management & Admin RWW414	78	66	84.62%	17	12	70.59%
370 WCSS Outpatient Department RWW425	163	116	71.17%	54	27	50.00%
370 Womens Health RWW408	207	103	49.76%	197	91	46.19%
<b>TRUST TOTAL</b>	<b>3915</b>	<b>2960</b>	<b>75.61%</b>	<b>2396</b>	<b>1489</b>	<b>62.15%</b>





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## Appendix 4 Induction Programme Summary of Feedback

### Subject Areas Induction Programme

<b>Session</b>	<b>Safeguarding Procedures (Children and Adults) Level 1</b>
<b>Facilitator</b>	<b>Lorraine Smith</b>

Evaluation forms currently ask delegates for feedback for each subject covered in relation to the following:

- Has the session met your expectations? If so, how?
- How could the session be improved?
- Was the information given clear, understandable and delivered at the right pace?
- Any further comments?

#### Comments Received:

- Yes – informative
- Informative
- Very informative and pointed out vital examples of neglect that you may not realise. Also, informed of what to do in certain situations and correct reporting procedures. Above expectations
- The first lady talked a bit too fast. The second one was fine. Really good key messages
- Good session
- Good overview of the subject and group scenarios were useful. Questions and interaction useful
- Balanced approach – well informed and right pace for me
- Informative
- Was very informative. Helpful to know who to contact. Was overall very good
- Very informative and reassuring. Very aware of where to go for support
- Very important topic in the hospital environment. Emphasised the policies in the hospital and how the procedures can be found on the Hub
- Really enjoyable and I feel confident in the policy/procedure
- Interesting and very useful as a newly qualified health professional
- Main message effective, clear and given good pace
- Informative and beneficial. Basic outline was clear and helpful
- Good update



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## Doctors F1- feedback

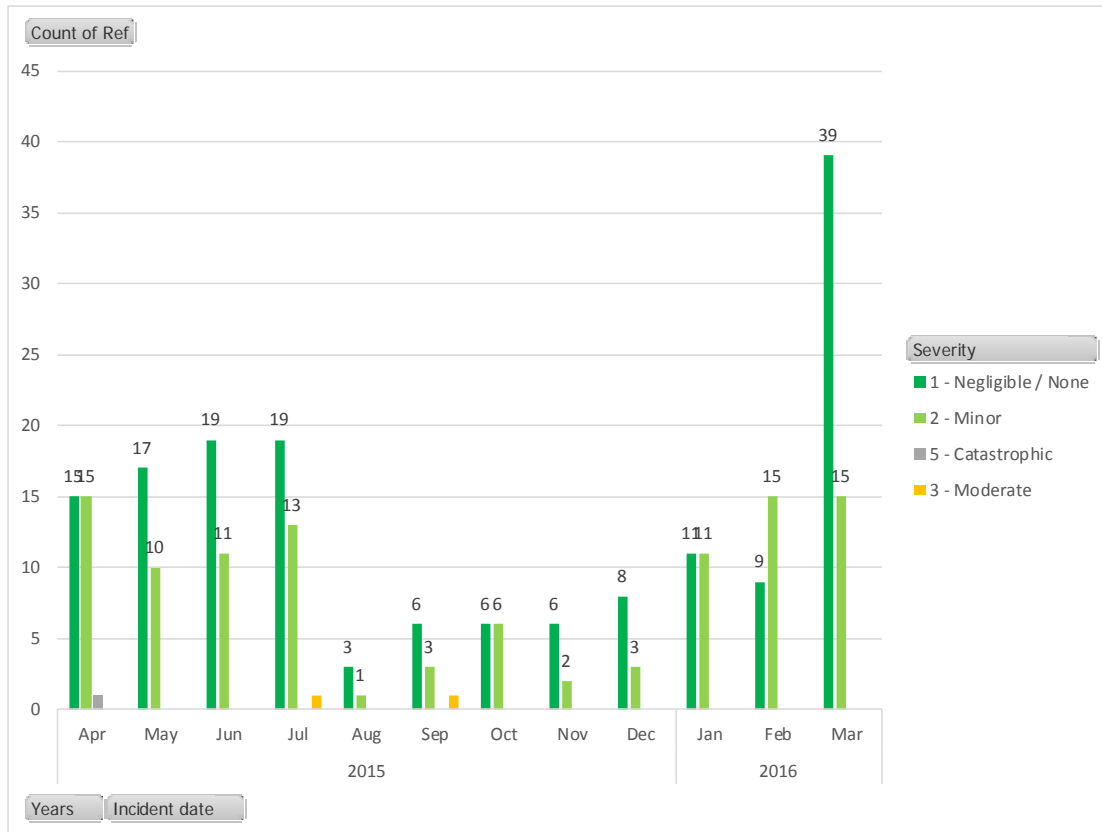
	VG	G	F	P	VP
The Session as a whole	25.00%	75.00%	0.00%	0.00%	0.00%
Content of the Session	50.00%	50.00%	0.00%	0.00%	0.00%
Presenter's Contribution to the Session	50.00%	50.00%	0.00%	0.00%	0.00%
Delivery Methods	50.00%	50.00%	0.00%	0.00%	0.00%
Explanations	50.00%	50.00%	0.00%	0.00%	0.00%
Tailoring of Session	50.00%	50.00%	0.00%	0.00%	0.00%
Examples and Illustrations	50.00%	50.00%	0.00%	0.00%	0.00%
Audience Confidence in Presenter's Knowledge	50.00%	50.00%	0.00%	0.00%	0.00%
Presenter's Enthusiasm	50.00%	50.00%	0.00%	0.00%	0.00%
Encouragement for Audience Interaction	50.00%	50.00%	0.00%	0.00%	0.00%
Availability of Additional Information	50.00%	50.00%	0.00%	0.00%	0.00%
Length of Session	50.00%	50.00%	0.00%	0.00%	0.00%
Relevance and Usefulness	50.00%	50.00%	0.00%	0.00%	0.00%
<b>What aspects of this session contributed most to your learning?</b>					
"very good. Great audience involvement with interactive quiz!"					
<b>What aspects of this session detracted from your learning?</b>					
no comment made					
<b>What suggestions do you have for improving the session?</b>					
no comment made					



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## Appendix 5 Datix incidents reported to the Safeguarding team for review

### Incidents by Severity and Month - 01/04/2015 - 31/03/2016



### Incidents by Category, Sub-Category and Month - 01/04/2015 - 1/03/2016

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
<b>Communications Issue (verbal, electronic and paper)</b>	0	1	0	0	1	1	0	0	0	1	0	0	4
Other	0	0	0	0	1	0	0	0	0	1	0	0	2
Hospital Policy	0	0	0	0	0	1	0	0	0	0	0	0	1
Working Process	0	1	0	0	0	0	0	0	0	0	0	0	1
<b>Resuscitation /</b>	0	0	0	0	0	0	1	0	0	0	0	0	1



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	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
<b>Cardiac Arrest</b>													
DNAR order in place but not reviewed	0	0	0	0	0	0	1	0	0	0	0	0	1
<b>Security Issue</b>	<b>2</b>	<b>4</b>	<b>2</b>	<b>10</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>39</b>
Missing patient	1	2	1	9	3	5	6	0	1	0	1	1	30
Alcohol / Substance Misuse	1	1	0	1	0	1	1	0	0	0	0	0	5
Suspicious Behaviour	0	1	1	0	2	0	0	0	0	0	0	0	4

### Incidents by Category, Sub-Category and Month - 01/04/2015 - 1/03/2016

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
<b>Staffing</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>3</b>
Breakdown in lines of communication	0	0	0	0	0	1	0	0	0	0	0	0	1
Lack of Staff	0	0	0	1	0	0	0	0	0	0	0	0	1
Staff transferred to another clinical area	0	1	0	0	0	0	0	0	0	0	0	0	1
<b>Domestic Abuse</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>1</b>
Non complaint with policy	0	0	0	0	0	0	0	0	0	0	0	1	1
<b>Verbal Assault/Threatening Behaviour</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2</b>
Verbal Assault/Threatening Behaviour Patient to	0	0	0	1	0	0	1	0	0	0	0	0	2



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	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
Staff													
<b>Unexpected events</b>	<b>3</b>	<b>3</b>	<b>6</b>	<b>4</b>	<b>4</b>	<b>3</b>	<b>9</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>37</b>
Patient behaviour	0	3	4	1	2	2	1	0	1	1	0	0	15
Patient absent without leave	2	0	0	3	0	1	2	0	0	0	1	0	9
Discharge against medical advice	1	0	1	0	2	0	1	0	0	0	0	0	5
Injury to Patient	0	0	0	0	0	0	2	0	0	0	0	1	3
Self Harm	0	0	1	0	0	0	2	1	0	0	0	0	4
Collapse due to condition	0	0	0	0	0	0	1	0	0	0	0	0	1
<b>Treatment</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2</b>
Inappropriate Treatment	0	0	0	0	1	0	0	0	1	0	0	0	2
<b>Mental Health Act</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>7</b>
Delay in assessment	0	0	1	0	0	0	0	0	0	0	0	0	1
Security Incident	0	0	0	1	0	1	0	0	0	0	0	1	3
Self harm issues	0	0	0	0	0	0	1	1	0	0	0	0	2
Concerns about patient Management	0	0	0	0	0	0	0	0	0	0	1	0	1
<b>Safeguarding Adults</b>	<b>1</b>	<b>4</b>	<b>1</b>	<b>2</b>	<b>5</b>	<b>5</b>	<b>7</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>2</b>	<b>29</b>
Failure to adhere to Domestic violence Policy	0	1	0	0	0	0	0	0	0	0	0	1	2
Concern with regard to standard of care within the Trust	0	1	0	1	3	2	2	0	0	0	0	0	9



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## Incidents by Category, Sub-Category and Month – 01/04/2015 - 1/03/2016

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
Potential safeguarding concern not identified or escalated	0	0	0	1	1	2	3	0	0	0	0	1	8
Concern with regard to standard of care external to the Trust	1	2	0	0	1	1	0	1	0	0	0	0	6
Failure to adhere to safeguarding policy	0	0	1	0	0	0	2	0	1	0	0	0	4
<b>Pressure Ulcer</b>	<b>9</b>	<b>2</b>	<b>31</b>	<b>1</b>	<b>4</b>	<b>3</b>	<b>1</b>	<b>1</b>	<b>3</b>	<b>6</b>	<b>4</b>	<b>3</b>	<b>68</b>
Grade 2 - Community Acquired	6	0	16	1	0	1	0	1	1	4	1	1	32
Grade 4 - Community Acquired	1	0	1	0	3	0	1	0	1	2	2	1	12
Suspected Deep Tissue Injury - Hospital Acquired	0	0	1	0	1	0	0	0	0	0	0	0	2
Suspected Deep Tissue Injury - Community Acquired	0	0	1	0	0	1	0	0	0	0	1	1	4
Grade 3 - Community Acquired	2	1	8	0	0	1	0	0	1	0	0	0	13
Grade 2 - Hospital Acquired	0	1	3	0	0	0	0	0	0	0	0	0	4
Grade 3 - Hospital Acquired	0	0	1	0	0	0	0	0	0	0	0	0	1
<b>Medicines</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>4</b>	<b>3</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>13</b>
Safe and secure	0	0	0	1	1	2	0	0	0	0	0	0	4



We are  
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	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
handling of medicines													
Prescription error - drug history / medicines reconciliation	0	0	0	0	1	0	0	0	0	0	0	0	1
Medications not transferred with patient	0	0	0	0	1	0	0	0	0	0	0	0	1
Controlled Drugs - Illicit drugs found on patient	0	0	1	0	1	0	0	0	0	0	0	0	2
Incorrect medicines information given	0	0	0	0	0	1	0	0	0	0	0	0	1
Pharmacy clinical checking error	0	0	0	0	0	0	1	0	0	0	0	0	1

### Incidents by Category, Sub-Category and Month – 01/04/2015 - 1/03/2016

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
Administration - Dose Incorrect/Unclear	0	0	0	0	0	0	0	0	0	1	0	0	1
Drugs not Given - Unsigned Prescription Chart	0	0	0	0	0	0	0	0	0	0	1	0	1
Administration - Time Incorrect/Unclear	1	0	0	0	0	0	0	0	0	0	0	0	1
<b>Physical Assault to Other eg Patient Visitor</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>7</b>
Clinical violence	1	0	1	1	0	0	0	0	0	0	0	0	3



