# Board of Directors

**25 September 2019, 12:00 to 16:00**
**Trust HQ Boardroom, RAEI**

## Agenda

### 1. Chair and quorum

Information

Robert Armstrong

### 2. Apologies for absence

Sumedh Talwalker

Information

Robert Armstrong

### 3. Declarations of interest

Information

Robert Armstrong

### 4. Minutes of previous meeting

Approval

Robert Armstrong

Minutes - P1 board - 31 July 2019.pdf (9 pages)

### 5. Patient experience video

Discussion

Helen Richardson

### 6. Chair and Chief Executive's report

Discussion

Robert Armstrong/Andrew Foster

CE's update 24.09.19.pdf (1 pages)

### 7. Assurance and governance:

### 7.1. Committee chairs' reports

Verbal item

Information

Committee chairs

### 7.2. Performance report

Discussion

H Richardson/M Fleming/S Arya

Trust Board Performance Report August 2019_v3.pdf (17 pages)

## 7.3. Finance report

Discussion

Rob Forster

Board Report 19-20 August month 05 PUBLIC.pdf (6 pages)

## 7.4. Safe staffing report

Discussion

Helen Richardson

Safe Staffing TB cover sheet July August 2019.pdf (2 pages)

Safe Staffing Report July August 19.pdf (15 pages)

# 8. Board assurance framework

Approval

Robert Armstrong

BAF - Partnerships - Sept 2019 SLA.pdf (2 pages)

BAF - Performance - Sept 2019.pdf (2 pages)

BAF Patients - September.pdf (2 pages)

BAF People - September 2019.pdf (3 pages)

# 9. Consent agenda:

## 9.1. Workforce race equality standard and workforce disability equality standard

WDES & WRES Report for Workforce Committe September 2019.pdf (14 pages)

## 9.2. Library services

Library Annual Report 2018-19.pdf (1 pages)

## 9.3. Employer based awards annual report

EBA annual report cover sheet.pdf (1 pages)

Employer Based Awards Annual Report Round -2018.pdf (3 pages)

## 9.4. Flu report

*To follow*

## 9.5. Mortality report

TB Mortality Update Q1 2019-20 Cover Sheet.pdf (1 pages)

Mortality Update Q1 2019-20.pdf (3 pages)

## 10. Questions from the public

Discussion

Robert Armstrong

## 11. Resolution to exclude the press and public

Approval

Robert Armstrong

## 12. Date, time and venue of next meeting

27 November 2019, 12 noon, RAEI

Information

Robert Armstrong

**WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST**

**MINUTES OF A MEETING OF THE BOARD OF DIRECTORS ("the Board")**

**HELD ON 31 JULY 2019, 12.00 NOON**

**AT ROYAL ALBERT EDWARD INFIRMARY, WIGAN LANE, WIGAN, WN1 2NN**

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**Part 1**

**Members' attendance record:**

| | | 22/05/2019 | 29/05/2019 | 31/07/2019 | 25/09/2019 | 27/11/2019 | 29/01/2020 | 25/03/2020 | 2019/20 attendance |
|---|---|---|---|---|---|---|---|---|---|
| Mr R Armstrong | Chair (in the Chair) | ✔ | A | ✔ | | | | | |
| Dr S Arya | Medical Director | ✔ | ✔ | ✔ | | | | | |
| Prof C Austin | Non-Executive Director | A | ✔ | A | | | | | |
| Mrs A Balson | Director of Workforce | ✔ | A | A | | | | | |
| Dr S Elliot | Non-Executive Director | A | ✔ | ✔ | | | | | |
| Mrs M Fleming | Chief Operating Officer | ✔ | ✔ | ✔ | | | | | |
| Mr R Forster | Director of Finance and Informatics | ✔ | ✔ | A | | | | | |
| Mr A Foster | Chief Executive | A | A | ✔ | | | | | |
| Mr M Guymer | Non-Executive Director | ✔ | ✔ | ✔ | | | | | |
| Mr I Haythornthwaite | Non-Executive Director | ✔ | ✔ | A | | | | | |
| Mr J Lloyd | Non-Executive Director | A | ✔ | ✔ | | | | | |
| Mrs L Lobley | Non-Executive Director | ✔ | ✔ | ✔ | | | | | |
| Mrs P Law | Chief Nurse (to August 2019) | ✔ | ✔ | ✔ | | | | | |
| Mr R Mundon | Director of Strategy and Planning | A | ✔ | ✔ | | | | | |
| Ms H Richardson | Chief Nurse (from August 2019) | --- | --- | --- | | | | | |
| Prof T Warne | Non-Executive Director | A | ✔ | ✔ | | | | | |

**Key:** ✔: Attended in person | T/V: Attended by tele/videoconference | A: Apologies sent | ✘: Did not attend or send apologies

**In attendance:**

| | |
|---|---|
| Dr A Abbasi | Divisional Medical Director (Medicine) |
| Miss C Alexander | Director of Governance |
| Mr J Baker | Deputy Director of Staff Engagement & Organisational Development |
| Mr P Howard | Company Secretary (minutes) |
| Mr G Murphy | Deputy Director of Finance |
| Mr S Talwalker | Divisional Medical Director (Specialist Services) |
| Miss D Jones | Inclusion and Diversity Service Lead (for item 118/19 only) |

1 governor, 2 members of staff and 1 member of the public were also in attendance.

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**113/19 Chair and quorum**

Mr R Armstrong took the chair and noted that due notice had been given to all directors and that a quorum was present. He therefore declared the meeting duly convened and constituted.

The Chair noted that the meeting would be the last to be attended by the Chief Nurse, Pauline Law, who would be retiring at the end of the week. He thanked her on behalf of the Board for her dedication to patient safety and quality during her time with the foundation trust.

**114/19 Apologies for absence**

Apologies for absence were received as shown in the members' attendance record, above.

**115/19 Declarations of interests**

No directors declared an interest in any of the items of business to be transacted.

**116/19 Minutes of the previous meeting**

The minutes of the previous meeting held on 29 May 2019 were agreed as a true and accurate record.

With regard to the action log, the Medical Director advised that he had recently circulated the NICE guidance on the management of Lyme Disease but noted that he had not yet discussed with the Director of Public Health how awareness of the condition could be raised across the borough. He agreed to follow up on this outside the meeting.

**117/19 Patient experience video**

The Chief Nurse presented a patient experience video which charted the story of a patient within the community who had accessed a variety of services across the borough. Three members of staff discussed how they had contributed to the patient's care and how their individual contributions had resulted in an overall successful intervention.

In response to a comment from Dr Abbasi, the Chief Operating Officer noted that members of the ACTS team would be available in the Emergency Department and acknowledged the importance of the respective management teams communicating well with each other to ensure effective integration. The Chief Operating Officer also noted the ability to streamline a number of pathways, such as referrals to the audiology department as referenced within the video, now that new services are provided by the foundation trust following the recent transfer of community services.

The board received and noted the patient experience video.

**118/19 Launch of the Rainbow Badge initiative**

Ms D Jones delivered a presentation to launch the Rainbow Badge initiative within the foundation trust and to outline the work that the foundation trust has undertaken to promote inclusion and diversity.

In response to a question from Dr S Elliot, Ms D Jones commented that it is hoped, subject to funding being made available, to invest in software to allow information on patients' access needs to be extracted from PAS automatically and incorporated within the electronic patient record. Dr S Elliot also noted the need to ensure that patient information leaflets are made available in all relevant languages, and the Board noted that it is also necessary to consider how patients wish to receive patient information, as many are likely to prefer online resources.

Directors were invited to sign up to the Rainbow Badge initiative and, on behalf of the foundation trust, the Board formally launched the initiative within the organisation.

**119/19 Chair and Chief Executive's report**

The Chair informed the Board that the Council of Governors had commenced the recruitment to the vacant non-executive director post and advised that interviews were scheduled to take place on 1 October 2019, with the intention of seeking approval of the appointment at the meeting of the Council of Governors on 16 October 2019. He reminded the Board that the Council of Governors would be seeking an individual with community services experience, to complement the skills of the current non-executive directors.

The Chief Executive presented a report which had been circulated in advance of the meeting to summarise the foundation trust's most up to date performance against a number of performance metrics and to brief on a number of strategic items. With regard to the recent improvements in performance against the Emergency Department 4-hour wait standard, Prof T Warne commented that it had been pleasing to see the foundation trust's hard work recognised at a recent meeting of the Greater Manchester Health and Care Board and the Chief Operating Officer acknowledged the supportive approach of the Chief Officer of the Greater Manchester Health and Social Care Partnership. Mrs L Lobley highlighted the fact that the Board had kept the matter under close review and had recently received a detailed briefing about the number of initiatives that had been implemented at its recent away day. The intention to keep the issue under review was also acknowledged.

The board received the report and noted the content.

**120/19 Risk escalation: maternity theatres**

The Chief Nurse presented a report which had been circulated with the agenda to escalate a risk to the Board, in line with the foundation trust's internal escalation processes. The report provided a summary of progress in ensuring that all elective maternity surgery is undertaken within a dedicated elective theatre as opposed to the maternity emergency theatre and the Board's attention was drawn to the various reports where this is recommended as best practice. Additionally, the Board noted that this had been identified as a "must do" action by the Care Quality Commission as part of its November 2017 inspection report. Confirmation was provided that the risk escalation document had previously been scrutinised by the Quality and Safety Committee.

The Chief Nurse advised that significant progress had been made since the matter was last escalated to the Board and confirmed that two sessions per week are provided for

elective caesarean sections to take place. She further noted that work is ongoing to consider whether a further session per week is necessary. The Chief Operating Officer cautioned that the ability to provide a third elective session had been predicated on the assumption that breast services would move to a different site within the foundation trust and noted that the ongoing Improving Specialist Care discussions would need to be taken into account once concluded.

The Chief Nurse also drew the Board's attention to the commentary in the report around the Midwifery 2020 standards which she confirmed as a separate issue for which a business case is in the process of being developed.

The Chair asked the Board whether it was assured that the foundation trust is able to safely meet the needs of the population it serves, to which it was agreed that it could. In response to a question from Mrs L Lobley, the Chief Nurse also confirmed that the Care Quality Commission was content with the foundation trust's proposed solution.

The Board received the report and noted the content.

**121/19 Committee chairs' reports**

The board received verbal reports from the following committees which had met since the previous meeting of the board:

(a) Audit Committee, held on 2 July 2019;

(b) Quality and Safety Committee, held on 12 June 2019 and 17 July 2019;

(c) Finance and Performance Committee, held on 26 June 2019 and also immediately prior to the meeting; and

(d) Workforce Committee, held on 6 June 2019.

In the absence of the committee chair, Mr M Guymer provided a summary of business transacted by the Audit Committee. He informed the Board that the committee had requested assurance around payroll processes following concerns that had been raised at the previous meeting and confirmed that the newly-appointed Head of Payroll Services had attended the meeting and had provided assurance regarding new processes that had been implemented, such as the standardisation of timesheets and reconciliation processes. The committee had also reviewed overpayments of salary and noted that, whilst a number were being pursued by an external debt collection agency, this had been caused by a particular issue and the committee had received assurance that processes had since been put in place to prevent recurrence.

Prof T Warne presented a summary of the business transacted by the Quality and Safety Committee and informed the Board that the Medical Director had provided an update on the matter of discharge letters, with some areas of improvement having been noted alongside some apparent areas of deteriorating performance. A good level of challenge had been provided by the committee, although he advised that the committee had not been assured that no harm had been caused as a result of General Practitioners not receiving discharge letters. The committee had therefore instructed the Medical Director to review a sample of patients to ascertain whether the discharge letter had been

received and, if not, whether any hard had been caused to the patient as a result. Prof T Warne also noted that a data quality dashboard was under development to provide greater transparency of the discharge letter sign-off process. The committee had also discussed the matter of Tier 4 beds for Child and Adolescent Mental Health Service patients.

Mrs L Lobley provided a verbal summary of the business at the recent Workforce Committee meeting and commented on the powerful nature of the staff story which had been shared with the committee. The committee had discussed staff retention in some detail and the intention to encourage conversations with staff members considering leaving the organisation at an early stage. The committee had also discussed the Developing Workforce Safeguards guidance and noted that some risks would need to be accepted in short-to-medium-term. The committee had also discussed the staff survey results and noted that engagement performance had declined since the previous survey. Confirmation was provided that divisional action plans had been developed to address the specific issues and that discussions were ongoing with the staff engagement and transformation teams as to actions can best be implemented.

With regard to the Finance and Performance Committee, Mr M Guymer summarised the meetings and highlighted in particular the recent changes to the performance report. He described the risk escalations that had been considered by the committee in relation to IM&T and confirmed that this would continue to be monitored within the organisation.

The board received the chairs' reports and noted the content.

**122/19 Performance report**

The Chief Nurse opened this item by noting the highlights and lowlights of the previous month, including low number of infections but highlighting some concern around the number of *C. difficile* infections in comparison with the annual trajectory. She noted that all of the reported infections had been subject to ribotyping and confirmed that there is no evidence of any cross-contamination within the organisation.

The Chief Operating Officer highlighted the strong A&E performance which she noted had improved month-on-month since January 2019. She noted the streaming arrangements that had been implemented and confirmed that 29% of patients had been streamed in June 2019 against an internal target of 30%. She further noted that the ambulance handover times were one of the lowest in Greater Manchester.

The Chief Operating Officer commented on the challenging nature of delivering 18-week performance and highlighted the recent issue with pension taxation nationally as an additional performance challenge.

Mrs L Lobley drew the Board's attention to the organisation's performance in responding to complaints and requested an update on what is being done to improve the situation. In response, the Director of Governance advised that a report would be taken to the Quality and Safety Committee in September 2019 for more detailed consideration.

The board received the performance report and noted the content.

**123/19 Financial position as at 30 June 2019**

The Deputy Director of Finance presented a report which had been circulated with the agenda to summarise the foundation trust's financial position as at 30 June 2019. He highlighted the final year-end position for 2018/19 and noted the investments that had been made to date. Confirmation was provided that the detailed financial position had been considered by the Finance and Performance Committee at its earlier meeting.

The Chair reminded the board of recent correspondence around national capital expenditure and iterated the fact that the organisation has a healthy cash balance, which it would wish to spend on capital, subject to the national position being resolved. Confirmation was provided that lobbying in this regard continues.

The board received the report and noted the content.

**124/19 Safe staffing report**

The Chief Nurse presented the regular safe staffing report which provides a summary of staffing levels on all in-patient wards across the foundation trust and across community services. She noted that the fill rate was less than 90% in some areas during the month of June, with the main issues being experienced within scheduled care. She expressed concern around the skill mix on wards and noted that registered nurse shifts remain challenging to fill.

The Chair noted that the board had taken the decision to proceed at risk to recruiting to community vacancies which were currently in train, and noted that there had been real successes in attracting health visitors as part of a recent recruitment drive.

The board received the report and noted the content.

**125/19 Bi-annual staffing report**

The Chief Nurse presented a report which had been circulated with the agenda to summarise, in accordance with NHS England's guidance, assurances around the ongoing monitoring and review of adult inpatient staffing establishments. She confirmed that there is sufficient budgeted resource to meet the needs of the services but noted that the level of vacancies impacts on the ability to react to demand variances. She reminded the Board that the organisation has access to real-time data through a electronic staffing tool which provides valuable management information. Note was made of the fact that a shift in the skill mix of staffing, predominately within scheduled care, had resulted in a dilution of the skill mix and that the planned review of new workforce models requires progression in order to prevent further deterioration of quality and patient experience. Note was also made of the fact that Ward Managers are regularly needing to include themselves when reporting nursing numbers, rather than acting in a supernumerary capacity.

The Board discussed the need to expedite the development of new workforce models and the need to develop parameters for closing a ward or specified area of a ward was also acknowledged. Prof T Warne commented that the need to develop parameters is sensible but urged caution in ensuring that such action is necessary and does not become the default approach. The Chief Nurse acknowledged this and commented that

the approach would necessarily be part of an overall escalation plan. The Medical Director and Chief Operating Officer noted the need to ensure that partner organisations are also involved in the discussions.

Mr M Guymer commented that whilst there are red flags within the safe staffing report, assurances are received from the Chief Nurse that the staffing levels remain safe. He noted the length of time that it had taken to develop a protocol to deal with the issue, to which the Chief Nurse responded that the data provided by the Safe Care Nursing Tool is now more accurate and takes account of patient acuity as well as numbers.

The Board received the report and noted the content, and noted the intention to develop parameters for closing a ward or specific area if necessary due to staffing concerns.

**126/19 Maternity staffing review**

The Chief Nurse presented a report which had been circulated with the agenda to summarise, per NHS England's guidance, the assurance around ongoing monitoring and midwifery staffing establishments. She confirmed that the matter had been considered by the Quality and Safety Committee and was presented to the Board for information.

The Board received the report and noted the content and recommended that the proposed changes to workforce modelling are progressed through the usual business planning processes.

**127/19 Mortality update Q4 2018/19**

The Medical Director presented a report which had been circulated with the agenda to summarise the foundation trust's mortality position as at Q4 2018/19. He noted an improving trend, with 159 fewer deaths when compared with the previous year and a reduction in the Hospital Standardised Mortality Rate.

The Board received the report and noted the content.

**128/19 Board assurance framework**

The Board reviewed the board assurance framework dashboards for each of the four areas of patients, people, performance and partnerships. It noted that an amber-green delivery confidence was reported for patients, an amber-red delivery confidence was reported for people, an amber-red delivery confidence had been recommended by the Finance and Performance Committee immediately before the meeting for performance and that an amber-red delivery confidence was recommended for partnerships.

The board **APPROVED** the board assurance framework dashboards as presented.

**129/19 Consent agenda**

The papers having been circulated in advance and the board having consented to them appearing on the consent agenda, the board RESOLVED as follows:

1. THAT the seven-day service assurance report be **APPROVED**.

2. THAT the proposed amendments to Standing Financial Instructions be **APPROVED**.

3. THAT the public version of the 2019-24 organisational strategy be **APPROVED**.

4. THAT the Modern Slavery Statement 2019/20 be **APPROVED**.

5. THAT the Freedom to Speak Up Guardian's Annual Report for 2018/19 be received and noted.

6. THAT the Guardian of Safe Working's Annual Report for 2018/19 be received and noted.

7. THAT the Medical Appraisal and Revalidation Annual Report for 2018/19 be received and noted.

**130/19 Questions from the public**

No questions from the public were received.

**131/19 Resolution to exclude the press and public**

The board RESOLVED that representatives of the press and other members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted.

**132/19 Date, time and venue of next meeting**

The next meeting of the Board of Directors will be held on 25 September 2019, 12 noon at Royal Albert Edward Infirmary, Wigan Lane, Wigan, WN1 2NN

## Action log

| Date of meeting | Minute ref. | Item | Action required | Assigned to | Target date | Update |
|---|---|---|---|---|---|---|
| --- | --- | --- | --- | --- | --- | --- |

**Chief Executive's Report 24 September 2019**

# PART ONE

**PERFORMANCE**

A&E performance continues its remarkable recovery from 75% in January to 81% in April and over 90% for each of the last 3 months. We are back to top in GM for the month, the quarter and the year to date. This has helped us achieve and maintain a position across all measures of 5th out of 136 acute Trusts in the country as shown at the start of this month's performance report.

We entertained Bill McCarthy last week. As the NHSI/E regional director for the NW he wanted to understand how we had managed this dramatic improvement. The answer is that it is the aggregate effect of a large number of small initiatives, the majority of which came from staff themselves. This underlines the point that staff engagement is much more effective than performance management.

As far as I know, we continue to meet all other major targets for the quarter.

**QUALITY**

The most up to date HSMR figure is 116 for May taking the year to date figure to 103.8. The latest annual SHMI data gives a figure of 108.7 for January to December 2018. The latest quarterly SHMI figure is 103.6 for October to December 2018.

So far this year we have had 2 Never Events, Zero MRSA and 11 C Diff (under the new 72 hour definition).

**BREACH OF DATA CONFIDENTIALITY**

We have now written to the 1700 individuals whose records were inappropriately accessed by ward staff. We have set up a helpline for those who want further information and this has proved extremely distressing for some, including for those who are receiving the calls. .

**LATEST CANCER SURVEY RESULTS**

Patients' average rating of care scored from very poor to good is 8.9. The national average score is 8.8. The trusts unadjusted score is 9. (0 being very poor and 10 being good). It is excellent that we are reporting better than the national average. The Trust's average is improving year on year. In 2015 the average was 8.80 and in 2018 it is 8.97.

