Board of Directors

27 November 2019, 12:00 to 14:00
The Boardroom, Royal Albert Edward Infirmary, Wigan Lane, Wigan, WN1 2NN

Agenda

1
Chair and quorum

Information

Robert Armstrong

2
Apologies for absence

Information

Robert Armstrong

3
Declarations of interest

Information

Robert Armstrong

4
Minutes of previous meeting

2 minutes
Approval

Robert Armstrong

Minutes - P1 board - 25 Sep 2019.pdf	(6 pages)	

5
Staff story

10 minutes
Discussion

Julie Barrett

6
Patient story

10 minutes
Discussion

Helen Richardson

7
Chair and Chief Executive's report

5 minutes
Discussion

Robert Armstrong/Silas Nicholls

Chief Executive's report.pdf	(5 pages)	
Pauline Fletcher Winter Letter 2019-11-05.pdf	(5 pages)	

8
Assurance and governance:

75 minutes

8.1
Board assurance framework and committee chairs' reports

Verbal reports

Information

Committee chairs

BAF Patients - November 2019.pdf	(2 pages)	
BAF People - November 2019.pdf	(3 pages)	
BAF - Performance - Nov 2019.pdf	(2 pages)	
BAF - Partnerships - Nov 2019.pdf	(2 pages)	

8.2

Performance report

Discussion

Helen Richardson/Mary Fleming/Sanjay Arya

Performance Report October 2019.pdf (12 pages)

8.3

Finance report

Discussion

Rob Forster

Finance report.pdf (6 pages)

8.4

Safe staffing report

Discussion

Helen Richardson

Safe staffing report.pdf (29 pages)

9

Care Quality Commission unannounced inspection feedback letter

10 minutes

Discussion

Helen Richardson

CQC inspection feedback letter.pdf (7 pages)

10

Consent agenda:

10.1

EPRR core standards report

Approval

EPRR cover.pdf (3 pages)

EPRR appendix.pdf (1 pages)

EPRR appendix 2.pdf (4 pages)

EPRR appendix 3.pdf (2 pages)

10.2

Review of cycle of business

Approval

Review of board cycle of business.pdf (4 pages)

11

Questions from the public

12

Resolution to exclude the press and public

WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST

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

HELD ON 25 SEPTEMBER 2019, 12.00 NOON

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

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	✔	✔	✔	A				
Mr R Forster	Director of Finance and Informatics	✔	✔	A	✔				
Mr A Foster	Chief Executive	A	A	✔	A				
Mr M Guymer	Non-Executive Director	✔	✔	✔	✔				
Mr I Haythornthwaite	Non-Executive Director	✔	✔	A	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)
Mr S Curran	Director of Operations, Medicine
Mr P Howard	Company Secretary (minutes)
Mr S Nicholls	Chief Executive Designate

2 governors and 2 members of staff were also in attendance.

143/19 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 opened by presenting the Deputy Chief Executive with his 10 year service award and by thanking the Chief Executive *in absentia* for his service as he approaches retirement, and to wish him well for the future. Note was made of the fact that further opportunities to acknowledge the work of the Chief Executive would be held later in the week.

144/19 Apologies for absence

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

145/19 Declarations of interests

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

146/19 Minutes of the previous meeting

The minutes of the previous meeting held on 31 July 2019 were agreed as a true and accurate record.

147/19 Patient experience video

The Chief Nurse presented a patient experience video which charted the story of a visually impaired patient from Wigan who accesses services for a variety of medical conditions at various locations across Greater Manchester. The video demonstrated the challenges faced by those who are reliant on public transport and noted that, on occasion, the time taken to travel to appointments can be significant. The Chair commented on how powerful the video was and agreed to share it with the Council of Governors at its next workshop for wider information.

The Director of Finance noted that the video emphasised the need for basic compassion and the Director of Strategy and Planning noted the importance of supporting patients with self-care as demonstrated in the video.

The Board received and noted the patient experience video.

148/19 Chair and Chief Executive's report

The Chair opened by noting that he had recently highlighted the issue of pension taxation in discussion with Baroness Dido Harding and also the issue of national capital constraints.

The Director of Finance presented the written report drafted by the Chief Executive which had been provided in advance of the meeting and highlighted in particular the achievements relating to Accident and Emergency performance.

In response to a question from the Chair on the quality metrics noted in the report, the Chief Nurse advised that every case of *C. difficile* is subject to review, including whether antibiotics were in use. She noted that the organisation seeks to learn lessons from each case and the Chair noted that the issue is monitored via the Quality and Safety Committee for assurance purposes.

The Board received the report and noted the content.

149/19 Committee chairs' reports

The Board received verbal reports from committees which had met since the previous meeting of the board.

Prof T Warne provided a summary of the recent Quality and Safety Committee meeting which had considered the matter of sepsis and confirmation was provided that a more detailed report would be provided to the October meeting of the committee. The committee had also received an informative presentation from the pressure ulcer task and finish group as well as a report on medicine management. Improvements, such as the need to standardise insulin charts, had been identified within the latter report and discussed by the committee. It had also received assurance around the pilot to deploy Pharmacy Technicians onto wards in support of discharge. An amber delivery confidence on the board assurance framework had been agreed.

The Quality and Safety Committee had also recently held an away day to consider the scope, function and membership of the group. Prof T Warne noted that updated terms of reference would be produced as a result for the Board's consideration.

Mrs L Lobley advised that the Workforce Committee had also held an away day session which had considered the issues that had been highlighted for the committee's review by the Board as well as providing an opportunity to better understand the workforce plan and alternative staffing models. The committee had heard a powerful staff story which had resulted in the development of a "fair experience for all" approach and had supported the development of the "civility saves lives" campaign. An amber-red delivery confidence had been agreed.

Mr M Guymer provided an overview of the Finance and Performance Committee meeting and noted that there had been two significant items of business; the presentation from the Division of Community Services and the financial forecast and strategy. A red delivery confidence had been agreed.

With regard to the board assurance framework for partnerships, the Chair noted that the Community Services Committee and the Secondary Care Transformation Board had recently met and that the former was delivering as anticipated. With regard to the Secondary Care Transformation Board, the Chair noted that it had not met for some time but that this had been the result of a conscious decision to allow a period of reflection on the purpose of the group. He also noted that an opportunities workshop would be held in the near future with commissioners to discuss the matter further. An amber-red delivery confidence was agreed.

The Board received the chairs' reports and noted the content. The Board also **APPROVED** the board assurance framework dashboards as presented.

150/19 Performance report

The Chief Nurse opened this item by highlighting the fact that no moderate or severe falls had been reported in-month and that the safety thermometer performance stood at 98% for the period. She confirmed that a never event had been reported in August 2019 and noted that a learning event would be taking place in October 2019 to ensure that learning from never events is appropriately shared.

The Board received the performance report and noted the content.

151/19 Financial position as at 31 August 2019

The Director of Finance presented a report which had been circulated with the agenda to summarise the foundation trust's financial position as at 31 August 2019. Note was made of the fact that more detailed analysis of the foundation trust's financial position had taken place at the Finance and Performance Committee earlier in the day.

The Board received the report and noted the content.

152/19 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.

The Chief Nurse highlighted the fact that the reports showed the positions based on the e-roster but clarified that dynamic risk assessments are undertaken and staff are moved as necessary to ensure safe staffing levels are maintained. She noted her intention to review the format and content of the report in the future and comments from directors were welcomed.

At the suggestion of the Chair, the Chief Nurse agreed to arrange for a demonstration of the Safer Care Tool at a future Board workshop.

ACTION: Chief Nurse

The Board received the report and noted the content.

153/19 Flu report

The Director of Strategy and Planning presented a report which had been circulated in advance of the meeting to outline the foundation trust's plan for flu vaccination.

The Board received the report and noted the content. It also confirmed its commitment to achieving the ambition of 100% of frontline healthcare workers being vaccinated against flu and for any healthcare worker who decides, on the balance of evidence and personal circumstances, against getting the vaccine to anonymously record their reason for declining vaccination.

154/19 Mortality report

The Medical Director presented a report which had been circulated with the agenda to provide the Board with information regarding mortality reviews as required by Learning from Deaths guidance.

The Board received the report and noted the content.

155/19 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 Workforce Race Equality Standard report and the Workforce Disability Equality Standard report be received and noted.

2. THAT the library service annual report 2018/19 be received and noted.

3. THAT the employer-based annual awards report for the 2018 round be **APROVED**.

It was agreed that a summary of progress in the three key equality areas would be provided to the Board at an appropriate point in time, once plans have been developed.

ACTION: Director of Workforce

156/19 Questions from the public

No questions from the public were received.

157/19 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.

158/19 Date, time and venue of next meeting

The next meeting of the Board of Directors will be held on 27 November 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
25 Sep 2019	152/19	Safe staffing report	Arrange for demonstration of Safer Care Tool at future Board workshop	Chief Nurse	ASAP	Session delivered in October 2019. **Action complete**.
25 Sep 2019	155/19	Consent agenda	Present a summary of progress in the three key equality areas at an appropriate point in time, once plans have been developed.	Director of Workforce	At an appropriate time.	Action not yet due.

REPORT

AGENDA ITEM: 7

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

To:	Board of Directors	**Date:**	27 November 2019
Subject:	Chief Executive's report		
Presented by:	Chief Executive	**Purpose:**	Information

Executive summary

The purpose of this report is to highlight a number of areas for the Board's information.

Risks associated with this report

There are no risks associated with the content of this report.

Link(s) to The WWL Way 4wards

☐	Patients	☐	Performance
☐	People	☐	Partnerships

The WWL Way

1. INTRODUCTION

1.1. I am delighted to return to Wrightington, Wigan and Leigh NHS FT and to present my first Chief Executive's report to the Board. Having worked here previously as Director of Strategy and Deputy Chief Executive from 2010 to 2014, I feel privileged to get the chance to return to the WWL family and I am looking forward to building on WWL's ethos of quality, staff engagement and strong performance against national standards. I have a clear and exciting vision for the organisation which, with the Board's support, I look forward to making a reality.

1.2. My first working day with WWL was on 28 October 2019 and I began the day by attending a meeting of our CQC Stakeholder Committee, where representatives from all parts of the organisation came together to discuss both the unannounced Care Quality Commission (CQC) inspection that had taken place in the previous week and our preparations for any subsequent inspections that may take place. The Chief Nurse will be providing an overview of the initial findings from the unannounced inspection later on the agenda, and colleagues will note that today's meeting is being observed by representatives from the CQC as part of the planned well-led inspection. I am sure you will join with me in welcoming them to the meeting.

1.3. As part of my return to the organisation I have attended the formal induction session on 4 November 2019 where I was able to meet with other new starters and discuss our thoughts and feelings as we embark on our new roles with WWL. I have also undertaken a number of visits to various sites to meet people and to get a feel for the various services that we provide. I would like to take the opportunity to thank everyone I have met who has been so accommodating – and so understanding when I have asked many questions! – and I look forward to undertaking many more visits in the future.

2. HEALTHIER WIGAN PARTNERSHIP AND THE LOCALITY PLAN REFRESH

2.1. Colleagues will be aware that we are having system-wide discussions about Healthier Wigan Partnership, the alliance between all health partners in Wigan, and how we can streamline the governance processes associated with it. As an organisation we are committed to the partnership and we have contributed to this important piece of work. I look forward to seeing the results being implemented in the near future.

2.2. We collectively believe that the Healthier Wigan Partnership should be the model under which all health and care services in Wigan should be provided. On 13 November 2019, the Healthier Wigan Partnership held a workshop to consider how the scope of the partnership can be expanded to support this aim.

2.3. In line with the place-based approach, all health partners in Wigan have contributed to a refreshed Locality Plan which was shared with the Board in draft form and endorsed. This document will be published in the near future and it will be supported by dedicated delivery plans for each of its key objectives. Copies of this document will be available to download from our website and from those of other key stakeholders across the borough.

3. WINTER PRESSURES LETTER FROM NHS ENGLAND AND IMPROVEMENT

3.1. Colleagues will have seen the letter from the National Director of Emergency and Elective Care, Pauline Philip, and the Executive Regional Director for the North West, Bill McCarthy, dated 5 November 2019 surrounding winter preparedness; a copy of which is appended to this report for information. The letter includes a suggestion to develop a "Winter Delivery

Agreement" and I will ask the Chief Operating Officer to elaborate on this more fully under the performance report agenda item.

3.2. The letter also references the continuing impact of pension taxes on doctors and notes the recent publication of guidance by NHS Employers. The letter sets out an expectation that organisations that have not yet done so should make immediate use of the flexibilities available under the NHS Employers guidance, including the potential to operate a "pension exchange" policy for eligible staff.

3.3. In line with the request from NHS England and Improvement, the issue has been considered in detail by the Directors of Workforce across Greater Manchester who have prepared a framework and policy with the aim of standardising any approach across the system. Importantly, the approach proposed by the Directors of Workforce would apply to all staff groups and includes robust eligibility criteria based on independent legal advice to mitigate known risk; most notably informed by an equality impact assessment. The criteria also provides assurance that any additional tax liability must have arisen from remuneration from an NHS employer and not as a results of supplementary income from private work, for example.

3.4. That said, it is generally felt across the system that the implementation of such a policy should be a matter of last resort and organisations should ensure that all other options have been exhausted before use. The reputational and engagement risk is significant and must be considered as part of our implementation considerations. As at the date of writing there is no formal agreement amongst Greater Manchester NHS organisations to implement the arrangements and I will invite the Director of Workforce to provide a more contemporaneous update at the meeting if one is available.