We are  
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	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
Malicious violence	0	0	0	1	1	1	1	0	0	0	0	0	4
<b>Discharge</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>2</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>6</b>
Lack of communication on discharge	0	1	1	1	0	0	0	0	0	1	0	0	4
Unable to discharge due to lack of Community Staff	0	0	0	1	0	0	0	0	1	0	0	0	2
<b>Disruption of services</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>
Clinical Services	0	0	0	1	0	0	0	0	0	0	0	0	1
<b>Consent &amp; Mental Capacity Act</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>2</b>
Inappropriate Consent	0	0	0	1	0	0	0	0	0	0	0	0	1
Breach of MCA Policy	0	0	0	0	0	0	0	0	0	1	0	0	1
<b>Patient Slips, Trips &amp; Falls</b>	<b>3</b>	<b>7</b>	<b>4</b>	<b>2</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>2</b>	<b>20</b>
Found on floor	1	2	1	1	0	1	0	0	0	0	0	0	6
Trip	0	0	0	1	0	0	0	0	0	0	0	0	1
Witnessed fall to floor	0	1	1	0	0	0	0	0	0	1	0	0	3
Fall from bed or trolley	0	3	0	0	0	0	0	0	0	0	0	1	4
Over balanced	1	1	0	0	0	0	0	0	0	0	0	1	3
Fall from Commode	1	0	0	0	0	0	0	0	0	0	0	0	1
Slip to floor	0	0	1	0	0	0	0	0	0	0	0	0	1
Other Aids	0	0	1	0	0	0	0	0	0	0	0	0	1
<b>Property Related</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>
Property Missing / Lost	0	0	0	1	0	0	0	0	0	0	0	0	1
<b>Patient Transfer</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>2</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>3</b>





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	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
From Halton	0	0	0	0	0	1	0	0	1	0	0	0	2
Patient did not meet transfer criteria	0	0	0	0	0	0	0	0	1	0	0	0	1
<b>Fire</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2</b>
Patient Related	0	0	0	0	1	0	0	0	0	0	0	0	1
Fire alarm activated patient/public	0	0	0	0	0	0	1	0	0	0	0	0	1

### Incidents by Category, Sub-Category and Month - 01/04/2015 - 1/03/2016

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total	
<b>Other Information</b>														
<b>Governance Issue</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	
Working Process	0	0	0	0	0	0	1	0	0	0	0	0	1	
<b>Diagnosis</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	
Delay in Diagnosis	0	0	0	0	0	0	1	0	0	0	0	0	1	
<b>Manual handling - Patient involved</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	
Patient lowered to floor with assistance	0	1	0	0	0	0	0	0	0	0	0	0	1	
<b>Recognising Risk in Deteriorating Patient</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	
By a Nurse / Midwife	0	0	1	0	0	0	0	0	0	0	0	0	1	
<b>Patient Choice</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	
Other	0	0	1	0	0	0	0	0	0	0	0	0	1	
<b>Bed management</b>			<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2</b>
Delay in transfer			1	0	0	0	1	0	0	0	0	0	2	



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	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
Assault non physical			1	0	4	0	0	2	0	0	0	0	7
Disruptive Behaviour			0	0	1	0	0	2	0	0	0	0	3
Abuse - verbal			1	0	1	0	0	0	0	0	0	0	2
Aggressive Behaviour			0	0	2	0	0	0	0	0	0	0	2
<b>Grand Total</b>	<b>22</b>	<b>24</b>	<b>54</b>	<b>31</b>	<b>27</b>	<b>30</b>	<b>33</b>	<b>4</b>	<b>10</b>	<b>12</b>	<b>8</b>	<b>11</b>	<b>266</b>

### Incidents by Location and Month - 01/04/2015 - 31/03/2016

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
A&E Majors	2	3	11	3	5	5	6	1	1	3	3	2	45
A1	4	1	10	3	0	0	2	0	1	1	0	0	22
A&E Clinical Decisions Unit (CDU)	1	0	3	6	2	2	2	0	0	1	1	1	19
A3 (OPAL)	3	2	1	2	2	0	3	0	1	1	0	1	16
B12	1	1	1	1	1	4	2	0	0	0	1	2	14
A2	1	0	5	0	2	1	1	1	0	2	0	0	13
C22	3	2	1	0	0	2	2	0	1	0	0	0	11
A&E Front end or Triage	0	2	1	0	1	2	3	0	0	0	1	0	10
C21	0	1	1	5	2	0	0	0	0	0	0	1	10
ITU	0	1	3	0	1	3	0	0	0	0	0	0	8
A&E Resuscitation	2	1	2	0	1	0	1	0	0	0	0	1	8
B19	1	2	2	0	1	0	1	0	0	0	0	0	7
B1 - Halton	0	0	0	0	0	3	1	0	1	0	1	1	7
A8	0	0	2	1	1	0	2	0	0	1	0	0	7



We are  
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	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
A4	1	1	3	0	1	0	0	0	0	0	0	0	6
B14	0	0	0	1	0	1	1	0	1	1	0	1	6
A7	0	1	0	1	2	1	1	0	0	0	0	0	6
A6	1	1	0	3	0	0	0	0	1	0	0	0	6
B18	0	2	1	1	0	1	0	0	0	0	0	1	6
A9	0	1	2	0	1	0	0	1	0	0	0	0	5
A5	0	0	1	1	0	1	0	0	1	0	0	0	4
A&E Minors	0	1	0	0	0	0	1	0	1	0	0	0	3
Patient's Home	0	0	0	0	1	1	0	0	0	0	0	0	2
Coronary Care Unit	1	0	0	0	0	0	0	0	0	0	1	0	2
A&E Reception / Admin	0	0	1	0	0	0	1	0	0	0	0	0	2
Surgical Assessment Unit	0	0	1	0	0	0	0	0	1	0	0	0	2
C20	0	0	0	1	0	0	0	1	0	0	0	0	2
Delivery Room 01	0	0	0	1	0	1	0	0	0	0	0	0	2
Pre-Op Ortho Clinic Warrington	0	0	0	0	0	0	0	0	0	1	0	0	1
Community Setting	0	0	0	0	1	0	0	0	0	0	0	0	1
B4 (General Surgery - Halton)	0	0	0	0	1	0	0	0	0	0	0	0	1
Halton Theatre 3	0	0	0	0	1	0	0	0	0	0	0	0	1
Short Term Assessment and Rehabilitation Unit	0	0	0	0	0	0	0	0	0	1	0	0	1
Endoscopy	0	0	0	0	0	0	1	0	0	0	0	0	1
Pharmacy	0	0	0	0	0	0	1	0	0	0	0	0	1



We are  
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	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
MIU Halton	0	0	0	1	0	0	0	0	0	0	0	0	1
Out Patients Department	0	0	0	0	0	1	0	0	0	0	0	0	1
CMTC Ward	0	0	0	0	0	0	1	0	0	0	0	0	1
Recovery Main	0	0	1	0	0	0	0	0	0	0	0	0	1
Any Other Location within other Organisation.	1	0	0	0	0	0	0	0	0	0	0	0	1
Breast Screening Kendrick Wing	0	0	0	0	0	1	0	0	0	0	0	0	1
Out-patients Department - Halton	0	0	1	0	0	0	0	0	0	0	0	0	1
Recovery Bay - Warrington Theatre	0	1	0	0	0	0	0	0	0	0	0	0	1
<b>Grand Total</b>	<b>22</b>	<b>24</b>	<b>54</b>	<b>31</b>	<b>27</b>	<b>30</b>	<b>33</b>	<b>4</b>	<b>10</b>	<b>12</b>	<b>8</b>	<b>11</b>	<b>266</b>

### Incidents by Location and Severity – 01/04/2015 - 31/03/2016

	1 - Negligible / None	2 - Minor	3 - Moderate	5 - Catastrophic	Grand Total
A&E Majors	29	15	1	0	45
Community Setting	1	0	0	0	1
Delivery Room 01	1	1	0	0	2
A&E Resuscitation	8	0	0	0	8
A2	7	6	0	0	13
MIU Halton	0	1	0	0	1



We are  
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	1 - Negligible / None	2 - Minor	3 - Moderate	5 - Catastrophic	Grand Total
C20	1	1	0	0	2
A&E Minors	1	2	0	0	3
A&E Front end or Triage	9	1	0	0	10
A1	13	9	0	0	22
A7	2	4	0	0	6
A8	6	1	0	0	7
B14	6	0	0	0	6
C21	5	5	0	0	10
A5	0	4	0	0	4
A&E Clinical Decisions Unit (CDU)	10	8	0	1	19
A6	3	3	0	0	6
A3 (OPAL)	9	7	0	0	16
B18	4	2	0	0	6
B12	9	5	0	0	14
Patient's Home	1	1	0	0	2
B19	5	2	0	0	7
A9	1	4	0	0	5
ITU	5	3	0	0	8
Halton Theatre 3	0	1	0	0	1
B4 (General Surgery - Halton)	0	1	0	0	1
A4	2	4	0	0	6
Breast Screening Kendrick Wing	1	0	0	0	1



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	1 - Negligible / None	2 - Minor	3 - Moderate	5 - Catastrophic	Grand Total
B1 - Halton	5	1	1	0	7
C22	7	4	0	0	11
Out Patients Department	1	0	0	0	1
A&E Reception / Admin	1	1	0	0	2
Pharmacy	0	1	0	0	1
Endoscopy	0	1	0	0	1
CMTC Ward	0	1	0	0	1
Surgical Assessment Unit	2	0	0	0	2
Short Term Assessment and Rehabilitation Unit	0	1	0	0	1
Pre-Op Ortho Clinic Warrington	0	1	0	0	1
Coronary Care Unit	1	1	0	0	2
Any Other Location within other Organisation.	0	1	0	0	1
Recovery Bay - Warrington Theatre	1	0	0	0	1
Recovery Main	1	0	0	0	1
Out-patients Department - Halton	0	1	0	0	1
<b>Grand Total</b>	<b>158</b>	<b>105</b>	<b>2</b>	<b>1</b>	<b>266</b>

David Kelly – Governance and Patient Safety Support Officer

Of the above incidents, 2 were awaiting final approval and 5 were being reviewed.



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## BOARD OF DIRECTORS

<b>AGENDA REFERENCE:</b>	<b>BM/16/196</b>
<b>SUBJECT:</b>	<b>Self-Certification Checklist – Agency Spend</b>
<b>DATE OF MEETING:</b>	30th November 2016
<b>ACTION REQUIRED</b>	<b>For Decision</b>
<b>AUTHOR(S):</b>	Roger Wilson
<b>EXECUTIVE DIRECTOR SPONSOR:</b>	Roger Wilson, Director of Human Resources & Organisational Development
<b>LINK TO STRATEGIC OBJECTIVES:</b>	All
<b>LINK TO BOARD ASSURANCE FRAMEWORK (BAF):</b>	BAF2.5: Right People, Right Skills in Workforce
	BAF2.2: Nurse Staffing
	BAF2.3: Medical Staffing
<b>STRATEGIC CONTEXT</b>	<p>NHS Improvement have enhanced their scrutiny on Trust performance on the management of Agency spend across the Board.</p> <p>The Trust has sought assurance on this issue for several years.</p> <p>It is a key issue across the range of our Quality, People and Sustainability framework.</p>
<b>EXECUTIVE SUMMARY (KEY ISSUES):</b>	<p>The Check list is effectively a summary of our activity in relation to the systems and processes we have in place to manage Agency Spend.</p> <p>It is a requirement that this is submitted to NHS Improvement by 30<sup>th</sup> November 2016.</p>
<b>RECOMMENDATION:</b>	<ol style="list-style-type: none"> <li>1. That the Trust Board note the content and give approval for the checklist to be submitted to NHS Improvement.</li> <li>2. That Trust Board delegates responsibility for the on-going oversight on the checklist to Finance and Sustainability Committee.</li> </ol>



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<b>PREVIOUSLY CONSIDERED BY:</b>	<b>Committee</b>	Not Applicable
	<b>Agenda Ref.</b>	
	<b>Date of meeting</b>	
	<b>Summary of Outcome</b>	
<b>FREEDOM OF INFORMATION STATUS (FOIA):</b>	Release Document in Full	
<b>FOIA EXEMPTIONS APPLIED:</b> <i>(if relevant)</i>	None	