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

# Board Performance Report

August 2019

**Your hospitals, your health, our priority**

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

## Top 10 Performance

| Group | ID | Metric Name | Period Covered | Date Last Updated | National Top 10% | Performance | Percentile | Rank / Trusts |
|---|---|---|---|---|---|---|---|---|
| Safe | 1 | Hospital Standardised Mortality Ratios (HSMR) | APR-19 - MAY-19 | 12/09/19 | No | 103.32 | 52.8% | 67/126 |
| Safe | 2 | Summary Hospital-level Mortality Indicator (SHMI) | JAN-19 - MAR-19 | 12/07/19 | No | 101.77 | 44.96% | 59/130 |
| Safe | 3 | Safety Thermometer / Harm Free Performance | JAN-19 | 14/02/19 | No | 92.49% | 74.55% | 83/111 |
| Safe | 4 | Cancer 2 Week Wait Performance | MAY-19 | 11/07/19 | No | 95.44% | 28.46% | 38/131 |
| Safe | 5 | 18 Week Incomplete Referral To Treatment (RTT) Performance | JUL-19 | 12/09/19 | No | 92.24% | 11.02% | 15/128 |
| Safe | 6 | Patient-led assessments of the care environment (PLACE) | JAN-18 - DEC-18 | 26/09/18 | Yes | 0.98% | 0.74% | 2/136 |
| Effective | 7 | Accident & Emergency 4 Hour Wait Performance | AUG-19 | 12/09/19 | No | 90.04% | 17.24% | 21/117 |
| Effective | 8 | Diagnostic 6 Week Wait Performance | JUL-19 | 12/09/19 | No | 0.73% | 25.78% | 34/129 |
| Caring | 10 | Friends & Family Assessment Result | JUL-19 | 12/09/19 | No | 95.75% | 29.46% | 39/130 |
| Caring | 11 | National Patient Survey Result | JAN-17 - DEC-17 | 19/07/18 | No | 0.84 | 14.93% | 21/135 |

Top 10%: 1
Top 25%: 3
Top 50%: 4
Bottom 50%: 2
Bottom 25%: 0
Bottom 10%: 0

## Top 5 Performing Metrics

| # | Metric Name | Rank |
|---|---|---|
| 1 | Patient-led assessments of the care environment (PLACE) | 2 |
| 2 | 18 Week Incomplete Referral To Treatment (RTT) Performance | 15 |
| 3 | National Patient Survey Result | 21 |
| 4 | Accident & Emergency 4 Hour Wait Performance | 21 |
| 5 | Diagnostic 6 Week Wait Performance | 34 |

## Bottom 5 Performing Metrics

| # | Metric Name | Rank |
|---|---|---|
| 1 | Safety Thermometer / Harm Free Performance | 83 |
| 2 | Hospital Standardised Mortality Ratios (HSMR) | 67 |
| 3 | Summary Hospital-level Mortality Indicator (SHMI) | 59 |
| 4 | Friends & Family Assessment Result | 39 |
| 5 | Cancer 2 Week Wait Performance | 38 |

## Local Trust Positions

| Provider Name | GM Rank | North Rank | National Rank |
|---|---|---|---|
| WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST | 1/7 | 3/44 | 5/136 |
| BOLTON NHS FOUNDATION TRUST | 2/7 | 6/44 | 15/136 |
| TAMESIDE HOSPITAL NHS FOUNDATION TRUST | 3/7 | 11/44 | 29/136 |
| MANCHESTER UNIVERSITY NHS FOUNDATION TRUST | 4/7 | 31/44 | 90/136 |
| SALFORD ROYAL NHS FOUNDATION TRUST | 5/7 | 34/44 | 97/136 |
| PENNINE ACUTE HOSPITALS NHS TRUST | 6/7 | 37/44 | 110/136 |
| STOCKPORT NHS FOUNDATION TRUST | 7/7 | 38/44 | 114/136 |

## In Month

18 Weeks: Incomplete — 92.02% — Target: 92.0%

Cancer 62 Day: GP Referral — 88.79% — Target: 85.0%

Diagnostics: 6 Weeks — 99.14% — Target: 99.0%

**A&E: 4 Hour Target — 90.11% — Target: 95.0%

C. Difficile Infections — 17 — YTD Target: 5

## Year To Date

Serious Falls — 3 — FY Target: 0

Never Events — 2 — FY Target: 0

MRSA — 0 — FY Target: 0

# Executive Summary (August 2019)

## Key Messages

Highlights

The Trust's Safety Thermometer data and VTE Assessment rates are above the National target.
The Trust has seen a reduction in moderate & severe falls.

Lowlights

The Trust reported 1 Never Event in August 2019, which took the Trust to 2 Never Events Year to Date.
The Trust has seen an increase in Harms overall, with Grade 2 Pressure Ulcers have increased in month, and Infections related to E-coli, Klebsiella and MSSA also have increased in month.
At the end of August 2019, the Trust had 17 Clostridium Difficile infections against an end of year trajectory of 20 cases.
The trust is working with NHSI and taking a targeted approach to improvements in infection control standards.

Please also see Scheduled Care Report and Unscheduled Care Report.

# 1.1 : Harm Free

| Metric Title | Target | Latest Actual | Latest Period | Latest RAG | Trend | Previous Actual | Previous Period | YTD Actual | YTD RAG | Sparkline - Latest 13 Months Chart | Min. Value | Max. Value | Period |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Serious Harms: Community Acquired Grade 3-4 Pressure Ulcers | ** | 1 | Aug-19 | | → | 1 | Jul-19 | 7 | | | 0 | 3 | Apr-19 to Aug-19 |
| Harms: Total | ** | 80 | Aug-19 | | ↑ | 76 | Jul-19 | 378 | | | 62 | 85 | Aug-18 to Aug-19 |
| Serious Harms: Total | ** | 10 | Aug-19 | | ↓ | 11 | Jul-19 | 50 | | | 3 | 14 | Aug-18 to Aug-19 |
| Serious Harms: Number of Never Events | <= 0 | 1 | Aug-19 | 🔴 | ↑ | 0 | Jul-19 | 2 | 🔴 | | 0 | 2 | Aug-18 to Aug-19 |
| Serious Harms: Number of Serious Falls | <= 0 | 0 | Aug-19 | 🟢 | ↓ | 2 | Jul-19 | 3 | 🔴 | | 0 | 2 | Aug-18 to Aug-19 |
| Serious Harms: Hospital Acquired Grade 3-4 Pressure Ulcers | ** | 2 | Aug-19 | | ↓ | 4 | Jul-19 | 11 | | | 0 | 4 | Aug-18 to Aug-19 |
| Number of Serious Incidents | <= 0 | 5 | Aug-19 | 🔴 | → | 5 | Jul-19 | 26 | 🔴 | | 0 | 10 | Aug-18 to Aug-19 |
| Mod/Low Harms: Hospital Acquired Pressure Ulcer Grade 2 | ** | 5 | Aug-19 | | ↑ | 1 | Jul-19 | 12 | | | 0 | 6 | Aug-18 to Aug-19 |
| Mod/Low Harms: Number of Moderate Falls | <= 0 | 0 | Aug-19 | 🟢 | ↓ | 1 | Jul-19 | 4 | 🔴 | | 0 | 3 | Aug-18 to Aug-19 |
| Mod/Low Harms: Safety Thermometer | >= 95.0% | 98.72% | Aug-19 | 🟢 | ↓ | 99.09% | Jul-19 | 98.56% | 🟢 | | 98.07% | 99.75% | Aug-18 to Aug-19 |
| Mod/Low Harms: Settled Clinical Litigation Cases | ** | 3 | Aug-19 | | ↓ | 4 | Jul-19 | 14 | | | 1 | 5 | Aug-18 to Aug-19 |
| Mod/Low Harms: VTE Assessments (% of Admissions) | >= 95.0% | 96.23% | Aug-19 | 🟢 | ↓ | 96.98% | Jul-19 | 96.51% | 🟢 | | 95.67% | 97.45% | Aug-18 to Aug-19 |

## Commentary (Page Owner : Director of Nursing and Performance)

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

In August 2019, the Trust reported 5 incidents to StEIS, one of which was a Never Event relating to a wrong implant and another was a Category 3 community acquired pressure ulcer where a lapse in care had been identified. A learning event in relation to Never Events is scheduled at Wrightington on the 11th October 2019. The Trust's improvement plan in relation to wound management was presented to Quality and Safety Committee in September 2019. An accelerated piece of work in relation to further embedding Local Safety Standards for Invasive Procedures (LocSSIPs), led by the Medical Director and Chief Nurse is to commence. The Safety Thermometer shows the percentage of patients receiving New Harm Free care in hospital was 95.92%.

# 1.2 : Harm Free - Infections

| | Latest | | | | | Previous | | YTD | | Sparkline - Latest 13 Months | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Metric Title | Target | Actual | Period | RAG | Trend | Actual | Period | Actual | RAG | Chart | Min. Value | Max. Value | Period |
| Infections/Bacteraemias: Total | ** | 10 | Aug-19 | | ↑ | 7 | Jul-19 | 45 | | | 2 | 16 | Aug-18 to Aug-19 |
| Serious Harms: Infections: Clostridium Difficile | <= 2 | 2 | Aug-19 | ● | ↓ | 3 | Jul-19 | 17 | ● | | 0 | 5 | Aug-18 to Aug-19 |
| Serious Harms: Infections: Clostridium Difficile Lapses in Care | <= 0 | 1 | Jul-19 | ● | → | 1 | Jun-19 | 4 | | | 0 | 1 | Aug-18 to Jul-19 |
| Infections: Catheter Associated Urinary Tract | <= 0 | 1 | Aug-19 | ● | ↑ | 0 | Jul-19 | 4 | ● | | 0 | 2 | Aug-18 to Aug-19 |
| Serious Harms: Bacteraemias: MRSA | <= 0 | 0 | Aug-19 | ● | → | 0 | Jul-19 | 0 | ● | | 0 | 1 | Aug-18 to Aug-19 |
| Serious Harms: Bacteraemias: MRSA - Avoidable Cases | ** | 0 | Aug-19 | ● | → | 0 | Jul-19 | 0 | ● | | 0 | 0 | Aug-18 to Aug-19 |
| Serious Harms: Bacteraemias: MSSA | ** | 2 | Aug-19 | | ↑ | 1 | Jul-19 | 4 | | | 0 | 4 | Aug-18 to Aug-19 |
| Serious Harms: Bacteraemias: E-coli | ** | 3 | Aug-19 | | ↑ | 1 | Jul-19 | 13 | | | 0 | 7 | Aug-18 to Aug-19 |
| Bacteraemias: Klebsiella | ** | 2 | Aug-19 | | ↑ | 1 | Jul-19 | 6 | | | 0 | 2 | Aug-18 to Aug-19 |
| Bacteraemias: Pseudomonas | ** | 0 | Aug-19 | ● | ↓ | 1 | Jul-19 | 1 | | | 0 | 1 | Aug-18 to Aug-19 |

## Commentary (Page Owner : Director of Nursing and Performance)

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

Two cases of Clostridium difficile infection within the Trust. These were unrelated and root cause analysis is underway. 17 C.difficile cases in total year to date. Work continues to address the recent increase in C.difficile cases compared to 2018/19. NHS Improvement has undertaken a review in August 2019 at our request. A C.difficile reduction strategy is being developed. Numbers of Gram-negative and MSSA bacteraemias remained low.

# 2 : Mortality

| | Latest | | | | | Previous | | YTD | | Sparkline - Latest 13 Months | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Metric Title | Target | Actual | Period | RAG | Trend | Actual | Period | Actual | RAG | Chart | Min. Value | Max. Value | Period |
| Number of Hospital Deaths | ** | 88 | Aug-19 | | ↓ | 94 | Jul-19 | 494 | | | 81 | 128 | Aug-18 to Aug-19 |
| Hospital Crude Death Rate | ** | 1.30% | Aug-19 | | ↑ | 1.27% | Jul-19 | 1.42% | | | 1.10% | 1.79% | Aug-18 to Aug-19 |
| PFD Coroner Notifications | ** | 0 | Aug-19 | ● | → | 0 | Jul-19 | 0 | ● | | 0 | 0 | Aug-18 to Aug-19 |
| Deaths after Readmission | ** | 20 | Aug-19 | | ↓ | 32 | Jul-19 | 147 | | | 20 | 38 | Aug-18 to Aug-19 |
| HSMR (Latest Month) | <= 90 | 111.6 | May-19 | ● | ↑ | 95.6 | Apr-19 | N/A | | | 81.2 | 118.4 | Apr-18 to May-19 |
| HSMR (Latest YTD) | * | 103.8 | May-19 | | ↑ | 95.5 | Apr-19 | N/A | | | 95.2 | 103.8 | Dec-18 to May-19 |
| HSMR Weekday | <= 90 | 101.1 | May-19 | ● | ↑ | 93.2 | Apr-19 | N/A | | | 75.0 | 116.1 | Apr-18 to May-19 |
| HSMR Weekend | <= 90 | 145.8 | May-19 | ● | ↑ | 102.8 | Apr-19 | N/A | | | 78.0 | 145.8 | Apr-18 to May-19 |
| SHMI (Rolling 12 Months) | <= 90.0 | 113.3 | Feb-19 | ● | ↑ | 112.6 | Jan-19 | N/A | | | 109.1 | 113.3 | Jun-18 to Feb-19 |

## Commentary (Page Owner : Medical Director)

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

Late summer and the mortality data reflects 2 different time periods. HSMR is still reflecting spring but number of deaths reflects summer. HSMR is high, but the number of deaths is low. SHMI is the unexpected result. Its gone back up. The way its calculated has changed. We get it sooner and on a monthly basis now. The calculation has been altered to improve it, but the changes seem to have worked against us. The change is unlikely to have a major long term effect.

# 3.1 : Midwifery - Part 1

| | Latest | | | | | Previous | | YTD | | Sparkline - Latest 13 Months | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Metric Title | Target | Actual | Period | RAG | Trend | Actual | Period | Actual | RAG | Chart | Min. Value | Max. Value | Period |
| Maternity: Midwife / Birth Ratio | <= 1.30 | 1.25 | Aug-19 | | → | 1.25 | Jul-19 | N/A | | | 1.24 | 1.27 | Aug-18 to Aug-19 |
| Maternity: Skills drills/2 day Mandatory Training Attendance | >= | 54.97% | Aug-19 | | → | 54.97% | Jul-19 | N/A | | | 8.09% | 95.37% | Aug-18 to Aug-19 |
| Maternity: Total monthly bookings | >= 240 | 240 | Jul-19 | | ↑ | 225 | Jun-19 | 908 | | | 197 | 292 | Aug-18 to Jul-19 |
| Maternity: Booked by 12+6 Weeks | >= 90.0% | 90.60% | Jul-19 | | ↓ | 94.42% | Jun-19 | N/A | | | 85.78% | 94.42% | Aug-18 to Jul-19 |
| Maternity: Induction of Labour | <= 30.0% | 39.05% | Aug-19 | | ↑ | 37.50% | Jul-19 | N/A | | | 32.03% | 41.05% | Aug-18 to Aug-19 |
| Maternity: Normal Deliveries | >= 60.0% | 57.35% | Aug-19 | | ↑ | 57.33% | Jul-19 | N/A | | | 49.10% | 67.89% | Aug-18 to Aug-19 |
| Maternity: Water Births | >= 8 | 10 | Aug-19 | | ↓ | 14 | Jul-19 | 60 | | | 7 | 16 | Aug-18 to Aug-19 |
| Maternity: Instrumental Deliveries | <= 10.0% | 12.80% | Aug-19 | | ↑ | 8.19% | Jul-19 | N/A | | | 8.19% | 13.88% | Aug-18 to Aug-19 |
| Maternity: Elective Caesarean Sections | <= 15.0% | 12.32% | Aug-19 | | ↑ | 11.64% | Jul-19 | N/A | | | 7.80% | 17.34% | Aug-18 to Aug-19 |
| Maternity: Emergency / Non Elective Caesarean Sections | <= 17.0% | 17.54% | Aug-19 | | ↓ | 22.84% | Jul-19 | N/A | | | 11.96% | 22.84% | Aug-18 to Aug-19 |
| Maternity: Total Caesarean Sections | <= 27.0% | 29.86% | Aug-19 | | ↓ | 34.48% | Jul-19 | N/A | | | 22.48% | 36.53% | Aug-18 to Aug-19 |

## Commentary (Page Owner : Director of Nursing and Performance)

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

Midwife to Birth ratio remains at 1:25. Birth rate + has identified an increased level of acuity within the WWL caseload. 1-2-1 care in labour remains compliant at 99%. Mandatory Training is not scheduled during August due to peak holiday period. Slightly below Target to achieve the 90% compliance by year end however this will be addressed to ensure staff are allocated. Induction of labour has again peaked to 39%, however, all Inductions were undertaken for medical/ Obstetric reasons and in accordance with guidelines and recommendations to optimise fetal and maternal outcomes. The main reasons for induction being reduced fetal movements and suspected or actual small for gestational age. Overall the Caesarean section rate is down at just below 30% remaining predominantly due to emergency Caesareans. This continues to affect the normal birth rate which has remained below the 60% target.

# 3.2 : Midwifery - Part 2

| Metric Title | Target | Latest Actual | Latest Period | Latest RAG | Trend | Previous Actual | Previous Period | YTD Actual | YTD RAG | Sparkline - Latest 13 Months Chart | Min. Value | Max. Value | Period |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Maternity: Total Births | >= 240 | 211 | Aug-19 | | ↓ | 232 | Jul-19 | 1,058 | | | 167 | 234 | Aug-18 to Aug-19 |
| Maternity: Episiotomy with normal birth | <= 6.0% | 9.09% | Aug-19 | | ↑ | 5.26% | Jul-19 | N/A | | | 2.22% | 10.07% | Aug-18 to Aug-19 |
| Maternity: 3rd/4th degree tears | <= 3.0% | 2.38% | Aug-19 | | ↑ | 1.29% | Jul-19 | N/A | | | 0.00% | 3.20% | Aug-18 to Aug-19 |
| Maternity: Initiation of breastfeeding | >= 55.0% | 45.97% | Aug-19 | | ↓ | 47.84% | Jul-19 | N/A | | | 44.29% | 54.15% | Aug-18 to Aug-19 |
| Maternity: Average post-natal length of stay | <= 1.8 | 1.2 | Aug-19 | | ↓ | 1.7 | Jul-19 | N/A | | | 1.2 | 2.0 | Aug-18 to Aug-19 |
| Maternity: Still Births (>24 weeks) | <= 1 | 1 | Aug-19 | | ↓ | 2 | Jul-19 | 5 | | | 0 | 2 | Aug-18 to Aug-19 |
| Maternal Readmissions within 30 Days | <= 5 | 4 | Aug-19 | | → | 4 | Jul-19 | 11 | | | 1 | 6 | Aug-18 to Aug-19 |
| Maternal admissions to ICU | <= 2 | 0 | Aug-19 | | → | 0 | Jul-19 | 0 | | | 0 | 1 | Aug-18 to Aug-19 |
| Maternity Complaints | <= 2 | 5 | Aug-19 | | ↑ | 1 | Jul-19 | 9 | | | 0 | 5 | Aug-18 to Aug-19 |
| Maternity: New Claims | * | 0 | Aug-19 | | → | 0 | Jul-19 | 0 | | | 0 | 3 | Aug-18 to Aug-19 |

## Commentary (Page Owner : Director of Nursing and Performance)

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

The operative virginal birth rate although has risen remains positively below the 13%. Last year was the third year in a row in which the number of live births has decreased nationally: down 3.2% on 2017, and nearly 10% on 2012. The downward trend is evident here at WWL as births per month remain below target however given the national trend and last year's birth figures the target will be adjusted accordingly from next month. Episiotomy with normal birth has seen a steady increase each quarter; it is difficult to obtain national rates for this, however, WWL has set a rate based on previous year's figures and this increase may now need to be audited to understand the reasons for this increase within our local rates. The Infant feeding team continue to work to promote and support mothers to initiate breastfeeding. However we have dipped for a second month below the target. WWL has full Baby Friendly accreditation and Gold status. There was 1 stillbirth which will have a full Multidisciplinary review in line with National recommendations. 5 complaints were received in August which is the highest number received in any month. No clear trends were identified from these which ranged from clinical care, process and staff attitude.