4. USE OF RESOURCES ASSESSMENT

4.1. On 11 November 2019 we were joined by representatives from NHS England and Improvement and the Care Quality Commission as we undertook our annual Use of Resources assessment. This assessment, which aligns with the annual well-led inspections undertaken by the CQC, looks at how effectively organisations are using their finite resources to provide high-quality, efficient and sustainable care for patients. This isn't just about money – the assessment looks at workforce, estates and facilities, technology and procurement.

4.2. Led by the Director of Finance, we provided a detailed submission and we spent a day with the assessors, responding to their questions and providing additional information on request. We look forward to hearing the outcome of the assessment in due course.

5. ORGANISATIONAL STRATEGY DEVELOPMENT

5.1. Colleagues will recall that the Board previously took the decision to pause the development of the new organisational strategy until I had taken up post. I have already begun the process of reviewing our approach and I will be working closely with the Director of Strategy and Planning to develop an updated strategy for the Board's consideration in the coming months.

5.2. As part of this strategy development I am keen to ensure that we take key stakeholders' views into account including our staff, patients, governors and partners. It is therefore my aim to ensure that we have an outline strategy developed for wider discussion in good time to allow us to consult with stakeholders and subsequently adopt the new strategy from April 2020.

6. CAPITAL EXPENDITURE

6.1. As a result of slippage in the capital programme, the Executive Team has recently considered and approved a number of additional business cases. Subject to final agreement by the Finance and Performance Committee, we will shortly be investing in a refresh of the decade-old IT system for pathology reporting which will help to improve reporting times and improve the patient experience by facilitating earlier diagnosis.

6.2. By the end of November 2019 we will have approved over £9m of capital projects covering medical equipment, estates and IT and more projects are expected to be approved in the coming months. As an organisation, we are committed to continued investment in maintaining the highest quality services for our patients, staff and visitors.

7. CORPORATE GOVERNANCE REVIEW

7.1. Working with the Chairman, I am keen for us as an organisation to review our corporate governance arrangements to ensure that we work as efficiently and as effectively as possible. The Chairman and I have asked the Company Secretary to undertake a review of the Board and Committee reporting arrangements and, as part of that review, to formulate recommendations on potential changes to the structure, meeting frequency and attendance. We look forward to discussing these proposals with the Board at a future workshop.

8. RECOGNISING EXCELLENCE AWARDS

8.1. On 8 November 2019, I attended the annual Recognising Excellence Awards ceremony along with many other Board members and I am sure that those of you who were also there will agree that it was a resounding success. The event, organised by a committee of willing volunteers and supported financially by sponsor organisations, was a real celebration of the work of our staff and it was great to see so many colleagues enjoying themselves together. I would like to thank everyone who was involved in putting the event together, as well as all those who submitted nominations for the awards.

8.2. The winners of the various awards were as follows:

- Best example of support services – Endoscope Reprocessing Unit
- The *Go Engage* award – the Communications, Quality and Governance teams for the ASPIRE accreditation system
- The Hidden Gem award – Vikki Lloyd
- Best example of care and compassion – the COPD team
- Best example of innovation and improvement (clinical) – Ambulance Assessment Team
- Best example of innovation and improvement (non-clinical) – Leigh Catering Team
- Best example of working together - the Multidisciplinary Team
- Learner of the Year – Lesley Ann Holding
- Chairman's Award – David Evans

9. OTHER AWARDS

9.1. I am sure that the Board will wish to join me in congratulating the *Go Engage* team for their success at the Business Culture Awards 2019. The awards recognise the importance of a

great culture in enhancing business performance and in attracting and retaining the best people, which has a real synergy with the organisational development work undertaken through the *Go Engage* programme; both in-house and externally.

9.2. The team had a tremendous success at the ceremony on 15 November 2019, not only winning awards for the Best Public/Not-For-Profit Organisation for Business Culture and for the Best Use of Technology and Analytics for Business Culture, but the team was also named as the Business Culture Award Overall Winner for 2019/20. This is a fabulous achievement, particularly given that they shared the stage with some real household names.

9.3. Our Independent Domestic Violence Advisor ("IDVA") Service Team was also announced as the deserving winner of the Patient Safety Improvement category at the Nursing Times Awards in October 2019. The team were crowned as winners for their work in creating and implementing the Hospital IDVA role which the first fully NHS-funded role in the country.

10. FLU VACCINATION

10.1. At its last formal meeting the Board confirmed its commitment to achieving the ambition of 100% of frontline healthcare workers being vaccinated against flu and for any healthcare worker who decides, on the balance of evidence and personal circumstances, against getting the vaccine to anonymously record their reason for declining vaccination.

10.2. As at the date of writing, 42% of frontline staff have received their vaccination and work continues to provide further vaccination opportunities. National challenges around availability of the vaccine have hindered progress to date somewhat and we are therefore increasing the number of vaccination sessions that are available across our sites.

10.3. This year we are also offering staff the opportunity to get a flu jab at a time and place convenient to them by providing vouchers which can be redeemed at over 3,000 retailers and pharmacies nationwide.

11. RECOMMENDATION

11.1. The Board is recommended to receive this report and note the content.

Skipton House

80 London Road

London

SE1 6LH

Publishing Approval Number: 001239

To

- **Trust Chairs and Chief Executives**
- **CCG Chairs and Accountable Officers**
- **Directors of Adult Social Services**
- **STP/ICS chairs and STP/ICS leads**

Tuesday 5th November 2019

Dear Colleague,

On behalf of the NHS, thank you for your leadership and the extraordinary dedication of your staff as the NHS looks after record numbers of patients.

During recent weeks, we have worked with you to complete a national stocktake of winter readiness and talked to many of you directly about how we can deliver for patients for the rest of this year.

It is clear from your feedback that local partnership working has further developed over the past year, providing the opportunity to jointly tackle challenges more effectively, with mutual assistance and accountability. It has been suggested that individual organisations would find it helpful if these arrangements were now confirmed locally in a 'Winter Delivery Agreement'. To support your work we have set out in Appendix 1 an approach you may find useful.

We have, as part of the stocktake discussions, been asked to set out what the expected national "defaults" now are on several important elements. They are:

1. This winter the goal should, wherever possible locally, be more General and Acute (G&A) hospital beds open, to reflect increased levels of patient need and admissions.
2. Work with Local Authorities to ensure the same or more care packages and nursing/residential home beds are available over the winter period than last year, with the same level of visibility and dual sign-off on these plans.
3. GP Out of Hours services should be expected to deliver services from 8pm to 8am 7 days per week and, critically, over bank holidays.

4. Ensure mental health services can respond quickly and comprehensively, particularly in relation to ED presentations.
5. Community health services able to operate to the same 'clock speed' of responsiveness as acute emergency services, e.g. 2 hour home response where that would avoid hospital admissions or speed discharges.
6. Improving uptake of the flu vaccine:
    - A further increase in staff vaccinated to 80% or above, including through the 'buddy' arrangements in place to support trusts that struggled with this last year;
    - Achieving maximum levels of vaccination for eligible patients in community, general practice and pharmacy settings.

We also heard clearly from the stocktake process that our most significant shared challenge relates to workforce availability – particularly nursing – and also the continuing impact of pensions taxes on doctors.

The Government's second consultation on reform of the NHS Pension Scheme closed on 1 November and they have agreed to review the tapered allowance.

In the meantime, NHS Employers have published guidance on the options available to trusts to support staff and service delivery in dealing with the pension tax. Many trusts have already put in place schemes with a positive impact on clinical workforce supply, but a number of provider board members have requested clarification on what the national 'default' should now be. We can confirm that of the options set out by NHS Employers, among the most effective have been local policies on the payment of employer contributions foregone as additional salary where scheme members have elected to opt out of the scheme due to tax arrangements (see in particular section 3b of the September 2019 guidance from NHS Employers). We are now signalling our expectation that trusts that have not done so already should make immediate use of the flexibilities available (unless they are demonstrably not experiencing any issues with medical staff availability). We can provide examples of guidance and Board papers used by trusts that have already implemented schemes if that would be helpful.

We would find it very helpful if chairs or chief executives confirm in the next fortnight the arrangements they have in place or intend to put in place, through Regional Directors. Given the urgency, where Remuneration Committee approval is considered necessary we would ask that these meetings are arranged on an extraordinary basis.

In the coming weeks Regional Directors will work with you to support the development of Winter Delivery Agreements and implementation of pension flexibilities. Please let them know if there is any further information or practical support we can provide, to understand the progress you are able to make and how we can best support you.

Yours Sincerely

Pauline Philip DBE
National Director of Emergency and Elective Care

Bill McCarthy
Executive Regional Director (North West)

Appendix 1: Developing a delivery agreement

From the feedback we have received we suggest that it would be helpful for each system to develop a 'Winter Delivery Agreement'. The agreement would build on the work that has taken place on winter planning at STP/ICS level. The focus of the Agreement would be to set out how organisations in the STP/ICS will work together to maximise capacity, both in hospitals and in the community during winter.

Systems are likely to want to:

- Discuss the progress of current winter planning and the extent to which it delivers additional capacity across key service components

- Discuss the outcomes of the stocktake exercise for all organisations in the system and the expectations for mutual support and support from programmes and corporate teams

- Agree what further can be done to increase capacity this winter to deliver the six priority expectations set out in this letter

You may also find it helpful to use the following list to help explore opportunities:

- GP Streaming – Increasing the proportion of patients who are streamed to primary care if they don't require A&E

- Same Day Emergency Care (SDEC) – Increasing the proportion of patients who can be treated without requiring an overnight hospital admission, and establishing an acute frailty team for 70 hours per week by the end of December 2019

- Increasing the proportion of patients discharged over weekends to reduce pressures on inpatient beds and patient flow at the start of the week

- Reducing the number of patients with a long length of stay to ensure inpatient spells are no longer than is clinically appropriate, in order to improve patient experience and to increase the available bed stock

- Continuing the increase of the number of people accessing support and bookable services through NHS 111

- Continuing to expand the availability of Urgent Treatment Centres to ensure that type 1 Emergency Departments are not the default for patients with minor injury and minor illness

- Escalation – Hospital supported by systems put measures in place including the use of full capacity protocols to minimise ambulance queues and improve patient flow out of EDs.

- Primary Care – ensuring GP OOHs provision have planned for activity peaks and that extended access hubs are well sign-posted

- Intermediate care – local community services should be assured that step-up/step-down beds and workforce capacity are sufficiently resourced for increased winter demand

- Elective care – capacity for elective treatment should be delivered so that elective treatment volumes agreed at the start of the year between commissioners and providers are delivered

- Cancer care – ensuring capacity for delivering and managing cancer diagnosis and treatment achieves improvements in the number of patients whose treatment starts in less than 62 days from urgent referral

- Diagnostic services – increasing capacity for diagnostic services to significantly reduce waits of over six weeks and in targeted service areas to reduce the lengths of wait for elective and cancer care

- Directory of Services and MiDOs – local partners should be assured that all information with the local DoS is up to date and well connected to the relevant ambulance service(s)

- Bank holiday capacity planning – as in previous years, a more detailed exercise will be run on planned bank holiday capacity to ensure gaps are avoided and sufficient capacity is planned for ahead of potential activity surge. This exercise will be run closer to the Christmas/NYE period once local demand and capacity planning has advanced and rostering is underway.

Our intention is that a Winter Delivery Agreement belongs to the system locally and we are not suggesting that it needs to be shared nationally. However, we are asking that you share with your Regional Director what additional capacity in terms of beds, out of hospital care, etc that you have been able to identify.

Patients:
Every patient receives the best possible care

Executive lead(s):	Director of Nursing Medical Director	**Reviewing committee:**	Quality and Safety Committee	**DELIVERY CONFIDENCE** **CURRENT MONTH:**	**WEIGHTED DASHBOARD** **MONTH:** 1.73 **YTD:** 3.11
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 ▪ Scrutiny by Board of Directors ▪ Use of internal and external auditors		▪ Escalation of emerging risks ▪ Divisional performance reviews ▪ REMC	**ROLLING TREND:** Oct 2019 / Sept 2019 / July 2019 / June 2019	**ROLLING TREND:** Oct 2019: 2.42 Sept 2019: 2.71 July 2019: 2.00 June 2019: 2.85

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	20
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

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	**0 MTD 3 YTD**	0 (MTD)		1 (MTD)	2 or 3	>3 (YTD)	**2**	1 x 2 = 2	5 x 2 = 10	Perf. Report (Oct 2019)
Patient Safety	% of 'red sepsis' patients receiving antibiotics within 1 hour in A&E	**70%**	≥95%	94% - 90%	89%-85%	84%-80%	<80%	**1**	5 x 1 = 5	---	A&E Monthly Audits
Patient Safety	No. of Never Events	**0 MTD 3 YTD**	0				1	**3**	1 x 3 = 3	5 x 3 = 15	Perf. Report (Oct 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 (Oct 2019)
Infection Control	No. of C. diff Lapses in Care	**0 MTD 6 YTD**	0	1 (MTD)	2	3 (YTD)	>4 (YTD)	**2**	1 x 2 = 2	5 x 2 = 10	Perf. Report (Oct 2019)
Patient Experience	% of patients recommending WWL for care	**94%**	≥95%	94% - 90%	89%-85%	84%-80%	<80%	**2**	2 x 2 = 4	---	Monthly FFT (Sept 2019)
Patient Experience	% of patients feeling involved with decisions about their discharge	**89.12%**	≥95%	94% - 90%	89%-85%	84%-80%	<80%	**1**	3 x 1 = 3	---	Perf. Report (Oct 2019)
Patient Experience	% of complaints responded to within the timescale agreed with the patient	**50%M 64.63% Y**	≥95%	94% - 90%	89%-85%	84%-80%	<80%	**1**	5 x 1 = 5	5 x 1 = 5	Perf. Report (Oct 2019)
Mortality	HSMR	**91.46% M 104.6% Y**	≤100 (MTD)	101-105 (YTD)	106-110	111-115	>115	**3**	1 x 3 = 3	2 x 3 = 6	Perf. Report (July 2019)
Mortality	SHMI	**114.8%**	≤100	101-105	106-110	111-115	>115	**1**		4 x 1 = 4	Perf. Report (May 2019)
Mortality	No. of PFDs	**0**	0	1	2	3	>4	**2**	1 x 2 = 2	1 x 2 = 2	Perf. Report (Nov 2019)
Medicines Management	% of critical medicines prescribed within 24 hours of admission or before the patient is transferred to a new area	**90.8%**	100%	99-95%	94-90%	89-80%	<80%	**1**	3 x 1 = 3	---	Pharmacy (Oct 2019)
Medicines Management	% of completed medicines reconciliation within 24 hours	**86.8%**	100%	99-95%	94-90%	89-80%	<80%	**2**	4 x 2 = 8	---	Pharmacy (Sept 2019)
Total									(45/26)	(56/18)	
Average									1.73	3.11	