Self-certification checklist Please discuss this in your board meeting		Yes - please specify steps taken	No. We will put this in place - please list actions
<b>Governance and accountability</b>			
1	Our trust chief executive has a strong grip on agency spending and the support of the agency executive lead, the nursing director, medical director, finance director and HR director in reducing agency spending.	Regular review of Workforce Controls take place through Executive Team meetings, at least fortnightly.	
2	Reducing nursing agency spending is formally included as an objective for the nursing director and reducing medical agency spending is formally included as an objective for the medical director.	Yes – included for both Medical Director and Chief Nurse	
3	The agency executive lead, the medical director and nursing director meet at least monthly to discuss harmonising workforce management and agency procurement processes to reduce agency spending.	Yes, meeting has been set up and will meet on a monthly basis.	
4	We are not engaging in any workarounds to the agency rules.	We can confirm that we are not engaged in any workarounds to the Agency Rules	
<b>High quality timely data</b>			
5	We know what our biggest challenges are and receive regular (e.g. monthly) data on: - which divisions/service lines spend most on agency staff or engage with the most agency staff - who our highest cost and longest serving agency individuals are - what the biggest causes of agency spend are (e.g. vacancy, sickness) and how this differs across service lines.	At Finance and Sustainability Committee on 23 <sup>rd</sup> November 2016, it was agreed that this information is received by them on a monthly basis.	
<b>Clear process for approving agency use</b>			
6	The trust has a centralised agency staff booking team for booking all agency staff. Individual service lines and administrators are not booking agency staff.	For Agency staff being booked for longer than two weeks, then approval must be sought through our Establishment Control processes. For periods shorter than 2 weeks, then centralised	The Trust does not currently have centralised booking arrangements in place for AHP and A+C staff: However, we are currently exploring this option with Liaison and exploring other options to introduce this.

		controls are in place for Medical and Nursing	
7	There is a standard agency staff request process that is well understood by all staff. This process requires requestors and approvers to certify that they have considered all alternatives to using agency staff.	For Nursing and Medical staff, this is in place. This requires requestors and approvers to follow a number of set steps.	Further rigour to be introduced for AHP and Admin and Clerical staff to mirror processes used for Medical and Nursing.
8	There is a clearly defined approvals process with only senior staff approving agency staff requests. The nursing and medical directors personally approve the most expensive clinical shifts.	Revised scheme of approval in place with senior Medics/Nurses signing these shifts off. Chief Executive sign off on bookings over £120	
<b>Actions to reducing demand for agency staffing</b>			
9	There are tough plans in place for tackling unacceptable spending; e.g. exceptional over-reliance on agency staffing services radiology, very high spending on on-call staff.	A revised performance management regime has been approved by Clinical Operational Board. This covers a range of people measures, including % of agency spend against overall paybill. The revised regime mirrors NHSI performance classifications.	
10	There is a functional staff bank for all clinical staff and endeavour to promote bank working and bank fill through weekly payment, auto-enrolment, simplifying bank shift alerts and request process.	This is in place for Nursing and we have developed plans to do this for medical staff.	For AHP and A+C staff: this is not in place, however we are currently exploring this option with Liaison
11	All service lines do rostering at least 6 weeks in advance on a rolling basis for all staff. The majority of service lines and staff groups are supported by eRostering.	Yes, there is supporting evidence to support this declaration. This will be presented to FSC in December 2016.	

12	There is a clear process for filling vacancies with a time to recruit (from when post is needed to when it is filled) of less than 21 days.	This measure has been discussed with NHSI, it has been agreed that whilst we await further clarity on the measure from them, that we look at this measure as – the time elapsed between an advert for a post closing and the time taken for an offer to be made to the successful candidate. Our current process requires us to do this within 14 days.	
13	The board and executives adequately support staff members in designing innovative solutions to workforce challenges, including redesigning roles to better sustain services and recruiting differently.	The Board and Executive team have supported a range of workforce innovation. Including supporting bids for Physician Associates, Associate Nurses, developments in Vanguard Wards and the roll out of the Calderdale Framework.	
14	The board takes an active involvement in workforce planning and is confident that planning is clinically led, conducted in teams and based on solid data on demand and commissioning intentions.	Recent work on STP has seen the Board sighted on workforce developments regarding the	Trust Board via Strategic People Committee need to have assurance on future approaches to Workforce Planning.
<b>Working with your local health economy</b>			
15	The board and executives have a good understanding of which service lines are fragile and currently being sustained by agency staffing.	The Board is sighted on the areas of high agency spend through FSC and SPC. Key	

		area of focus is in Acute Care	
16	The trust has regular (e.g. monthly) executive-level conversations with neighbouring trusts to tackle agency spend together.	Regular contact is made with Executive colleagues to explore shared rotas and holding the line on agency caps Through LDS/STP work sustainable services are a key focus for future developments. The Trust recently brokered a Cheshire and Merseyside summit on the challenges facing provider organisations on this agenda.	

**Signed by**

[Date]

**Trust Chair:**

[Signature]

**Trust Chief Executive:**

[Signature]

*Please submit signed and completed checklist to the agency inbox (NHSI.agencyrules@nhs.net) by 30 November 2016*



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## BOARD OF DIRECTORS

<b>AGENDA REFERENCE:</b>	<b>BM/16/197</b>
<b>SUBJECT:</b>	<b>People Measures – Pilot Performance Improvement Proposal</b>
<b>DATE OF MEETING:</b>	30th November 2016
<b>ACTION REQUIRED</b>	<b>For Assurance</b>
<b>AUTHOR(S):</b>	Roger Wilson
<b>EXECUTIVE DIRECTOR SPONSOR:</b>	Roger Wilson, Director of Human Resources & Organisational Development
<b>LINK TO STRATEGIC OBJECTIVES:</b>	All
<b>LINK TO BOARD ASSURANCE FRAMEWORK (BAF):</b>	BAF2.5: Right People, Right Skills in Workforce
	BAF2.2: Nurse Staffing
	BAF2.3: Medical Staffing
<b>STRATEGIC CONTEXT</b>	<p>As part of the integrated performance report considered by Trust Board, there has been some under performance on People measures.</p> <p>The Trust is looking to mirror the NHS Improvement Performance classifications for all areas of the Trust.</p> <p>This may be approach which if successful, is utilised for all areas of Trust Performance.</p>
<b>EXECUTIVE SUMMARY (KEY ISSUES):</b>	<ul style="list-style-type: none"> <li>• Pilot a revised approach to Performance assessment across a core set of People measures</li> <li>• Approach has been agreed with Clinical Operational Board</li> <li>• Approach mirrors NHS Improvement performance classifications.</li> <li>• Detailed outline of support offer for areas under-performing on their people measures.</li> </ul>
<b>RECOMMENDATION:</b>	<p>That the Trust Board note the approach for Assurance.</p> <p>That the Trust Board delegate authority to Strategic People Committee for oversight of development in</p>



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	this area.	
	That the Trust Board receives an update on progress and classifications in February 2017.	
<b>PREVIOUSLY CONSIDERED BY:</b>	<b>Committee</b>	Not Applicable
	<b>Agenda Ref.</b>	
	<b>Date of meeting</b>	
	<b>Summary of Outcome</b>	
<b>FREEDOM OF INFORMATION STATUS (FOIA):</b>	Release Document in Full	
<b>FOIA EXEMPTIONS APPLIED:</b> <i>(if relevant)</i>	None	

## BOARD OF DIRECTORS

<b>SUBJECT</b>	<b>People Measures – Pilot Performance Improvement Proposal</b>	<b>AGENDA REF:</b>	<b>16/197</b>
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### 1. INTRODUCTION

Since April 2016, performance across the Trust on People issues, has been below our expected standard. Despite a letter in June 2016 clarifying the need for grip and focus, performance still falls short of what we (and our staff) would expect. Performance across our critical People areas must be improved, if we are to attract and retain staff today and in the future? This applies to all areas of the Trust, both clinical and corporate and all managers and Heads of Department.

### 2. PROPOSAL

NHS Improvement has recently published a revised set of performance categories or “segmentation classification”. They are as follows: -

- a) Maximum Autonomy
- b) Providers Offered targeted support
- c) Providers receiving mandated support for significant concerns
- d) Special Measures

It is proposed that for the remainder of the 2016/2017 financial year that these be adopted and adapted to measure performance across a range of People Measures. They will be piloted to see if this approach is effective in raising standards to the required level.

The four categories would be as follows: -

- a) Maximum Autonomy
- b) Function offered targeted support
- c) Function receiving mandated support for significant concerns
- d) Special Measures

It is essential that a consistent, fair, equitable and transparent process for assessing performance against these people measures is adopted.

### 3. RESPONSIBLE OFFICER

Roger Wilson, Director of Director of Human Resources & Organisational Development.



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#### 4. IMPACT ON QPS?

The proposed pilot should have a positive impact across the QPS framework, raising compliance rates across a range of measures, should enhance quality, whilst reducing cost and improving staff engagement and involvement. A test of the pilot will be the impact the approach has had on our People measures.

#### 5. MEASUREMENTS/EVALUATIONS

The measures to be used for assessment are as follows:-

- a) Year to Date Absence
- b) Year to date Return to Work interview completion
- c) % Agency Spend
- d) Turnover
- e) PDR Compliance
- f) Essential Training Compliance
- g) Clinical Training Compliance

These are the core measures, there will be the need to develop further measures during the course of the pilot, especially around staff engagement. In the first instance all areas will be assessed against their performance regarding staff survey response rates, during the course of this current campaign.

#### 6. TRAJECTORIES/OBJECTIVES AGREED

The performance expected for each of these areas, will be as follows: -

##### Targeted People KPIs

KPI	Green RAG Rating	Amber RAG Rating	Red RAG Rating
Sickness Absence % YTD	<4.2%	4.2% - 4.5%	>4.5%
Return to Work Interview Compliance %	>85%	70% - 85%	<70%
Agency Cost %	<3%	3% - 5%	>5%
Turnover %	7% - 10%	5%-7% or 10%-12%	<5% or >12%
Essential Training Compliance %	>85%	70% - 85%	<70%
Clinical Training Compliance %	>85%	70% - 85%	<70%
PDR Compliance %	>85%	70% - 85%	<70%

It is proposed that the following measures will be used to categorise each area of the Trust: -





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## Segmentation Classification

1. Maximum autonomy	• All KPIs are RAG rated green
2. Clinical or Corporate area offered targeted support	• 0 KPIs are RAG rated red
3. Clinical or Corporate area receiving mandated support for significant concerns	• No more than 3 KPIs are RAG rated red
4. Special measures	• 4 or more KPIs are RAG rated red

As with NHS improvement's framework, there must be consequences of being classified in 2, 3 or 4. The intensity of support and scrutiny increases through the levels.

## Support Offers

1. Universal support (Classification 1)	• Business as usual
2. Targeted support (Classification 2 & 3)	<ul style="list-style-type: none"> <li>• Clinical or Corporate area to produce action plan with HR Business Partner and submit to HR Director</li> <li>• Clinical or Corporate area held to account on plan at monthly People Performance and Governance Meetings</li> <li>• Updates to Operational People Committee via HR Business Partner</li> <li>• Assurance to Strategic People Committee via HR Director</li> </ul>
3. Mandated support (Classification 4)	<ul style="list-style-type: none"> <li>• Clinical or Corporate area to produce action plan with HR Business Partner and submit to HR Director</li> <li>• Clinical or Corporate area to attend fortnightly meetings (supported by HR Business Partner) with HR Director to update on progress</li> <li>• Clinical or Corporate area held to account on plan at monthly People Performance and Governance Meetings</li> <li>• Updates to Operational People Committee via HR Business Partner</li> <li>• Assurance to Strategic People Committee via HR Director</li> </ul>

## 7. MONITORING/REPORTING ROUTES

Monitoring and reporting will be through the Operational People Committee.

## 8. NEXT STEPS

1. Each CBU and corporate function will be informed of their indicative classification and the appropriate next steps
2. Additional discussions to take place with Divisional Director of Operations and Functional Directors about incremental progression for managers outside of classification 1.
3. As progress is made across these key areas, classifications will be reviewed on a regular basis.
4. Individual Executive Team members ensure that the process is cascaded through their management tiers and include it on their team agendas.
5. Executive Team members routinely review their own areas performance against these criteria.



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## 9. ASSURANCE COMMITTEE

Strategic People Committee.

## 10. RECOMMENDATIONS

That Trust Board note the approach outlined in the paper and seek a further update at the Trust Board meeting in February 2017.