# 4.1 : Patient Experience - Part 1

| | Latest | | | | | Previous | | YTD | | Sparkline - Latest 13 Months | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Metric Title | Target | Actual | Period | RAG | Trend | Actual | Period | Actual | RAG | Chart | Min. Value | Max. Value | Period |
| Number of Complaints Upheld by Ombudsman | ** | 1 | Aug-19 | | ↑ | 0 | Jul-19 | 1 | | | 0 | 1 | Aug-18 to Aug-19 |
| Percentage of Complaints Responded to on Time | ** | 72.97% | Aug-19 | | ↓ | 76.60% | Jul-19 | 66.84% | | | 34.88% | 89.13% | Aug-18 to Aug-19 |
| Patient Survey Q1: Staff Introduction | >= 90.0% | 89.61% | Aug-19 | Amber | ↓ | 92.27% | Jul-19 | 91.69% | Green | | 88.51% | 96.53% | Aug-18 to Aug-19 |
| Patient Survey Q2: Worries and Fears | >= 90.0% | 85.71% | Aug-19 | Amber | ↓ | 85.99% | Jul-19 | 88.83% | Amber | | 85.71% | 93.89% | Aug-18 to Aug-19 |
| Patient Survey Q3: Pain Control | >= 90.0% | 89.61% | Aug-19 | Amber | ↓ | 95.17% | Jul-19 | 93.55% | Green | | 89.61% | 96.53% | Aug-18 to Aug-19 |
| Patient Survey Q4: Family and Doctor | >= 90.0% | 90.91% | Aug-19 | Green | ↑ | 89.86% | Jul-19 | 90.94% | Green | | 88.08% | 95.27% | Aug-18 to Aug-19 |
| Patient Survey Q5: Decisions about Care and Treatment | >= 90.0% | 82.47% | Aug-19 | Red | ↑ | 81.64% | Jul-19 | 83.87% | Red | | 78.38% | 88.19% | Aug-18 to Aug-19 |
| Patient Survey Q6: Food Choice | >= 90.0% | 95.45% | Aug-19 | Green | ↓ | 97.10% | Jul-19 | 96.90% | Green | | 95.27% | 98.73% | Aug-18 to Aug-19 |
| Patient Survey Q7: Healthy Food | >= 90.0% | 90.26% | Aug-19 | Green | ↑ | 86.96% | Jul-19 | 91.32% | Green | | 86.96% | 97.22% | Aug-18 to Aug-19 |
| Patient Survey Q9: Know Consultant | >= 90.0% | 83.12% | Aug-19 | Red | ↑ | 79.71% | Jul-19 | 82.13% | Red | | 73.28% | 90.28% | Aug-18 to Aug-19 |

## Commentary (Page Owner : Director of Nursing and Performance)

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

During August 2019, 27 out of 37 responses were sent within the timescales agreed with the complainant at the start of the complaints process (73%). Quality and Safety Committee discussed actions to be taken to improve this. One partially upheld report was received from the Ombudsman. The complaint was partially upheld (without recommendations) due to the communication between WWL and another NHS Trust. Comprehensive, open and transparent responses to complainants are incredibly important and improve patient experience and satisfaction. For Real Time Patient Survey commentary, please see overleaf.

# 4.2 : Patient Experience - Part 2

| Metric Title | Target | Latest Actual | Latest Period | Latest RAG | Trend | Previous Actual | Previous Period | YTD Actual | YTD RAG | Sparkline - Latest 13 Months Chart | Min. Value | Max. Value | Period |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Delivering Same Sex Accommodation: Mixed Sex Accommodation Breaches | * | 1 | Aug-19 | | ↓ | 5 | Jul-19 | 9 | | | 0 | 5 | Apr-19 to Aug-19 |
| Patient Survey Q10: Enough Privacy | >= 90.0% | 94.81% | Aug-19 | ● | ↓ | 99.03% | Jul-19 | 98.51% | ● | | 94.81% | 100.00% | Aug-18 to Aug-19 |
| Patient Survey Q11: Call Bell | >= 90.0% | 93.51% | Aug-19 | ● | ↓ | 96.62% | Jul-19 | 96.53% | ● | | 92.73% | 98.08% | Aug-18 to Aug-19 |
| Patient Survey Q12: Compassion | >= 90.0% | 97.40% | Aug-19 | ● | ↓ | 97.58% | Jul-19 | 97.64% | ● | | 96.62% | 99.30% | Aug-18 to Aug-19 |
| Patient Survey Q13: Given Required Care | >= 90.0% | 96.10% | Aug-19 | ● | ↓ | 98.07% | Jul-19 | 97.39% | ● | | 94.90% | 99.31% | Aug-18 to Aug-19 |
| Friends & Family: Decisions about Discharge Home? | >= 90.0% | 87.08% | Aug-19 | ● | ↓ | 89.67% | Jul-19 | N/A | | | 83.95% | 91.94% | Aug-18 to Aug-19 |

## Commentary (Page Owner : Director of Nursing and Performance)

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

In relation to the Real Time Patient Survey, the question “Do you know which consultant is currently treating you? has increased but the overall score is of concern. The Trust is re-invigorating the ‘Hello my name is…” campaign. The question “Do you think the hospital staff did everything they could to help control your pain? has significantly decreased by over 5%. The question “Have you been given enough privacy when being examined, treated or discussing your care?” also significantly dropped which was a disappointment. Patients reporting that they felt involved in decisions about their discharge home decreased slightly in August 2019 in comparison to September 2019. Safe discharge remains a priority for the Trust and the Discharge Improvement Group is leading the actions being taken.

# 5 : Workforce

| | Latest | | | | | Previous | | YTD | | Sparkline - Latest 13 Months | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Metric Title | Target | Actual | Period | RAG | Trend | Actual | Period | Actual | RAG | Chart | Min. Value | Max. Value | Period |
| Total Pay vs Budget | <=£ 0 k | £ 285 k | Aug-19 | | | £ -21 k | Jul-19 | £ 223 k | | | £ -149 k | £ 1,276 k | Aug-18 to Aug-19 |
| Friends & Family Test - Recommendation as place to work | >= 75.0% | 69.56% | Jul-19 | | | 61.94% | Apr-19 | N/A | | | 61.94% | 71.59% | Oct-18 to Jul-19 |
| Clinical & Non Clinical Overall Vacancy Rate | <= 3.5% | 10.41% | Jul-19 | | | 10.50% | Jun-19 | 10.64% | | | 7.05% | 10.87% | Aug-18 to Jul-19 |
| Sickness absence - Total | <= | 4.41% | Jul-19 | | | 4.69% | Jun-19 | 4.42% | | | 4.04% | 5.04% | Aug-18 to Jul-19 |
| Quarterly Engagement Score | >= 4.00 | 3.95 | Jul-19 | | | 3.90 | Apr-19 | N/A | | | 3.90 | 4.01 | Sep-18 to Jul-19 |
| Appraisals over rolling 12 months | >= 90.0% | 84.76% | Jul-19 | | | 86.19% | May-19 | N/A | | | 84.76% | 89.45% | Aug-18 to Jul-19 |
| Friends & Family Test - Recommendation as place for treatment | >= 80.0% | 78.56% | Jul-19 | | | 76.11% | Apr-19 | N/A | | | 76.11% | 79.42% | Oct-18 to Jul-19 |
| Mandatory Training over rolling 12 months | >= 95.0% | 92.36% | Jul-19 | | | 90.12% | May-19 | N/A | | | 90.12% | 96.05% | Aug-18 to Jul-19 |
| Agency vs NHSI Ceiling | <=£ 0 k | £ 885 k | Aug-19 | | | £ 756 k | Jul-19 | £ 2,570 k | | | £ 101 k | £ 885 k | Aug-18 to Aug-19 |

## Commentary (Page Owner : Director of Workforce)

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

Rolling 12-month sickness from Aug 18 - Jul 19 decreased marginally to 4.43% (compared to 4.44% last reported). The in-month sickness rate also decreased to 4.41% (compared to 4.69% in Jun 19). Temp spend in Aug 19 increased by £293k to £2,061k (compared to £1,768k in Jul 19). There were increases in Agency, Bank NHSP, Locum and Zero Hour Contracts (increased by £129k, £89k, £99k and £34k respectively). There were marginal reductions in Cost per case (£2k) and overtime (£1k) with a £55k reduction in Additional sessions spend. Overall, the results of the Jul 19 Staff Engagement Quarterly Pulse Check highlight a moderate level of engagement within the Trust. The overall engagement score for Jul 19 is 3.95 compared to 3.90 in Apr 19. Whilst job plan compliance is at 100%, the plans are at various stages within the system. Trustwide there are 188 job plans at the following stages: 36 (Discussion), 48 (1st sign off), 11 (2nd sign off), 93 (fully signed off). Please note that these figures relate only to Consultant job plans.

# 6.1 : Access

| Metric Title | Target | Latest Actual | Latest Period | Latest RAG | Trend | Previous Actual | Previous Period | YTD Actual | YTD RAG | Sparkline - Latest 13 Months Chart | Min. Value | Max. Value | Period |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Access: 18 Weeks Referral To Treatment Incomplete Pathway | >= 92.0% | 92.02% | Aug-19 | | | 92.24% | Jul-19 | 92.44% | | | 92.02% | 93.45% | Aug-18 to Aug-19 |
| Access: Referral to Treatment over 52 weeks wait | <= 0 | 1 | Aug-19 | | | 0 | Jul-19 | 5 | | | 0 | 2 | Aug-18 to Aug-19 |
| Outpatients: Backlog of Follow Ups | ** | 14,470 | Aug-19 | | | 14,055 | Jul-19 | N/A | | | 12,467 | 14,470 | Aug-18 to Aug-19 |
| Stroke - High Risk TIA Patients Treated within 24 Hrs | >= 60.0% | 82.35% | Aug-19 | | | 81.25% | Jul-19 | 85.71% | | | 57.69% | 92.59% | Aug-18 to Aug-19 |
| Stroke - Stroke Patients spending 90% of their Hospital Stay on a Stroke unit | >= 80.0% | 81.48% | Aug-19 | | | 80.00% | Jun-19 | 79.81% | | | 60.00% | 92.59% | Aug-18 to Aug-19 |
| Diagnostics: Patients waiting over 6 weeks | >= 99.0% | 99.14% | Aug-19 | | | 99.27% | Jul-19 | 98.97% | | | 98.17% | 99.42% | Aug-18 to Aug-19 |

## Commentary (Page Owner : Director of Operations)

Please see Scheduled Care Report.

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

# 6.2 : Access - Cancer

| Metric Title | Target | Latest Actual | Latest Period | Latest RAG | Trend | Previous Actual | Previous Period | YTD Actual | YTD RAG | Sparkline - Latest 13 Months Chart | Min. Value | Max. Value | Period |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Two week wait from referral to date first seen: all urgent cancer referrals (cancer suspected) | >= 93.0% | 93.40% | Jul-19 | | ↓ | 95.90% | Jun-19 | 94.64% | | | 93.40% | 97.95% | Aug-18 to Jul-19 |
| Two week wait from referral to date first seen: symptomatic breast patients (cancer not initally suspected) | >= 93.0% | 94.21% | Jul-19 | | ↓ | 94.68% | Jun-19 | 95.67% | | | 91.24% | 100.00% | Aug-18 to Jul-19 |
| All Cancers: 31 day wait for diagnosis to first treatment | >= 96.0% | 100.00% | Jul-19 | | → | 100.00% | Jun-19 | 99.51% | | | 97.73% | 100.00% | Aug-18 to Jul-19 |
| All Cancers: 31 day wait for second or subsequent treatment: anti cancer drug treatments | >= 98.0% | 100.00% | Jul-19 | | → | 100.00% | Jun-19 | 100.00% | | | 100.00% | 100.00% | Aug-18 to Jul-19 |
| All Cancers: 31 day wait for second or subsequent treatment: surgery | >= 94.0% | 100.00% | Jul-19 | | → | 100.00% | Jun-19 | 100.00% | | | 93.33% | 100.00% | Aug-18 to Jul-19 |
| All Cancers: 62 day wait for first treatment from urgent GP referral to treatment | >= 85.0% | 88.79% | Jul-19 | | ↓ | 91.74% | Jun-19 | 85.59% | | | 80.13% | 94.29% | Aug-18 to Jul-19 |
| All Cancers: 62 day wait for first treatment from consultant screening service referral | >= 90.0% | 92.31% | Jul-19 | | ↑ | 90.91% | Jun-19 | 94.56% | | | 90.91% | 100.00% | Aug-18 to Jul-19 |

## Commentary (Page Owner : Director of Operations)

Please see Scheduled Care Report.

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

# 6.3 : Access - A&E

| | Latest | | | | | Previous | | YTD | | Sparkline - Latest 13 Months | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Metric Title | Target | Actual | Period | RAG | Trend | Actual | Period | Actual | RAG | Chart | Min. Value | Max. Value | Period |
| NWAS: Handovers >30 Mins | * | 81 | Aug-19 | | ↑ | 42 | Jul-19 | 573 | | | 42 | 203 | Apr-19 to Aug-19 |
| Number of A&E Attendances (All Types) | ** | 12,279 | Aug-19 | | ↓ | 12,950 | Jul-19 | 62,295 | | | 12,279 | 12,950 | Apr-19 to Aug-19 |
| Average Daily A&E Attendances (All Types) | ** | 396.1 | Aug-19 | | ↓ | 417.7 | Jul-19 | 407.2 | | | 396.1 | 417.7 | Apr-19 to Aug-19 |
| NWAS: Handovers between 15-30 mins | - | - | - | | | - | - | - | | | 337 | 612 | Aug-18 to Mar-19 |
| NWAS: Handovers <=30 mins | * | 1,723 | Aug-19 | | ↑ | 1,711 | Jul-19 | 8,825 | | | 1,711 | 1,830 | Apr-19 to Aug-19 |
| NWAS: Handovers between 30-60 mins | - | - | - | | | - | - | - | | | 86 | 269 | Aug-18 to Mar-19 |
| 4 Hour A&E Breach Performance % (All Types) | >= 95.0% | 90.11% | Aug-19 | ● | ↓ | 94.76% | Jul-19 | 86.68% | ● | | 75.11% | 94.76% | Aug-18 to Aug-19 |
| A&E Attendances that result in an inpatient episode | * | 2,548 | Aug-19 | | ↓ | 2,643 | Jul-19 | 11,719 | | | 2,136 | 2,643 | Aug-18 to Aug-19 |
| A&E Attendances: Out of Area | ** | 1,245 | Aug-19 | | ↑ | 1,236 | Jul-19 | 5,809 | | | 976 | 1,245 | Aug-18 to Aug-19 |

## Commentary (Page Owner : Director of Operations)

Please see Unscheduled Care Report.

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

# 7.1 : Productivity - Part 1

| | Latest | | | | | Previous | | YTD | | Sparkline - Latest 13 Months | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Metric Title | Target | Actual | Period | RAG | Trend | Actual | Period | Actual | RAG | Chart | Min. Value | Max. Value | Period |
| % Hospital Cancelled OP Appointments | <= 5.0% | 7.60% | Aug-19 | | | 6.15% | Jul-19 | 6.53% | | | 6.06% | 7.60% | Aug-18 to Aug-19 |
| % Hospital Cancelled OP Appointments < 6 weeks | <= 0.0% | 83.96% | Aug-19 | | | 80.66% | Jul-19 | 81.37% | | | 75.60% | 83.96% | Aug-18 to Aug-19 |
| % Hospital Cancelled OP Appointments < 6 weeks (Pts Best Interest) | * | 10.71% | Aug-19 | | | 13.65% | Jul-19 | 11.56% | | | 10.23% | 13.65% | Aug-18 to Aug-19 |
| Cancelled Operations % | <= 0.8% | 1.98% | Aug-19 | | | 2.08% | Jul-19 | 1.89% | | | 1.42% | 2.22% | Aug-18 to Aug-19 |
| Cancelled Operations: 2nd Urgent Hospital | <= 0 | 0 | Aug-19 | | | 0 | Jul-19 | 0 | | | 0 | 0 | Aug-18 to Aug-19 |
| Average Spell Length of Stay (Elective Inpatient) | * | 3.3 Days | Aug-19 | | | 3.1 Days | Jul-19 | 3.1 Days | | | 2.8 Days | 3.5 Days | Aug-18 to Aug-19 |
| Average Spell Length of Stay (Non Elective) | * | 3.5 Days | Aug-19 | | | 3.4 Days | Jul-19 | 3.7 Days | | | 3.4 Days | 4.1 Days | Aug-18 to Aug-19 |
| Delayed Transfers of Care | ** | 76 | Aug-19 | | | 50 | Jul-19 | 306 | | | 37 | 81 | Aug-18 to Aug-19 |
| Delayed Transfer of Care Days | ** | 214 | Aug-19 | | | 174 | Jul-19 | 1,148 | | | 153 | 289 | Aug-18 to Aug-19 |

## Commentary (Page Owner : Director of Operations)

Please see Scheduled Care Report.

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

# 7.2 : Productivity - Part 2

| | Latest | | | | | Previous | | YTD | | Sparkline - Latest 13 Months | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Metric Title | Target | Actual | Period | RAG | Trend | Actual | Period | Actual | RAG | Chart | Min. Value | Max. Value | Period |
| Community: % IAPT Patients beginning treatment within 18 weeks | >= 95.0% | 100.00% | Jul-19 | | → | 100.00% | Jun-19 | 100.00% | | | 100.00% | 100.00% | Apr-19 to Jul-19 |
| Community: % IAPT Patients beginning treatment within 6 weeks | >= 75.0% | 96.74% | Jul-19 | | ↓ | 97.46% | Jun-19 | 97.32% | | | 96.74% | 97.67% | Apr-19 to Jul-19 |
| Theatre Effectiveness % - RAEI | >= 70.0% | 56.85% | Aug-19 | | ↑ | 54.46% | Jul-19 | N/A | | | 54.46% | 60.63% | Aug-18 to Aug-19 |
| Theatre Effectiveness % - Wrightington | >= 70.0% | 55.31% | Aug-19 | | ↓ | 63.33% | Jul-19 | N/A | | | 55.31% | 68.23% | Aug-18 to Aug-19 |
| Theatre Effectiveness % - Leigh | >= 70.0% | 54.40% | Aug-19 | | ↓ | 54.50% | Jul-19 | N/A | | | 54.15% | 61.83% | Aug-18 to Aug-19 |

## Commentary (Page Owner : Director of Operations)

Please see Scheduled Care Report.

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

# NHSI Metrics

| | Latest | | | | | Previous | | YTD | | Sparkline - Latest 13 Months | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Metric Title | Target | Actual | Period | RAG | Trend | Actual | Period | Actual | RAG | Chart | Min. Value | Max. Value | Period |
| 4 Hour A&E Breach Performance % (All Types) | 95.0% | 90.11% | Aug-19 | | | 94.76% | Jul-19 | 86.68% | | | 75.11% | 94.76% | Aug-18 to Aug-19 |
| Access: 18 Weeks Referral To Treatment Incomplete Pathway | 92.0% | 92.02% | Aug-19 | | | 92.24% | Jul-19 | 92.44% | | | 92.02% | 93.45% | Aug-18 to Aug-19 |
| Diagnostics: Patients waiting over 6 weeks | 99.0% | 99.14% | Aug-19 | | | 99.27% | Jul-19 | 98.97% | | | 98.17% | 99.42% | Aug-18 to Aug-19 |
| Two week wait from referral to date first seen: all urgent cancer referrals (cancer suspected) | 93.0% | 93.40% | Jul-19 | | | 95.90% | Jun-19 | 94.64% | | | 93.40% | 97.95% | Aug-18 to Jul-19 |
| Two week wait from referral to date first seen: symptomatic breast patients (cancer not initally suspected) | 93.0% | 94.21% | Jul-19 | | | 94.68% | Jun-19 | 95.67% | | | 91.24% | 100.00% | Aug-18 to Jul-19 |
| All Cancers: 62 day wait for first treatment from urgent GP referral to treatment | 85.0% | 88.79% | Jul-19 | | | 91.74% | Jun-19 | 85.59% | | | 80.13% | 94.29% | Aug-18 to Jul-19 |
| All Cancers: 62 day wait for first treatment from consultant screening service referral | 90.0% | 92.31% | Jul-19 | | | 90.91% | Jun-19 | 94.56% | | | 90.91% | 100.00% | Aug-18 to Jul-19 |
| Serious Harms: Infections: Clostridium Difficile | 2 | 2 | Aug-19 | | | 3 | Jul-19 | 17 | | | 0 | 5 | Aug-18 to Aug-19 |
| Serious Harms: Infections: Clostridium Difficile Lapses in Care | 0 | 1 | Jul-19 | | | 1 | Jun-19 | 4 | | | 0 | 1 | Aug-18 to Jul-19 |
| Community: % IAPT Patients beginning treatment within 6 weeks | 75.0% | 96.74% | Jul-19 | | | 97.46% | Jun-19 | 97.32% | | | 96.74% | 97.67% | Apr-19 to Jul-19 |
| Community: % IAPT Patients beginning treatment within 18 weeks | 95.0% | 100.00% | Jul-19 | | | 100.00% | Jun-19 | 100.00% | | | 100.00% | 100.00% | Apr-19 to Jul-19 |