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. Corporate objectives: • Improve staff engagement and organisational culture so that staff feel happy and supported in work, feeling empowered to deliver positive change • 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 ▪ Scrutiny by Board of Directors ▪ Use of internal and external auditors		▪ Escalation of emerging risks ▪ Exec-to-exec meetings ▪ REMC	ROLLING TREND:				ROLLING TREND:			
				Sep 2019	Jul 2019	Jun 2019	May 2019	4.00 Sep 2019	4.00 Jul 2019	4.00 Jun 2019	3.25 May 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	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.	20
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

Employment Essentials

- Nurse recruitment & retention proposal supported by Executives and submitted to F&P for approval
- One stop recruitment event 6/11/19 successful. Events to be run quarterly, with targeted advertising support
- Workforce plan has been developed, focusing on the multi-disciplinary team and skills & competencies wrapped around patients. This includes complimentary workforce models, enhanced advance practice roles and addresses skill mix concerns.
- New Direct Engagement system in place, using NHSP
- The WWL Just Culture & Civility programme has been launched.
- LLP pilot operational. Consideration of alternative pension tax schemes.
- Chief AHP appointed.

Go Engage

- New approach to internal communication commencing, including enhanced use of technology
- Go Engage Teams programme – positive number of applications for the next cohort
- Strategy development – with engagement of staff
- Freedom To Speak UP Guardian business case approved for appointment
- Exit interview and itchy feet processes now agreed

Steps 4 Wellness

- Business cases are in final sign off stages – health & well-being app and attendance management system.
- Britain's Healthiest Workplace – most improved organisation. Demonstrates evidence based approach to health & well-being interventions and impact.

WWL Route Planner

- Core skills matrix being considered at Education Governance at the end of November. Action plans to address low levels of compliance in relevant areas
- "Learn and Grow" employment USP to be underpinned by an education and leadership strategy – framework to be presented at Workforce Committee in December
- Review of the My Route Plan documentation has commenced, incorporating feedback from MIAA audit.

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	8.46%	≤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	16.01%	≤10%	11-14%	15-20%	21-24%	≥25%	1	3 x 1 = 3	3 x 1 = 3	Workforce team
Route Planner	PDR completion	83.8%	≥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								8	32	32	
Average									4	4	

Performance:
We aim to be in the top 10%

Executive lead(s):	Chief Operating Officer 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:** 3.39 **YTD:** 3.57
Sources of assurance:	▪ Scrutiny by Finance and Performance Committee ▪ Scrutiny by Board of Directors ▪ Use of internal and external auditors ▪ Escalation of emerging risks ▪ Divisional performance reviews ▪ REMC			**ROLLING TREND:**  Oct 2019 Sep 2019 Jul 2019 Jun 2019	**ROLLING TREND:** 2.83 3.04 2.74 3.47 Oct 2019 Sep 2019 Jul 2019 Jun 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 considered in October 2019.	20
Potential closure of RAEI theatre 1 and 2 following annual verification report	20	Risk escalation considered in October 2019.	20
Accuracy and reliability of community information	15	Risk escalated to Quality and Safety Committee, task and finish group created	20
Finance 2019/20	15	Divisions tasked to assess their own finance risks	20
Failure of standalone chilled water system serving CT scanner 2	20	(New risk) Accepted as a 20, work ongoing to mitigate	20
Potential risk of theatre 6 failure following next revalidation	20	(New risk) IPC team to share risk assessment for inclusion.	20
Radiology PACS hardware	20	(New risk) Business case on 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: **31 OCT 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	86.12% M 87.15% Y	≥95%	94.9-90%	89.9-80% M & YTD	79.9-70%	≤70%	2	3 x 2 = 6	3 x 2 = 6	BI (Oct 2019)
12-hour operational standard	No patient requiring emergency admission will wait 12 hours in A&E	2 M 2 Y	0 MTD & YTD				1	2	5 x 2 = 10	5 x 2 = 10	BI (Oct 2019)
Ambulance handover standard	All handovers between ambulance and A&E must take place within 15 mins with none waiting >60m	21 > 60m M 76 > 60m Y	≤ 15 mins	15-30 mins		30-59 mins MTD	>60 mins M & YTD	1	5 x 1 = 5	5 x 1 = 5	BI (Oct 2019)
Cancer treatment times	85% should wait no more than 62 days from urgent referrer to first definitive treatment	81.63% M 85.59% Y	≥85% YTD				≤84.9% Mth	2	5 x 2 = 10	1 x 2 = 2	BI (Oct 2019)
18-week RTT	92% on incomplete RTT pathways (yet to start treatment) should wait no more than 18 weeks	91.19% M 92.01 Y	≥92% YTD				≤91.9% Mth	1	5 x 1 = 5	1 x 1 = 1	BI (Oct 2019)
52-week RTT	Zero tolerance for patient waits over 52 weeks on an incomplete pathway	0 M 3 Y	0 Mth				≥1 YTD	2	1 x 2 = 2	5 x 2 = 10	BI (Oct 2019)
Diagnostic waiting times	99% of service users waiting for a diagnostic test should receive it within 6 weeks of referral	99.20% M 99.01% Y	≥99% MTD				≤98.9%	1	1 x 1 = 1	1 x 1 = 1	BI (Oct 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 2 quarter	Achieve 4 quarters	3 quarters	2 quarters	1 quarter	0 quarters	4	3 x 4 = 12	3 x 4 = 12	Forecast
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 2 quarter	Achieve 4 quarters	3 quarters	2 quarters	1 quarter	0 quarters	4	3 x 4 = 12	3 x 4 = 12	Forecast
Transformation	SAVI delivery against target	(37.5%) - M (9%) - Y	Achieved YTD	Fail by <10% M	Fail by 10-20% MTD	Fail by 20-30%	Fail by >30% Y	3	2 x 3 = 6	5 x 3 = 15	Finance report
IT	Completion of agreed IT priorities in line with plan	71% M	100%	90-99%	80-89% MTD	70-79%	≤70%	2	4 x 2 = 8	---	IT department
Total								25	78(/23)	75(/21)	
Average									**3.39**	**3.57**	

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: 2.75 YTD: 2.75
Sources of assurance:	▪ Scrutiny by committee ▪ Scrutiny by Board of Directors ▪ Use of internal and external auditors	▪ Escalation of emerging risks ▪ Exec-to-exec meetings ▪ REMC		ROLLING TREND: Sep 2019, Jul 2019, May 2019, Apr 2019	ROLLING TREND: 2.88 (Sep 2019), 2.96 (Jul 2019), 3.08 (May 2019), 2.92 (Apr 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
Unable to effectively implement Population Health within Wigan	16	IM&T Strategy Committee to review. Discussion with CCG about alternatives on funding.	16

NARRATIVE

Delivery confidence remains as last month at amber-red. The community services transfer is now supported by a signed Business Transfer Agreement and IT SLA but financial pressures remain. Re-engagement with Bolton on a strategic alliance has taken place but still little practical progress. 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. Encouraging session with locality partners on the future of Healthier Wigan Partnership.

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	Major concerns	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	3	5 x 3 = 15	5 x 3 = 15	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	2 x 3 = 6	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	2 x 2 = 4	Self-assessment
Locality partnership	Community services transfer	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
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	66/24	76/24	
Average									**2.75**	**2.75**	

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

Board Performance Report

October 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	47.2%	60/126
Safe	2	Summary Hospital-level Mortality Indicator (SHMI)	JUN-18 - MAY-19	17/10/19	No	114.81	91.34%	117/128
Safe	3	Safety Thermometer / Harm Free Performance	SEP-19	18/10/19	No	96.34%	12.26%	14/107
Safe	4	Cancer 2 Week Wait Performance	AUG-19	17/10/19	No	89.76%	71.54%	94/131
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	SEP-19	10/10/19	No	89.35%	22.31%	30/131
Effective	8	Diagnostic 6 Week Wait Performance	AUG-19	10/10/19	No	0.86%	24.22%	32/129
Caring	10	Friends & Family Assessment Result	AUG-19	15/10/19	No	96.80%	15.5%	21/130
Caring	11	National Patient Survey Result	JAN-18 - DEC-18	15/10/19	No	0.81	48.85%	65/132

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

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	Safety Thermometer / Harm Free Performance	14
4	Friends & Family Assessment Result	21
5	Accident & Emergency 4 Hour Wait Performance	30

Bottom 5 Performing Metrics

#	Metric Name	Rank
1	Summary Hospital-level Mortality Indicator (SHMI)	117
2	Cancer 2 Week Wait Performance	94
3	National Patient Survey Result	65
4	Hospital Standardised Mortality Ratios (HSMR)	60
5	Diagnostic 6 Week Wait Performance	32

Local Trust Positions

Provider Name	GM Rank	North Rank	National Rank
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	1/7	6/44	12/136
BOLTON NHS FOUNDATION TRUST	2/7	13/44	30/136
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	3/7	17/44	41/136
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	4/7	18/44	45/136
SALFORD ROYAL NHS FOUNDATION TRUST	5/7	31/44	81/136
STOCKPORT NHS FOUNDATION TRUST	6/7	35/44	101/136
PENNINE ACUTE HOSPITALS NHS TRUST	7/7	36/44	104/136

In Month

18 Weeks: Incomplete
91.19%
Target: 92.0%

Cancer 62 Day: GP Referral
81.63%
Target: 85.0%

Diagnostics: 6 Weeks
99.20%
Target: 99.0%

**A&E: 4 Hour Target
86.11%
Target: 95.0%

C. Difficile Infections
28
YTD Target: 10

Year To Date

Serious Falls
3
FY Target: 0

Never Events
3
FY Target: 0

MRSA
0
FY Target: 0

Executive Summary (October 2019)

Key Messages

Highlights

The majority of the patient experience measures continue to be reported positively by our patients with the exception of “Do you know which consultant is treating you?”
Although the Trust has existing challenges responding to complaints within the timescale agreed with the complainants the Trust has not had any complaints upheld by the Ombudsman year to date.

Lowlights

The Trust has reported 15 serious incidents in October 2019. 6 of those were related to Pressure Ulcers with lapses in care (4 hospital acquired and 2 community acquired).
The number of Clostridium Difficile cases is above trajectory, however, lapses in care and cross infection remains at 2 cases.
The latest SHMI is 115.8 which is an increase from the previous reporting period.

Please Note:

Work is ongoing to incorporate appropriate Community Quality & Experience metrics.

Please also see Scheduled Care Report and Unscheduled Care Report.

1.1 : Harm Free

	Latest					Previous		YTD		Sparkline - Latest 13 Months			
Metric Title	Target	Actual	Period	RAG	Trend	Actual	Period	Actual	RAG	Chart	Min. Value	Max. Value	Period
Serious Harms: Community Acquired Grade 3-4 Pressure Ulcers	**	2	Oct-19		↑	1	Sep-19	10			0	3	Apr-19 to Oct-19
Harms: Total	**	94	Oct-19		→	94	Sep-19	567			62	94	Oct-18 to Oct-19
Serious Harms: Total	**	14	Oct-19		↑	9	Sep-19	73			3	14	Oct-18 to Oct-19
Serious Harms: Number of Never Events	<= 0	0	Oct-19	●	↓	1	Sep-19	3	●		0	1	Oct-18 to Oct-19
Serious Harms: Number of Serious Falls	<= 0	0	Oct-19	●	→	0	Sep-19	3	●		0	2	Oct-18 to Oct-19
Serious Harms: Hospital Acquired Grade 3-4 Pressure Ulcers	**	4	Oct-19		↑	1	Sep-19	16			0	4	Oct-18 to Oct-19
Number of Serious Incidents	<= 0	15	Oct-19	●	↑	8	Sep-19	49	●		0	15	Oct-18 to Oct-19
Mod/Low Harms: Hospital Acquired Pressure Ulcer Grade 2	**	5	Oct-19		↑	1	Sep-19	18			0	6	Oct-18 to Oct-19
Mod/Low Harms: Number of Moderate Falls	<= 0	0	Oct-19	●	↓	3	Sep-19	7	●		0	3	Oct-18 to Oct-19
Mod/Low Harms: Safety Thermometer	>= 95.0%	97.38%	Oct-19	●	↓	99.45%	Sep-19	98.51%	●		97.38%	99.54%	Oct-18 to Oct-19
Mod/Low Harms: Settled Clinical Litigation Cases	**	7	Oct-19		↑	2	Sep-19	23			1	7	Oct-18 to Oct-19
Mod/Low Harms: VTE Assessments (% of Admissions)	>= 95.0%	97.12%	Oct-19	●	↑	96.65%	Sep-19	96.63%	●		95.67%	97.45%	Oct-18 to Oct-19

Commentary (Page Owner : Director of Nursing and Performance)

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

In October 2019, the Trust reported 15 incidents to StEIS, an increase on 8 the previous month. These consisted of 4 Hospital Acquired Pressure Ulcers all of which occurred on our Medical Wards and 2 Community Acquired Pressure Ulcers where lapses in care were identified. Other incidents included delayed Cancer treatment, 2 alleged abuse incidents, an Information Governance breach, a Safeguarding Adults incident and a delay in returning a patient to theatre. The Safety Thermometer is a point prevalence audit undertaken one day a month. In October 2019 the percentage of patients who were free from new harms was 97.38%.