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## BOARD OF DIRECTORS

<b>AGENDA REFERENCE:</b>	<b>BM/16/198</b>
<b>SUBJECT:</b>	<b>People Strategy</b>
<b>DATE OF MEETING:</b>	30th November 2016
<b>ACTION REQUIRED</b>	<b>For Decision</b>
<b>AUTHOR(S):</b>	
<b>EXECUTIVE DIRECTOR SPONSOR:</b>	Roger Wilson, Director of Human Resources & Organisational Development
<b>LINK TO STRATEGIC OBJECTIVES:</b>	SO2: To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work together to care for our patients
<b>LINK TO BOARD ASSURANCE FRAMEWORK (BAF):</b>	BAF2.1: Engage Staff, Adopt New Working, New Systems
	BAF2.4: Engaging & Involving Workforce
	BAF2.5: Right People, Right Skills in Workforce
<b>STRATEGIC CONTEXT</b>	<p>The People Strategy translates the Trust's Strategic Plan into practice by providing both direction and detail of how the people aspects of our overall strategy will be achieved. It focuses on 5 interlinked principles.</p> <ul style="list-style-type: none"> <li>• Engage - <i>Create a progressive, engaging &amp; healthy working environment</i></li> <li>• Attract - <i>Attract and recruit the best staff</i></li> <li>• Retain – <i>Retain and reward staff through recognition of their value</i></li> <li>• Develop –<i>Develop and support all staff to achieve their potential.</i></li> <li>• Perform – <i>Enable the delivery high quality safe healthcare</i></li> </ul> <p>These aims support the Trust's strategic priorities and will help to further embed our organisational values and behaviours.</p>
<b>EXECUTIVE SUMMARY (KEY ISSUES):</b>	In recent years, the Trust has not had a People Strategy, an overarching strategy giving direction and purpose to its People agenda. However, work has been ongoing at WHH to set the foundations to improve our workforce measures



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	<p>across the organisation.</p> <p>Our People Strategy recognises that effective governance, education, leadership and management of people issues takes place across the Trust and at all levels of activity and must be accessible and achievable.</p> <p>It recognises that steps have been made across the organisation but that upon solid foundations we need to develop the ethos that 'our People are central to our success'. Good management and strong leadership will lead to more engaged staff and ultimately better patient care.</p>	
<b>RECOMMENDATION:</b>	<p>That the strategy is approved and implemented throughout the organisation from 1<sup>st</sup> December 2016</p>	
<b>PREVIOUSLY CONSIDERED BY:</b>	<b>Committee</b>	
	<b>Agenda Ref.</b>	
	<b>Date of meeting</b>	
	<b>Summary of Outcome</b>	
<b>FREEDOM OF INFORMATION STATUS (FOIA):</b>		
<b>FOIA EXEMPTIONS APPLIED:</b> <i>(if relevant)</i>		

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# Our People Strategy

2016 – 2019

# Contents

1. Foreword
2. Purpose, vision and mission
  - 2.1 Introduction
  - 2.2 WHH Context
  - 2.3 WHH Strategy
  - 2.4 We are WHH
3. Our approach
  - 3.1 Where are we now?
  - 3.2 Branding and Identification
  - 3.1 Leadership & Management
  - 3.2 Our Model
4. Strategic Aims
  - 4.1 Engage
  - 4.2 Attract
  - 4.3 Recruit
  - 4.4 Develop
  - 4.5 Perform
5. Outcomes
  - 5.1 For our Staff
  - 5.2 For our Patients
6. Implementation
7. Resources
8. Monitoring and Evaluation
9. Summary and Conclusion
10. References

# 1. Foreword

Welcome to Warrington & Halton (WHH) Hospitals NHS Foundation Trust's "People Strategy". We believe that our people are our greatest asset and that it is our people that make the difference between good care and excellent care.

Our People Strategy has been derived from the Trust's Strategic Plan - *Creating Tomorrow's Health Care today*. It is informed by the many challenges facing the National Health Service and sets out a clear forward-looking People Agenda, intended to underpin the delivery of high quality, safe healthcare and uphold its central role in the implementation of the Quality, People and Sustainability framework (QPS).

This "People Strategy" will support and enable the Trust to deliver our quality outcomes of providing:

- Clinical Effectiveness
- A Safe Organisation
- Excellent Patient Experience

The Trust has been on a journey since early 2015, when we started to review our values and behaviours. This was achieved by undertaking a large exercise of staff engagement and developing our present behaviours - "We are WHH and together we make a difference".

Within this strategy you will see that our journey continues with "People" at its core, developing and building on the excellent work that has already been undertaken. We support our staff to deliver high quality care by utilising the words of Professor Michael West "patient satisfaction is significantly higher in Trusts with higher levels of employee engagement"(2014).

Our People Strategy allows anyone to understand our ambition, our expectations of each other and what working for WHH is like. Our expectations of a member of team WHH and what they can expect from WHH.

Cultural change is neither easy nor speedy but it is with the small steps towards our goal that we will get to our destination, taking our people with us.

**Roger Wilson**  
**Director of HR & OD**

## 2. Purpose, vision and mission

### 2.1 Introduction

The NHS is changing both locally and nationally. This political context places considerable pressure on our staff as they strive to deliver the best outcomes for our patients. We need to plan for how we will continually respond to these changes so that we can deliver high quality care as well as being a good employer.

There are real challenges for us, as for all healthcare providers, to ensure we have the right capacity and capability to deliver high quality care.

This People Strategy recognises that effective governance, education, leadership and management of people issues takes place across the Trust and at all levels of activity and must be accessible and achievable.

In order to develop our People Strategy we have consulted with staff at all levels. All staff were asked to tell us ‘what makes them come to work’ and ‘what we could do better’, the results of which have influenced this strategy. We have also used other data available to us through our on-boarding and exit questionnaires, our Staff Friends & Family Tests and the results of the National Staff Survey.

It recognises that steps have been made across the organisation but that upon solid foundations we need to build upon the ethos that ‘our People are central to our success’. Good management and strong leadership will lead to more engaged staff and ultimately better patient care.

The People Strategy translates the Trust’s Strategic Plan into practice by providing both direction and detail of how the people aspects of our Trust strategy, ‘*Creating Tomorrow’s Healthcare Today*’ will be achieved. It is made up of five inter-related strategic aims:

- Engage - *Create a progressive, engaging & healthy working environment*
- Attract - *Attract and recruit the best staff*
- Retain – *Retain and reward staff through recognition of their value*
- Develop – *Develop and support all staff to achieve their potential*
- Perform – *Enable the delivery of high quality, safe healthcare*

These aims support the Trust’s strategic priorities and will help to further embed our organisational values and behaviours.

In order to deliver the People Strategy, an operational delivery plan, our Operational People Plan will be developed as a framework of measurement; it will include KPIs and success criteria and will form the basis of our Operational People Committee.



## 2.2 WHH Context

WHH employs approximately 4200 people and provides health care services across the towns of Warrington, Runcorn (where Halton General Hospital is based), Widnes and the surrounding areas. We are responsible for a budget of around 215 million each year and provide access to care for over 500,000 patients.

In recent years, the Trust has not had a People Strategy, an overarching strategy giving direction and purpose to its People agenda. However a work has been ongoing at WHH to improve our workforce measures across the organisation. During the last 18 months the following developments have taken place:

- **Performance Improvement** - A revised approach to Performance Improvement has been introduced, linking incremental progression to satisfactory performance.
- **Managers Training** – Introduced Essentials for Managers, this is a revised and refreshed approach to the development of our managers and leaders on the People Management Agenda.
- **Employee Relations Review** – This development has included a revised approach to Employee Relations across the Trust and will fully be in place from 1<sup>st</sup> April 2017
- **CBU Launch and development programme** – Having first been discussed in February 2015, following the CQC inspection, this huge organisational development initiative was implemented on 1<sup>st</sup> April 2016. Implementation followed a robust consultation period and a rigorous assessment process
- **Implementation of Trust values and behaviours** – Although the Trust did have a values and behaviours framework in place in early 2015, following a review, a decision was taken to re-consult and ensure that they were effectively embedded in the organisation. This is still evolving but the Values and Behaviours have underpinned the Readiness Assessment process for the CBU Project. In addition each member of staff has a values and behaviours card and they are being incorporated into contracts of employment and across our policies and procedures.
- **Flu Fighter** – In 2015 the Trust vaccinated the second highest number of clinical staff in the country and was shortlisted for a NHS Employers Award for the most improved Acute Trust. In terms of take up of the flu vaccine by our front line staff, this was as a result of a clear campaign, accessible sessions and superb staff engagement.
- **Staff Recognition** – Building on the existing Thank You Awards, this was taken to another level with a new venue and new awards. We have also rebooted employee and team of the month scheme and additional recognition for outstanding contribution to each of our Trust values.

- **Calderdale Framework** – Alongside colleagues across the Health and Social Care network, the Trust successfully fronted up a bid to introduce the Calderdale Framework, a system for developing capability in Competency-Based Workforce Planning. This was launched in September 2016 and will be a key underpinning workstream for the emergent People Strategy. This builds on the innovative approach adopted to the recruitment and development of the Physician Associate role and looking forward to the Nurse Associate role.
- **Freedom to Speak up Guardian** – Building on the Trust commitment to supporting staff to raise concerns, the Trust has an identified Freedom to Speak up Guardian. This further develops the strong Trust stance on supporting staff to raise concerns. It is the next step on from the Trust supporting the RCN initiative Speak Out Safely and is part of the Trust response to Francis and other NHS learning.
- **Robust approach to Workforce Audits** – As part of a revised approach to governance supporting the HR & OD Directorate, the Directorate has adopted a more robust approach to the management of audits, utilising Audit to provide assurance across a range of people management activity and ensuring that new initiatives are effectively embedded.
- **Strengthened governance around Equality and Diversity** – Working on the Workforce Race Equality Scheme and the emergent Workforce Disability Equality Scheme, the Trust has much work to do in this area, but has much stronger infrastructure and focus in place to drive the agenda forward.
- **Enhanced alignment of HR & OD focus and support to clinical and corporate services** – Whilst people management is the domain of every manager and leader in the organisation, they need a strong, supportive, facilitative and enabling HR & OD team behind them. With the focus on a Business Partnering and the development of revised Divisional Support teams, the support to line managers has been enhanced and expectations are clarifying. This has also seen the adoption of a refreshed approach to employee relations casework, ensuring that this is dealt with in a timely manner and that a more central overview of progress is adopted.
- **Effective and timely recruitment processes** - Whilst significant progress has been made work in ongoing to ensure it becomes efficient and effective.
- **Rolling Recruitment Campaigns** – The Trust has significantly reduced the time to recruit into posts and has also has begun to establish itself as an attractive employment proposition, from Radiology to Cardiology. The Trust is currently developing a partnership with Gatenby Sanderson as our recruitment partners for senior Medical positions.
- **Coaching Culture** – The Trust has a long established structured approach to Culture, but this is further developed and enhanced year on year, ensuring that colleagues are supported to be the best they can be.

- **Attendance Management** – A new attendance management policy has been introduced at the trust and there has been a significant focus on the need for timely Return to work interviews.
- **Retention** – our retention rates remain a frustration and the People Strategy will enhance our ability to recruit high quality staff who will live and breathe our Values and Behaviours but also to enhance our ability to retain and develop them.
- **Ageing workforce** – The trust has begun to map its age profile and has been involved nationally with work around skill retention and role. This is a significant piece of work within the strategy and will require greater intelligence gathering to enable success.

All of these developments have been supported by enhanced and improved workforce KPI reporting to Trust Board, this has been integrated into the Integrated Performance Report. The governance around the people agenda has been strengthened to with added clarity given to the role of Strategic People Committee, the introduction of Operational People Committee, as well as the Divisional engagement mechanism – the Workforce Governance and Performance Groups.

Whilst all of these developments, show real progress and desire on behalf of the organisation to become an employer of choice and ensure that our staff have a great experience, the September 2016 Trust Board meeting still saw performance falling short in some key areas: -

- Return to work interview compliance
- Recruitment times
- Turnover
- Agency Nurse Spending

The Trust has played a strong leadership role in the Cheshire and Merseyside response to the Agency Pay bill Challenge. The challenge of reducing pay bill costs is present across our health economy.

The wider health and social care picture is one which has become increasingly pressing and involving with the Trust playing a progressive role in moving the shared agenda forward, both in terms of developing a shared service approach and also a unified workforce development response to emerging clinical configurations.

It is therefore upon a solid foundation that we have developed our People Strategy which will allow us to move forward with a clear direction.

## 2.3 WHH Strategy

The Trust’s overarching 5 year strategy sets out our organisation’s vision and mission:

Our vision: *‘To be the most clinically and financially successful healthcare provider in the min-Mersey region’*

Our mission: *‘To provide high quality, safe Integrated healthcare to all our patients’*

To achieve our vision we believe we need to focus on quality of our services, on the people who deliver them and on ensuring our organisation’s sustainability within the wider health economies in which we operate. This is our QPS framework and puts our people at the centre.

### The QPS Aims and Objectives are:

<p><b>Quality</b></p> <p>Delivering excellence for our patients</p> 	<ol style="list-style-type: none"> <li>1 We will reduce harm and focus on having no avoidable deaths by managing and reducing clinical and operational risks.</li> <li>2 We will improve outcomes, based on evidence and deliver care in the right place, first time, every time.</li> <li>3 We will focus on the patient and their experience, adopting ‘no decision about me without me’ as a way of life and we will get the basics right so our patients will be warm, safe, clean, well fed and well cared for.</li> </ol>
<p><b>People</b></p> <p>Committed to and caring for our staff</p> 	<ol style="list-style-type: none"> <li>4 We will ensure that our teams are skilled, available in the right numbers to deliver our services and fit and well in work so that we improve their working lives.</li> <li>5 We will communicate openly with our teams and expect the same from them in return. We expect staff to take accountability for their actions 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.</li> <li>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.</li> </ol>
<p><b>Sustainability</b></p> <p>Being here for our communities now and going forward</p> 	<ol style="list-style-type: none"> <li>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.</li> <li>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&amp;T and look for opportunities to collaborate on services for reciprocal benefit.</li> <li>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.</li> </ol>

## 2.4 We are WHH – Our culture

The Trust has developed its “We are” values in consultation with staff, which were introduced on 1 April 2016. The values now underpin the Human Resources and Organisational Development activity at all levels within the organisation from recruitment to retention.