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

# Finance Report

## Month 05 ending 31st August 2019

The WWL Way

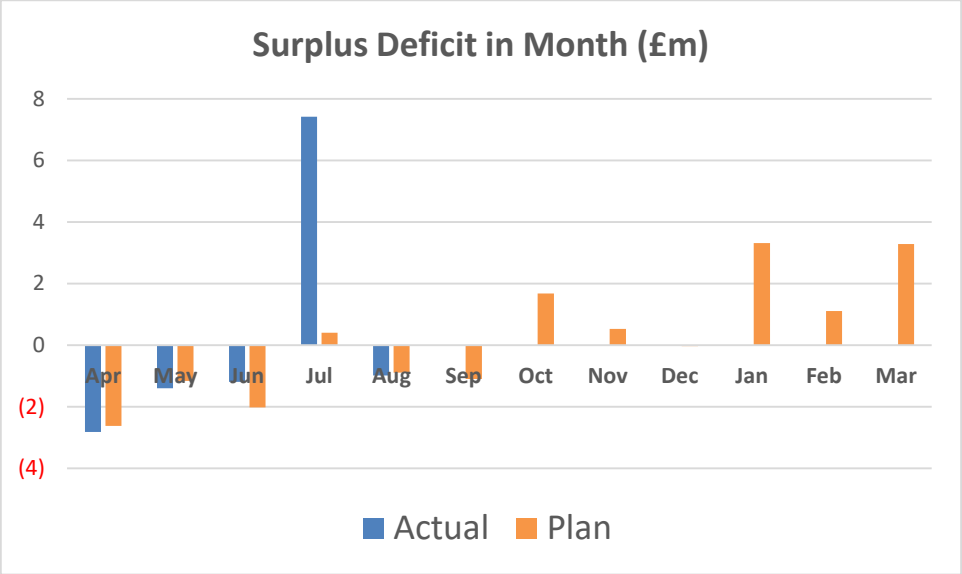
# Contents

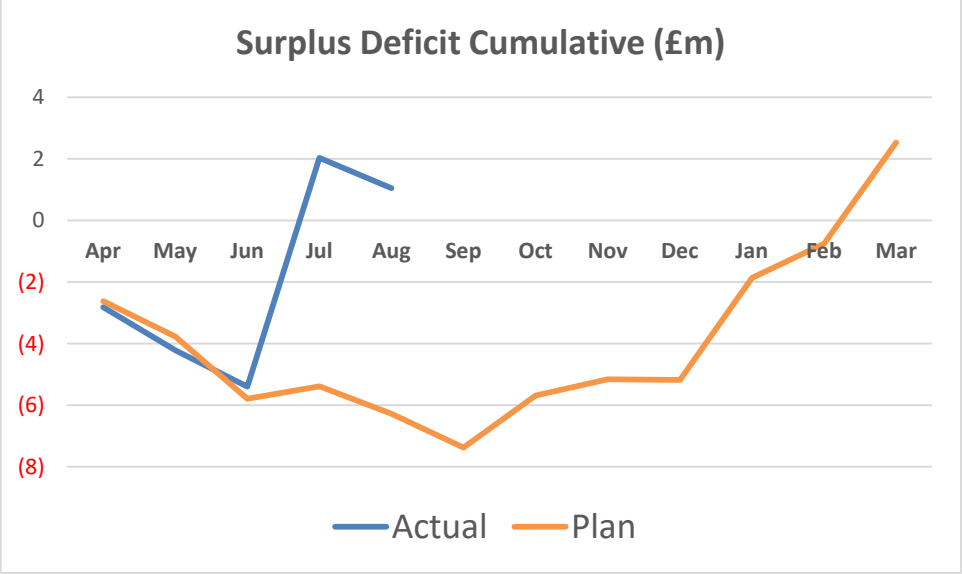
## Performance on a Page

| | In Month | | | Year to Date | | |
|---|---|---|---|---|---|---|
| | Actual £000's | Plan £000's | Var £000's | Actual £000's | Plan £000's | Var £000's |
| Income | 29,626 | 30,349 | (723) | 149,211 | 150,277 | (1,066) |
| Expenditure | (29,561) | (30,239) | (678) | (151,068) | (151,575) | 507 |
| Surplus / Deficit | (980) | (885) | (95) | 1,048 | (6,273) | 7,321 |
| Cash Balance | 51,201 | 15,004 | 36,197 | 51,201 | 15,004 | 36,197 |
| Capital Spend | 186 | 1,209 | 1,023 | 3,001 | 5,238 | 2,237 |
| UOR | 3 | 3 | 0 | 3 | 3 | 0 |

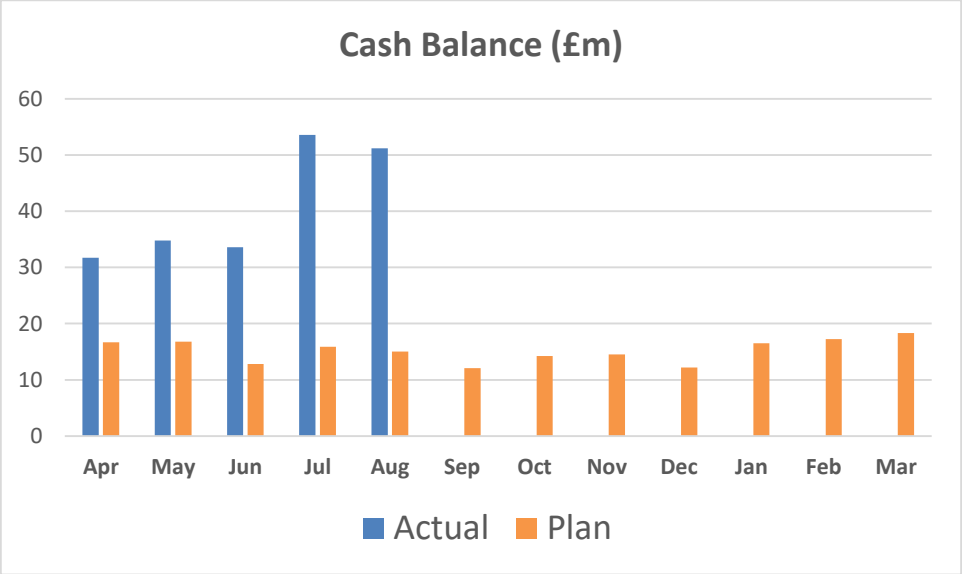
- Trust reporting a £1.0m surplus year to date which is £7.3m better than plan. This includes £7.9m for transfer of assets from Bridgewater Community Services to the Trust following completion of the business transfer agreement. This is a non-trading transaction therefore the underlying trading position year to date is a £6.9m deficit.
- Cash is £36.2m better than plan.
- Capital is underspent by £2.2m.

## Surplus Deficit

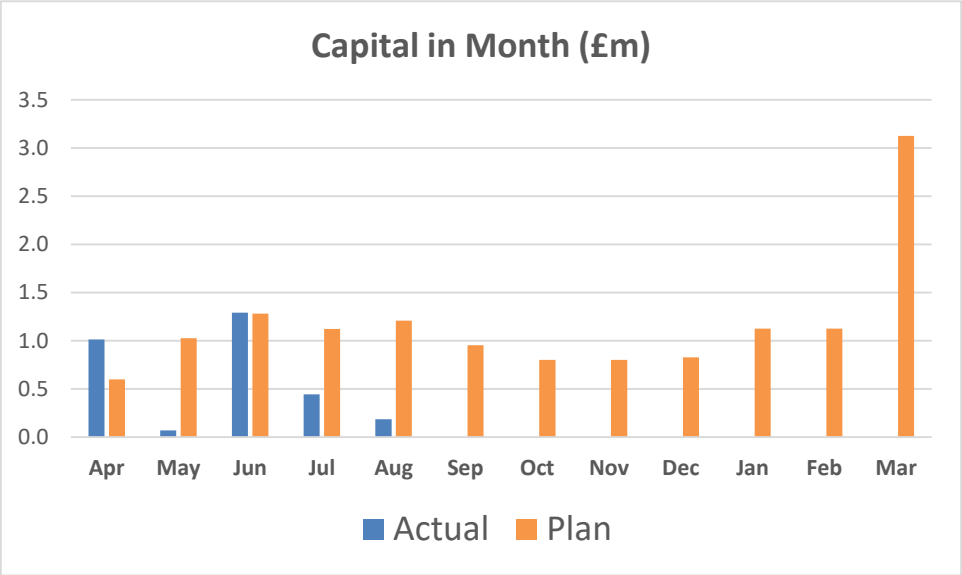


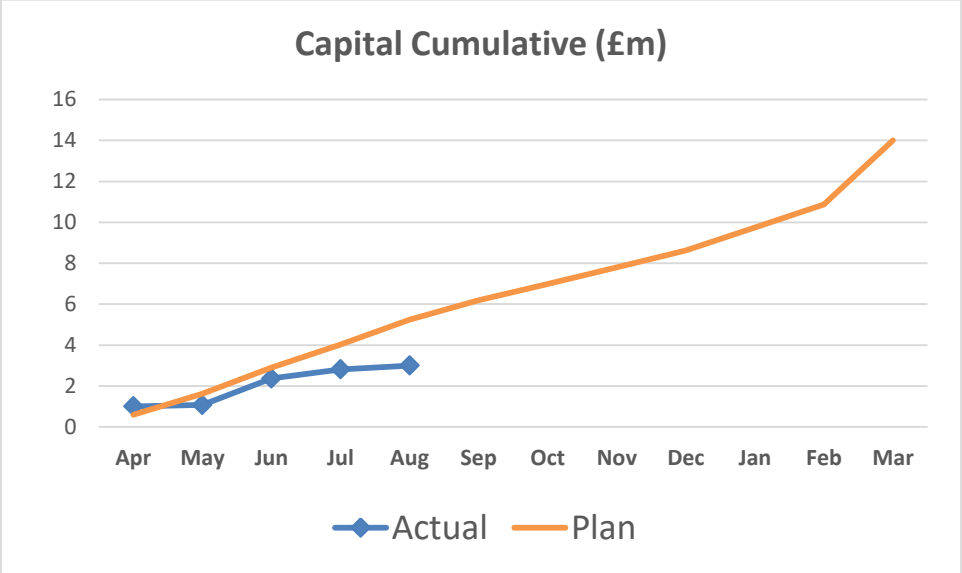



## Cash Balance



## Capital Spend



# REPORT

**AGENDA ITEM: 7.4**

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **To:** | Trust Board | **Date:** | |
| **Subject:** | Safe Staffing Report | | |
| **Presented by:** | Allison Edis | **Purpose:** | Information and assurance |

## Executive summary

This report is provided to the Board to provide assurance of the ongoing monitoring of nurse staffing levels across inpatient areas.

The Board are asked to note;

- The ongoing risks associated with high vacancy rates across the nursing workforce
- The incidence of harm reported linked to nurse staffing levels and skill mix within Scheduled Care; this is more apparent with pressure ulcers and a Trust wide improvement plan is being developed
- The increase in red flags associated with delays in administration of pain relief
- Positive progress made with Health Visitor recruitment
- The positive benchmarked position of CHPPD and nurse staffing costs with both peers and nationally
- The continued progress to embed SafeCare, reporting of red flag incidents and use of redeployment functions on the system.

## Risks associated with this report

Staffing levels and skill mix remain a concern across clinical divisions with individual wards being noted on the Corporate Risk Register.

Nurse Staffing remains the biggest risk on the risk register.

Risks reported with respect to vacancies within District Nursing Services and concerns raised relating to caseload and skill mix.

Increase in the number of red metrics for staffing at night which suggest non-adherence to the e roster policy.

The lack of triangulation of red metrics for staff fill rates and red flags reported by the ward teams

The WWL Way

| Link(s) to The WWL Way 4wards | | | |
|---|---|---|---|
| ☒ | Patients | ☒ | Performance |
| ☒ | People | ☒ | Partnerships |

Wrightington, Wigan and Leigh NHS
NHS Foundation Trust

**Safe Staffing Report – July/August 2019**

## 1.0 INTRODUCTION

This report provides a monthly summary of Nurse Staffing on all in-patient wards across the Trust. It includes exception reports related to nurse staffing levels, related incidents and red flags which are then triangulated with a range of quality indicators.

## 2.0 SAFER STAFFING EXCEPTION REPORT

The nurse staffing exception report (Appendix1), provides the established versus actual fill rates on a ward by ward basis. Fill rates are RAG rated with supporting narrative by exception, and a number of related factors are displayed alongside the fill rates to provide an overall picture of safe staffing.

- Sickness rate and Vacancy rate are the two main factors that affect fill rates.
- Datix incident submissions related to staffing and Red Flags are monitored on a daily basis to act as an early warning system and inform future planning.
- Nurse Sensitive Indicators demonstrate the outcome for patients by measuring harm.
    - Cases of Clostridium Difficile (CDT);
    - Pressure Ulcers Grade 1&2 / Grade 3&4;
    - *Falls resulting in physical harm / not resulting in physical harm;
    - *Medication administration errors resulting in harm / not resulting in harm.

  (*All incidents displayed by: those that resulted in moderate and severe harm / resulted in minor or no harm)
- The impact of Nurse staffing on Patients' Experience can be demonstrated by two specific questions from the monthly Real Time Patient Experience Survey. The NICE guidance on safe staffing in hospitals suggests using a number of questions in the form of a patient experience survey. For some of the NICE questions the trust has an equivalent question, or proxy question within the monthly Real Time Patient Experience survey or Always Events Survey, with the two questions matching most closely featuring in this report.

## 3.0 CURRENT POSITION – JULY AND AUGUST

The overall fill rate for registered nurses for July was 90.3% and 89.52% in August resulting in an amber rating for staffing for the Trust collectively.

Appendix 2 Table 1 indicates a reduction in the number of areas flagging red for registered nurse fill rates from the previous month. The pattern of red rated areas has, however, continued to increase for night shifts and this continues to be most prevalent in Scheduled Care.

Appendix 2, Table 2 provides details of the vacancies within the inpatient wards for July and August and vacancies for Community Services in August. Community figures include vacancies for nursing and Allied Health Professionals in both published figures. Particular areas of note are Rainbow Ward with 11.84 WTE registered vacancies; 6.64WTE have been recruited and will commence in post in September. Throughout July and August bed capacity was reduced, when needed, to ensure safe staffing within the unit. Within Scheduled Care there continues to be high levels of vacancies within the Cardio-respiratory Unit, Pemberton and Shevington Wards and the Division is continuing to review alternative workforce models to support the needs of the patients. Within the community division incidents have been reported raising concerns with respect to caseload size for the district nursing team. There are currently 17.22 WTE registered nurse vacancies across the District Nursing teams, 6.0 WTE of these are currently in the recruitment process. Work has commenced to ensure there is process in place clearly identifying appropriate District Nurse Caseloads taking into account the complexity of the patients. The previously reported 11.03 Health Visitor vacancies have been recruited to and are awaiting start dates.

All wards are currently utilising SafeCare although further work is required to ensure data is captured as required, cascade training is completed and full functionality of the system is utilised. For the time period of the report the redeployment function was used to record the movement of staff to support patient need (116 staff moves July and 123 staff moves in August). It should be noted that the majority of these moves were recorded by staff in specialist services and reflect movement of staff between inpatient and day case areas on the Wrightington Site.

The number of red flags reported within acute inpatient areas (Table 4) has fallen for the reporting period despite as indicated in Appendix 1. The majority of the red flags are associated with a shortfall of registered nurses within a clinical area; this shortfall is linked to predominantly to vacancies, sickness and maternity leave. There continue to be reports of red flags raised relating to delays in the administration of pain relief. This is directly linked to the transfer of some analgesics to controlled medication to enable closer monitoring of use across clinical areas. There have been 14 red flags raised in both months where there have been less than 2 registered nurses available.

A eeview of quality metrics and the areas of high vacancies show that on Rainbow Ward no harm has been reported relating to staffing levels. There continues to be reported avoidable harms with respect to pressure ulcers within Scheduled Care in the Division of Medicine. There is some triangulation of incidents with shortfalls in registered nurse staffing. All the pressure ulcers have been escalated onto StEIS and will be subject to concise investigation in accordance with Trust processes. There have been some improvements in patient experience scores in this reporting period however there continue to be 3 areas with red metrics relating to the management of pain; these metrics are being monitored by the divisions and it is anticipated that this situation will improve in the September report.

Table 6 provides information from the Model Hospital for May 2019 with respect to Care Hours per Patient Day (CHPPD) and Nursing Costs. In accordance with NHSI requirements the external reporting of fill rates for registered and unregistered nursing staff has ceased and CHPPD only is being utilised as a comparator for benchmarking purposes. The Trust continues to compare favourably for CHPPD against peers and national benchmarking data, however when considering registered nurse CHPPD this stands at 4.5 against a national average of 4.8.

The overall cost of nursing staff also compares favourably. The Board should note, however, that this cost reduction is likely to be associated with the difficulties filling registered posts and an over reliance on unregistered staff to provide adequate nursing numbers to provide direct care.

The staff incentive scheme to support registered nurse vacancies ends at the end of August. Divisions are continuing to progress plans with alternative workforce models to ensure appropriate skill mix and care is maintained within clinical areas.

The Trust has been accepted onto the NHSI Retention Programme and will be attending the first meeting in September 2019. A full review will be undertaken in September.

**4.0 ACTIONS BEING TAKEN**

Further scrutiny of rosters is required to ensure adequate skill mix and cover during night shifts, and to ensure that the roster policy is adhered to. Check and challenge sessions will be commencing in September

Introduction of safer staffing huddle in September to review planned versus actual staffing levels and proactive planning utilising Safecare in real time led by the Deputy Chief Nurse which aims to improve real time use of the system and embed into daily practices

Work has commenced to receive and scrutinise rapid reviews where there have been red flags raised relating to less than 2 registered staff being on duty in a ward; this will be linked to the daily staffing huddle to ensure a proactive approach to staffing is taken.

A Task and Finish Group was commissioned in July 2019 to develop an integrated plan to address the learning from pressures ulcers across the acute and community division. This is scheduled to be presented to Quality and Safety Committee in September 2019.

Pain management; the pilot utilising the pharmacy technician has commenced on MAU. Additional technicians have been recruited and are awaiting a start date. Evaluation of the project to date is favourable and it is likely that this model will be rolled out.

Plans to review and amend the nurse staffing escalation policy to ensure that community staffing levels are incorporated into the overall staff management plans.

**5.0 SUMMARY**

The Trust continues to compare favourably for overall CHPPD and for nursing and midwifery staffing costs, however if registered staffing CHPPD is considered performance is reversed.

The reporting of red flags within nursing continues to provide evidence of pressures within the core wards on the acute site. Further work is required with the redeployment element of SafeCare to provide assurance to the Board that this risk is being mitigated by the movement of staff in accordance to need and to provide assurance that staff movement is responsive to patient need.

There are high vacancy rates within the Division of Medicine, particularly within Scheduled Care.

Harms have been reported in Scheduled Care on the wards where fill rates for registered nurses are low and there remain concerns with respect to skill mix and supervision of unregistered staff which are being addressed within the Division and overseen corporately.

Further scrutiny of roster practices is required to improve the number of red rated areas for registered staffing at night.

**6.0 RECOMMENDATIONS**

The Board is asked to receive the paper for information and assurance.