1.2 : Harm Free - Infections

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
Infections/Bacteraemias: Total	**	12	Oct-19		↑	10	Sep-19	67			2	16	Oct-18 to Oct-19
Serious Harms: Infections: Clostridium Difficile	<= 1	5	Oct-19	🔴	↓	6	Sep-19	28	🔴		0	6	Oct-18 to Oct-19
Serious Harms: Infections: Clostridium Difficile Lapses in Care	<= 0	0	Sep-19	🟢	↓	2	Aug-19	6			0	2	Oct-18 to Sep-19
Infections: Catheter Associated Urinary Tract	<= 0	1	Oct-19	🔴	↓	2	Sep-19	7	🔴		0	2	Oct-18 to Oct-19
Serious Harms: Bacteraemias: MRSA	<= 0	0	Oct-19	🟢	→	0	Sep-19	0	🟢		0	1	Oct-18 to Oct-19
Serious Harms: Bacteraemias: MRSA - Avoidable Cases	**	0	Oct-19	🟢	→	0	Sep-19	0	🟢		0	0	Oct-18 to Oct-19
Serious Harms: Bacteraemias: MSSA	**	2	Oct-19		↑	0	Sep-19	6			0	4	Oct-18 to Oct-19
Serious Harms: Bacteraemias: E-coli	**	3	Oct-19		↑	1	Sep-19	17			0	7	Oct-18 to Oct-19
Bacteraemias: Klebsiella	**	1	Oct-19		↑	0	Sep-19	7			0	2	Oct-18 to Oct-19
Bacteraemias: Pseudomonas	**	0	Oct-19	🟢	↓	1	Sep-19	2			0	1	Oct-18 to Oct-19

Commentary (Page Owner : Director of Nursing and Performance)

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

5 cases of Clostridium Difficile attributed to the Trust. A comprehensive Clostridium Difficile reduction plan is being published. Typing of cases does not suggest direct transmission is occurring. Neighbouring Trusts have seen a similar recent increase. One MRSA bacteraemia but this is a community case. Low numbers of other reportable infections.

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	**	110	Oct-19		↑	89	Sep-19	693			81	128	Oct-18 to Oct-19
Hospital Crude Death Rate	**	1.39%	Oct-19		↑	1.25%	Sep-19	1.39%			1.10%	1.79%	Oct-18 to Oct-19
PFD Coroner Notifications	**	0	Oct-19	●	→	0	Sep-19	0	●		0	0	Oct-18 to Oct-19
Deaths after Readmission	**	27	Oct-19		↑	26	Sep-19	206			22	38	Oct-18 to Oct-19
HSMR (Latest Month)	<= 90	87.0	Jul-19	●	↓	122.9	Jun-19	N/A			81.5	122.9	Apr-18 to Jul-19
HSMR (Latest YTD)	*	104.6	Jul-19		↑	103.8	May-19	N/A			95.2	104.6	Dec-18 to Jul-19
HSMR Weekday	<= 90	80.1	Jul-19	●	↓	123.4	Jun-19	N/A			73.6	123.4	Apr-18 to Jul-19
HSMR Weekend	<= 90	104.5	Jul-19	●	↓	121.6	Jun-19	N/A			74.4	154.1	Apr-18 to Jul-19
SHMI (Rolling 12 Months)	<= 90.0	115.8	Jun-19	●	↑	114.8	May-19	N/A			109.1	115.8	Jun-18 to Jun-19

Commentary (Page Owner : Medical Director)

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

The data for October 2019 suggests a pattern anticipated over the Winter period. The total number of deaths is rising which is ominous given comparison to last Winter. Corrected mortality rates HSMR and SHMI are conflicting. HSMR for the latest available month (July 2019) is good; however, the more significant number is the year to date rate which is 104.6. SHMI is higher than HSMR. The latest available data is 115.8 (from July 2018 – June 2019). The Medical Director is working with Dr Foster and the Business Intelligence Team to understand clinical pathways requiring review.

3.1 : Midwifery - Part 1

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: Midwife / Birth Ratio	<= 1.30	1.24	Oct-19		→	1.24	Sep-19	N/A			1.24	1.27	Oct-18 to Oct-19
Maternity: Skills drills/2 day Mandatory Training Attendance	>=	72.88%	Oct-19		↑	62.43%	Sep-19	N/A			8.09%	95.37%	Oct-18 to Oct-19
Maternity: Total monthly bookings	>= 240	207	Sep-19		↑	203	Aug-19	1,318			203	292	Oct-18 to Sep-19
Maternity: Booked by 12+6 Weeks	>= 90.0%	91.88%	Sep-19		↑	88.38%	Aug-19	N/A			85.78%	94.42%	Oct-18 to Sep-19
Maternity: Induction of Labour	<= 30.0%	35.53%	Oct-19		↓	35.68%	Sep-19	N/A			32.03%	41.05%	Oct-18 to Oct-19
Maternity: Normal Deliveries	>= 60.0%	53.02%	Oct-19		↓	56.88%	Sep-19	N/A			49.10%	61.78%	Oct-18 to Oct-19
Maternity: Water Births	>= 8	15	Oct-19		↑	9	Sep-19	84			7	15	Oct-18 to Oct-19
Maternity: Instrumental Deliveries	<= 10.0%	9.91%	Oct-19		↑	7.80%	Sep-19	N/A			7.80%	13.17%	Oct-18 to Oct-19
Maternity: Elective Caesarean Sections	<= 15.0%	15.09%	Oct-19		↓	15.60%	Sep-19	N/A			9.95%	17.34%	Oct-18 to Oct-19
Maternity: Emergency / Non Elective Caesarean Sections	<= 17.0%	21.98%	Oct-19		↑	19.72%	Sep-19	N/A			13.68%	22.84%	Oct-18 to Oct-19
Maternity: Total Caesarean Sections	<= 27.0%	37.07%	Oct-19		↑	35.32%	Sep-19	N/A			26.70%	37.07%	Oct-18 to Oct-19

Commentary (Page Owner : Director of Nursing and Performance)

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

Midwife to Birth ratio remains unchanged at 1:24. The Increase in staffing levels and supernumerary shift coordinators in place has contributed to the positive birth to Midwife ratio. The birth rate for the year remains below expected target however with the introduction of the Continuity of Care model it is envisaged this will encourage women to choose WWL as place of birth. Mandatory Training remains below target to achieve the 90% compliance by year end, however, there is a plan in place over the next 2 months to ensure all staff receive mandatory training. Induction of labour remains high however this is due to the high acuity of women and the impact of Saving Babies Lives 2 focusing on reduced fetal movements and suspected or actual small for gestational age in accordance with National recommendations. Caesarean section rate has increased to 37% and this continues to affect the normal birth rate which has remained below the 60% target. Real time case review of emergency caesarean sections has been undertaken and the outcome awaited.

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	232	Oct-19			218	Sep-19	1,508			167	234	Oct-18 to Oct-19
Maternity: Episiotomy with normal birth	<= 6.0%	4.88%	Oct-19			6.45%	Sep-19	N/A			2.22%	10.07%	Oct-18 to Oct-19
Maternity: 3rd/4th degree tears	<= 3.0%	1.32%	Oct-19			0.47%	Sep-19	N/A			0.46%	3.20%	Oct-18 to Oct-19
Maternity: Initiation of breastfeeding	>= 55.0%	52.59%	Oct-19			44.95%	Sep-19	N/A			44.29%	54.15%	Oct-18 to Oct-19
Maternity: Average post-natal length of stay	<= 1.8	1.6	Oct-19			1.7	Sep-19	N/A			1.3	2.0	Oct-18 to Oct-19
Maternity: Still Births (>24 weeks)	<= 1	0	Oct-19			0	Sep-19	5			0	2	Oct-18 to Oct-19
Maternal Readmissions within 30 Days	<= 5	0	Oct-19			4	Sep-19	15			0	6	Oct-18 to Oct-19
Maternal admissions to ICU	<= 2	1	Oct-19			0	Sep-19	1			0	1	Oct-18 to Oct-19
Maternity Complaints	<= 2	1	Oct-19			2	Sep-19	12			0	5	Oct-18 to Oct-19
Maternity: New Claims	*	0	Oct-19			1	Sep-19	1			0	3	Oct-18 to Oct-19

Commentary (Page Owner : Director of Nursing and Performance)

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

The Infant feeding team continue to work to promote and support mothers to initiate breastfeeding. WWL has full Baby Friendly accreditation and Gold status which identifies that those who choose to Breast feed sustain this, however the number of mothers who opt not to breastfeed remains lower than the national average and the midwifery team continue to promote the benefits of breastfeeding to all mothers and families. Postnatal Length of Stay needs to be reviewed as it has remained either amber/red for 8 out of 10 months. Complaints remain consistent and at low numbers. No clear trends have been identified from these which range from clinical care and process to staff attitude. No new legal claims were received in month.

4.1 : Patient Experience

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
Number of Complaints Upheld by Ombudsman	**	0	Oct-19		→	0	Sep-19	0			0	0	Oct-18 to Oct-19
Number of Complaints Partially Upheld by Ombudsman	**	0	Oct-19		→	0	Sep-19	1			0	1	Apr-19 to Oct-19
Percentage of Complaints Responded to on Time	**	50.00%	Oct-19		↓	69.64%	Sep-19	64.63%			34.88%	76.60%	Oct-18 to Oct-19
Friends & Family: Decisions about Discharge Home?	>= 90.0%	89.12%	Oct-19		↓	91.46%	Sep-19	N/A			83.95%	91.46%	Oct-18 to Oct-19
Delivering Same Sex Accommodation: Mixed Sex Accommodation Breaches	*	0	Oct-19		→	0	Sep-19	9			0	5	Apr-19 to Oct-19

Commentary (Page Owner : Director of Nursing and Performance)

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

During October 2019, 24 out of 48 responses were sent within the timescales agreed with the complainant at the start of the complaints process (50%). A Complaints Response Rate Improvement Plan is well underway and an update is due to be received by CQEC in November. No requests for records were received from the Ombudsman. Comprehensive, open and transparent responses to complainants are incredibly important and improve patient experience and satisfaction. The Friends and Family results for patients feeling involved in decisions about their discharge home deteriorated slightly in October 2019. Work is being undertaken to review the discharge planning processes and how we ensure patients are fully engaged in decision making.

4.2 : Patient Experience Survey

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
Patient Survey Q1: Staff Introduction	>= 90.0%	92.76%	Oct-19		↑	90.95%	Sep-19	91.70%			88.51%	96.53%	Oct-18 to Oct-19
Patient Survey Q2: Worries and Fears	>= 90.0%	91.45%	Oct-19		↓	93.81%	Sep-19	90.07%			85.71%	93.89%	Oct-18 to Oct-19
Patient Survey Q3: Pain Control	>= 90.0%	92.76%	Oct-19		↓	96.19%	Sep-19	93.92%			89.61%	96.53%	Oct-18 to Oct-19
Patient Survey Q4: Family and Doctor	>= 90.0%	93.42%	Oct-19		↓	97.14%	Sep-19	92.38%			89.86%	97.14%	Oct-18 to Oct-19
Patient Survey Q5: Decisions about Care and Treatment	>= 90.0%	91.45%	Oct-19		↑	91.43%	Sep-19	86.22%			78.38%	91.45%	Oct-18 to Oct-19
Patient Survey Q6: Food Choice	>= 90.0%	94.74%	Oct-19		↓	99.05%	Sep-19	97.00%			94.74%	99.05%	Oct-18 to Oct-19
Patient Survey Q7: Healthy Food	>= 90.0%	90.79%	Oct-19		↓	96.19%	Sep-19	92.12%			86.96%	97.22%	Oct-18 to Oct-19
Patient Survey Q9: Know Consultant	>= 90.0%	81.58%	Oct-19		↓	82.86%	Sep-19	82.19%			73.28%	90.28%	Oct-18 to Oct-19
Patient Survey Q10: Enough Privacy	>= 90.0%	97.37%	Oct-19		↓	99.52%	Sep-19	98.54%			94.81%	100.00%	Oct-18 to Oct-19
Patient Survey Q11: Call Bell	>= 90.0%	96.71%	Oct-19		↑	95.71%	Sep-19	96.40%			92.73%	98.08%	Oct-18 to Oct-19
Patient Survey Q12: Compassion	>= 90.0%	96.71%	Oct-19		↓	97.62%	Sep-19	97.52%			96.62%	99.30%	Oct-18 to Oct-19
Patient Survey Q13: Given Required Care	>= 90.0%	96.71%	Oct-19		↑	96.67%	Sep-19	97.17%			94.90%	99.31%	Oct-18 to Oct-19

Commentary (Page Owner : Director of Nursing and Performance)

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

For the 2nd month in a row we have seen good results in the Real Time Patient Experience Survey, with just one question remaining in the red zone “Do you know which consultant is currently treating you”. From the deep dive last month we have looked into how Specialist Services at Wrightington are achieving their 100% scores. The reason they are achieving higher scores is that they have already met their Consultant at the Outpatient appointment so already know the name of their Consultant. As the Consultants name is behind the patients bed we feel as though the patients doesn’t see the name. We are looking to develop a small A frame “ Hello my name is” white board that will be placed on the moveable bed tables so patients can actually see the Consultants name in front of them. We are hoping that this will give the patient a constant reminder who their Consultant is and will tie in with the trusts “Hello my name is campaign”.