WHH aspires to embed a culture that promotes learning from its mistakes, from excellence and innovations and create an environment where our staff feel valued for their contribution to delivering a first class service. This is reflected in our strategic aims and supporting documentation.

**HIGH QUALITY, SAFE HEALTHCARE**  
QUALITY PEOPLE SUSTAINABILITY

Warrington and Halton Hospitals **NHS**  
NHS Foundation Trust

**We are**  
**WHH**

**And together we make a difference.**

- Working together**  
We promise an environment where patient care is paramount and our staff matter.
- Excellence**  
We ensure excellence across our teams in providing the best care for our patients.
- Accountable**  
We make sure everyone is involved in making decisions.
- Role models**  
We inspire and Innovate through great leadership to provide excellent care for our patients.
- Embracing change**  
We are open to new ideas from patients, public and everyone in our team.

**Our values shape the way that we deliver high quality, safe and effective healthcare for patients.**  
for more information visit [www.whh.nhs.uk](http://www.whh.nhs.uk)

The Trust regularly participates in a number of key cultural barometers/surveys. These include:

- Staff Survey
- Friends and Family Test
- Patient Experience Surveys

The findings of which are cross referenced and analysed to ensure that our cultural direction is appropriate and we are listening to all areas of our organisation. Our actions will be reflected within our Operational People Plan.

## 3. Our approach

### 3.1 We are WHH - Where are we now?

It is our expectation that everyone working at or joining WHH will live our values and demonstrate the required behaviours in everything that they do. We will be clear on expectation for this and ensure that the behaviours are embedded throughout the organisation through both our daily work and the process of recruitment and selection.

We need to be honest about this expectation with everyone. The catalyst to behavioural change is often demonstration of the behaviours and our leaders need to be our role models. The Clinical Business Unit selection process began to embed this ethos. Our people need regular feedback, coaching and recognition when these behaviours are demonstrated well even when this is deemed difficult. Being clear in expectation from the outset will allow everyone at WHH to make appropriate choices and ensure best fit.

### 3.2 Branding and Identification

A significant amount of work has been carried out, which has laid the foundations for this strategy. Unfortunately, sometimes the links between events and activities and our overall aims are not always apparent to staff. This was particularly apparent with regard to staff health and wellbeing. Therefore, building upon our "We Are" values and behaviours and the development of our staff as personal and organisational role models, we have amalgamated our health and well-being initiatives and developed a brand that mirrors the Trust branding and behaviours but gives this important work stream its own identity.



As part of our People Strategy we will continue to define and develop our brand and look to expand these principles wider through the Directorate. We will use the brand through our advertising, online (social media activity) to distinctively develop the “People” brand as a recognisable concept related to our specific activities.

### 3.3 Leadership and Management

The implementation of Clinical Business Units (CBUs) at WHH has had a significant impact on the development of this People Strategy. The intrinsic use of the organisational values and behaviours and the focus on people skills has demonstrated that these are essential qualities of our senior managers.

Further evidence has shown that sufficient levels of supervisory support and wider staff engagement are associated with the delivering of better patient care through greater staff satisfaction and health outcomes (Dawson, 2014).

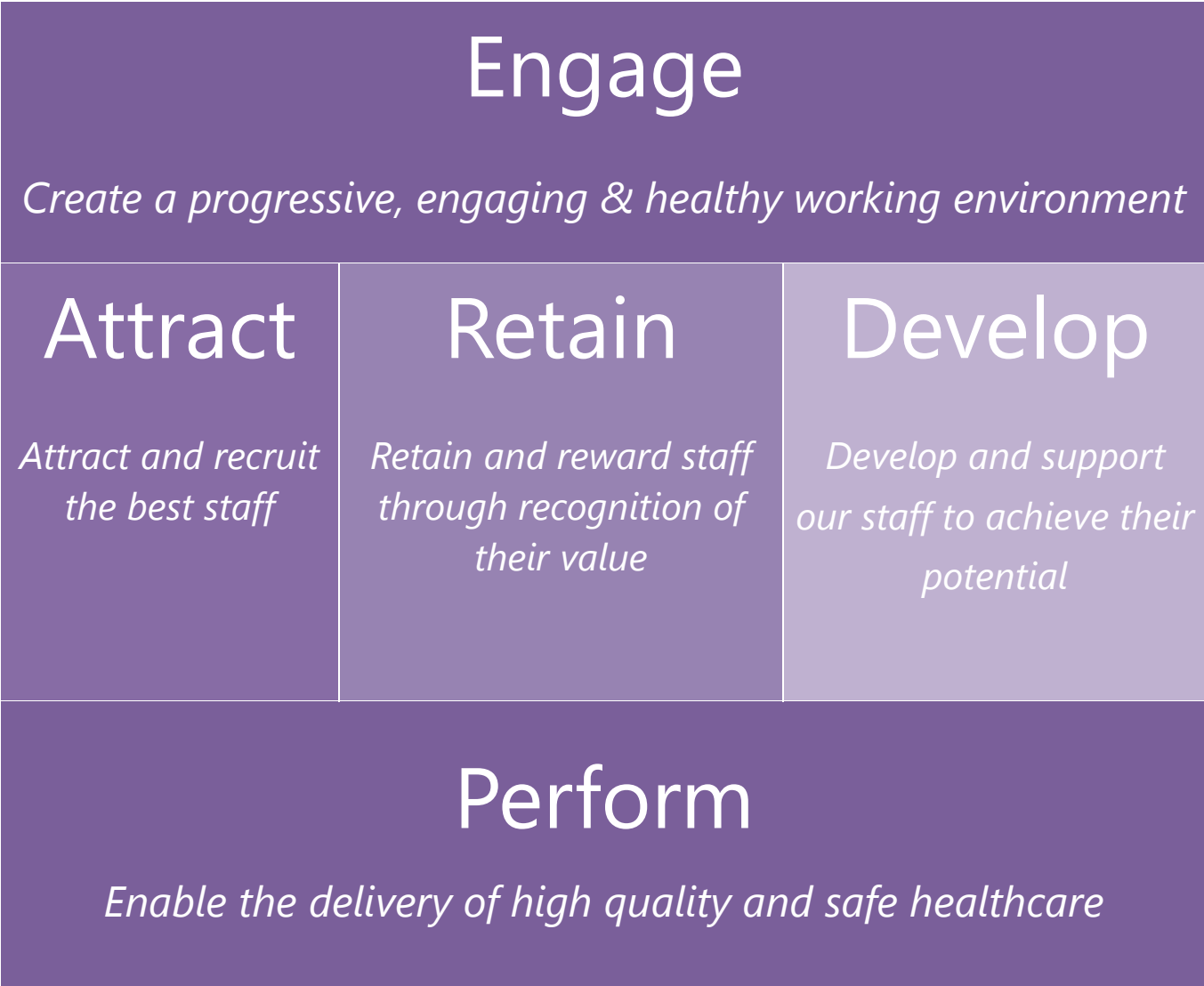
As part of our Trust behaviours work the organisation implemented a Behaviours matrix in April 2016. This is a detailed operational document that segments the organisation by level of management responsibility and not banding. It sets out the behavioural expectations for each level, giving clear guidance as to the practical implementation of our behaviours. It therefore gives a pathway for development of managers and leaders and should be used with all staff during performance reviews and talent management.

Our strategic aims cannot be achieved without exemplary leadership skills. In order to be successful, we will need to continue to develop our leadership competencies at all levels. This will ensure that staff understand their own leadership styles and can adapt them to deal with different situations, to motivate and energise their teams. We will prepare staff for leadership roles early in their careers, so that they have the necessary depth and breadth of experience to take on roles with greater responsibility. It will be important to understand how we can make leadership roles more attractive and appealing to a wider talent pool.

Management skills will be equally important to leadership skills and great emphasis will be placed on preparing managers to deliver change and innovation effectively and swiftly, in a highly demanding environment. Through development, coaching and mentoring, managers will become accomplished in creating a high-performance culture, and will be confident in dealing with every aspect of managing staff, from setting clear expectations and rewarding excellence, to managing poor performance and staff exits where necessary.

### 3.4 Our Model

Our People Strategy is focussed on 5 interlinked principles. The delivery of these strategic aims will support the delivery of the Trust’s strategic priorities and will enable the organisation to further embed the organisational values and behaviours.



### 4. Strategic Aims

- 4.1 Engage
- 4.2 Attract
- 4.3 Retain
- 4.4 Develop
- 4.5 Perform



# Engage:

*Creating a progressive, collaborative and healthy working environment, that is conducive and beneficial to both the staff and patient experience.*

Engaging with our staff is critical to the success of WHH, we recognise that engaging staff is an on-going process and that staff in their day-to-day work recognise what needs to change. There is significant value in engaging with our staff early when planning changes to the way we work so that they can inform the solutions.

## We will:

- Continually and effectively communicate, engage and listen to staff throughout the organisation.
- Work in partnership with staff side colleagues to ensure the culture of joint working is embodied in supporting documentation and frameworks.
- Support our managers to proactively manage staff wellbeing, with practical support for implementing relevant strategy and guidance.
- Foster a culture where CBU staff are engaged and motivated by team managers who lead by example as role models and encourage employees to have a voice.
- Develop an environment of continuous improvement to help staff grow and develop and improve patient care.
- Make our staff feel valued, involved and fulfilled in the work that they do.
- Enable all staff to embody the Trust's behaviours and to feel supported to challenge colleagues who fail to do the same.
- Develop a culture where all staff demonstrate the Trust behaviours and where they are supported, respected and valued.

## Examples of Key measures of success and impact

- The Trust is perceived as an excellent place to work (National Staff Survey , Staff FFT)
- Overall staff engagement score increase (National Staff Survey)
- Improve overall Staff Satisfaction (Staff FFT, National Staff Survey)
- Improved attendance rates (including specific measures relating to workplace wellbeing)
- Increased Participation in wellbeing interventions
- Workplace Health and Wellbeing department services utilisation and feedback rates

# Attract:

*Attracting and recruiting the best staff is crucial to the future sustainability and success of our organisation. We must recruit the highest quality employees that align to our culture and workforce plans.*

Attracting staff at WHH needs to be flexible to meet the needs of the market.

The NHS is facing key challenges in relation to having sufficient numbers of qualified professional registrants across a number of professions. WHH needs to have a flexible approach to attracting high calibre staff on a local, regional and national and international level.

## We will:

- Develop our employer reputation and become an employer of choice.
- Through business and workforce planning processes, clearly identify roles required for the sustainability and future development of our organisation, fostering a culture of succession planning.
- Further enhance our recruitment process and practices to ensure that they are flexible and attuned to our needs.
- Ensure all recruitment is founded on the principles of our behaviours matrix
- Understand the employment market locally, nationally and internationally to enable us to attract the best talent.
- Enhance the Trust's offer to prospective staff and develop an attraction strategy for key posts across the organisation.
- Work with our Higher Education Colleagues to promote and attract high calibre recruits to the organisation.

## Examples Key measures of success and impact

- Reduced turnover rate
- No newly qualified staff nurses should leave in the first 12 months of employment with the Trust
- Increased staff stability rate
- Reduction in number of adverts that are sent out more than once.
- On-boarding questionnaire to show positive trends and delivery on promises

**Retain:** *We want to create an environment in which our staff can see (and are rewarded for) an alignment between their overall contribution and the quality of patient care delivered.*

Labour turnover at WHH is higher than we would desire. In order to maintain a strong reputation as a good quality local employer, it is important to develop our Reward and Recognition Scheme, expanding our focus on an individual's wellbeing, ability to be healthy and achieve continuous positive satisfaction within their role.

## We will:

- Further develop our approach to reward and recognition to ensure it is flexible and fair and supports the achievement of the Trust's strategic vision and embeds our behaviours.
- Develop and deliver a robust approach to temporary staffing across all professions, through the development of a resourcing and retention plan.
- Further develop and deliver a comprehensive Engagement and Wellbeing plan across all staff.
- Support CBUs to achieve and maintain 100% of their available staff receive a meaningful annual Personal Development Review and plan.
- Create a talent management process that identifies and rewards the achievement of staff, developing enhancement opportunities for advancement and retains our highest performers
- Celebrate diversity within our workforce recognising how all staff contribute to, and enhance, the overall success of the Trust.
- Engage managers to deliver the NHS Five Year Forward Plan through effective management of people.