**Allison Luxon: Deputy Chief Nurse**

# Appendix 1
# SAFE STAFFING EXCEPTION REPORT – July 2019

## Division of Medicine – Scheduled Care

| | Average Fill Rates (%) & CHPPD | | | | | | Staff Availability | | Staff Experience | Nurse Sensitive Indicators | | | | Patient Experience % (Number surveyed) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | RN / RM | | | CSW | | | | | | | | | | | |
| Ward | Day shift (%) | Night shift (%) | CHPPD | Day shift (%) | Night shift (%) | CHPPD | Sickness (%) | Vacancies (%) | Datix Incidents - related to staffing/Red Flags | CDT | Falls (Harm / No Harm) | PU (Grade 1&2 / Grade 3 & 4) | Drug Admin Errors (Harm / No Harm) | Do you think the hospital staff did everything they could do to control your pain? | Have you been given the care you felt you required when you needed it most? |
| Acute Stroke Unit | 87.0% | 100.0% | 3.1 | 157.6% | 135.8% | 6.7 | 1.74% | 8.83% | 4 | 1 | 1/3 | | | 100.00% | 100.00% |
| Cardio and Respiratory | 87.7% | 69.8% | 2.5 | 108.7% | 106.2% | 4.1 | 8.01% | 10.81% | 12 | | 0/2 | 0/1 | 0/1 | 96.20% | 92.59% |
| Coronary Care Unit | 102.0% | 97.6% | 9.0 | 123.0% | | 3.3 | 3.68% | 5.03% | 3 | | 0/1 | | | 100.00% | 100.00% |
| Elderly Care Unit | 94.0% | 101.5% | 2.5 | 138.3% | 143.2% | 5.6 | 5.48% | 7.02% | seven | | 0/10 | 1/2 | | 85.70% | 100.00% |
| Highfield | 90.6% | 55.5% | 3.9 | 109.9% | 96.7% | 5.5 | | | 6 | | 0/2 | 0/1 | | | |
| Pemberton | 82.3% | 100.1% | 4.4 | 130.2% | 117.7% | 4.8 | 8.42% | 21.14% | 4 | 1 | 0/3 | | 0/1 | | |
| Shevington | 90.6% | 72.8% | 2.5 | 110.6% | 139.7% | 4.3 | 4.51% | 18.07% | 5 | | 1/3 | | 1/1 | 100.00% | 100.00% |
| Taylor Unit | | | | | | | | | | | | | | | |

## Division of Medicine – Unscheduled Care

| | Average Fill Rates (%) & CHPPD | | | | | | Staff Availability | | Staff Experience | Nurse Sensitive Indicators | | | | Patient Experience % (Number surveyed) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | RN / RM | | | CSW | | | | | | | | | | | |
| Ward | Day shift (%) | Night shift (%) | CHPPD | Day shift (%) | Night shift (%) | CHPPD | Sickness (%) | Vacancies (%) | Datix Incidents - related to staffing/Red Flags | CDT | Falls (Harm / No Harm) | PU (Grade 1&2 / Grade 3 & 4) | Drug Admin Errors (Harm / No Harm) | Do you think the hospital staff did everything they could do to control your pain? | Have you been given the care you felt you required when you needed it most? |
| A&E Emg Care | 97.7% | 103.4% | | 89.6% | 162.4% | | 2.75% | 15.97% | 0 | | 0/2 | | 0/3 | | |
| A&E Paeds | 81.0% | 122.3% | | | | | 1.74% | 13.95% | 0 | | | | 0/1 | | |
| CDW | 86.1% | 95.8% | | 97.3% | 137.9% | | 5.79% | 12.60% | 5 | | | | | 66.70% | 100.00% |
| Medical Assessment Unit | 93.2% | 91.0% | | 93.0% | 102.0% | | 7.37% | 6.93% | 51 | | 1/11 | | 0/3 | 100.00% | 100.00% |

## Division of Surgery

| | Average Fill Rates (%) & CHPPD | | | | | | Staff Availability | | Staff Experience | Nurse Sensitive Indicators | | | | Patient Experience % (Number surveyed) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | RN / RM | | | CSW | | | | | | | | | | | |
| Ward | Day shift (%) | Night shift (%) | CHPPD | Day shift (%) | Night shift (%) | CHPPD | Sickness (%) | Vacancies (%) | Datix Incidents - related to staffing/Red Flags | CDT | Falls (Harm / No Harm) | PU (Grade 1&2 / Grade 3 & 4) | Drug Admin Errors (Harm / No Harm) | Do you think the hospital staff did everything they could do to control your pain? | Have you been given the care you felt you required when you needed it most? |
| ICU/HDU | 85.2% | 82.9% | 34.3 | 91.3% | | 5.2 | 7.27% | 1.55% | 29 | | | | 0/2 | | |
| Langtree | 84.4% | 100.0% | 2.5 | 120.6% | 163.6% | 3.2 | 1.98% | 7.93% | 8 | | 1/6 | | 0/2 | 77.80% | 100.00% |
| Orrell | 100.8% | 102.4% | 4.4 | 127.2% | 168.7% | 5.5 | 2.79% | 0.88% | 4 | | 0/2 | | 0/3 | 90.00% | 100.00% |
| Swinley | 98.6% | 108.3% | 2.8 | 96.3% | 104.2% | 2.4 | 6.67% | 1.79% | 7 | | 0/1 | | 0/1 | 90.00% | 100.00% |
| Maternity Unit | 98.1% | 94.1% | 12.5 | 74.4% | 96.3% | 3.5 | 3.47% | 0.00% | 1 | | | | | 100.00% | 100.00% |
| Neonatal Unit | 91.2% | 100.0% | 12.8 | 100.0% | | 2.2 | 2.06% | 8.08% | 0 | | | | | 100.00% | 100.00% |
| Rainbow | 90.6% | 76.5% | 10.8 | 100.2% | 91.8% | 4.6 | 8.42% | 16.06% | 14 | 1 | | | 0/1 | 100.00% | 100.00% |

Rainbow ward: During the reporting period safe staffing has been maintained within the framework set out in the Standard Operational Procedures for the safe running of Rainbow ward and Escalation procedure.

## Division of Specialist Services

| | Average Fill Rates (%) & CHPPD | | | | | | Staff Availability | | Staff Experience | Nurse Sensitive Indicators | | | | Patient Experience % (Number surveyed) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | RN / RM | | | CSW | | | | | | | | | | | |
| Ward | Day shift (%) | Night shift (%) | CHPPD | Day shift (%) | Night shift (%) | CHPPD | Sickness (%) | Vacancies (%) | Datix Incidents - related to staffing/Red Flags | CDT | Falls (Harm / No Harm) | PU (Grade 1&2 / Grade 3 & 4) | Drug Admin Errors (Harm / No Harm) | Do you think the hospital staff did everything they could do to control your pain? | Have you been given the care you felt you required when you needed it most? |
| Aspull | 105.2% | 69.8% | 3.1 | 134.9% | 180.5% | 4.97 | 6.21% | 11.24% | 556 | | 0/1 | | | 100.00% | 100.00% |
| Ward A | 104.9% | 79.0% | 3.7 | 82.8% | 98.1% | 3.44 | 15.16% | 8.08% | 2 | | | | | 100.00% | 100.00% |
| Ward B | 93.7% | 97.6% | 4.1 | 95.5% | 96.6% | 4.45 | 4.96% | 4.88% | 0 | | | | 0/1 | 100.00% | 100.00% |
| JCW | 82.3% | 82.3% | 5.8 | 78.4% | 77.4% | 3.30 | 0.43% | 6.53% | 0 | | 0/1 | | | | |

# SAFE STAFFING EXCEPTION REPORT – August 2019

**Division of Medicine – Scheduled Care**

| | Average Fill Rates (%) & CHPPD | | | | | | Staff Availability | | Staff Experience | Nurse Sensitive Indicators | | | | Patient Experience % (Number surveyed) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | RN / RM | | | CSW | | | | | | | | | | | |
| Ward | Day shift (%) | Night shift (%) | CHPPD | Day shift (%) | Night shift (%) | CHPPD | Sickness (%) | Vacancies (%) | Datix Incidents - related to staffing/Red Flags | CDT | Falls (Harm / No Harm) | PU (Grade 1&2 / Grade 3 & 4) | Drug Admin Errors (Harm / No Harm) | Do you think the hospital staff did everything they could do to control your pain? | Have you been given the care you felt you required when you needed it most? |
| Acute Stroke Unit | 96.1% | 94.5% | 3.0 | 139.5% | 130.2% | 6.1 | 7.77% | 9.56% | 3 | 1 | 0/2 | | 0/2 | 100.00% | 100.00% |
| Cardio and Respiratory | 92.2% | 69.4% | 2.5 | 119.1% | 134.7% | 4.7 | 7.57% | 9.76% | 10 | | 0/5 | 1/1 | 0/2 | 100.00% | 95.00% |
| Coronary Care Unit | 99.1% | 99.3% | 7.3 | 161.8% | | 3.2 | 3.86% | 5.03% | 4 | | 0/1 | | | 100.00% | 100.00% |
| Elderly Care Unit | 93.8% | 98.9% | 2.5 | 119.6% | 122.4% | 4.8 | 6.90% | 6.40% | two | | 0/5 | 0/1 | 0/4 | 67.00% | 100.00% |
| Highfield | 111.3% | 49.3% | 3.9 | 127.6% | 103.6% | 5.8 | 0.0% | 0.0% | 2 | 1 | | 1/0 | | | |
| Pemberton | 74.8% | 100.8% | 4.4 | 121.5% | 101.8% | 4.6 | 2.73% | 24.30% | 0 | | 0/3 | | 0/1 | | |
| Shevington | 75.4% | 72.0% | 2.2 | 131.4% | 147.0% | 4.8 | 3.29% | 15.70% | 3 | | | | 0/1 | 90.91% | 100.00% |
| Taylor Unit | | | | | | | | | | | | | | | |

**Division of Medicine – Unscheduled Care**

| | Average Fill Rates (%) & CHPPD | | | | | | Staff Availability | | Staff Experience | Nurse Sensitive Indicators | | | | Patient Experience % (Number surveyed) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | RN / RM | | | CSW | | | | | | | | | | | |
| Ward | Day shift (%) | Night shift (%) | CHPPD | Day shift (%) | Night shift (%) | CHPPD | Sickness (%) | Vacancies (%) | Datix Incidents - related to staffing/Red Flags | CDT | Falls (Harm / No Harm) | PU (Grade 1&2 / Grade 3 & 4) | Drug Admin Errors (Harm / No Harm) | Do you think the hospital staff did everything they could do to control your pain? | Have you been given the care you felt you required when you needed it most? |
| A&E Emg Care | 85.5% | 92.5% | | 106.1% | 179.3% | | 3.43% | 15.97% | 0 | | 0/1 | | 0/1 | | |
| A&E Paeds | 85.7% | 98.8% | | | | | 2.34% | 13.95% | 0 | | | | | | |
| CDW | 88.2% | 97.5% | | 98.0% | 109.0% | | 8.87% | 12.60% | 1 | | | | | 85.71% | 100.00% |
| Medical Assessment Unit | 80.8% | 87.3% | | 113.1% | 130.2% | | 7.37% | 5.80% | 46 | | 0/15 | | 0/5 | 81.25% | 100.00% |

**Division of Surgery**

| | Average Fill Rates (%) & CHPPD | | | | | | Staff Availability | | Staff Experience | Nurse Sensitive Indicators | | | | Patient Experience % (Number surveyed) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | RN / RM | | | CSW | | | | | | | | | | | |
| Ward | Day shift (%) | Night shift (%) | CHPPD | Day shift (%) | Night shift (%) | CHPPD | Sickness (%) | Vacancies (%) | Datix Incidents - related to staffing/Red Flags | CDT | Falls (Harm / No Harm) | PU (Grade 1&2 / Grade 3 & 4) | Drug Admin Errors (Harm / No Harm) | Do you think the hospital staff did everything they could do to control your pain? | Have you been given the care you felt you required when you needed it most? |
| ICU/HDU | 83.5% | 82.4% | 27.6 | 79.0% | | 3.0 | 10.75% | 3.50% | 10 | | 0/1 | 2/0 | 0/3 | | |
| Langtree | 86.6% | 98.4% | 2.5 | 110.7% | 126.7% | 2.7 | 0.75% | 9.87% | 0 | | 0/1 | | | 100.00% | 100.00% |
| Orrell | 112.8% | 100.0% | 4.2 | 124.9% | 191.9% | 5.5 | 5.18% | 0.88% | 25 | | 0/2 | 1/0 | 0/1 | 85.71% | 100.00% |
| Swinley | 98.9% | 107.1% | 2.7 | 100.6% | 99.5% | 2.5 | 6.97% | 1.78% | 22 | | 0/4 | | 0/1 | 88.89% | 89.89% |
| Maternity Unit | 102.8% | 96.0% | 13.6 | 74.2% | 96.4% | 3.7 | 3.02% | 3.66% | | | | | | 88.89% | 88.89% |
| Neonatal Unit | 87.5% | 100.0% | 17.9 | 97.3% | | 2.4 | 6.34% | 8.68% | 0 | | | | | 100.00% | 0.00% |
| Rainbow | 83.8% | 77.5% | 11.2 | 110.2% | 77.4% | 4.8 | 8.97% | 17.87% | 4 | | | | | 100.00% | 100.00% |

**Division of Specialist Services**

| | Average Fill Rates (%) & CHPPD | | | | | | Staff Availability | | Staff Experience | Nurse Sensitive Indicators | | | | Patient Experience % (Number surveyed) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | RN / RM | | | CSW | | | | | | | | | | | |
| Ward | Day shift (%) | Night shift (%) | CHPPD | Day shift (%) | Night shift (%) | CHPPD | Sickness (%) | Vacancies (%) | Datix Incidents - related to staffing/Red Flags | CDT | Falls (Harm / No Harm) | PU (Grade 1&2 / Grade 3 & 4) | Drug Admin Errors (Harm / No Harm) | Do you think the hospital staff did everything they could do to control your pain? | Have you been given the care you felt you required when you needed it most? |
| Aspull | 86.2% | 70.7% | 2.5 | 154.7% | 183.4% | 5.26 | 5.02% | 8.48% | 38 | | 0/3 | | | 90.91% | 81.82% |
| Ward A | 103.5% | 75.8% | 3.3 | 96.4% | 105.5% | 3.82 | 11.85% | 5.53% | 1 | | | | | 83.33% | 100.00% |
| Ward B | 86.7% | 82.3% | 4.8 | 84.8% | 76.3% | 4.85 | 7.29% | 5.00% | 0 | | | | | 100.00% | 100.00% |
| JCW | 91.7% | 85.8% | 5.7 | 72.6% | 90.3% | 3.02 | 4.44% | 6.53% | 0 | | | | | | |

| | |
|---|---|
| | <=84% |
| | 85 - 94% |
| | 95 - 119% |
| | >=120% |

**Appendix 2**

| | June 2019 | | July 2019 | | August 2019 | |
|---|---|---|---|---|---|---|
| No of areas | Red Metrics Registered Staff Days | Red Metrics Registered Staff Nights | Red Metrics Registered Staff Days | Red Metrics Registered Staff Nights | Red Metrics Registered Staff Days | Red Metrics Registered Staff Nights |
| 24 | 4 | 8 | 4 | 8 | 5 | 8 |

*Table 1. Red Metrics June 2019/August 2019*

| | June 2019 | | July 2019 | | August 2019 | |
|---|---|---|---|---|---|---|
| Specialty | Qualified | Unqualified | Qualified | Unqualified | Qualified | Unqualified |
| Medicine | 44.86 | 12.61 | 33.72 | 7.16 | 41.21 | 6.91 |
| Surgery | 23.76 | 2.36 | 32.34 | 1.76 | 35.43 | 2.0 |
| Specialist Services | 14.52 | 5.77 | 34.87 | 6.62 | 15.10 | 8.6 |
| Community Services Adult | No data | No data | No data | No data | 56.75 | 12.19 |
| Community Services Children | 14.67 | 2.74 | No data | No data | 29.88 | 5.26 |
| **Total** | | | | | **186.37** | **34.96** |

*Table 2. Nurse Vacancies June/July/August 2019 by Division*

| Month | Qualified WTE | Unqualified WTE |
|---|---|---|
| April 18 | 48.38 | 9.39 |
| May 2018 | 55.94 | 13.03 |
| June 2018 | 49.21 | 13.15 |
| July 2018 | 59.44 | 10.48 |
| August 2018 | 56.89 | 12.89 |
| September 2018 | 50.78 | 8.37 |
| October 2018 | 51.88 | 9.643 |
| November 2018 | 67.28 | 14.83 |
| December 2018 | 64.71 | 15.47 |
| January 2019 | 70.36 | 7.3 |
| February 2019 | 62.49 | 7.3 |
| March 2019 | 87.17 | 16.68 |
| April 2019 | 160.11 | 23.32 |
| May 2019 | 149.41 | 22.86 |
| June 2019 | 97.81* | |

*Table 3. Nurse Vacancies April 2018 – June 2019; *Adult community figures not included within June report (Trust Wide)*

| **Red Flag Category** | **No. of Incidents July 2019** | **No. of Incidents August 2019** |
|---|---|---|
| Shortfall of more than 8 hours or 25% of registered nurses in a shift | 161 | 99 |
| Delay of 30 minutes or more for the administration of pain relief | 40 | 54 |
| Delay or omission of intentional rounding | 1 | 0 |
| Less than 2 registered nurses on shift | 14 | 14 |
| Vital signs not assessed or recorded as planned | 1 | 6 |
| Unplanned omission of medication | 1 | 2 |
| **Total** | **217** | **171** |

*Table 4. Nursing Red Flags July/August 2019*

| Red Flag Category | No. of Incidents July 2019 | No. of Incidents August 2019 |
|---|---|---|
| Unit on Divert | 0 | 0 |
| Co-Ordinator Unable to Remain Super-numerary | 0 | 0 |
| Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing) | 1 | 1 |
| Delay of 30 or more between presentation and triage | 0 | 0 |
| Delay of 2 hours or more between admission for induction and beginning of process | 0 | 0 |
| Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour | 0 | 0 |
| **Total** | **1** | **1** |

*Table 5. Maternity Red Flags July/August 2019*

| Money & Resources | Data period | Trust value | Peer median | National median | Chart | Actions |
|---|---|---|---|---|---|---|
| Cost per WAU - Substantive Nursing & Midwifery Staff | 2017/18 | £880 | £750 | £710 | | |
| Total Nursing & Midwifery FTE | 2017/18 | 2,096.0 | 2,629.8 | 2,096.6 | | |
| Care Hours per Patient Day - Total Nursing & Midwifery Staff | May 2019 | 9.0 | 8.8 | 8.1 | | |
| Cost per Care Hour - Total Nursing & Midwifery Staff | Mar 2019 | £20.64 | £23.60 | £23.65 | | |
| Cost per Patient Day - Total Nursing & Midwifery Staff | Mar 2019 | £174.38 | £195.28 | £189.65 | | |
| Average Staff Cost - All Nursing & Midwifery Staff | 2017/18 | £37,456 | £39,233 | £39,279 | | |

*Table 6.Use of Resources May 2019 (Source Model Hospital)*

## Partnerships:
## We work together for the best patient outcomes

| | | | | | |
|---|---|---|---|---|---|
| **Executive lead(s):** | Director of Strategy and Planning | **Reviewing committee:** | Board of Directors | **DELIVERY CONFIDENCE** | **WEIGHTED DASHBOARD** |
| **Strategic importance:** | Effective partnership working underpins our strategic direction | | | | **MONTH:** 2.88 **YTD:** 3.16 |
| **Sources of assurance:** | ▪ Scrutiny by committee<br>▪ Scrutiny by Board of Directors<br>▪ Use of internal and external auditors | ▪ Escalation of emerging risks<br>▪ Exec-to-exec meetings<br>▪ REMC | | **ROLLING TREND:** Jul 2019, May 2019, Apr 2019, Mar 2019 | **ROLLING TREND:** 2.96 (Jul 2019), 3.08 (May 2019), 2.92 (Apr 2019), 2.92 (Mar 2019) |

| Individual risks | Original Score | Mitigations | Current score |
|---|---|---|---|
| Lack of Tier 4 CAMHS beds | 16 | Escalated to Q&S in June 2019 | 20 |
| Non-achievement of KPIs relating to cellular pathology | 16 | Shared Services Board re-established. A recovery plan has been agreed to create additional capacity. | 16 |
| High proportion of non-compliant SLAs | 20 | SLA database in place. Performance improved and MIAA audit planned. | 15 |

## NARRATIVE

Delivery confidence remains as last month at amber-red. The community services transfer is now supported by a signed Business Transfer Agreement and the IT SLA is virtually complete but financial pressures remain. Re-engagement with Bolton on a strategic alliance has taken place. Concerns about the ISC (Theme 3) impact on Wigan have been raised, particularly in terms of hollowing out DGH services and a Wigan option still remains on the table for breast services. Executive Programme Oversight Board (EPOG) established for NW sector collaboration.