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	£ 797 k	Oct-19			£ -233 k	Sep-19	£ 787 k			£ -233 k	£ 1,276 k	Oct-18 to Oct-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%	9.96%	Sep-19			10.41%	Jul-19	10.51%			7.05%	10.87%	Oct-18 to Sep-19
Sickness absence - Total	<=	4.59%	Sep-19			4.78%	Aug-19	4.51%			4.17%	5.04%	Oct-18 to Sep-19
Quarterly Engagement Score	>= 4.00	3.95	Jul-19			3.90	Apr-19	N/A			3.90	4.01	Jan-19 to Jul-19
Appraisals over rolling 12 months	>= 90.0%	83.79%	Sep-19			84.76%	Jul-19	N/A			83.79%	89.45%	Nov-18 to Sep-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%	93.68%	Sep-19			92.36%	Jul-19	N/A			90.12%	95.28%	Nov-18 to Sep-19
Agency vs NHSI Ceiling	<=£ 0 k	£ 900 k	Oct-19			£ 935 k	Sep-19	£ 4,405 k			£ 101 k	£ 935 k	Oct-18 to Oct-19

Commentary (Page Owner : Director of Workforce)

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

Rolling 12-month sickness from Oct 18 - Sep 19 decreased marginally to 4.50% (compared to 4.51% last reported). The in-month sickness decreased to 4.59% (compared with 4.78% in Aug 19). Temporary spend increased by £31k to £1,978k (compared to £1,947k in Sep 19). There were increases in Additional sessions, Internal Bank, Bank NHSP & Locum Spend (increased by £5k, £4k and £28k and £217k respectively). There were decreases in Agency & Cost per case (decreased by £134k and £3k respectively). 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. Trustwide there are 210 job plans at the following stages: 39 (Discussion), 39 (1st sign off), 13 (2nd sign off), 119 (fully signed off). Please note that these figures relate only to Consultant job plans.

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%	86.11%	Oct-19			89.36%	Sep-19	86.97%			75.11%	94.76%	Oct-18 to Oct-19
Access: 18 Weeks Referral To Treatment Incomplete Pathway	92.0%	91.19%	Oct-19			90.88%	Sep-19	92.01%			90.88%	93.18%	Oct-18 to Oct-19
Diagnostics: Patients waiting over 6 weeks	99.0%	99.20%	Oct-19			99.04%	Sep-19	99.01%			98.17%	99.42%	Oct-18 to Oct-19
Two week wait from referral to date first seen: all urgent cancer referrals (cancer suspected)	93.0%	93.43%	Sep-19			89.39%	Aug-19	93.56%			89.39%	97.95%	Oct-18 to Sep-19
Two week wait from referral to date first seen: symptomatic breast patients (cancer not initally suspected)	93.0%	97.20%	Sep-19			94.07%	Aug-19	95.63%			91.24%	98.57%	Oct-18 to Sep-19
All Cancers: 62 day wait for first treatment from urgent GP referral to treatment	85.0%	81.63%	Sep-19			89.22%	Aug-19	85.59%			80.13%	94.29%	Oct-18 to Sep-19
All Cancers: 62 day wait for first treatment from consultant screening service referral	90.0%	94.74%	Sep-19			90.91%	Aug-19	94.20%			90.91%	100.00%	Oct-18 to Sep-19
Serious Harms: Infections: Clostridium Difficile	1	5	Oct-19			6	Sep-19	28			0	6	Oct-18 to Oct-19
Serious Harms: Infections: Clostridium Difficile Lapses in Care	0	0	Sep-19			2	Aug-19	6			0	2	Oct-18 to Sep-19
Community: % IAPT Patients beginning treatment within 6 weeks	75.0%	96.61%	Sep-19			95.57%	Aug-19	96.99%			95.57%	97.67%	Apr-19 to Sep-19
Community: % IAPT Patients beginning treatment within 18 weeks	95.0%	99.15%	Sep-19			100.00%	Aug-19	99.91%			99.15%	100.00%	Apr-19 to Sep-19

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

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

Finance Report

Month 07 ending 31st October 2019

The WWL Way

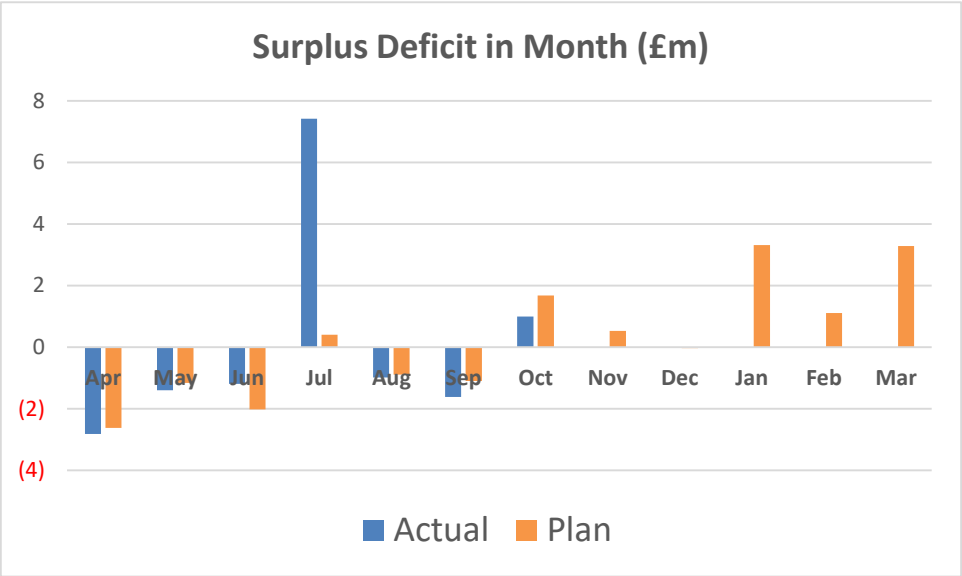
Contents

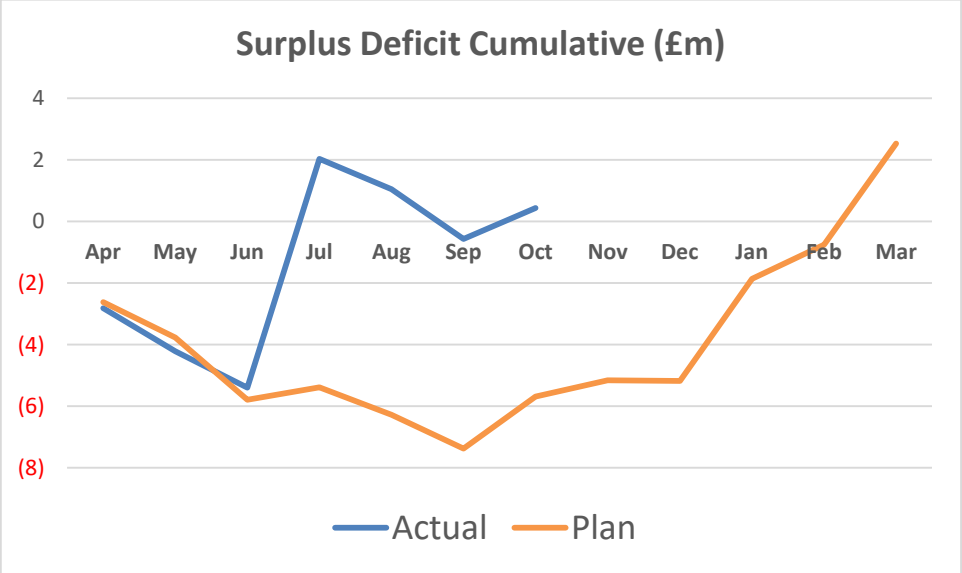
Performance on a Page

	In Month			Year to Date		
	Actual £000's	Plan £000's	Var £000's	Actual £000's	Plan £000's	Var £000's
Income	33,495	32,461	1,034	213,299	212,787	512
Expenditure	(31,485)	(29,783)	1,702	(212,118)	(211,513)	606
Surplus / Deficit	997	1,683	(686)	434	(5,689)	6,123
Cash Balance	49,811	14,239	35,572	49,811	14,239	35,572
Capital Spend	646	802	156	4,280	6,993	2,713
UOR	3	3	0	3	3	0

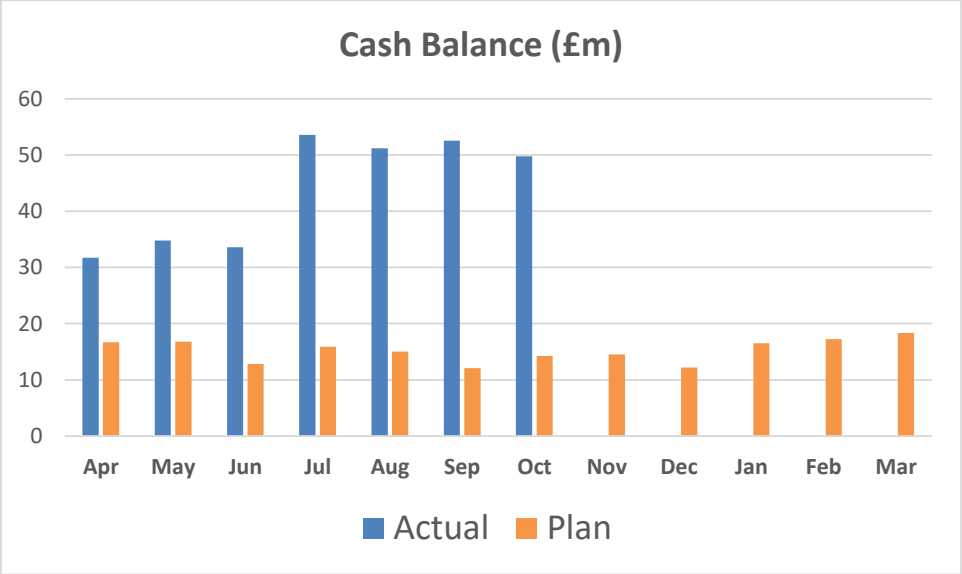
- Trust reporting a £0.4m surplus year to date which is £6.1m better than plan. This includes £7.9m for transfer of assets from Bridgewater Community Services and losses from asset impairments of £1.4.m. This is a non-trading transaction therefore the underlying trading position year to date is a £6.1m deficit.
- Cash is £45.6m better than plan.
- Capital is underspent by £2.7m.

Surplus Deficit

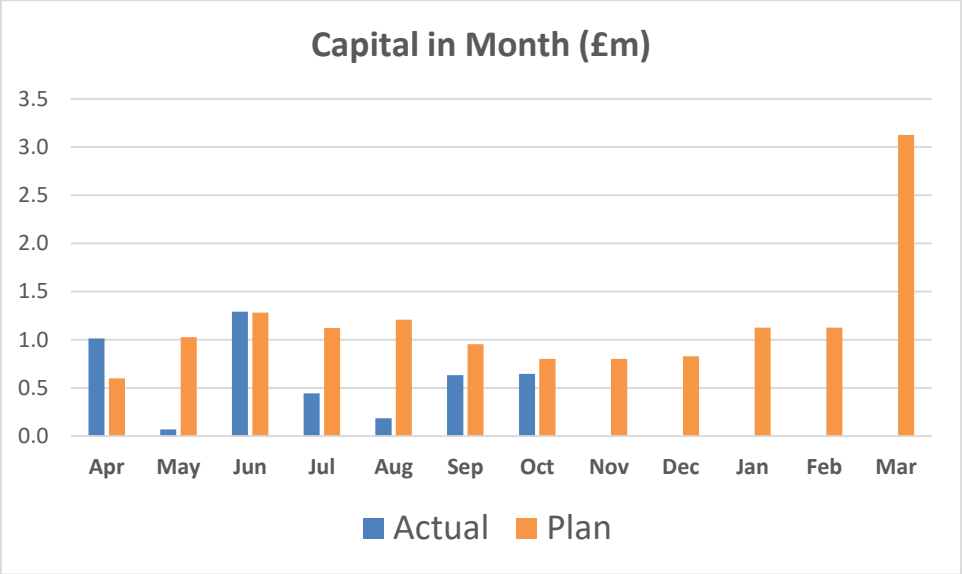


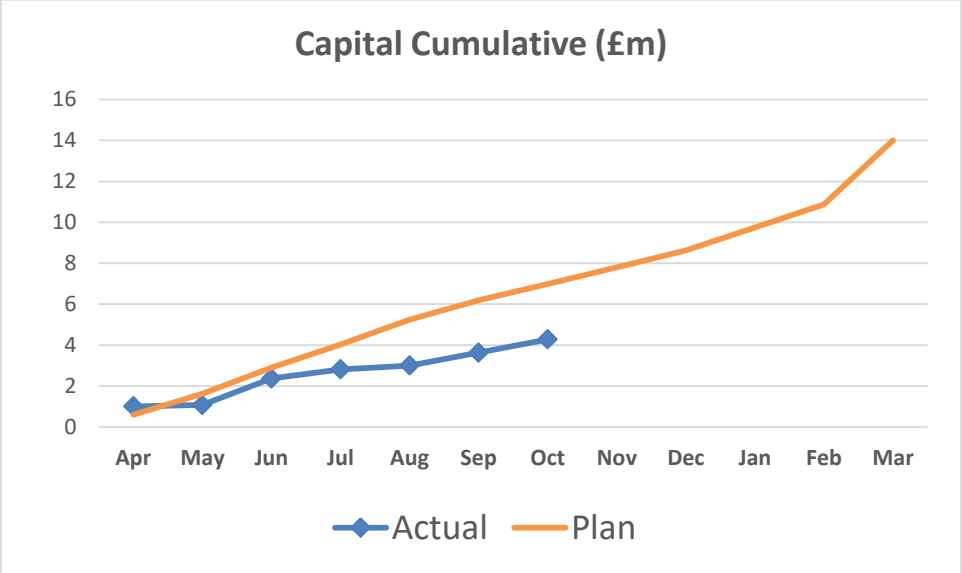


Cash Balance



Capital Spend





REPORT

AGENDA ITEM: 8.4

Wrightington, Wigan and Leigh NHS Foundation Trust

To:	Board of Directors	**Date:**	27 November 2019
Subject:	Safe Staffing Report		
Presented by:	Chief Nurse	**Purpose:**	Information and assurance

Executive summary

The purpose of this report is to provide the Board assurance of the ongoing monitoring of nurse staffing levels across inpatient areas.