## Examples Key measures of success and impact

- Increased number of high performing staff promoted and recognised internally
- Reduced number of staff leaving the trust for roles of equal standing or a promotion to other local NHS organisations
- The trust is perceived as an excellent place to work where staff are listened to and actions are taken to redress issues (National Staff Survey , SFFT)
- Reduced staff turnover rates
- Successful completion of Management courses at all levels
- A successfully implemented talent management programme
- Highly utilised Health and Wellbeing service and executed strategy

# Develop:

*WHH is committed to developing a culture of lifelong learning to support patient safety and quality of care delivery.*

Our commitment to develop staff through personal and professional development is key to ensuring that we have the right workforce and skill mix for the future. Our People Strategy has a talent management approach at the heart of it to ensure that we provide structured development pathways for staff at all levels within the organisation, which will maximise their personal contribution.

## We will:

- Develop a culture for collaborative learning through safety and quality improvement networks via a robust integrated governance framework.
- Support staff so they are able to contribute to quality improvement and safety of services to patients.
- Commit to developing a culture of lifelong learning to support patient safety and quality of care through customised training for the workforce.
- Support the development of teams to work across traditional boundaries and ensure they have the skills and expertise to respond to the service needs through collaborative working.
- Ensure that leaders and managers actively support and develop their staff through excellent HR / OD practices, promoting staff health and well-being, involving staff in decision making and innovation, providing staff feedback and recognising good performance and making sure staff feel, supported, respected and valued at work.
- Create a culture through development reviews and talent management process to support succession planning. Continually identifying and growing the Trust's internal talent and staffing profile.
- Ensure that staff have access to the best knowledge and evidence. Challenge staff to ensure that everything they do is backed by the best available evidence, best practice and NICE Guidance.

## Examples of Key measures of success and impact

- All staff have a meaningful Performance Development Review (PDR) (National Staff survey)
- Achieve PDR rate KPI's
- Development and enhancing of staff coaching and mentoring network.
- Robust evaluation of leadership development programmes
- Increased percentage of staff who believe that the organisation takes staff health and wellbeing seriously (National Staff Survey)

# Perform:

*Enable the delivery of high quality  
and safe healthcare*

## Examples of Key measures of success and impact

In order to support the Trust overall strategy the outcome of the People Stagey must be to ensure it delivers a workforce engaged, motivated and capable of delivering the level of performance necessary to deliver high quality and safe healthcare.

- Encourage leaders to set challenging and measurable objectives: facilitate communication and coordination within and among teams, encouraging time out to review their performance and reflect upon how it can be improved.
- Create an environment where staff embrace technology and welcome change.
- Allow an environment where staff are flexible and actively participate in organisational change
- Foster a culture where a flexible and planned approach is taken to facilitate an ageing workforce to ensure safe and effective working partnership.
- Ensure robust HR & OD policies and practices are in place, utilising technology to support efficiencies in their process.
- Develop the HR & OD Directorate to influence and challenge the strategic readiness and culture of the organisation to deliver change to meet its strategic aims.
- Enable staff to perform to the best of their capability with the support for both their mental and physical health and wellbeing.
- Achieve high quality safe healthcare by utilising consistent robust approaches to measurement with a continuous improvement framework for staffing to ensure that staff feel safe, effective, responsive and well-led.

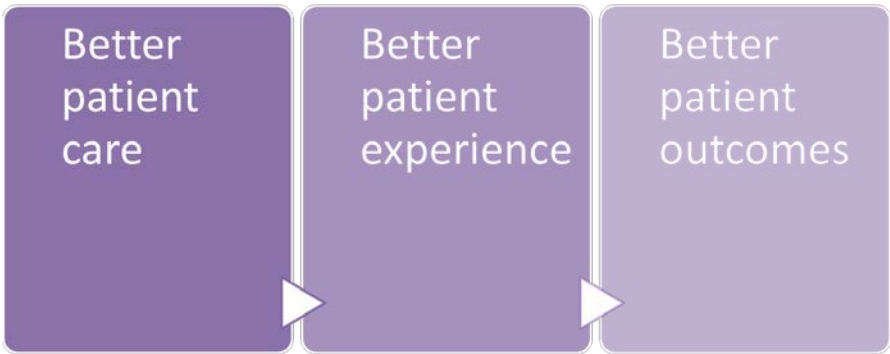
- Implementation and take up of health and wellbeing strategies for staff.
- Flexible working policy to reflect changes to thinking
- Staff and managers are able to access HR & OD information easily in the first instance online.
- Staff report increased levels of feeling safe (National Staff survey)
- Staff reporting increased levels of feeling well-led at all levels (National Staff survey)

# 5. Outcomes

## 5.1 For our staff



## 5.2 For our patients



# 6. Implementation

Our People Strategy recognises that to be useful and progressive it needs to be implemented throughout the organisation. Widespread implementation of the People Strategy will strengthen its delivery. The Human Resources and Organisational Development directorate can act as the catalyst but the strategy needs to be translated into achievable management actions for change to happen.

Each of our CBUs will be asked to make a pledge to their staff. Detailing how they will deliver the core principles of our People Strategy and embed the Trust behaviours. Our behaviours cascade and so will our people pledges.

Our Trust pledge is a summary of the People Strategy and our expectations as an organisation. WHH is committed to and caring for our staff, and pledges to you:

<b>W</b>	<ul style="list-style-type: none"><li>• Ensure our staff feel listened to and acting on feedback</li><li>• Provide regular, honest feedback to our staff</li><li>• Support staff to maintain their health, wellbeing and safety</li></ul>
<b>E</b>	<ul style="list-style-type: none"><li>• Balance safety, quality and efficiency</li><li>• Support the delivery of our services efficiently and always aim to give our staff the resources they need to do a good job</li><li>• Personally act as a role model for our Behaviours in everything we do</li></ul>
<b>A</b>	<ul style="list-style-type: none"><li>• Support and develop our staff so they always act in the patient's best interest</li><li>• Ensure our staff are supported always to have the courage to speak up if they have any concerns</li><li>• Enable our staff to understand how they contribute to our overall success and to understand the Trust's strategic journey</li></ul>
<b>R</b>	<ul style="list-style-type: none"><li>• Ensure our senior managers are visible and accessible to staff and that they model the Trust's Behaviours</li><li>• Support a range of initiatives that support our staff and help them to demonstrate the right values and behaviours at all times</li><li>• Recognise hard work and performance</li></ul>
<b>E</b>	<ul style="list-style-type: none"><li>• Engage staff in decisions that affect them and the services they provide</li><li>• Empower staff to put forward ways to deliver better and safer services for patients and their families</li><li>• Actively encourage and support our staff to gain the skills that enable success for the individual and meeting the needs of our Trust.</li></ul>

## 7. Resources

To support the delivery of Our People Strategy and ultimately for the Trust to deliver high quality and safe health care, the Human Resources and Organisational Directorate is aligned to provide support to the organisation in attracting, retaining, developing and rewarding our people.

The Human Resources and Organisational Development Directorate comprises a dedicated professional team of staff who operate at a strategic and operational level. Our aim is to provide a business oriented, client-facing service to the Trust.

Following a restructure in 2014 the service reflects the organisational structure of Clinical Business Units. This allows the service an appropriate balance between sustaining the highest professional standards, while tailoring the service to meet the diverse needs of different parts of the Trust. The role of the department is to act as a strategic partner in the development of the Trust as an organisation.

In line with the Trusts values and behaviours the Human Resources and Organisational Development Directorate will:

- Operate as a strategic, integrated and business-oriented service across all that we do. Exhibiting a progressive outlook in our approach to shaping our people agenda.
- Work in partnership with managers, staff, trade unions and all other relevant stakeholders.
- Ensure that our services are always delivered in a timely, responsive, flexible and solutions-focused way and that our customers feel it is easy to get things done; process and systems relating to our workforce are customer focused and friendly.
- Value and celebrate difference while upholding the highest standards of equality of opportunity for all.
- Ensure that equity, fairness and transparency shape and inform our policies, practices and processes.
- Encourage the highest standards of integrity, probity and professional conduct in our approach to our work and the service that we provide to all.
- Embrace a culture of continuous improvement.
- Create an environment that fosters creativity and innovation in our ideas, initiatives and the solutions we offer.
- Act in a way that is responsible, accountable and ethical



## 8. Monitoring and Evaluation

The current NHS climate both locally and nationally is changing and it is not possible to accurately foresee the future as it may once have been expected. This strategy will be live for 3 years in light of this but will be reviewed annually to ensure it is fit for purpose.

In order to deliver the People Strategy, an operational delivery plan will be developed as a framework of measurement; it will include KPIs and success criteria. Progress against the Operational People Plan will be monitored by the Operational People Committee and reported to the Strategic People Committee.

The key principles of the plan will be to support the trust with the workforce challenges, developing our workforce to be flexible and responsive to the challenges facing the trust internally and externally.

The Operational People Plan will be annually refreshed and reviewed in line with local and regional and national work streams and an annual report on progress against the People Strategy will be prepared and presented to the Strategic People Committee.

## 9. Summary and Conclusion

Our People Strategy provides focus and clarity on the workforce priorities for WHH. It should create greater understanding at all levels which will allow focus and generation of solutions across the organisation, to the workforce problems that we face.

If our People Strategy achieves its aims the following statements will be felt by the organisation:

- We consistently identify talent and match talent to deliver our challenging strategic direction.
- We consistently provide the appropriate training for everyone. Offering opportunities that are flexible across the organisation to retain and develop talent, ensuring we retain skills and experience
- We recognise and reward our people with tailored solutions. Recognising the different professions and departments and that their different needs are met but look for opportunities for a holistic approach wherever possible.
- Our employees feel that they are cared for and safe, in that they have access to wellbeing and support programmes to enhance their contributions.
- We recognise innovation and performance, share best practice, seeking to learn whenever things do not go as planned.

Our people are our best advocates and by enabling the development of our current systems and staff and attracting the best people with the right skills and behaviours, we should achieve the objectives of this People Strategy. It will therefore be successful in supporting the Trusts overall strategic aim and delivering High quality safe healthcare.

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# Appendix 1 – We are WHH - Behaviours matrix



## Behaviours Matrix

# On the 1<sup>st</sup> April 2016 we launched our Trust behaviour's. Our core

behaviours set out how we will work, regardless of the role we hold in the organisation. These behaviours, consistently carried out, will embed the everyday values in our everyday working lives, and support the delivery of safe and compassionate care on a daily basis.

## To support this we have developed examples of the core behaviours we expect our staff to demonstrate.

Span of Control		Value focus
Leader of Leaders	Executive Directors and Deputies	Strategic & Operational oversight
Leader of Managers	Divisional Directors CBU Leads Heads of Service	Strategic implementation and operational assurance
Team Manager	Ward Managers	Operational delivery
Team Player	Therapies, Staff Nurse	Performance excellence

# Working together - Together we will work as one.

“We promise an environment where patient care is paramount and our staff matter”

Leaders of Leaders	Leader of Managers	Team Manager	Team Player
<ul style="list-style-type: none"> <li>▪ Demonstrates effective collaborative partnership relationship across professional, organisational and sector boundaries</li> <li>▪ Actively engages with service user and the public through relevant networks</li> <li>▪ Understands the organisations, community and the dynamic between them so as to lead</li> <li>▪ Effectively adapts to the situation</li> </ul>	<ul style="list-style-type: none"> <li>▪ Sets out team goals to ensure patient is at the centre.</li> <li>▪ Ensures staff are supported to enable to achieve results.</li> <li>▪ Actively engages with others to ensure WHH is the best</li> <li>▪ Communicates openly across teams and facilitates integration</li> <li>▪ Builds high performance teams</li> </ul>	<ul style="list-style-type: none"> <li>▪ Guides the team and promotes team working</li> <li>▪ Supports understanding of what’s important from a patient perspective</li> <li>▪ Brings people together to create plans and identify opportunities for improvement</li> <li>▪ Facilitates teams problem solving</li> </ul>	<ul style="list-style-type: none"> <li>▪ Team player</li> <li>▪ Understands the part they play in delivering excellence for our patients</li> <li>▪ Collaborates and coordinates to support others’ efforts</li> <li>▪ Shares information and keeps people up to date</li> </ul>

# Excellence – Together we will achieve excellence

“We ensure excellence across our teams in providing the best care for our patients”