## PARTNERSHIPS: WEIGHTED DASHBOARD

| Performance | Measure | Result | 1 (Green) | 2 (Amber-Green) | 3 (Amber) | 4 (Amber-Red) | 5 (Red) | Weight | Month | Year | Source |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Transformation | Support to BIG projects | Fully provided | Fully provided | Mostly provided | Mild problems | Moderate problems | Major problems | 2 | 1 x 2 = 2 | 1 x 2 = 2 | Self-assessment |
| Research | Numbers recruited against target | Target complete | Target complete | Ahead of target | On track | Off target | Way off target | 1 | 1 x 1 = 1 | 1 x 1 = 1 | R&D report |
| Bolton partnership | Progress on 8 key projects | Mod. concern | Fully on track | Almost on track | Mild concerns | Moderate concerns | Major concerns | 3 | 4 x 3 = 12 | 4 x 3 = 12 | Self-assessment |
| Locality partnership | Locality plan performance matrix | Mild concerns | Fully on track | Almost on track | Mild concerns | Moderate concerns | Major concerns | 2 | 3 x 2 = 6 | 3 x 2 = 6 | Self-assessment |
| Locality partnership | Transformation of hospital care | Almost on track | Fully on track | Almost on track | Mild concerns | Moderate concerns | Major concerns | 3 | 2 x 3 = 6 | 3 x 3 = 9 | Self-assessment |
| Locality partnership | Healthier Wigan partnership score | Almost on track | Fully on track | Almost on track | Mild concerns | Moderate concerns | Major concerns | 2 | 2 x 2 = 4 | 4 x 2 = 8 | Self-assessment |
| Locality partnership | Community services transfer | Mild concerns | Fully on track | Almost on track | Mild concerns | Moderate concerns | Major concerns | 3 | 3 x 3 = 9 | 4 x 3 = 12 | Self-assessment |
| NW Sector p/ship | Highlight report for NWSP | Mod. concerns | Fully on track | Almost on track | Mild concerns | Moderate concerns | Major concerns | 1 | 4 x 1 = 4 | 4 x 1 = 4 | Self-assessment |
| GM partnership | Combined theme 3 status | Mod. concerns | Fully on track | Almost on track | Mild concerns | Moderate concerns | Major concerns | 2 | 4 x 2 = 8 | 4 x 2 = 8 | Self-assessment |
| GM partnership | Orthopaedic theme 3 status | Fully on track | Fully on track | Almost on track | Mild concerns | Moderate concerns | Major concerns | 3 | 1 x 3 = 3 | 1 x 3 = 3 | Self-assessment |
| GM partnership | Cardiology theme 3 status | Almost on track | Fully on track | Almost on track | Mild concerns | Moderate concerns | Major concerns | 2 | 2 x 3 = 6 | 2 x 3 = 6 | Self-assessment |
| SLAs | Compliance | 55% | >95% | 95-80% | 80-60% | 60-40% | <40% | 2 | 4 x 2 = 8 | 4 x 2 = 8 | SLA database |
| Total | | | | | | | | 24 | 69/24 | 79/25 | |
| Average | | | | | | | | | **2.88** | **3.16** | |

## Performance:
## We aim to be in the top 10%

| | | | | | |
|---|---|---|---|---|---|
| **Executive lead(s):** | Chief Operating Officer<br>Director of Finance & Informatics | **Reviewing committee:** | Finance and Performance Committee | **DELIVERY CONFIDENCE** | **WEIGHTED DASHBOARD** |
| **Strategic importance:** | Delivery of operational and finance performance underpins clinical care, facilitates the patient journey and enhances the patient experience, and affects the organisation's financial performance. | | |  | **MONTH:** 3.04 **YTD:** 2.74 |
| **Sources of assurance:** | ▪ Scrutiny by Finance and Performance Committee<br>▪ Scrutiny by Board of Directors<br>▪ Use of internal and external auditors<br>▪ Escalation of emerging risks<br>▪ Divisional performance reviews<br>▪ REMC | | | **ROLLING TREND:**<br>  <br>Jul 2019 Jun 2019 May 2019 Apr 2019 | **ROLLING TREND:**<br>2.74 3.47 3.43 1.66<br>Jul 2019 Jun 2019 May 2019 Apr 2019 |

| Individual risks scoring ≥20 | Original Score | Mitigations | Current score |
|---|---|---|---|
| Risk of failure/vulnerability of back-end infrastructure resulting in no access to IT systems | 20 | Risk escalation on F&P agenda | 20 |

### NARRATIVE

Please note that, whilst a forecast of achieving 2 quarters has been provided in the weighted dashboard overleaf for both the "Forecast position: Achieve finance control total before PSF" and "Forecast position: Achieve use of resources risk rating as per plan" metrics, there is significant risk associated with these forecasts.

## PERFORMANCE: WEIGHTED DASHBOARD

Performance data as at: **30 SEPT 2019**

| Performance | Measure | Result | 1 (Green) | 2 (Amber-Green) | 3 (Amber) | 4 (Amber-Red) | 5 (Red) | Weight | Month | Year | Source |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 4-hour standard | 95% of patients should be admitted, transferred or discharged within 4 hours of arrival at A&E | 90.04% M<br>83.93% Y | ≥95% | 94.9-90% MTD | 89.9-80% YTD | 79.9-70% | ≤70% | 2 | 2 x 2 = 4 | 3 x 2 = 6 | BI (Aug 2019) |
| 12-hour operational standard | No patient requiring emergency admission will wait 12 hours in A&E | 0 M<br>0 Y | 0 MTD & YTD | | | | 1 | 2 | 1 x 2 = 2 | 1 x 2 = 2 | BI (Aug 2019) |
| Ambulance handover standard | All handovers between ambulance and A&E must take place within 15 mins with none waiting >60m | 0 > 60m M<br>49 > 60m Y | ≤ 15 mins | 15-30 mins | | 30-59 mins MTD | >60 mins YTD | 1 | 4 x 1 = 4 | 5 x 1 = 5 | BI (July 2019) |
| Cancer treatment times | 85% should wait no more than 62 days from urgent referrer to first definitive treatment | 80.13% M<br>81.50% Y | ≥85% | | | | ≤84.9% Mth & YTD | 2 | 5 x 2 = 10 | 5 x 2 = 10 | BI (July 2019) |
| 18-week RTT | 92% on incomplete RTT pathways (yet to start treatment) should wait no more than 18 weeks | 92.02% M<br>92.44% Y | ≥92% MTD & YTD | | | | ≤91.9% | 1 | 1 x 1 = 1 | 1 x 1 = 1 | BI (Aug 2019) |
| 52-week RTT | Zero tolerance for patient waits over 52 weeks on an incomplete pathway | 1 M<br>1 Y | 0 | | | | ≥1 (M & Y) | 2 | 5 x 2 = 10 | 5 x 2 = 10 | BI (Aug 2019) |
| Diagnostic waiting times | 99% of service users waiting for a diagnostic test should receive it within 6 weeks of referral | 99.14% M<br>98.97 Y | ≥99% MTD & YTD | | | | ≤98.9% | 1 | 1 x 1 = 1 | 1 x 1 = 1 | BI (Aug 2019) |
| Paper switch off programme | By 1 Oct 2018, NHS E-referral will be used for all relevant consultant-led first OPD appointments | Complete | 100% | | | | ≤99.9% | 1 | 1 x 1 = 1 | 1 x 1 = 1 | Complete |
| Control total achievement | Forecast position: Achieve finance control total before PSF | Forecast 1 quarter | Achieve 4 quarters | 3 quarters | 2 quarters | 1 quarter | 0 quarters | 4 | 3 x 4 = 12 | 3 x 4 = 12 | Forecast (RF) |
| Control total achievement | Forecast position: Achieve A&E control total trajectory | No longer applicable | Achieve 4 quarters | 3 quarters | 2 quarters | 1 quarter | 0 quarters | 2 | --- | --- | Forecast |
| Use of resources risk rating | Forecast position: Achieve use of resources risk rating as per plan | Forecast 1 quarter | Achieve 4 quarters | 3 quarters | 2 quarters | 1 quarter | 0 quarters | 4 | 3 x 4 = 12 | 3 x 4 = 12 | Forecast (RF) |
| Transformation | SAVI delivery against target | (85%) M<br>(102.7) Y | Achieved YTD | Fail by <10% | Fail by 10-20% MTD | Fail by 20-30% | Fail by >30% | 3 | 1 x 3 = 3 | 1 x 3 = 3 | Finance report |
| IT | Completion of agreed IT priorities in line with plan | (50%) M | 100% | 90-99% | 80-89% MTD | 70-79% | ≤70% | 2 | 5 x 2 = 10 | --- | IT department |
| Total | | | | | | | | 27 | (70/23) | 63(/23) | |
| Average | | | | | | | | | **3.04** | **2.74** | |

## Patients:

## Every patient receives the best possible care

| | | | | | |
|---|---|---|---|---|---|
| **Executive lead(s):** | Director of Nursing<br>Medical Director | **Reviewing committee:** | Quality and Safety Committee | **DELIVERY CONFIDENCE**<br>**CURRENT MONTH:** | **WEIGHTED DASHBOARD**<br>**MONTH:** 2.73 **YTD:** 3 |
| **Strategic importance:** | Provision of safe, effective, high-quality and evidence based care is at the heart of everything we do. | | | | |
| **Sources of assurance:** | ▪ Scrutiny by Quality and Safety Committee<br>▪ Scrutiny by Board of Directors<br>▪ Use of internal and external auditors | | ▪ Escalation of emerging risks<br>▪ Divisional performance reviews<br>▪ REMC | **ROLLING TREND:**<br>July 2019 · June 2019 · May 2019 · April 2019 | **ROLLING TREND:**<br>July 2019: 2.00 · June 2019: 2.85 · May 2019: 1.96 · April 2019: 2.15 |

| Individual risks | Original Score | Mitigations | Current score |
|---|---|---|---|
| There is a risk that patients with infectious conditions may not be able to be appropriately isolated in a timely manner due to a lack of side rooms | 20 | GM pipeline bid for additional beds including side rooms | 20 |
| Inability to recruit to required staffing levels, in particular nurse staffing (numerous entries) | 20 | Board and Workforce Cttee briefed on this issue, various options being pursued | 20 |
| The provision of a 7 day pharmacy service across the RAEI and Wrightington sites is currently compromised | 20 | Ongoing development of alternative workforce models | 20 |
| Failure to identify the root cause and lessons learned from never events reported during 2017-18 and 2018-19 creates a risk around patient safety, reputational damage and increased regulatory scrutiny | 16 | Reported to Board. Themed SIRI Panel in Mar 2019 on actions/lessons learned | 16 |
| Upgrade to Somerset cancer registry interface on PAS has potential to delay cancer diagnosis | 20 | Installed. Interface currently being tested for supplier issues. | 20 |
| Only 1 maternity theatre available for elective and emergency cases | 20 | Dedicated theatre staff available for all elective caesareans. Staff review to start in October. | 20 |
| Patients not being admitted to the right ward due to bed blockages, posing a risk to patient care and a potential increase in the length of hospital stay | 20 | Previously escalated to Q&S | 20 |
| There is a risk to patient safety due to a lack of medical beds resulting in patients being harmed. | 20 | Escalated to Trust Board. | 20 |
| Concern that discharge letters are not being sent to GPs and therefore follow up activities are being missed | 16 | Previously escalated to Q&S | 20 |

## PATIENTS: WEIGHTED DASHBOARD

| Performance | Measure | Result | 1 (Green) | 2 (Amber-Green) | 3 (Amber) | 4 (Amber-Red) | 5 (Red) | Weight | Month | Year | Source |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Harm free care | %VTE Assessments undertaken within 24 hours of admission (indicative data) | **96.2% M 96.5% Y** | ≥95% | 94% - 90% | 89%-85% | 84%-80% | <80% | **1** | 1 x 1 = 1 | 1 x 1 = 1 | Perf. Report (Aug 2019) |
| Harm free care | No. Serious Falls | **1 MTD 3 YTD** | 0 | | 1 (MTD) | 2 or 3 | >3 (YTD) | **2** | 3 x 2 = 6 | 5 x 2 = 10 | Perf. Report (Aug 2019) |
| Patient Safety | % of 'red sepsis' patients receiving antibiotics within 1 hour in A&E | **89%** | ≥95% | 94% - 90% | 89%-85% | 84%-80% | <80% | **1** | 3 x 1 = 3 | --- | A&E Monthly Audits |
| Patient Safety | No. of Never Events | **1 MTD 2 YTD** | 0 | | | | 1 | **3** | 5 x 3 = 15 | 5 x 3 = 15 | Perf. Report (Aug 2019) |
| Patient Safety | 100% compliance with appropriate frequency of observations | **100%** | 100% | 99-95% | 94-90% | 89-80% | <80% | **1** | 1 x 1 = 1 | --- | NEWS quarterly Audits (3,6,9,12) |
| Infection Control | No. of MRSA | **0 MTD 0 YTD** | 0 | | | | 1 | **3** | 1 x 3 = 3 | 1 x 3 = 3 | Perf. Report (Aug 2019) |
| Infection Control | No. of C. diff Lapses in Care | **1 MTD 3 YTD** | 0 | 1 (MTD) | 2 | 3 (YTD) | >4 | **2** | 2 x 2 = 4 | 4 x 2 = 8 | Perf. Report (June 2019) |
| Patient Experience | % of patients recommending WWL for care | **94.3%** | ≥95% | 94% - 90% | 89%-85% | 84%-80% | <80% | **2** | 2 x 2 = 4 | --- | Monthly FFT (June 2019) |
| Patient Experience | % of patients feeling involved with decisions about their discharge | **87.1%** | ≥95% | 94% - 90% | 89%-85% | 84%-80% | <80% | **1** | 3 x 1 = 3 | --- | Perf. Report (August 2019) |
| Patient Experience | % of complaints responded to within the timescale agreed with the patient | **72.9% M 66.8% Y** | ≥95% | 94% - 90% | 89%-85% | 84%-80% | <80% | **1** | 5 x 1 = 5 | 5 x 1 = 5 | Perf. Report (Aug 2019) |
| Mortality | HSMR | **111.6% M 103.8% Y** | ≤100 (MTD) | 101-105 (YTD) | 106-110 | 111-115 (MTD) | >115 | **3** | 4 x 3 = 12 | 2 x 3 = 6 | Perf. Report (May 2019) |
| Mortality | SHMI | **114.3%** | ≤100 | 101-105 | 106-110 | 111-115 | >115 | **1** | | 4 x 1 = 4 | Perf. Report (March 2018) |
| Mortality | No. of PFDs | **0** | 0 | 1 | 2 | 3 | >4 | **2** | 1 x 2 = 2 | 1 x 2 = 2 | Perf. Report (Aug 2019) |
| Medicines Management | % of critical medicines prescribed within 24 hours of admission or before the patient is transferred to a new area | **90.1%** | 100% | 99-95% | 94-90% | 89-80% | <80% | **1** | 4 x 1 = 4 | --- | Pharmacy (Aug 2019) |
| Medicines Management | % of completed medicines reconciliation within 24 hours | **90.6%** | 100% | 99-95% | 94-90% | 89-80% | <80% | **2** | 4 x 2 = 8 | --- | Pharmacy (July 2019) |
| Total | | | | | | | | | (71/26) | (54/18) | |
| Average | | | | | | | | | 2.73 | 3 | |

## People:
## Everyone has the opportunity to achieve their purpose

| | | | | | |
|---|---|---|---|---|---|
| **Executive lead(s):** | Director of Workforce | **Reviewing committee:** | Workforce Committee | **DELIVERY CONFIDENCE** | **WEIGHTED DASHBOARD** |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Strategic importance:** | Every member of staff has the opportunity to achieve their purpose.<br>Corporate objectives:<br>• Improve staff engagement and organisational culture so that staff feel happy and supported in work, feeling empowered to deliver positive change<br>• Develop and implement a creative workforce plan across the Trust that delivers improved and appropriate workforce models to the benefit of staff and patients | | |  | | | | MONTH: 4 | | YTD: 4 | |
| **Sources of assurance:** | ▪ Scrutiny by Workforce Committee<br>▪ Scrutiny by Board of Directors<br>▪ Use of internal and external auditors | | ▪ Escalation of emerging risks<br>▪ Exec-to-exec meetings<br>▪ REMC | ROLLING TREND: | | | | ROLLING TREND: 4.00 | 4.00 | 3.25 | 3.25 |
| | | | | Jul 2019 | Jun 2019 | May 2019 | Apr 2019 | July 2019 | Jun 2019 | May 2019 | Apr 2019 |

| Individual risks | Original Score | Mitigations | Current score |
|---|---|---|---|
| HR 84 - Ability to recruit and retain to required staffing levels for service delivery and service development plans | 20 | International recruitment, nursing incentive schemes, return to practice programmes, nursing pipeline. Workforce Summit held Feb 2019 to explore alternative staffing models. Plans to develop a bottom up workforce plan. | 20 |
| HR 86 - Lack of assurance around medical job plans will lead to both negative service and financial impacts for the Trust | 12 | E-job planning | 16 |
| HR93 – Breaching the NHSI agency ceiling | 12 | Temporary staffing protocols, nursing incentive schemes, international recruitment, Steps 4 Wellness programmes, regional collaboration. Agency ceiling remains at roughly £5.1m. Score increased to 5 x 4 = 20 due to significant overspend in the opening months of the year. | 20 |
| HR101 – Access to intranet (Wally) | 16 | Requirement to change passwords will move to yearly. IT Services are looking into the potential to remove the requirement for a password entirely but need to explore the potential for data security issues. May be that there will be a password requirement for some areas of the intranet. A solution for ESR interface with active directory has been found but will require implementation. | 16 |

| | | | |
|---|---|---|---|
| HR104 – sickness absence above target | 12 | Advice/support available via HR/Occupational Health and wide range of initiatives in place as part of the 'Steps 4 Wellness' programme. Pilot due to commence to deliver physio, health checks and mental health advice to wards. Agreement to explore sickness absence management system, health and wellbeing app and increase of flexible working opportunities and job crafting. | 15 |
| HR109 – Quality of appraisals | 16 | PDR documentation and framework in place; plans to review documentation; quality audit to be undertaken; introduction of 'My Route Plan' as a part of level 3/5 Learning and Management Apprenticeships; training to be offered to managers; review of the Trust strategy and objectives. | 16 |
| HR110 – Impact of tax/pension threshold on the senior medical workforce | 16 | Exploring the use of alternative approaches such as pay flexibilities, alternative benefits and third party LLP contracting; lobbying around pension reform nationally; exploration of alternative workforce models; potential to recruit substantive consultants in specialties where there are no shortages. | 16 |
| HR82 – Declines in safety culture and staff confidence in reporting errors, near misses and incidents. | 16 | Plans to build this into the Just Culture programme of work that is being undertaken; plans to build into the FTSU action plan. | 16 |
| HR115 – Organisational Staff Engagement Levels | 16 | Steps 4 Wellness provision review; Development of divisional engagement plans; Talent Management plan; development of Just Culture; Listening Events; Job Crafting; work around 'safe rule breaking'. | 16 |

## NARRATIVE

New workforce risk added to the corporate risk register: HR109 – Quality of Appraisals.

**Employment Essentials**

- WWL has been accepted onto the NHSI Nursing retention programme (cohort 5), which commences in September 2019.
- A recruitment fayre is being planned for October / November 2019, which will be a one-stop shop.
- Pay modelling has been completed with NHSP to make bank work more attractive
- Alternative plans are ready to be implemented following the removal of the Direct Engagement arrangements previously operated by Brookson / Plus Us
- The WWL Just Culture programme has been developed for implementation, which includes a response to the Fair Experience for All publication.
- The LLP and other pension flexibilities arrangements are due to commence in pilot form, subject to Board approval.
- Funding has been identified to facilitate the recruitment of a Chief AHP. The job description is now ready for the banding process. This role will be pivotal in progressing the AHP workforce development, including escalating progress with alternative workforce models.
- HR re-structure is creating additional senior HR capacity to support divisions with strategic workforce transformation, including workforce planning and alternative workforce models

**Go Engage**

- A series of "wicked issue" solution focussed listening events are being planned with input from the Transformation Team.

- An overarching “civility saves lives” campaign will be the basis of the “Just Culture” communication and engagement programme.
- The business case for a new substantive Freedom To Speak UP Guardian are progressing. Plans are also in place to address gaps in response to the national Freedom to Speak Up Board Guidance and Training requirements

**Steps 4 Wellness**

- Business cases are in development for the two successful Dragons Den bids – attendance management system & well-being app
- MIAA are completing a review of medical attendance management. We will take forward the recommendations identified in the report.

**WWL Route Planner**

- New educational governance structures are being implemented to support the prioritisation of learning and development, along with career progression and succession planning.
- MIAA are completing a review of appraisal quality. We will take forward the recommendations identified in the report.

## PEOPLE: WEIGHTED DASHBOARD

| Performance | Measure | Result | 1 (Green) | 2 (Amber-Green) | 3 (Amber) | 4 (Amber-Red) | 5 (Red) | Weight | Month | Year | Source |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Go Engage | Friends and family test (work) | 61.94% | ≥95% | 72-94% | 68-71% | 64-67% | ≤63% | 2 | 5 x 2 = 10 | 5 x 2 = 10 | Workforce team |
| Employment Essentials | Turnover | 8.48% | ≤8% | 8.01-8.5% | 8.51-9% | 9.01-9.9% | ≥10% | 1 | 2 x 1 = 2 | 2 x 1 = 2 | Workforce team |
| Employment Essentials | Leavers with less than 12 months’ service | 13.75% | ≤10% | 11-14% | 15-20% | 21-24% | ≥25% | 1 | 2 x 1 = 2 | 2 x 1 = 2 | Workforce team |
| Route Planner | PDR completion | 84.8% | ≥95% | 86-94% | 78-85% | 73-77% | ≤72% | 1 | 2 x 1 = 2 | 2 x 1 = 2 | Workforce team |
| Steps 4 Wellness | Energy levels | 3.33 | ≥4.00 | 3.7-3.99 | 3.61-3.69 | 3.47-3.6 | ≤3.46 | 1 | 5 x 1 = 5 | 5 x 1 = 5 | Workforce team |
| Go Engage | Cultural enabler score | 32.59 | ≥36 | 35.01-35.9 | 34.01-35 | 33.61-34 | ≤33.6 | 2 | 5 x 2 = 10 | 5 x 2 = 10 | Workforce team |
| Total<br>Average | | | | | | | | 8 | 31<br>3.875 | 31<br>3.875 | |

# REPORT

**AGENDA ITEM: 9.1**

| | | | |
|---|---|---|---|
| **To:** | Board of Directors | **Date:** | 17 September 2019 |
| **Subject:** | WRES & WDES Annual Reports 2019 | | |
| **Presented by:** | Director of Workforce | **Purpose:** | Approval |

## Executive summary

As a public sector NHS organisation the Trust is required to collect data and report a range of Equality & Diversity measures which include the Workforce Race Equality Standard (WRES) and Gender Pay Gap & Workforce Disability Equality Standard (WDES).