The attached reports cover the time periods of both September and October 2019

The Board are asked to note;

- The ongoing risks associated with significant Registered Nurse (RN) vacancy rates
- The CHPPD benchmarking for RN levels being below the national average
- A reduction in the RN vacancies across both September and October through the proactive recruitment of new registrants
- The RN fill rates for September at 91.6% and October at 91.88%
- The incidence of harm reported in relation to areas where there are RN shortfalls within the Division of Medicine particularly related to Pressure Damage in both months
- The reported incidence in delay in administration of pain medication and the development of the pharmacy role within the funded establishment to improve medicines administration
- Positive progress made with daily Safer Staffing Huddle
- The planned commencement of weekly roster check and challenge meetings to improve consistency of rostering across the 24/7 period.
- The one stop shop recruitment event on 6 November 2019 as part of a quarterly event.
- A biannual review of funded nursing establishments is being undertaken and will report to Board in Januray2020.

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.

Risks reported with respect to vacancies within District Nursing Services

The WWL Way

The incidence of harm reported in relation to areas where there are RN shortfalls particularly related to Pressure Damage

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

Wrightington, Wigan and Leigh NHS
NHS Foundation Trust

Safe Staffing Report – September 2019

1.0 INTRODUCTION

The purpose of this report is to provide Trust Board with a summary of Nurse Staffing on all in-patient wards across the Trust for the month of September 2019.
The report includes exception reports related to nurse staffing levels, Care Hours per Patient Day (CHPPD) and related incidents and red flags which are then triangulated with a range of nurse sensitive quality indicators.
The report will provide an overview of actions being taken to mitigate any risks identified.

CURRENT POSITION – September 2019

Overall Staffing and Registered Nurse Fill Rates

The nurse staffing exception report (Appendix1) provides information relating to the Care Hours per Patient Day (CHPPD) and 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.

There has been an increase in the number of areas flagging red for registered nurse fill rates from the previous month; 13 to 20 areas (Appendix 2 Table 1). The pattern of red rated areas has continued to most prevalent for night shifts with this featuring across all the clinical divisions.

Analysis of this information shows that in September the overall fill rate for registered nurses in month was 91.6% resulting in an amber rating for staffing for the Trust collectively. This percentage fill rate has been relatively static for the last 12 months.

CHPPD

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. When considering overall CHPPD the Trust continues to compare favourably against peers and national benchmarking data. However when registered nurse CHPPD is considered independently the registered nursing care hours provided is lower than the national average (Appendix 2 Table 6).

Vacancies

There continues to be significant level of Registered Nurse vacancies across the trust with 159.13 WTE reported in month

Particular areas of note with respect to registered nurse vacancies are;

- Overall vacancies reported have reduced in month by 27.24 WTE. This is aligned to the proactive recruitment of newly qualified staff who commenced in post throughout September across all areas of the Trust; it should be noted that these staff members are supernumerary for the first 4 weeks of their employment and therefore the impact of their commencement in post will not be reflected in fill rates until October 2019 All new registrants are supported through the trust preceptorship programme.
- Rainbow Ward, where there have been longstanding vacancies has recruited 6.64WTE commencing post in September 2019. However there are 5.2 WTE with staff also leaving in month.
- Scheduled Care continues to report high levels of vacancies within the Cardio-respiratory Unit (7.75 WTE), Pemberton (3.5 WTE), Highfield (3.86 WTE) and Shevington Wards (4.0 WTE). Work continues to progress supported by the corporate team on the development of alternative workforce models to support patient acuity and need. The Division has actively sought to fill gaps in the roster with additional hours and temporary staffing to mitigate the risk.
- District Nursing vacancies are reported as 17.66 WTE with a vacancy rate of 21 %. The benchmarking of District Nurse Caseloads continues to progress within the community division. The Division has actively sought to fill gaps with additional hours and temporary staffing to mitigate the risk. A further listening event with District Nurses is scheduled in November.

Details of the vacancies within the inpatient wards and community services in September 2019 are provided in Appendix 2, Table 2. Community figures include vacancies for both nursing and Allied Health Professionals.

Safer Care

All wards are currently utilising SafeCare although further work is ongoing to ensure data is captured with consistency and the 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. In the month of September it is recorded that staff were moved on 62 occasions, this is comparable to previous months.

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, and movement to support the trauma ward on the acute site. SafeCare acuity and dependency data will be utilised to inform the second biannual staffing review due at Trust Board in January 2020.

2.0 Nurse Sensitive Quality Indicators

The key issues reported in month were;

- An increase in the number of nursing red flags raised from 171-221. Nursing Red Flags are indictors of actual and potential deterioration of nursing care hours or interventions that have the potential to lead to harm or adversely impact on the patient experience (Appendix 2, Table 4).
- There is a correlation to the number of areas reporting red metrics for registered staff within the report and nursing red flags raised by staff.
- The majority of the red flags continue to be associated with a shortfall of registered nurses within a clinical area; this shortfall is linked predominantly to vacancies, sickness and maternity leave; the Medical Assessment Unit reported the highest number of red flags for shortfalls of nursing staff.
- There have been 28 red flags raised in month where there have been less than 2 registered nurses available. Rapid reviews have been completed and these indicate that with the exception of Highfield Ward these initial red flags raised were mitigated with the movement of staff from other areas to provide the second registered nurse. Review of the acuity and dependency of the patients on the Highfield Ward at the time of the incident demonstrated that the patients being cared for within the ward could be appropriately cared for with the staffing model allocated to the ward, and there were no reported harms during these shifts.
- 6 incidents were raised within the month within the community division with respect to staff shortfalls and risks to patient care on caseloads particularly out of hours. Whereas there have been no reported incidents of harm directly related there has however been an increase in the reported incidence of pressure damage within community services.

A review of quality metrics for with the areas of high vacancies show that:

- On Rainbow Ward no harm has been reported correlating to nurse staffing levels. The ward has an escalation process in place to maintain safe staffing ratios by managing its bed capacity according to staffing levels.
- There is some triangulation related to incidents of avoidable harm with shortfalls in registered and unregistered nurse staffing levels; For the 2nd consecutive month there have been reports of avoidable harms within the Division of Medicine predominantly within Scheduled Care with an increased incidence of Hospital Acquired Pressure Ulcers. There has also been a report of 1 fall with harm within the MAU.
- There have been no Maternity Red Flags raised in September

  All reportable harm incidents are subject to investigation in accordance with Trust processes and have been reported onto StEIS incident reporting system.

Patient Experience

- Patient experience scores in this reporting period remain positive with the exception of 3 areas with red metrics within unscheduled care relating to the management of pain and the provision of care.

4.0 ACTIONS BEING TAKEN

- Safe Staffing Huddles with the Matrons commenced in September led by the Deputy Chief Nurse. The huddles provide the opportunity to review staffing for the day and following day, advise the operational team of the availability of staff should escalation of an area be required, and considers any potential problems with staffing for the following 24 hours and over the weekend. This huddle has improved collaborative working across the divisions and also awareness of operational pressures on other sites that impact on staffing and use of safer care tool in real time.
- 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. These review sessions will commence in October led by the Deputy Chief Nurse.
- The Nurse Staffing Escalation Policy has been reviewed and refreshed and is currently out to consultation.
- A template for the rapid review of areas where there has been a challenge to maintain 2 registered staff on duty has been developed and is being utilised by the divisions.
- A Trust wide recruitment event has been planned for 6 November 2019 at Leigh Sports Village.
- A scoping exercise to improve retention has been undertaken and an action plan developed.
- This report is being further developed to include funded and actual comparators. It is anticipated that this information will be included within the report in December 2019.

5.0 SUMMARY

There remain pressures across all division on the acute site for nurse staffing, and there is evidence of avoidable harms occurring where there have been shortfalls of staffing.

There has been an improvement in the reporting of nursing and midwifery red flags as demonstrated in the Nursing Quality Indicator section of the report.

The reporting of red flags within nursing continues to demonstrate evidence of pressures within the core wards on the acute site.
The daily Matron Staffing Huddle chaired by the Deputy Chief Nurse will focus in month on the management of patient safety risks through the redeployment of staff across the Trust to accurately reflect the mitigation of hours required to deliver safe car and to support the Matrons in their decision making.

Overall vacancy rates for registered staff have reduced by 27.24 WTE due to the commencement of newly registered nurses across the Trust.

Incidents of avoidable harm have been reported in the Division of Medicine on the wards where fill rates for registered nurses are below the funded level.

There have been no reported harms associated with fill rates for registered nurses within the Paediatric inpatient ward. The escalation process to support acuity and capacity has been appropriate used throughout the month.

Where red flags have been raised by nursing staff relating to having one registered nurse on duty for a shift there is evidence of staff redeployment to mitigate the risk.

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 – September 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	81.4%	98.3%	3.0	169.3%	131.8%	6.8	0.78%	6.41%	7		0/6		0/0	100.00%	100.00%
Cardio and Respiratory	83.7%	69.8%	2.5	128.5%	124.6%	4.9	5.40%	10.76%	18	1	0/9	1/0	0/4	100.00%	100.00%
Coronary Care Unit	106.6%	99.2%	7.6	168.8%	0.0%	3.4	2.71%	5.20%	1		0/0		0/0	100.00%	100.00%
Elderly Care Unit	93.0%	99.9%	2.5	142.7%	152.5%	5.9	7.22%	5.42%	six	1	1/5		0/0	100.00%	100.00%
Highfield	69.0%	57.8%	3.2	111.3%	91.7%	5.1			13		0/2		0/0		
Pemberton	70.1%	97.6%	4.2	131.3%	130.6%	5.5	3.70%	24.39%	5		0/3		0/1		
Shevington	79.2%	68.7%	2.3	147.3%	196.7%	5.8	6.86%	17.03%	8		0/5	0/1	0.2	100.00%	100.00%

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	99.8%	90.0%		103.3%	168.1%		1.27%	19.65%	0		0/2		0/1		
A&E Paeds	91.4%	104.2%					0.32%	25.76%	0		0/0		0/0		
CDW	91.1%	96.7%		98.4%	116.0%		2.81%	7.99%	5		0/2		0/0	71.43%	100.00%
Medical Assessment Unit	79.6%	84.8%		107.5%	112.2%		6.27%	8.40%	52	1	1/10		1/0	64.00%	79.00%
A&E NP's	79.6%	0.0%													

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	87.3%	84.2%	28.2	75.4%	0.0%	2.8	7.01%	2.45%	19	1	0/0		0/0		
Langtree	83.5%	96.7%	2.4	95.6%	124.2%	2.5	3.74%	6.97%	17	2	0/3		0/1	100.00%	90.91%
Orrell	99.8%	100.0%	4.2	129.8%	160.7%	5.3	5.00%	0.88%	25		0/5		0/0	88.89%	88.89%
Swinley	97.7%	104.0%	2.7	100.2%	108.0%	2.5	4.03%	8.82%	16		0/2		1/0	100.00%	100.00%
Maternity Unit	97.0%	92.1%	11.8	72.6%	98.2%	3.4	9.49%	0.00%	6		0/0		0/0	100.00%	100.00%
Neonatal Unit	94.3%	99.3%	13.4	97.4%	0.0%	1.8	2.50%	7.47%	2		0/0		0/1		
Rainbow	83.5%	75.3%	8.9	100.3%	91.6%	4.0	5.99%	11.17%	7		0/0		0/3	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	100.7%	69.9%	3.0	138.2%	148.2%	4.50	6.57%	8.06%	11		0/4		0/1	100.00%	90.91%
Ward A	95.3%	75.9%	3.7	87.8%	77.4%	3.73	5.85%	5.54%	4		0/0		0/0	100.00%	100.00%
Ward B	108.6%	101.4%	3.6	94.4%	93.5%	3.41	4.92%	5.24%	0		0/0		0/1	100.00%	100.00%
JCW	77.0%	88.8%	5.6	69.9%	93.8%	3.21	3.87%	12.58%	5		0/2		0/0		

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

Appendix 2

	July 2019		August 2019		September 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	5	8	10	10

Table 1. Red Metrics July 2019- September 2019

	August 2019		September 2019	
Specialty	Registered	Unregistered	Registered	Unregistered
Medicine	41.21	6.91	41.21	5.97
Surgery	35.43	2.0	22.35	9.07
Specialist Services	15.10	8.6	15.08	4.72
Community Services Adult	56.75	12.19	80.49	16.05
Community Services Children	29.88	5.26		
Total	**186.37**	**34.96**	**159.13**	**35.81**