Leader of Leaders	Leader of Managers	Team Manager	Team Player
<ul style="list-style-type: none"> <li>▪ Sets out a culture of continuous improvement and innovation and promotes success</li> <li>▪ Challenges existing norms, standards and expectations</li> <li>▪ Benchmarks organisations performance against High performing organisations</li> <li>▪ Focuses on delivering quality service user care, across the sector, taking into account competing priorities and demands on resources</li> <li>▪ Links information from across the whole health and social care landscape</li> <li>▪ Effectively anticipates the impact and mitigation of key risks at a broad, strategic level</li> </ul>	<ul style="list-style-type: none"> <li>▪ Sets out clear vision of excellence for service</li> <li>▪ Ensures focus on areas to improve</li> <li>▪ Encourages people to go above and beyond</li> <li>▪ Creates incentives to exceed expectations</li> <li>▪ Strategically addresses areas of underperformance</li> <li>▪ Sets policy and standards based on best evidence based practice</li> <li>▪ Defines innovation for others and encourages a culture of creativity</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ensures staff know what “good looks like”</li> <li>▪ Gives regular and constructive feedback</li> <li>▪ Helps people to improve what and how they work</li> <li>▪ Takes time out to celebrate success</li> <li>▪ Ensures standards are met</li> </ul>	<ul style="list-style-type: none"> <li>▪ Sets high standards for themselves</li> <li>▪ Is conscientious, thorough and pays attention to detail</li> <li>▪ Is determined to use initiatives to get it right for patients</li> <li>▪ Goes the extra mile to benefit patient care</li> <li>▪ Takes ownership of professional development</li> </ul>



# Accountable – Together we will be accountable

“We make sure everyone is involved in making decisions”

Leader of Leaders	Leader of Managers	Team Manager	Team Player
<ul style="list-style-type: none"> <li>▪ Owns responsibility for the reputation of WHH and position in the Local health economy</li> <li>▪ Holds the organisation to account</li> <li>▪ Provides Board assurance</li> <li>▪ Takes the initiative and responsibility to put things right even if it may involve considerable personal risk</li> <li>▪ Holds self and others to account for the delivery of quality service user care within budget in the organisation</li> <li>▪ Readily takes ultimate responsibility of decisions made and risks taken and acts as a role model to others by learning from success / failure</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ensures accountability and responsibility, are explicit and people understand the implications</li> <li>▪ Sets the performance framework for their service</li> <li>▪ Holds appropriate people to account</li> <li>▪ Provides evidence based assurance for the Board</li> <li>▪ Sets out risk management / governance process</li> </ul>	<ul style="list-style-type: none"> <li>▪ Recognises and takes actions to ensure excellence patient care</li> <li>▪ Ensures staff are equipped to deliver</li> <li>▪ Puts plans in place to deliver goals and objectives</li> <li>▪ Monitors progress and is proactive and alerts people when off track</li> <li>▪ Takes action to avoid / minimise risk to patients or service delivery</li> </ul>	<ul style="list-style-type: none"> <li>▪ Understands their responsibilities and demonstrates confidence to make the right decisions seeks support when needed</li> <li>▪ Ensures they deliver against expectations</li> <li>▪ Organises themselves to deliver on time</li> <li>▪ Ensures they have the skills and resources to meet patient needs / service expectations</li> </ul>

# Role models – Together we will aspire to be role models

“We will inspire and innovate through great leadership to provide excellent care for our patients”

Leader of Leaders	Leader of Managers	Team Manager	Team Player
<ul style="list-style-type: none"> <li>▪ Is visible and approachable, demonstrating compassion and care</li> <li>▪ Champions a mind-set of high ambition for individuals, teams and the organisation</li> <li>▪ Shows a desire to achieve or exceed</li> <li>▪ Acts with integrity and honesty in all dealings even when faced with challenge</li> <li>▪ Behaves consistently and makes sure that others do so even when under pressure</li> <li>▪ Inspires others by helping them to focus in the value of their contribution</li> <li>▪ Recognises and actively appreciates each person’s unique perspectives, contributions and experience / shares the credit when things go well</li> </ul>	<ul style="list-style-type: none"> <li>▪ Leads by example ensuring they consistently demonstrates the Trusts values</li> <li>▪ Inspires others to be the best they can be</li> <li>▪ Willing to challenge status quo mediocrity</li> <li>▪ Gains the respect of staff and colleagues</li> <li>▪ Builds trust through credibility and strategic insights</li> </ul>	<ul style="list-style-type: none"> <li>▪ Demonstrates credibility through what they do</li> <li>▪ Listens to others issues and concerns and follows through</li> <li>▪ Seeks to understand issues from others’ perspectives</li> <li>▪ Challenges inappropriate behaviour</li> <li>▪ Committed to the Trust’s goals</li> </ul>	<ul style="list-style-type: none"> <li>▪ Treats people with dignity, respect, compassion and care at all times</li> <li>▪ Listens and communicates well</li> <li>▪ Shows concern and compassion for others</li> <li>▪ Remains up to date and is well informed</li> <li>▪ Is committed to the organisations goals and mission</li> </ul>

## Embracing Change – Together we will embrace change

“We are open to new ideas from patient, public and everyone in our team”

Leader of Leaders	Leader of Managers	Team Manager	Team Player
<ul style="list-style-type: none"> <li>▪ Is passionate and enthusiastic in conveying the sense of what is possible for service users (passion) and local populations</li> <li>▪ Encourages others to deliver on a shared purpose, as much as individual targets</li> <li>▪ Has a vision of what the future will ‘look like’ and the steps needed to get there at a variety of levels</li> <li>▪ Actively seeks innovation and new ideas</li> </ul>	<ul style="list-style-type: none"> <li>▪ Sets ambitious goals to develop their service to better meet the needs of the patients</li> <li>▪ Encourages an environment of experimentation and innovation</li> <li>▪ Actively learns from other organisations or services and introduces best evidence based practice</li> <li>▪ Supports and encourages others through the process of change</li> </ul>	<ul style="list-style-type: none"> <li>▪ Understands and recognises the need for change</li> <li>▪ Takes initiative to make things happen</li> <li>▪ Removes barriers to change</li> <li>▪ Addresses people’s concerns about change and helps people prepare and adapt</li> </ul>	<ul style="list-style-type: none"> <li>▪ Open to new ideas and puts forward suggestions to improve how we work and what we do</li> <li>▪ Demonstrates enthusiasm for change</li> <li>▪ Flexible and adaptable to the needs and priorities of the service and patients</li> </ul>



We are  
WHH

## BOARD OF DIRECTORS

<b>AGENDA REFERENCE:</b>	<b>BM/16/199</b>	
<b>SUBJECT:</b>	<b>Trust Engagement Dashboard</b>	
<b>DATE OF MEETING:</b>	30th November 2016	
<b>ACTION REQUIRED</b>	<b>For Assurance</b>	
<b>AUTHOR(S):</b>	Pat McLaren, Director Community Engagement	
<b>EXECUTIVE DIRECTOR SPONSOR:</b>	Mel Pickup, Chief Executive Choose an item.	
<b>LINK TO STRATEGIC OBJECTIVES:</b>	All	
<b>LINK TO BOARD ASSURANCE FRAMEWORK (BAF):</b>	BAF2.1: Engage Staff, Adopt New Working, New Systems	
	BAF2.4: Engaging & Involving Workforce	
	Choose an item.	
<b>STRATEGIC CONTEXT</b>	<p>The Trust is committed to expanding and supporting relationships with the communities and people who use, work, visit, volunteer, support, commission, partner or donate to our hospitals in Warrington and Halton. Consistent, effective stakeholder engagement is key to the Trust delivering its QPS objectives and provides opportunities to further align practices and plans with stakeholder needs and expectations.</p>	
<b>EXECUTIVE SUMMARY (KEY ISSUES):</b>	<p>Measurement of engagement across our key stakeholder groups is reported in this engagement dashboard.</p> <p>While a simple and fairly crude tool, the trust is now able to evaluate trends and key themes and developments enabling better targeting of limited resources.</p>	
<b>RECOMMENDATION:</b>	The Board is asked to receive and note the dashboard.	
<b>PREVIOUSLY CONSIDERED BY:</b>	<b>Committee</b>	Not Applicable
	<b>Agenda Ref.</b>	
	<b>Date of meeting</b>	
	<b>Summary of Outcome</b>	
<b>FREEDOM OF INFORMATION STATUS (FOIA):</b>	Release Document in Full	

## Media

A very difficult month for the organisation with communications resources focusing on corrections, rebuttals and issuing of factual statements.

- The release of the NHS Car Parks short stay league tables generated over 200 pieces of negative media coverage with significant national coverage
- A national Freedom of Information request on staffing of maternity units overnight, to coincide with Baby loss Awareness Week generated significant negative reporting
- Proactive media work generated positive news including:
  - the 1-year MRSA free press release and the improved A&E performance
  - Positive performance against the 4-hour standard in the A&E
  - Publication of the annual complaints report

## Social media engagement

- We continue to concentrate on social media engagement and the number of followers on Twitter continues to grow with almost 7.7K followers and a reach of 105K users. Most successful tweets in month are:
  - @Warrington Mayor and World Stroke Day at WHH
  - Positive experience at Halton UCC
- Facebook Activity remains strong with likes slightly up in month. Most successful campaigns with more than 1K impressions were:
  - WHH Charity hand puppets for the Children's Ward
  - One year without MRSA
  - Repair works affecting the entrance to Croft Wing (maternity unit)
  - Orthoptics Team Halloween party for young patients
  - NHS Champions needed for Foundation Trust Governor roles

## Web engagement

- Slight increase in visitors in month which is on average 20K per month
- Arrivals to the website via social media referrals was significantly up in month with 83 (56) which is excellent, key referral source is Facebook accounting for 87%
- All metrics for sessions, views, session duration and bounce rate we improved in month
- Three quarters of all visitors arrived via search engines with 15% arriving from other sites, 8% keying in whh.nhs
- UK visitors continue to account for over 90% of visitors but USA visitors was significantly up in month with 238 unique visitors

# Trust Engagement Dashboard Summary: October 2016

## Patient Engagement

A very positive month for patient engagement via FFT but very few posts on NHS Choices

- The average star rating for all hospitals was very slightly down to 4.80 (4.83)
- Total reviews were up in month at 2054 (1890)
- % likely to recommend were static at 95.3% (95.2%) which is excellent
- % likely to recommend were reduced to 0.8% (1.4%) again excellent
- The top three services were: Paediatric A&E, Paediatric Orthotics and Ward B11
- The bottom three services were: Ward B11, PAU and Paeds OPD
- NHS Choices comments down to 3 in month (10), however all 5\* comments for CMTC and Halton General

## Staff Engagement

A very busy month for staff engagement with the WHH Flu Stakes, the Annual Thank You Awards and the NHS Staff Survey being launched.

- Staff uptake of the Flu vaccine is overall performing well – national metrics close on 30<sup>th</sup> December
- NHS Staff Survey is a whole-census this year and efforts continue to drive up response rates – survey closes 1<sup>st</sup> December
- The Thank You Awards launched and nominations are coming in as deadline of 30<sup>th</sup> November approaches



We are WHH

# Media Dashboard (Public Engagement) 1-31 October 2016

Total media coverage = 400 reports (↑from 128 last month)

## Warrington and Halton Hospitals

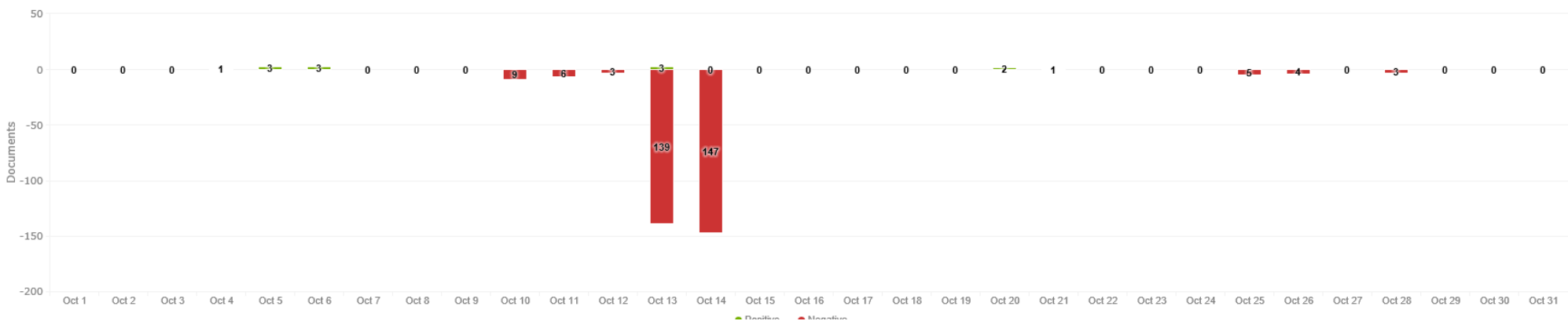
Top 10 Publications by Reach

125.9 M	Daily Mail Online
83.9 M	Mail On Sunday
83.9 M	Daily Mail (eClips We
46.8 M	The Telegraph (eClip
31. M	The Guardian (eClips
7.9 M	BT.com
5.2 M	ITV.com
3.2 M	AOL
2.7 M	一点资讯
2.2 M	突袭新闻