This report summarises the Trust`s latest Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) information.

## Risks associated with this report

## Link(s) to The WWL Way 4wards

| | | | |
|---|---|---|---|
| ☐ | Patients | ☒ | Performance |
| ☒ | People | ☐ | Partnerships |

**Statutory Equality & Diversity reporting**

## 1 Background

As a public sector NHS organisation the Trust is required to collect data and report a range of Equality & Diversity measures which include the Workforce Race Equality Standard (WRES) Workforce Disability Equality Standards (WDES) .

This report summarises the Trust`s latest Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES).

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## 2 Workforce Race Equality Standard (WRES)

### 2.1 Information on the WRES

In 2016 NHS organisations through the NHS standard contract were required to implement the Workforce Race Equality Scheme (WRES). The aim of the Workforce Race Equality Standard (WRES) is to improve the experience of Black and Minority Ethnic (BME) staff in the workplace. This includes employment, promotion and training opportunities. It also applies to BME people who want to work in the NHS. Additionally, this applies to BME staffs' experience of the employee relations process. This can be achieved by taking positive action to eliminate discrimination, harassment and unfair treatment of BME staff in the workplace.

### 2.2 WRES: Key themes for the Trust

Appendix 1 includes a full copy of the Trust`s 2019 WRES submission which relates to data from 1 April 2018-31 March 2019. The data collection is extensive and is drawn from a range of sources including the Electronic Staff Record (ESR), the Trust`s recruitment system TRAC and a number of National staff survey indicators.

Key points to note are:

- The Trust`s BME representation is currently 8% compared with 3% BME for the Wigan Borough
- A high level of staff have self-reported their ethnicity at 99%
- White staff were 1.25 more likely to be appointed from shortlisting compared with BME applicants which is a an improved position from previous year's data at 1.52.
- BME staff were 0.70 times more likely than white staff to enter a formal disciplinary process which is an improvement on the previous year's data at 1.02 in 2017/18
- In the 2018 staff survey 34.60% of BME staff report bullying & harassment or abuse from patients, relatives or the public compared with 19.50% of white staff. This is a deteriorating position from previous year's results where 13.33% of BME staff reported bullying & harassment or abuse.
- In the 2018 staff survey higher levels 26.9% of BME staff report bullying & harassment or abuse from staff compared with 19.50% of white staff. This is an improvement compared with the 2017/18 results when 35.48% of BME staff reported bullying & harassment or abuse.
- 85% of BME staff believe the Trust provides equal opportunities for career progression or promotion compared with 87.13% of white staff. This is an improvement on the previous year's results which were 70.83% of BME staff reporting that the Trust provides equal opportunities for career progression.

- 11.50% of BME staff report experiencing discrimination at work compared with 6.69% of white staff which is a significant improvement from 2017 data at 19.35% of BME staff.

## 3 Workforce Disability Equality Standard (WDES)

The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) that will enable NHS organisations to compare the experiences of Disabled and non-disabled staff.

The WDES is mandated through the NHS Standard Contract and it is restricted to NHS Trusts and Foundation Trusts for the first two years of implementation. The implementation of the WDES will enable NHS Trusts and Foundation Trusts to better understand the experiences of their disabled staff. It will support positive change for existing employees, and enable a more inclusive environment for disabled people working in the NHS. Like the Workforce Race Equality Standard on which the WDES is in part modelled, it will also allow us to identify good practice and compare performance regionally and by type of trust.

There are 10 WDES metrics, which cover such areas as the Board, recruitment, bullying and harassment, engagement and the voices of Disabled staff. The statutory information was required to be published in August 2019 on a public facing website.

### 3.1 WDES : Key themes for the Trust

Appendix 2 includes a full copy of the Trust`s 2019 WDES submission which relates to data from 1 April 2018 - 31 March 2019. The data collection is extensive and is drawn from a range of sources including the Electronic Staff Record (ESR), the Trust`s recruitment system TRAC and a number of National staff survey indicators.

Key points to note are as follows:-

- Disabled staff are 1.7 times more likely of being appointment from shortlisting compared to Non-Disabled staff.
- The % of disabled staff who experience harassment, bullying and or abuse from their Line Manager, Colleagues & Patients is higher than that for non-disabled staff with the % of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months was higher for disabled staff than non-disabled staff.

| | Disabled | Non Disabled |
|---|---|---|
| % of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public in the last 12 months | 27.8% | 19.1% |
| % of staff experiencing harassment, bullying or abuse from managers in the last 12 months | 18.8% | 17.3% |
| % of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months | 25.0% | 16.1% |
| % of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months | 44.4% | 37.1% |

- The % of staff believing that the Trust provides equal opportunities for career progression or promotion was lower for disabled (77.1%) staff than non-disabled staff (83%)
- The % of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties was higher for disabled (36.4%) staff than non-disabled staff (23.3%).
- The % staff saying that they are satisfied with the extent to which their organisation values their work is lower for disabled staff (38.5%) compared to non-disabled staff (43.5%).
- 60.5% of disabled staff stated that their employer has made adequate adjustment(s) to enable them to carry out their work.
- There are no reported disabled staff for voting or non voting Board members.

## 4 Actions in response to the WDES & WRES

The actions in response to the WDES & WRES are incorporated into the Equality Delivery System Action Plan which is overseen by the Inclusion & Diversity Steering Group. (Appendix 3)

Key actions in response to the WDES & WRES data are a specific on further reducing inequalities experienced by staff and applicants with BME and Disability protected characteristic.

Some of the key actions include:-

- Introduction of the Exec Scrutiny Panel for review of Disciplinary Cases
- Launch of the Just Culture Programme which includes a focus on bullying/harassment, civility saves lives, embedding within performance management frameworks and a zero tolerance programme in relation to physical and verbal abuse of employees
- BME & Disability Focus Groups concentrating on bullying & harassment from colleagues, managers and patients
- Review of Recruitment stats in order to identify any key themes

All actions in relation to WDES & WRES will be incorporated within the Trust's EDS Action Plan.

## 6 Conclusion

Workforce Committee are requested to note the content of the report.

Joanne O'Brien

Assistant HR Business Partner

September 2019

# Appendix 1

# 2019 Workforce Race Equality Standard submission

**Name of organisation:**
Wrightington, Wigan and Leigh NHS Foundation Trust

**2 Date of report**

**Month/Year:**
March/2019

**3 Name and title of Board lead for the Workforce Race Equality Standard**

**Name and title of Board lead for the Workforce Race Equality Standard :**
Alison Balson, Director of Workforce

**4 Name and contact details of lead manager compiling this report**

**Name and contact details of lead manager compiling this report:**
Philip Makin, 01942 244000

**5 Names of commissioners this report has been sent to**

**Complete as applicable:**
Julie Southworth

## Workforce Race Equality Standard reporting template

**6 Name and contact details of co-ordinating commissioner this report has been sent to**

**Complete as applicable.:**
Sally Forshaw
Director of Quality & Safety,
Wigan Borough CCG,
Wigan Life Centre,
College Avenue,
Wigan, WN1 1NJ

**7 Unique URL link on which this report and associated Action Plan will be found**

**Unique URL link on which this Report and associated Action Plan will be found:**
http://www.wwl.nhs.uk/Equality/wres.aspx

**8 This report has been signed off by on behalf of the board on**

**Name::**
Alison Balson

**Date::**
September 2019

## Background narrative

**9 Any issues of completeness of data**

**Any issues of completeness of data:**
BME data recorded on ESR is good quality and we are able to report against a range of indicators. However, our central electronic recording of training data includes internal training only and so we are unable to report on all training undertaken. Therefore, we are currently unable to provide data on the relative likelihood of BME staff accessing non-mandatory training and CPD as compared to White staff (Section 20).

**10 Any matters relating to reliability of comparisons with previous years**

**Any matters relating to reliability of comparisons with previous years:**
None.

## Self reporting

**11 Total number of staff employed within this organisation at the date of the report:**
**Total number of staff employed within this organisation at the date of the report:**
**5095**

**12 Proportion of BME staff employed within this organisation at the date of the report?**
**Proportion of BME staff employed within this organisation at the date of the report:**

**8.34%**

**13 The proportion of total staff who have self reporting their ethnicity?**

**The proportion of total staff who have self–reported their ethnicity:**

**99%**

**14 Have any steps been taken in the last reporting period to improve the level of self reporting by ethnicity?**
**Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity:**
Woven Reports are reviewed on a monthly basis and any gaps are duly followed up.

**15 Are any steps planned during the current reporting period to improve the level of self reporting by ethnicity?**
**Are any steps planned during the current reporting period to improve the level of self reporting by ethnicity:**
Response rate is high so no current concerns.

## Workforce data

**16 What period does the organisation's workforce data refer to?**
**What period does the organisation's workforce data refer to?:**
01 April 2018 to 31 March 2019

## Workforce Race Equality Indicators

**17 Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.**

**Data for reporting year:**

| | | | |
|---|---|---|---|
| Clinical | Band 1 | 4 | 294 |
| | Band 2 | 20 | 797 |
| | Band 3 | 2 | 126 |
| | Band 4 | 3 | 129 |
| | Band 5 | 46 | 687 |
| | Band 6 | 20 | 545 |
| | Band 7 | 6 | 344 |
| | Band 8a | 4 | 82 |
| | Band 8b | 1 | 10 |
| | Band 8c | | 5 |
| | Band 8d | | 2 |
| | Medical & Dental Consultant | 1 | 2 |
| | Medical & Dental Consultant | 118 | 76 |
| | Medical & Dental Non-Consultant Career Grade | 76 | 33 |
| | Medical & Dental Trainee Grades | 95 | 52 |
| | AP30 | | 4 |
| | WQ00 | | 7 |

| | | | |
|---|---|---|---|
| Non Clinical | Band 1 | 4 | 89 |
| | Band 2 | 14 | 434 |
| | Band 3 | 8 | 269 |
| | Band 4 | 8 | 293 |
| | Band 5 | 2 | 112 |
| | Band 6 | | 58 |
| | Band 7 | 4 | 66 |
| | Band 8a | 2 | 48 |
| | Band 8b | | 25 |

| | | |
|---|---|---|
| Band 8c | | 5 |
| Band 8d | 1 | 10 |
| Band 9 | | 7 |
| VSM | | 6 |
| AP30 | | 6 |
| CRRW | | |
| WQ00 | | 2 |

**Data for previous year:**
Non Clinical Workforce

| | WHITE | BME |
|---|---|---|
| Under Band 1 | 2 | 0 |
| Band 1 | 103 | 5 |
| Band 2 | 417 | 14 |
| Band 3 | 280 | 9 |
| Band 4 | 287 | 6 |
| Band 5 | 113 | 4 |
| Band 6 | 64 | 0 |
| Band 7 | 59 | 3 |
| Band 8a | 50 | 1 |
| Band 8b | 24 | 0 |
| Band 8c | 8 | 0 |
| Band 8d | 9 | 0 |
| Band 9 | 4 | 0 |
| VSM | 12 | 0 |

Clinical Workforce of which non- medical

| | WHITE | BME |
|---|---|---|
| Under Band 1 | 9 | 0 |
| Band 1 | 309 | 3 |
| Band 2 | 778 | 14 |
| Band 3 | 136 | 1 |
| Band 4 | 122 | 0 |
| Band 5 | 684 | 52 |
| Band 6 | 514 | 16 |
| Band 7 | 360 | 4 |
| Band 8a | 74 | 5 |
| Band 8b | 10 | 0 |
| Band 8c | 6 | 0 |
| Band 8d | 2 | 0 |
| Band 9 | 0 | 0 |
| VSM | 2 | 1 |

Of which Medical and Dental

| | WHITE | BME |
|---|---|---|
| Consultants | 71 | 116 |
| Non-Consultant Career Grade | 31 | 61 |
| Trainee Grades | 2 | 71 |
| Other | 40 | 34 |

**The implications of the data and any additional background explanatory narrative:**
The Trust's BME representation is currently 8% compared to 3% BME for the Wigan Borough. A large percentage of BME employees are within clinical staff groups and in particular the Medical & Dental staff group. There are no areas of concern from the data at the present time.

**Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:**
There are no concerns from the data at the present time.

**18 Relative likelihood of staff being appointed from shortlisting across all posts.**

**Data for reporting year:**
White staff were 1.25 times more likely to be appointed from shortlisting compared to BME applicants.

**Data for previous year:**
White staff were 1.52 times more likely to be appointed from shortlisting compared to BME applicants.

**The implications of the data and any additional background explanatory narrative:**
Improvements seen since 2018 however, further analysis will be undertaken at a more granular level to identify any particular areas of concern.

**Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:**
The Trust's Equality Objectives for the forthcoming year include a specific focus on further reducing inequalities experienced by staff and applicants from a BME background by develop the BME Leaders module within the WWL Leadership Programme as well as BME coaching and mentoring.

**19 Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.**

**Data for reporting year:**

BME staff were 0.70 times more likely than white staff to enter a formal disciplinary process.

**Data for previous year:**
BME staff were 1.02 times more likely than white staff to enter a formal disciplinary process.

**The implications of the data and any additional background explanatory narrative:**
Significant improvement since last year's submission.

**Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:**
Work continues within the trust in order to continually reduce this figure, currently reviewing recruitment training for Interview Panellists for Consultant Recruitment. The trust has introduced an Exec Scrutiny Review Panel for Disciplinary Cases.

**20 Relative likelihood of staff accessing non-mandatory training and CPD.**

**Data for reporting year:**
N/A

**Data for previous year:**
N/A

**The implications of the data and any additional background explanatory narrative:**
See Question 9 - Background Narrative.

**Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:**
New IT Training system being introduced to include the new national mandatory training modules which may be able to provide the information required for this metric.

## Workforce Race Equality Indicators

**21 KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.**

**Data for reporting year:**

**White: 19.50%**

**BME: 34.60%**

**Data for previous year:**

**White:**
18.70%
**BME:**
13.33%

**The implications of the data and any additional background explanatory narrative:**
Increase in BME staff experiencing harassment, bullying or abuse from patients, relatives or the public within this year's results.

**Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:**
The trust will be implementing a just culture programme. This will include a focus on any bullying/harassment, civility saves lives.

**22. KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.**

**Data for reporting year:**

**White:**
**27.80%**
**BME:**
**26.9%**

**Data for previous year:**

**White:**
22.42%
**BME:**
35.48%

**The implications of the data and any additional background explanatory narrative:**
Significantly reduced % rate of BME experiencing discrimination at work within this year's results compared with last year.

**Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:**
Focus Groups have been held on a regular basis to gain feedback from staff around any areas of concern. We will continue to review internally reported Dignity At Work related Grievances to establish any trends/hotspots requiring further action.

**23 KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.**

**Data for reporting year:**

**White:**
**81.0%**
**BME:**
**85%**

**Data for previous year:**

**White:**
87.13%
**BME:**
70.83%
**The implications of the data and any additional background explanatory narrative:**
Increase % BME staff believing the Trust provides equal opportunities within this year's results.

**Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:**
Promotions data is included within the annual inclusion & diversity report and this will be triangulated with the staff survey feedback. Associated actions to be built into EDS action plan.

**24 Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.**

**Data for reporting year:**

**White:**
**6.60%**
**BME:**
**11.50%**

**Data for previous year:**

**White:**
5.41%
**BME:**
19.35%

**The implications of the data and any additional background explanatory narrative:**
Improvement in the score from previous year with less BME staff reporting discrimination at at work from Manager/Team Leader or other colleagues.

**Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:**
BME Focus Group will be held in order to look at the bullying and harassment from managers/colleagues to identify any actions.

**25 Percentage difference between the organisations' Board voting membership and its overall workforce.**

**Data for reporting year:**

**White:**
**92.9% of the Trust Board membership was White compared to 90.6 % of the workforce**

**BME:**
**7.1% of the Trust Board membership was BME compared to 8.4 % of the workforce**

**Data for previous year:**

**White:**
93.3% of the Trust Board membership was White compared with 90.4% of the Trust workforce.
**BME:**
6.7% of the Trust Board membership was BME compared with 8.3% of the Trust workforce.

**The implications of the data and any additional background explanatory narrative:**
Small differential between the percentage BME Trust Board membership when compared to the Trust workforce.

**Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:**
None at present.

**26 Are there any other factors or data which should be taken into consideration in assessing progress?**

**Are there any other factors or data which should be taken into consideration in assessing progress?:**
The Trust has run several BME focus groups over a number of years and these sessions have been extremely beneficial in enabling proactive engagement with BME staff and key actions have been incorporated into the EDS action plan in response to feedback obtained.

The Trust reports on other BME data items such as PDR, leavers, flexible working applications and promotions within its Annual Inclusion & Diversity Monitoring Report.

**27 Organisations should produce a detailed WRES action plan, agreed by its board. It is good practice for this action plan to be published on the organisation's website, alongside their WRES data. Such a plan would elaborate on the actions summarised in this report, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other workstreams agreed at board level, such as EDS2. You are asked to provide a link to your WRES action plan in the space below.**

**Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other workstreams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.:**
The Trust's EDS Action Plan focuses on actions associated with this year's WRES.

## Appendix 2

## Workforce Disability Equality Standard (WDES) 2019 Submission

### Trust information

**1 Name of organisation:**
**Name of organisation::**
Wrightington, Wigan & Leigh NHS Foundation Trust

**2 Date of report:**
**Month/year::**
August/2019

**3 Name and title of the Board lead for the Workforce Disability Equality Standard:**
**Name and title of Board lead for the Workforce Disability Equality Standard::**
Alison Balson - Director of Workforce

**4 Name and contact details of the lead compiling this report:**
**Name and contact details of lead compiling this report:**
Joanne O'Brien
Assistant HR Business Partner & I & D Lead
Suite 7
Buckingham Row
Brick Kiln Lane
Wigan
WN1 1XX

**5 Does your organisation participate in any programmes or initiatives that are focused on disability equality and inclusion?**
Yes

**If yes, please provide details::**
The Trust has held annual Disability Focus Groups over the past 4 years with the aim of engaging with trust staff living with a a disability. Associated actions identified from the focus groups have been built into the EDS Action Plan.
Bespoke training on Autsim Awareness has been undertaken and was open to all staff to participate.
As part of the Trust's Inclusion & Diversity Mandatory training there is a Disability Podcast available to view and raise awareness for all staff.
Disability Confident Scheme
The Trust Introduced in 2019 I & D Training Programmes for Level 3 & 5 Managers.

### Trust information

**6 Name and contact details of the commissioner(s) this report will be sent to:**
**Name and contact details of commissioner(s) this report will be sent to:**
Sally Forshaw
Director of Quality & Safety,
Wigan Borough CCG,
Wigan Life Centre,
College Avenue,
Wigan, WN1 1NJ

**7 Unique URL link, or existing web page, on which the WDES Metrics data and associated Action Plan will be published:**
**Unique URL link, or existing web page, on which the WDES Metrics data and associated Action Plan will be published::**

https://www.wwl.nhs.uk/Equality/WDES.aspx

**8 Date of Board meeting at which organisation's WDES Metrics data and action plan were, or will be, ratified:**
**Date of Board meeting at which organisation's WDES Metrics data and action plan were, or will be, ratified::**

17th September 2019 Workforce Committee (sub-committee of the Trust Board)

**9 Total number of staff employed within the organisation on 31 March 2019:**

**Total number of staff employed within the organisation on 31 March 2019:**
5095

**% Disabled staff::**
2.22%
**% Non-disabled staff::**
68.75%
**% Unknown/Null::**
0.02%
**% Other::**
**% Prefer not to say::**
29.01%

## Data quality

**10 Did your organisation undertake the NHS Staff Survey in the past year?**

Yes
Sample staff survey

**11 Give the total number and % of responses to the NHS Staff Survey in your organisation:**
**Give the total number and % of responses to the NHS Staff Survey in your organisation::**

Survey sent to 1250 staff - 429 (34.3%) returned

**12 Give the total number and % of Disabled staff responses to the NHS Staff Survey in your organisation:**
**Give the total number and % of Disabled staff responses to the NHS Staff Survey in your organisation::**

81 disabled staff responded - 20% of survey respondents

**13 Do your staff have access to the ESR self-service portal?**
Yes

## Metric 1 - Workforce representation

**14 Please describe any challenges that your organisation has experienced in reporting data for this Metric:**
**Please describe any challenges that your organisation has experienced in reporting data for this Metric::**

No challenges experienced in recording data against this metric.

**15 Have any steps been taken in the last 12 months within your organisation to improve the declaration rate for disability status on ESR?**

Yes

**16 Please share any examples of interventions that have increased declaration rates at your organisation:**
**Please share any examples of interventions that have increased declaration rates at your organisation::**

To improve the levels of undeclared disability data, the Trust undertook a communication campaign with staff to raise awareness and provided step by step guides for employees to change their details via ESR.