Table 2. Nurse Vacancies August/September 2019 by Division

Month	Registered WTE	Unregistered 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*	
August 2019	186.37	34.96

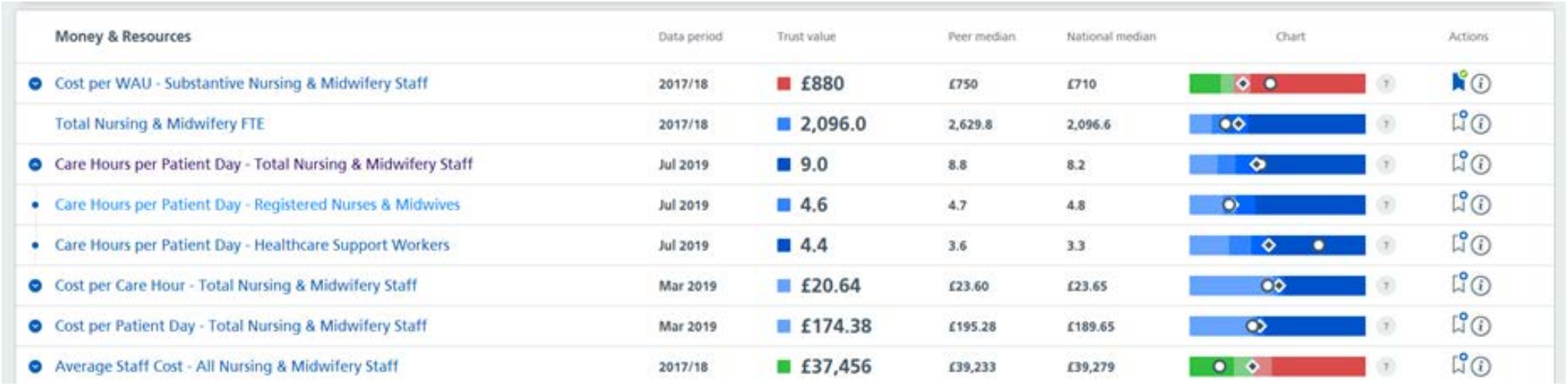
*Table 3. Nurse Vacancies April 2018 – June 2019; *Adult community figures not included within June report (Trust Wide)*

Red Flag Category	No. of Incidents August 2019	No. of Incidents September 2019
Shortfall of more than 8 hours or 25% of registered nurses in a shift	99	158
Delay of 30 minutes or more for the administration of pain relief	54	29
Delay or omission of intentional rounding	0	0
Less than 2 registered nurses on shift	14	28
Vital signs not assessed or recorded as planned	6	3
Unplanned omission of medication	2	3
Total	171	**221**

Table 4. Nursing Red Flags August/September 2019

Red Flag Category	No. of Incidents August 2019	No. of Incidents September 2019
Unit on Divert	0	3
Co-Ordinator Unable to Remain Super-numerary	0	3
Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	1	0
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	**6**

Table 5. Maternity Red Flags August/September 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	Jul 2019	9.0	8.8	8.2		
Care Hours per Patient Day - Registered Nurses & Midwives	Jul 2019	4.6	4.7	4.8		
Care Hours per Patient Day - Healthcare Support Workers	Jul 2019	4.4	3.6	3.3		
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)

Wrightington, Wigan and Leigh NHS
NHS Foundation Trust

Safe Staffing Report – October 2019

1.0 INTRODUCTION

The purpose of this report is to provide Trust Board with a summary of Nurse Staffing on all in-patient wards across the Trust. It includes exception reports related to nurse staffing levels, Care Hours per Patient Day (CHPPD) and related incidents and red flags which are then triangulated with a range of quality indicators. The report will provide an overview of actions being taken to mitigate any risks identified.

2.0 CURRENT POSITION – October 2019

Overall Staffing and Registered Nurse Fill Rates

The nurse staffing exception report provides the Care Hours per Patient Day (CHPPD) and 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 (Appendix1).

There has been a reduction in the number of areas flagging red for registered nurse fill rates from the previous month; 20 to 11 areas (Appendix 2 Table 1). The pattern of red rated areas has reduced for night shifts which is an improving position.
In line with the vacancies reported above, the majority of the areas flagging red for fill rates are within Scheduled Care this month.

Analysis of this information shows that in October the overall fill rate for registered nurses in month was 91.88% resulting in an amber rating for staffing for the Trust collectively. This percentage fill rate has been relatively static for the last 12 months.

CHPPD

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. When considering overall CHPPD the Trust continues to compare favourably against peers and national benchmarking data. However when registered nurse CHPPD is considered independently the registered nursing care hours provided continues to be lower than the national average (Appendix 2 Table 6).

Vacancies

There continues to be significant level of Registered Nurse vacancies across the trust with 132.9WTE vacancies for inpatient and community areas across the Trust reported in month

Details of the vacancies across the inpatient wards and community services in October 2019 are provided in Appendix 2, Table 2. Community figures also include vacancies for nursing and Allied Health Professionals within the published figures.

Particular areas of note with respect to registered nurse vacancies are;

- Vacancies reported have reduced in month by 26.23 WTE. This continues to be aligned to the proactive recruitment of newly qualified staff who commenced in post throughout October across all areas of the Trust
- Rainbow Ward continues to an area where vacancies are prevalent with 7.89 WTE RSCN vacancies with 5 WTE recruited to but not yet in post. RSCN guidelines for registered staff to children continue to be maintained within the clinical area with the temporary restriction of beds where necessary to maintain safe staffing levels.
- Scheduled Care continues to have significant of vacancies within the Cardio-respiratory Unit (7.75 WTE), Pemberton (3.5 WTE), Highfield (4.14 WTE), Elderly Care Unit (4.56 WTE) and Shevington Wards (4.31 WTE). Work continues to progress supported by the corporate team on the development of alternative workforce models to support patient acuity and need with pharmacy technician roles being recruited to across the division as part of the ward funded establishments. The Division continues to take proactive approach to fill gaps in the rosters with additional hours and temporary staffing to mitigate the risk.
- District Nursing 23.88 WTE representing a vacancy rate of 21%. The Division continues to actively seek to fill gaps with additional hours and temporary staffing to mitigate the risk. Work is ongoing regarding integrated working with the District Nursing service and review of DN caseloads.

Safer Care

All wards are currently utilising the Safe Care tool.
For the time period of the report the redeployment function was used to record the movement of staff to support patient need.
In the month of October it is recorded that there were 53 staff moves, 33 across Specialist Services Division and 20 on the RAEI; this a reduction in staff movement since the last report.

3.0 ANALYSIS OF NURSE SENSITIVE QUALITY INDICATORS
Avoidable Harms

The main issues reported were;

- An increase in the number of nursing red flags raised from 221 - 274. Nursing Red Flags are indictors of actual and potential deterioration of nursing care hours or interventions that have the potential to lead to harm or adversely impact on the patient experience (Appendix 2, Table 4).
- From the information provided from vacancies and fill rates there appears to be an under-reporting of nursing red flags within Scheduled Care; 54 were reported in October. Matrons have been requested to review the reporting of red flags, particularly with respect to shortfalls in nursing care.
- The majority of the red flags continue to be associated with a shortfall of registered nurses within a clinical area; this shortfall is linked predominantly to vacancies, sickness and maternity leave.
- The Medical Assessment Unit continues to report the highest number of red flags for shortfalls of nursing staff.
- There have been 19 red flags raised in month where there have been less than 2 registered nurses available. Redeployment of staff was utilised to address this with the exception of Highfield Ward. Review of the acuity and dependency of patients within the ward provided assurance that their care needs could be safely met with the workforce allocated to the clinical area.
- 80 Nursing Red Flags have been raised relating to delays in the administration of pain medication. The reporting of this nursing quality indicator is more prevalent within the Surgical Wards and on Aspull Ward where there is higher usage of opiate based medications. There is triangulation of this metric with shortfalls in Registered Nurse Staffing on Langtree Ward.
- 3 incidents were raised within the month with respect to staff shortfalls which relate to District Nursing services provided out of hours; this a reduction on the previous month. There have been no reported incidents of harm directly related to this point.
- A review of quality metrics and the areas of high vacancies show that on Rainbow Ward 1 harm has been reported , a category 2 pressure ulcer. This developed in relation to a medical device in use and is subject to local investigation. When staffing levels within the area cannot

be maintained at the required level ratios, numbers have been reduced on the ward to address this and Treat and Transfer has been initiated when capacity has been exhausted.

- There is a continuing trend of avoidable harms within the Division of Medicine predominantly within Scheduled Care; 2 Category 2 and 3 Category 3 Hospital Acquired Pressure Ulcers.
- All reportable harm incidents are subject to concise investigation in accordance with Trust processes and reported via the StEIS incident reporting system.
- The Division of Medicine has appointed a Quality and Safety Matron to work alongside Ward Managers to coach and support the teams.
- There have been no Maternity Red Flags raised in October.

Patient Experience

There is further deterioration in the patient experience metrics in relation to the management of pain (2 red and 3 amber); this triangulates with the red flags raised by nursing staff on SafeCare where there have been delays in the administration of pain relief as previously discussed. The Trust continues to progress the introduction of Pharmacy Technicians to acute inpatient areas which is anticipated to have a positive impact on patient experience.

4.0 ACTIONS BEING TAKEN

- The Trust has relaunched the Registered Nurse Incentive Scheme which will commence 18 November 2019.
- Roster Check and Challenge meetings are starting to become embedded into practice. Membership has increased to include the e roster team.
- Use of the redeployment function within SafeCare will continue to be a focus at the Matron Daily Staffing Huddle throughout November.
- A Trust wide recruitment event has been planned for 6 November 2019 at Leigh Sports Village.
- Review of NHSP agency cascade has been undertaken and the strengthening of a Break Glass process for nurse agency staffing is being introduced.

This report is being further developed to include funded and actual comparators. It is anticipated that this information will be included within the report in December 2019.

5.0 SUMMARY

There remain pressures across all division on the acute site for nurse staffing, and there is evidence of avoidable harms occurring where there have been shortfalls of staffing.

Overall vacancy rates have reduced by 26.23 WTE in month.

Daily Safe Staffing Huddles with the Matrons have continued throughout October led by the Deputy Chief Nurse. The huddles provide the opportunity to review staffing for the day and following day and consider any potential challenges with staffing levels for the following 24 hours and over the weekend. This huddle has improved collaborative working across the divisions

The daily Safe Staffing Huddles continue to capture the redeployment of staff across the Trust to address patient needs and support patient safety and experience. This is providing greater oversight and scrutiny of Trust staffing.

Incidents of avoidable harm continue to be reported in the Division of Medicine on the wards where fill rates for registered nurses are below the funded level. This is particularly noticeable with Hospital Acquired Pressure Ulcers.

A Quality and Safety Matron has been appointed within the Division to assist with quality improvement and to provide coaching to staff whilst working alongside them.

The reporting of red flags within nursing continues to provide evidence of pressures within the core wards on the acute site.

Roster Check and Challenge meetings are now established in practice and are providing the opportunity to supportively challenge rostering practices and encourage discussion of rostering difficulties.

The Trust continues to explore mechanisms to improve fill rates for registered staff across the Trust.

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 – October 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	75.3%	98.7%	2.8	166.8%	138.7%	6.9	1.49%	4.96%	4		0/7		0/1	100.00%	100.00%
Cardio and Respiratory	77.8%	75.6%	2.3	116.8%	123.3%	4.6	5.25%	10.12%	18	1	0/5	0/1	0/3	100.00%	100.00%
Coronary Care Unit	110.8%	98.7%	9.4	145.8%	0.0%	3.6	4.54%	0.00%	2			1/0		88.89%	88.89%
Elderly Care Unit	102.5%	98.4%	2.6	138.8%	165.2%	6.0	5.76%	4.36%	7	3	0/3	1/1		100.00%	100.00%
Highfield	77.4%	52.6%	3.5	123.1%	89.0%	5.7			6		0/1				
Pemberton	78.7%	100.3%	4.3	148.7%	131.0%	5.5	8.62%	22.75%	6		0/3		0/1		
Shevington	77.7%	66.6%	2.2	123.8%	171.6%	5.0	9.57%	15.47%	11	1	0/3	0/3	0/1	92.86%	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	93.0%	96.5%		102.5%	145.5%		2.74%	19.82%	0		0/3		0/1		
A&E Paeds	91.7%	87.8%					0.00%	27.25%	0						
A&E NP's	159.8%	4.7%													
CDW	91.3%	99.4%		95.1%	96.8%		3.75%	3.55%	1					100.00%	100.00%
Medical Assessment Unit	91.0%	86.3%		102.6%	105.5%		9.54%	4.00%	42		0/15		1/0	90.00%	91.67%

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	89.3%	85.0%	35.6	80.6%	0.0%	3.7	6.88%	0.64%	20				0/1		
Langtree	93.1%	99.1%	2.6	117.3%	137.5%	2.9	2.24%	3.82%	17		0/1	1/0	0/3	83.33%	100.00%
Orrell	97.0%	95.5%	3.9	124.5%	183.9%	5.7	6.36%	0.88%	31		0/1		0/2	85.71%	100.00%
Swinley	101.0%	99.4%	2.5	107.5%	126.6%	2.8	0.38%	3.60%	34		0/3			100.00%	100.00%
Maternity Unit	104.4%	94.3%	12.9	75.7%	96.3%	3.6	0.56%	0.00%						100.00%	100.00%
Neonatal Unit	111.3%	109.7%	14.9	90.2%	0.0%	1.5	3.38%	0.14%	7				0/2	80.00%	80.00%
Rainbow	89.4%	79.6%	10.9	106.5%	85.2%	4.2	6.88%	12.68%	11		0/2	1/0		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	98.2%	71.0%	3.0	146.2%	166.8%	4.99	5.00%	10.38%	52		0/2		0/1	100.00%	100.00%
Ward A	101.9%	86.2%	3.6	87.6%	92.1%	3.46	5.98%	9.88%	1				0/2	85.71%	92.86%
Ward B	100.1%	95.2%	4.3	97.7%	92.6%	4.41	3.13%	5.24%	1					85.71%	85.71%
JCW	97.3%	100.2%	6.9	80.6%	106.6%	3.77	1.94%	12.31%	3						