Dashbo... > Monitor > Media... >  
Warrington and Halton Hospitals, Oct 6th  
Oct 1, 2016 - Oct 31, 2016



Sentiment ▾  
Oct 1, 2016 - Oct 31, 2016





We are WHH

## Media Dashboard (Public Engagement)/2

Headline	Source	Reach	Sentiment
Great care	Warrington Guardian	61697	Positive
UK Hospital Celebrates a MRSA-free Year	Cleaning & Maintenance Management	NA	Positive
Political game	Warrington Guardian	61697	Positive
Warrington Hospital celebrates a year without any MRSA cases	Warrington Guardian	61697	Positive
A&E performance at Warrington and Halton hospitals improves but still short of national target	Liverpool Echo	157887	Positive
Positive impact of infection prevention on the management of nosocomial outbreaks	Future Medicine	69329	Positive
Good Samaritan Vicky talked woman out of bridge jump	St Helens Star	14095	Positive
Warrington Hospital helper Vicky Whittle helps to talk woman down from bridge over M62 at Winwick	Warrington Guardian	66713	Positive

Headline	Source	Reach	Sentiment
Don't have your NHS baby out of hours: Three-quarters of maternity wards have no consultant on duty overnight	Daily Mail Online	41953817	Negative
Third of England's hospital trusts raise parking charges over year	Daily Mail Online	41953817	Negative
Heartbreaking pictures show a couple cradling their stillborn daughter who died after a midwife told her mother to go home and take paracetamol despite her excruciating pain	Mail On Sunday	41953817	Negative
'Musketeer' nurse at heart of Morecambe Bay baby death scandal 'significantly overpaid' in goodbye deal	The Telegraph (eClips Web)	23375160	Negative

### Warrington Hospital helper Vicky Whittle helps to talk woman down from bridge over M62 at Winwick



Warrington Hospital worker Vicky Whittle has spoken of the moment she helped to talk down a woman who was threatening to jump from the bridge over the M62 at Winwick.

ON October 2 I was admitted to Warrington Hospital with severe breathing problems. The first response ambulance arrived at my property within 10 minutes. The second ambulance arrived shortly afterwards. I was admitted to ICU and then to ward A7. The staff, from the cleaners to the consultants, were exemplary. The care, compassion and professionalism shown was fantastic. I would just like to thank all those involved in my care. I wish I could say it was a pleasant experience but you made the situation much more bearable.

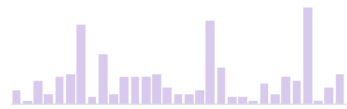
DARREN ROWLAND Howley



A&E performance at Warrington and Halton hospitals improves but still short of national target



Link clicks  
**233**



On average, you earned **8 link clicks** per day

Retweets  
**206**



On average, you earned **7 Retweets** per day

Likes  
**352**



On average, you earned **11 likes** per day

Replies  
**34**



On average, you earned **1 replies** per day

Oct 31  
7 likes

Oct 31  
0 replies

Oct 31  
2 Retweets

Tweets **Top Tweets** Tweets and replies Promoted Impressions

**Warrington&HaltonNHS** @WHHNHS · Oct 28 5,711  
Great to have support from @WarringtonMayor and @Bridgety\_1984 for World Stroke Day 2016! #WSD16 @Mel\_Pickup @StrokeAssocNW @WStrokeCampaign  
pic.twitter.com/3zIFGw1RH  
[View Tweet activity](#)

**Warrington&HaltonNHS** @WHHNHS · Oct 11 2,586  
Thank you to all our volunteers for taking part in Harvest Festival. @Morrisons Warrington amazing sheaf loaf!  
pic.twitter.com/HCU0AdCsQo  
[View Tweet activity](#)

**Warrington&HaltonNHS** @WHHNHS · Oct 10 2,034  
We really appreciate your fab feedback and we hope you're feeling better!  
Our Halton UCC is quick, efficient and great for minor injuries! [twitter.com/david\\_m\\_ellis/...](#)  
[View Tweet activity](#)

**Warrington&HaltonNHS** @WHHNHS · Oct 29 1,739  
Today is World Stroke Day. Face the facts: stroke is treatable. Join the campaign today. #WSD16 @WStrokeCampaign @StrokeAssocNW  
pic.twitter.com/OFdUOnPMnG  
[View Tweet activity](#)

Twitter



**7,692**  
Followers

Last month: 7,555



**89**  
WHH  
Tweets

Last month: 112



**105k**  
Reach

### Active Posts from 1 October 2016 to 1 November 2016

Impressions: Organic/Paid Post Clicks Reactions, comments

Published	Post	Impressions	Engagement
24/10/2016 14:50	WHH Charity has a vision to offer every child in need of our services, a little something special, a knit	2.9K	187 51
11/10/2016 12:43	The Trust is celebrating a year without a case of MRSA, read more about the work that has gone in	2.2K	248 10
19/10/2016 11:17	This is an important message for expectant mums and their partners. Starting on Monday 31st Octob	1.8K	275 29
28/10/2016 14:29	Our wonderful Orthoptics team threw a lovely Hall oween patch party for some of our younger patient	1.7K	423 78
31/10/2016 11:11	NHS champions needed for important governor roles - Warrington and Halton Hospitals NHS Found	1.6K	9 5



Facebook



**3,291**  
Total  
Likes

Last month: 3,255



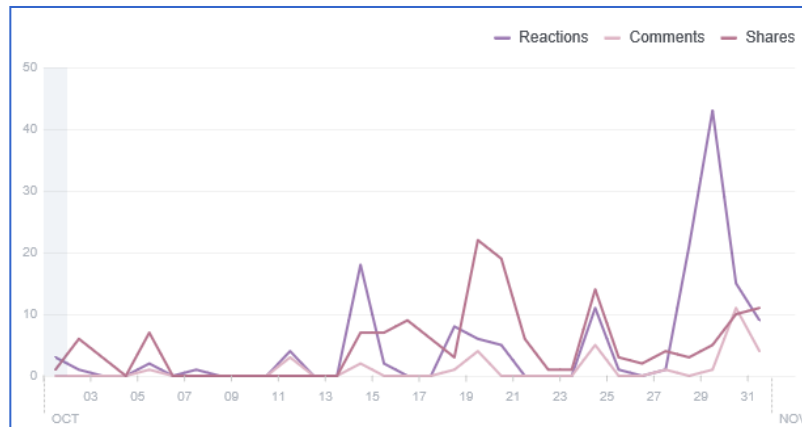
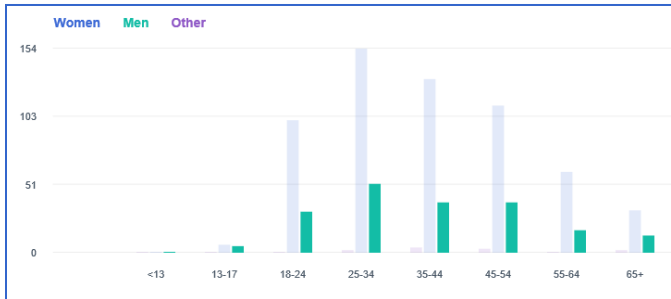
**9**  
WHH  
Posts

Last month: 22



**13.9K**  
Reach  
(impressions)

Last month: 7.5K







We are WHH

Sessions

0.19%

20,847 vs 20,808



Users

1.98%

15,637 vs 15,334



Pageviews

7.35%

48,277 vs 44,972



Pages / Session

7.15%

2.32 vs 2.16



Avg. Session Duration

9.43%

00:01:31 vs 00:01:23



Bounce Rate

-4.41%

62.05% vs 64.92%



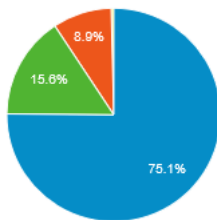
% New Sessions

2.24%

65.68% vs 64.24%



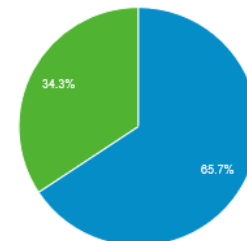
Organic Search  
Referral  
Direct  
Social



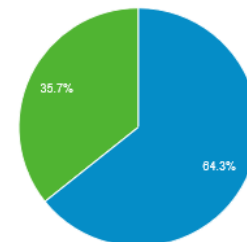
Country	Sessions	% Sessions
1. United Kingdom	19,076	91.50%
2. (not set)	445	2.13%
3. United States	238	1.14%
4. Russia	210	1.01%
5. India	111	0.53%
6. Australia	66	0.32%
7. Ireland	39	0.19%
8. Germany	37	0.18%
9. Kyrgyzstan	37	0.18%
10. Malaysia	34	0.16%

New Visitor Returning Visitor

Oct 1, 2016 - Oct 31, 2016



Aug 31, 2016 - Sep 30, 2016



Sessions % Sessions

Website

WHH

20,847 Visits

Last month: 20,082



83

Last month: 56

Social Media Referrals



1min 31s

Length of average time

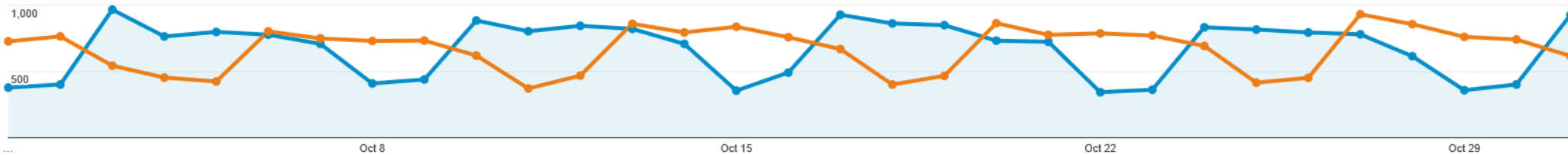
Social Network	Sessions	% New Sessions	New Users
	83 % of Total: 0.40% (20,847)	86.75% Avg for View: 65.68% (32.07%)	72 % of Total: 0.53% (13,693)
1. Facebook	72 (86.75%)	87.50%	63 (87.50%)
2. Twitter	10 (12.05%)	80.00%	8 (11.11%)
3. Pinterest	1 (1.20%)	100.00%	1 (1.39%)

Sessions VS. Select a metric

Hourly Day Week Month

Oct 1, 2016 - Oct 31, 2016: Sessions

Aug 31, 2016 - Sep 30, 2016: Sessions



# Patient Engagement

**Warrington and Halton Hospitals  
NHS Foundation Trust**

**Date:  
01 October - 31  
October**

Your average score for all questions this period  
4.80

Reviews this period  
2054

Your recommend scores  
4.78

% Likely to recommend  
95.3%

% Unlikely to recommend  
0.8%

Top three services (with 5 reviews or more)

Paediatric Accident & Emergency Department	5.00
Paediatric Orthoptics	4.84
Ward B11	4.81

Bottom three services (with 5 reviews or more)

Ward B11	4.81
Paediatric Assessment Unit Warrington	4.75
Paediatric OPD Warrington	4.60

## NHS Choices



3

No. of comments posted

Last month: 10



100%

No. of comments responded to within five working days

Last month: 100%



Halton – 5 stars  
CMTC - 5 stars  
Warr – 3.5 stars



★★★★★ Anonymous gave General Surgery at Halton General Hospital a rating of 5 stars

### Double hernia repair

From start to finish staff (who were there all day on a 12 hour shift!) were friendly, helpful and professional, making a daunting experience (the first time I've had any significant surgery) bearable. Thank you.

Visited in October 2016. Posted on 26 October 2016

★★★★★ Anonymous gave Cheshire and Merseyside Treatment Centre a rating of 5 stars

### Brill , better than private !!

After several procedures on a dodgy hip including one costing £8000 at a private hospital , I can honestly say this place is the best . Amazing from start to finish . If you going here you are in good hands .

Visited in October 2016. Posted on 24 October 2016

[Report as unsuitable](#)

# Staff Engagement



## WHH new Extranet engagement:

- ↑ 2,760 staff registered on the new extranet since launch 24.2.16 (increase in month of 254 new registrants)
- Most viewed workspaces: Develop/Grow/e-Learning/Compliance-reports

## Key current staff initiatives

Flu Vaccinations  
*'The WHH Flu Stakes'*

The Annual Staff Thank You Awards are open



NHS Staff Survey is open (deadline 1<sup>st</sup> Dec 2016)

NHS Staff Survey 2015 – Engagement score 3.74 (worse than similar Trusts)

% of Frontline Staff Vaccinated @11/11/16