## Metric 2 - Shortlisting

**17 Please describe any challenges that your organisation has experienced in reporting data for this Metric:**
**Please describe any challenges that your organisation has experienced in reporting data for this Metric::**
No challenges reporting data against this Metric.

**18 Has your organisation signed up to the Disability Confident Scheme?**

Yes
Level 2 - Employer

**19 Does your organisation use a Guaranteed Interview Scheme?**

Yes

## Metric 3 - Capability

**20 Did your organisation submit data for Metric 3 this year?**

No

**If yes, please describe any challenges that your organisation has experienced in reporting data for this Metric::**
**If no, please explain why you did not submit data for this year::**

As a trust we do not centrally record all formal capability data in relation to sickness.

**21 Is capability on the grounds of ill health and capability on the grounds of performance managed by different policies in your organisation?**

Yes

**If yes, please state the policies::**

Attendance Management Policy to manage capability on the grounds of ill health and Performance Management Policy to manage capability on grounds of performance.

**22 What are your views about including capability on the grounds of ill health and performance as two parts of a future Metric?**
**What are your views about including capability on the grounds of ill health and performance as two parts of a future Metric?:**

I believe reporting capability separately for ill health and performance would be preferable.

## Metric 4 - Harassment, bullying and abuse

**23 Are there any issues with the data for this Metric?**
**Are there any issues with the data for this Metric?:**

Yes - the national staff survey data has highlighted potential issues with regards to this metric for disabled staff, as these disabled respondents reported higher
levels of harassment, bullying and abuse than non-disabled respondents.
% of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public in the last 12 months
Disabled Non Disabled
27.8% 19.1%
% of staff experiencing harassment, bullying or abuse from managers in the last 12 months
Disabled Non Disabled
18.8% 17.3%
% of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months
Disabled Non Disabled
25.0% 16.1%
% of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months
Disabled Non disabled
44.4% 37.1%

**24 Has your organisation compared Staff Survey results against other datasets that may be held, e.g. bullying and harassment advisers,**

**Freedom to Speak Up guardians, grievances, etc.**

Yes

**If yes, please provide further details on what comparison your organisation has undertaken::**

We compare the national staff survey results against our local quarterly Your Voice surveys and incident reporting. The findings for comparable measures is consistent

**25 Please summarise any actions taken to reduce harassment, bullying and abuse in relation to Disabled staff:**
**Please summarise any actions taken to reduce harassment, bullying and abuse in relation to disabled staff::**

The Trust plans to triangulate the staff survey data against other data sets in order to identify specific areas of concern. Actions will be developed and includedwithin the EDS Action Plan.
The Trust will be launching its just culture programme in the coming months. This will include a focus on any bullying / harassment, civility saves lives, embedding within performance management frameworks and a zero tolerance programme in relation to physical and verbal abuse of employees.

## Metric 5 - Career promotion and progression

**26 Are there any issues with the data for this Metric?**
**Are there any issues with the data for this Metric?:**

Yes - the staff survey reported the % of disabled staff being lower than non disabled for those believing the Trust provided equal opportunities for career progression or promotion.
Disabled
77.1%
Non Disabled
83%

**27 Does your organisation provide any targeted career development opportunities for Disabled staff?**
No
**If yes, please provide further details::**
No currently

## Metric 6 - Presenteeism

**28 Are there any issues with the data for this Metric?**
**Are there any issues with the data for this Metric?:**

Yes -The national staff survey highlighted a higher % of disabled staff compared to non disabled staff stating that they have felt pressure from their line manager
to come to work, despite not feeling well enough to perform their duties.
Disabled
36.4%
Non Disabled
23.3%

**29 Does your organisation provide any targeted actions to reduce presenteeism i.e. feeling pressured to come to work when not feeling well?**
Yes
**If yes, please provide further details::**
We are intending to purchase a health & well-being app and attendance management system that has an evidence base to reduce presentism, by improving overall well-being. We will be rolling out job crafting (one team is currently part of the GM pilot) next year. The literature review for this in relation to ED&I suggests a positive impact for employees who are living with a disability.

## Metric 7 - Staff satisfaction

**30 Are there any issues with the data for this Metric?**
**Are there any issues with the data for this Metric?:**
Yes -– The national staff survey highlighted a higher % of disabled staff compared to non disabled staff say that they are less satisfied with the extent to which the
organisation values their work.
Disabled
38.5%
Non Disabled
43.5%
**31 Does your organisation provide any targeted actions to increase the workplace satisfaction of Disabled staff?**
Yes
**If yes, please provide further details::**
The Trust has offered staff opportunity to attend the annual disability focus groups in order to discuss key issues affecting staff living with a disability. Many of the
issues/ideas from these focus groups are taken as actions and incorporated within the EDS Action Plan.

## Metric 8 - Reasonable adjustments

**32 Are there any issues with the data for this Metric?**
**Are there any issues with the data for this Metric?:**
No issues with this metric.

**33 Does your organisation have a reasonable adjustments policy?**
Yes

**34 Are costs for reasonable adjustments met through centralised or local budgets?**
Local

**35 Has your organisation taken action to improve the reasonable adjustments process?**
No

**If yes, please provide further details::**

## Metric 9 - Disabled staff engagement

**36 Are there any issues with the data (9a) or evidence (9b) for this Metric?**
No
**If yes, please provide details::**
**37 Does your organisation have a Disabled Staff Network (or similar)?**
No
No
**If you answered yes to the above, please give details of the expected timescale.:**
No current plans to establish a network

## Metric 10 - Board representation

**38 Please describe any challenges that your organisation has experienced in collecting and reporting data for this Metric:**
**Please describe any challenges that your organisation has experienced in collecting and reporting data for this Metric::**
None
**39 Does your Board have a champion for disability equality?**
Yes
**If yes, with their permission, please provide name and position of the Board/Executive champion/sponsor::**
Robert Foster
Director of Finance & Deputy Chief Executive
Champion for Inclusion & Diversity

# WWL Trust Library Service 2018/19 Annual Review

What the Trust Library service did for WWL in 2018/19

The WWL Way

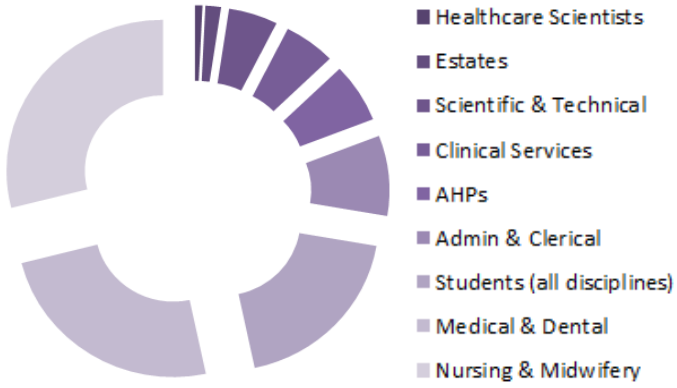
NHS Wrightington, Wigan and Leigh NHS Foundation Trust

## People

**55, 152 VISITORS**

### Membership

The Library Service is multi-professional with membership made up from **230** different jobs roles from all disciplines.




**436 NEW MEMBERS**

## Performance

**2262 book issues**

**22% increase in loans**

**100% KPI achievement**

The library responded to all enquires, and delivered all requests for information within agreed timescales.

**6269 enquiries answered**

120 enquiries per week, 25 enquiries a day.
60% of enquires received are complex information resource enquires requiring the action and support of a professional librarian.

**22 KNOWLEDGE SUMMARIES**

completed that contributed towards service development, management decision making, patient care and research.

## Patients

**185 items sent to other NHS Trusts**

WWL Library now works in partnership will **ALL** NHS Libraries in England for the sharing of resources

**£2500 SAVED**

WWL has used the partnership scheme to borrow books and obtain journal articles saving WWL £2500 on British Library fees.

## Partnerships

**INDUCTIONS**

**263 staff**

library inductions to staff of all grades and all professions.

**6 organisations**

inductions delivered and services provided to staff and students from 6 organisations.

**Information retrieval and critical appraisal skills taught to 104 users**

# REPORT

**AGENDA ITEM: 9.3**

Wrightington, Wigan and Leigh NHS Foundation Trust

| | | | |
|---|---|---|---|
| **To:** | Board of Directors | **Date:** | 17 September 2019 |
| **Subject:** | Employer Based Annual Awards (2018 round) | | |
| **Presented by:** | Director of Workforce | **Purpose:** | Approve |

## Executive summary

The Committee is asked to approve the annual report for the 2018 Employer Based Awards (Clinical Excellence Awards). The round was run in accordance with the Trust policy and national guidelines.

The Committee will note that not all awards were distributed. This results in a carry forward, with the expectation under the national guidelines that all awards are paid by the end of the three year transition period. Given the low number of applications, which has been replicated nationwide, it is hoped that national agreement will be reached between NHS Employers and the BMA regarding the management of any awards not distributed at the end of the three year transition (2020 round).

The annual report meets the required national guideline requirements and has been approved by the LNC. The report will be published when approved by Workforce Committee.

## Risks associated with this report

## Link(s) to The WWL Way 4wards

| | | | |
|---|---|---|---|
| ☐ | Patients | ☐ | Performance |
| ☒ | People | ☐ | Partnerships |

The WWL Way

## ADVISORY COMMITTEE ON CLINICAL EXCELLENCE AWARDS
## LOCAL CLINICAL EXCELLENCE AWARDS
## ANNUAL REPORT FOR 2018 AWARDS ROUND

**Annual report** 1.12 Employers must produce an annual report, to be shared with the trust board and JLNC, detailing the number of consultants eligible, the number of awards granted and the total spend on performance awards including that spent on existing LCEAs. The report will also detail distribution by protected characteristic within the trust. After consideration by the trust board and the JLNC, the report will be available on the trust website. Employing trusts should also make available via the trust intranet a list of successful applicants and the value of award gained. NHS Employers would welcome a copy of the annual report to monitor implementation of the new arrangements and to inform future negotiations on any revised approaches to LCEAs.

**NAME OF ORGANISATION:** **Wrightington Wigan and Leigh NHS Foundation Trust**

**1 Committee Composition**

| Name of Chair | Role |
|---|---|
| Andrew Foster | Chief Executive |
| **Name of Members** | |
| Lynne Lobley | Non -Executive Director |
| Dr Sanjay Arya | Medical Director |
| Alison Balson | Director fo Workforce |
| Dr Nayyar Naqvi | Responsbile Officer |
| Dr Ian O'Connell | LNC Chair |
| Mr Sumedh Talwalker | Divisional Medical Director-Specialist Services |
| Dr Andrew Twist | Divisional Medical Director-Surgery |
| Dr Phil Bliss | Clinical Director - Medicine Division |
| Dr Muhammad Ilyas | Non Award Holder |
| Dr David Valentine ( Absent due to sickness) | External Representative |
| Linda Sykes | Governor |

| | | |
|---|---|---|
| **2** | Were Members selected to comply with the Guidance | YES |
| **3** | Have all Members received training in Valuing Diversity? | YES |
| **4** | Overall number of Consultants eligible for consideration: | 148 |
| | The number of: | |
| | i) Consultants in academic posts | 0 |
| | ii) Women Consultants | 33 |
| | iii) Black, Minority & Ethnic Consultants | 71 |
| | iv) Part Time | 25 |
| **5** | Minimum investment available in [prev year]* | N/A |
| | Amount actually spent in [prev.year] | N/A |
| | Amount carried over into [current year] (if relevant) | N/A |
| | Investment available in 2018 | 135720 |
| | Amount actually spent in 2018 | 99528 |
| **6** | Overall number of award receivers from current year recommendations | 16 |
| | The number of: | |
| | i) Consultants in academic posts | 0 |
| | ii) Women Consultants | 3 |
| | iii) Black, Minority & Ethnic Consultants | 12 |
| | iv) Part Time | 1 |

**7** I confirm that all Consultants recommended for awards have complied with the following criteria during the last 12 months

- had a formal appraisal
- agreed a job plan
- fulfilled their contractual obligations
- complied with private practice code of conduct
- worked to the standards of professional & personal conduct required by GMC/GDC

**8** Recommendation for Awards payable in 2018 Round
Insert these on Tab 2

**9** **Appeals. Please give the numbers of:**

| | |
|---|---|
| i) Appeals received | 0 |
| ii) Appeals upheld (original decision revised or revisited) | 0 |
| iii) Appeals rejected (original decision upheld) | 0 |

**10** **Compliance statement:**
The process adopted by the Trust(s) was completed fairly and in accordance with the guidance issued by ACCEA and mechanisms are in place to advise and support consultants who, having applied for an award, are not advancing in the system.

**11** **Verification of Completion:**

| | | |
|---|---|---|
| | Name of person completing this Report: | Vicky Bateson, Senior HRBP |
| **12** | Submitted to JLNC ( Date of Meeting) | 30.07.19 |
| **13** | Submitted to Workforce Committee ( Date of Meeting) | 17.09.19 |
| **14** | Published on Intranet Site ( Following Workforce committee) | TBC |

**8** Recommendation for Awards payable for 2018 Round

| Name (title, initial, surname) | Level of Award | | Speciality |
|---|---|---|---|
| | Number of Awards | Duration of Award | |
| Liew, Matthew | ***3 Levels*** | ***2 Years*** | ***Urology*** |
| Singh,Fiona | ***3 Levels*** | ***2 Years*** | ***Radiology*** |
| Ismail, Ahmed | ***3 Levels*** | ***2 Years*** | ***Radiology*** |
| Krishnamoorthy, Ramanarayanan | ***3 Levels*** | ***2 Years*** | ***naesthetic*** |
| Chitale, Sarang | ***3 Levels*** | ***2 Years*** | ***heumatolo*** |
| Sreenivasa, Harish | ***3 Levels*** | ***2 Years*** | ***Paediatrics*** |
| Gregory, Chistopher | ***2 Levels*** | ***2 Years*** | ***aematolog*** |
| Hulgur,Mruthunjaya | ***2 Levels*** | ***2 Years*** | Anaesthetic |
| Akhtar, Sohail | ***2 Levels*** | ***2 Years*** | Orthopaedic |
| Tuano-Donnelly, Raquel | ***2 Levels*** | ***2 Years*** | Radiology |
| Kumar, Surrinder | ***2 Levels*** | ***2 Years*** | upational H |
| Flatt,Nick | ***1 Level*** | ***2 Years*** | Anaesthetic |
| Verma,Amit | ***1 Level*** | ***2 Years*** | Obs & Gyn |
| Zipitis, Christos | ***1 Level*** | ***2 Years*** | Paediatrics |
| Ahmed, Syma | ***1 Level*** | ***2 Years*** | Obs & Gyn |
| Khan, Shams | ***1 Level*** | ***2 Years*** | rgency Med |

# REPORT

**AGENDA ITEM: 9.5**

Wrightington, Wigan and Leigh NHS Foundation Trust

| | | | |
|---|---|---|---|
| **To:** | Board of Directors | **Date:** | 25th September 2019 |
| **Subject:** | Mortality Update Q1 2019-20 | | |
| **Presented by:** | Dr Sanjay Arya, Medical Director | **Purpose:** | Information |

## Executive summary

The purpose of this report is to provide the Board of Directors with information regarding Mortality Reviews required by the Learning from Deaths Guidance. This includes the following:

- The total number of the Trust's inpatient deaths (including Emergency Department deaths for acute Trusts);
- Deaths subjected to review: Trusts are required to provide estimates of how many deaths were judged more likely than not to have been due to problems in care.

This report also includes a section on learning from deaths in Community Division.

## Risks associated with this report

There is a divisional Governance risk related to:

- Failure to achieve an improved benchmarked position for mortality.

## Link(s) to The WWL Way 4wards

| | | | |
|---|---|---|---|
| ☒ | Patients | ☒ | Performance |
| ☐ | People | ☐ | Partnerships |

The WWL Way

Wrightington, Wigan and Leigh NHS Foundation Trust

# Mortality Review
# 2019-20 Quarter 1

## 1.0 Introduction

In December 2016 a report from the Care Quality Commission (CQC) *'Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England'* found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements may be missed. In March 2017 the National Quality Board published National Guidance on Learning from Deaths, a framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting, investigating and learning from deaths in care.

The guidance advised that Trusts were required to publish their policy and approach to Learning from Deaths. The Trust published its Mortality Framework at the end of September 2017 and is located here: http://www.wwl.nhs.uk/about_us/mortality_review_framework.aspx

The guidance also advised that Trusts are required to collect specified information on deaths and publish on a quarterly basis. The quarterly reports should be scheduled on the agenda of public Board meetings. The report should include:

- The total number of the Trust's inpatient deaths (including Emergency Department deaths for acute Trusts);
- Deaths subjected to review: Trusts are required to provide estimates of how many deaths were judged more likely than not to have been due to problems in care.

The purpose of this report is to provide the Board of Directors with information regarding Mortality Reviews required by the Learning from Deaths Guidance, outlined above.

## 2.0 Total Number of Inpatient Deaths (By Quarter)

The total number of hospital deaths in 2019-20 Q1 was 312 in comparison with 2018-19 Q4 343, Q3 286, Q2 274 and Q1 293.

## 3.0 Deaths Subjected to Review

The Corporate Mortality Review Team, led by Dr Martin Farrier, Associate Medical Director, amended their processes for reviewing deaths at the beginning of October 2017 to reflect the recommendations from the Learning from Deaths Guidance. The Corporate Mortality Review for Q1 2019-20 concluded the following:

| | Deaths | | | Review and Score | | | | | | Learning Disability | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Quarter | Total | Reviewed | Avoidablity >50% | Score 6 - Definitely not avoidable | Score 5 - Slight evidence Avoidability | Score 4- Possibly avoidable but not very likely | Score 3- Possibly avoidable | Score 2 - strong evidence of avoidabilty | Score 1 - Definitely avoidable | Total | Reviewed | Avoidability |
| Q1 19/20 | 312 | 108 | 1 | 95 | 8 | 6 | 1 | 0 | 0 | 0 | 0 | 0 |

### 3.1 Potentially Preventable Deaths

**1** death was escalated by the Corporate Mortality Review Team as potentially preventable related to missed sepsis. This was de-escalated following further investigation.

### 3.2 Themes/Learning

Learning noted by the Corporate Mortality Review Team and shared included:

- Drug omissions in a patient with Parkinson's
- Long wait in A&E
- Delayed treatment in sepsis
- Failure to respond to deterioration
- Missed dose of antibiotics
- Missed medication because of transfer
- Missed pelvic fracture
- Failure to escalate
- Patient with gastrointestinal bleed transferred over from Wrightington
- Failure to detect a pericardial bleed
- Failed discharge
- Care of patient with end stage renal failure
- Surgery performed; however, unclear if this was beneficial

## 4.0 Unexpected Deaths Reported to STEIS in Q1 (2019-20)

The Trust submitted **2** unexpected or potentially avoidable deaths to STEIS in Q1 (2019-20):

1. Missed medication to prevent the development of gastric ulcers;
2. A neonatal death.

## 5.0 Prevention of Future Deaths Notices

The Trust did not receive a Prevention of Future Deaths (PFD) Notice from the Coroner in Q1 2019-20.

## 6.0 SHMI (Summary Hospital Level Mortality Indicator) and HSMR (Hospital Standardised Mortality Rate)

The Trust's HSMR YTD to March 2019 (latest available data) was 98.4. The last two months of available data for weekend HSMR has demonstrated improvements (99.7 in February 2019 and 87.3 in March 2019). The Trust's SHMI was 113.3 for a rolling 12 months from March 2018 to February 2019, a decline from 109.1 for the previous reporting period.

## 7.0 Mortality Group

The Trust Mortality Group, chaired by the Medical Director, met in June 2019. The Group received a presentation from Dr Foster regarding the Trust's weekend mortality data. The Group also received case reviews related to the following:

- Unplanned Transfers from Wrightington;
- Endocarditis;
- NIV Pathway.

## 8.0 Community Division

Community Services transferred to WWL from Bridgewater Healthcare NHS Foundation Trust in August 2019. Community deaths are currently not reviewed by the Corporate Mortality Review Team.

Further consideration is required to integrate Community into the Trust-wide approach for mortality review given the different systems and notification of deaths. There is a process in place to review deaths. Community staff are requested to report all unexpected deaths they become aware of as an incident. Community staff are also requested to report child deaths, deaths of patients with a learning disability, deaths of patients under care of the Community Response Team and deaths of patients in community beds at Bedford House care home. Reviews are undertaken and considered at the Community Divisions Patient Safety Review meeting. Concerns regarding lapses in care are then escalated to Executive Scrutiny Committee. In Q1 2019-20 3 deaths were reported as an incident, 2 child deaths (no concerns related to the care) and 1 adult death which is under review.

The Medical Director has commissioned a review of deaths within 30 days of discharge by a GP, which will consider care and treatment provided by Primary Care and Community.

**Director of Governance and the Corporate Mortality Review Team**
**September 2019**