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

Appendix 2

	August 2019		September 2019		October 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	5	8	10	10	5	6

Table 1. Red Metrics August to October 2019

	August 2019		September 2019		October 2019	
Specialty	Registered	Unregistered	Registered	Unregistered	Registered	Unregistered
Medicine	41.21	6.91	41.21	5.97	41.71	6.97
Surgery	35.43	2.0	22.35	9.07	26.74	7.2
Specialist Services	15.10	8.6	15.08	4.72	16.79	5.72
Community Services Adult	56.75	12.19	80.49	16.05	39.4	12.69
Community Services Children	29.88	5.26			8.26	0.0
Total	**186.37**	**34.96**	**159.13**	**35.81**	**132.9**	**32.58**

Table 2. Nurse Vacancies August to October 2019 by Division (Community figures include therapy staff)

Month	Registered WTE	Unregistered 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*	
August 2019	186.37	34.96
September 2019	159.13	35.81

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

Red Flag Category	**No. of Incidents August 2019**	**No. of Incidents September 2019**	**No. of Incidents October 2019**
Shortfall of more than 8 hours or 25% of registered nurses in a shift	99	158	174

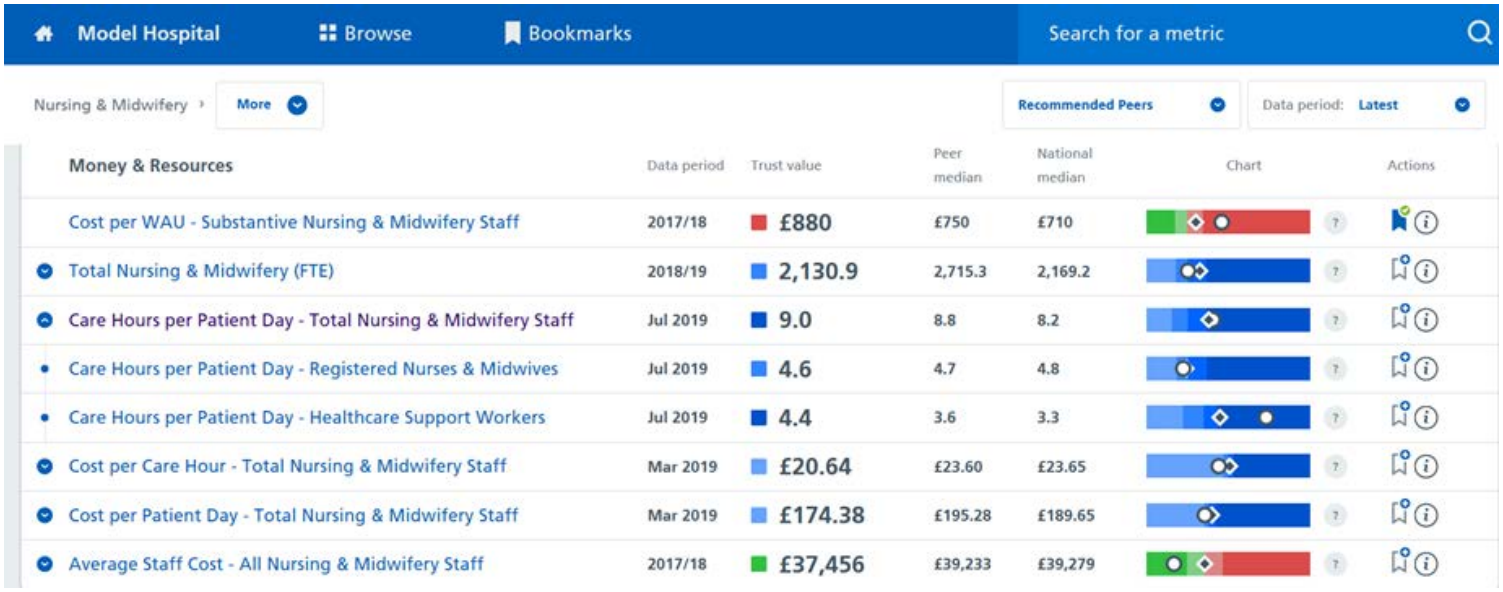
Red Flag Category	No. of Incidents August 2019	No. of Incidents September 2019	No. of Incidents October 2019
Delay of 30 minutes or more for the administration of pain relief	54	29	81
Delay or omission of intentional rounding	0	0	1
Less than 2 registered nurses on shift	14	28	20
Vital signs not assessed or recorded as planned	6	3	3
Unplanned omission of medication	2	3	1
Total	171	**221**	**280**

Table 4. Nursing Red Flags August to October 2019

Red Flag Category	No. of Incidents August 2019	No. of Incidents September 2019	No. of Incidents October 2019
Unit on Divert	0	3	0
Co-Ordinator Unable to Remain Super-numerary	0	3	0
Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	1	0	0
Delay of 30 or more between presentation and triage	0	0	0
Delay of 2 hours or more between admission for induction and beginning of process	0	0	0

Red Flag Category	No. of Incidents August 2019	No. of Incidents September 2019	No. of Incidents October 2019
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	0
Total	1	**6**	**0**

Table 5. Maternity Red Flags August to October 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)	2018/19	2,130.9	2,715.3	2,169.2		
Care Hours per Patient Day - Total Nursing & Midwifery Staff	Jul 2019	9.0	8.8	8.2		
Care Hours per Patient Day - Registered Nurses & Midwives	Jul 2019	4.6	4.7	4.8		
Care Hours per Patient Day - Healthcare Support Workers	Jul 2019	4.4	3.6	3.3		
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 July 2019 (Source Model Hospital)

REPORT

AGENDA ITEM: 9

Wrightington, Wigan and Leigh NHS Foundation Trust

To:	Board of Directors	**Date:**	27 November 2019
Subject:	**CQC Unannounced Inspection (22- 24 October 2019) Initial CQC Feedback**		
Presented by:	Chief Nurse	**Purpose:**	Discussion

Executive summary

The purpose of this report is to provide the Board with feedback relating to the recent CQC unannounced inspection and to share with the Board the letter received from the CQC and any actions taken.

On the 22nd-24th October 2019, the Care Quality Commission (CQC) undertook an unannounced inspection of three core services: Surgery, Maternity and Critical Care. *Appendix A* is a letter from the CQC to Silas Nichols, Chief Executive Officer, providing the Trust with initial feedback following the inspection.

During the verbal feedback received on the 24th October 2019 and as outlined in the letter dated the. 1st November 2019, positive feedback was noted from patients about all of the core services inspected by the CQC, and from the staff who felt supported by their leadership teams. Further positive feedback is outlined in section 2.0. Two key highlights are the management of NatSSIPs and LocSSIPs at Wrightington Hospital and the improvements identified in Maternity Services since the previous inspection in November 2017.

During the inspection action was taken to repair a theatre door at Wrightington Hospital. Actions taken during and following the inspection are outlined in sections 3.0 and 4.0. CQC has requested further information to inform their inspection report as outlined in section 5.0.

The Board of Directors is asked to discuss the CQC's initial findings and actions being taken.

Risks associated with this report

The Trust remains within the inspection period. The CQC could return at any time to any area. The information that has been provided to the CQC following the inspection will inform their inspection report.

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

CQC Unannounced Inspection (22nd-24th October 2019)

1.0 Introduction

The Care Quality Commission (CQC) undertook an unannounced inspection of the Trust on the 22nd - 24th October 2019. Three core services were inspected: Surgery (at Royal Albert Edward Infirmary, Wrightington Hospital and Leigh Infirmary), Maternity and Critical Care.

The CQC provided the Trust with verbal feedback on the 24th October 2019 and followed this with the attached letter (*Appendix A*) to Silas Nichols, Chief Executive Officer.

2.0 Feedback Received

The CQC reported positive findings for each of the core services inspected. The Trust was pleased to receive feedback from all areas regarding the caring interactions observed by the inspection team, the positive feedback received from patients and staff reporting that they felt supported by the leadership in the teams. Positive feedback by core services is outlined below:

2.1 **Surgery:** The urology service at Leigh Infirmary; the work undertaken at Wrightington Hospital following never events particularly related to NatSSIPs and LocSSIPs; day case hip replacements and the use safer care app to plan staffing were noted; breast surgery day case outcomes and the care of patients requiring enhanced care were highlighted.

2.2 **Maternity:** Improvements from the services previous inspection in November 2017 were acknowledged by the CQC; the introduction of the Bereavement Midwife role and Maternity Voices Partnership were noted.

2.3 **Critical Care:** Patients privacy and dignity was respected; national audit data was in line with national standards; the CQC noted the unit's very embedded follow-up process for patients once they had left the department and highlighted that patient diaries were very personal to patients.

3.0 Actions Taken During Inspection

Actions were taken during the inspection to repair a Theatre door on the Wrightington site. Out of date sundries were removed and in one area actions were taken to address the storage of patient identifiable information.

4.0 Actions Taken Following Inspection

A Trust-wide review of the storage of cleaning products in dirty utilities has been undertaken. The issues identified by the CQC regarding the Theatre environment at Leigh Infirmary were address by the Trust Estates Team on the 26th and 27th October 2019. The Trust has provided the CQC with information regarding actions taken to mitigate environmental risks during periods of heavy rain at Wrightington Hospital.

5.0 Further Information Requested

CQC has outlined in their letter and subsequently requests for further information in relation to the following as discussed at Quality and Safety Committee:

- Safeguarding Children Training Levels;
- Paediatric Basic Life Support Training Levels;
- Medical Presence at Leigh Hospital in the evenings;
- Presence of Paediatric Nurses in Theatres at Royal Albert Edward Infirmary.

6.0 Next Steps

The Trust remains in the inspection phase and the CQC could return at any time to any area. The Well-Led Inspection is scheduled to take place on the 26th – 28th November 2019.

7.0 Recommendation

The Board of Directors is asked to discuss the CQC's initial findings and actions being taken.

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

By email only

Mr Silas Nichols
Chief Executive
Wrightington, Wigan and Leigh NHS Foundation Trust
The Elms
Royal Albert Edward Infirmary
Wigan Lane
Wigan
WN1 2NN

Date: 1 November 2019

Your account number: RRF
Our reference: INS2-7161639425

Dear Mr Nichols

CQC inspection of Wrightington, Wigan and Leigh NHS Foundation Trust

Following the feedback meeting with Jonathan Driscoll and Caroline Taylor-Smith on 24 October 2019. I thought it would be helpful to give you written feedback as highlighted at the core service inspection and given to the trust leadership team at the feedback meeting.

This letter does not replace the draft report and evidence appendix we will send to you, but simply confirms what we fed-back on 24 October 2019 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence appendix, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied in to this letter.

An overview of our feedback

Surgery

- We would be requesting information about children safeguarding training and paediatric basic life support training levels for staff.

Leigh Infirmary

- We saw some environmental issues in theatres.
- We would be requesting further information about processes when there was no medical presence in the evenings.
- The urology service had a strong multidisciplinary team with nurse led clinics and one-stop clinics.
- We had positive feedback from patients using the service.
- Local leadership were reported to be accessible and staff felt well supported.

Wrightington Hospital

- The new theatre suite was modern, clean and well designed.
- We found environmental issues with the old theatre suite environment.
- During the inspection we raised concerns about the door to theatre one, which was acted on immediately.
- Water leaking from the roof and surface water at times of heavy rain appeared to be a risk. From the information we have seen this has only been recorded recently.
- We saw lots of works around NATSIPS and LOCCSIPS since the previous never events.
- Staff told us about innovative work such as day case hip replacements.
- Patients spoke positively about all staff groups.
- Staff reported a positive culture and felt supported by managers.

Royal Albert Edward Infirmary

- Patients spoke highly of the care they received.
- We wound be asking for information about paediatric nurses in theatres.
- During the inspection we noted we had seen out of date sundry items and patient identifiable information in some areas.
- We found unsecured cleaning products in dirty utilities on three wards.
- The care hours app for staffing looked to be a good way of planning staffing.
- There were examples of positive outcomes for patients such as the 93% rate for breast surgery as day cases.
- Staff were positive about the system for getting enhanced care for patients.
- Staff spoke highly of leadership and said it was a good place to work.

Critical Care

- We observed caring staff and privacy and dignity being respected.
- National audit data was in line with national standards.
- We saw strong multidisciplinary working between staff.
- There was a very embedded follow-up process for patients who had been in the department and patient diaries were very personal to patients.
- The service had identified delayed discharges as an area for improvement and had actions in place.
- Staff working in the unit said there was a positive culture and that staff worked well together.

Maternity

- We saw improvements since the last inspection and it appeared that the issues had been acted upon. For example, improvements in guidelines and use of early warning scores.
- We saw caring interactions with women and their families.
- We saw that women were being prescribed medication appropriate to their weight but there appeared to be a recording issue.
- Staffing levels had improved with new midwifery and support staff
- The service now had a bereavement midwife in post and had developed the maternity voices partnership.
- Staff were positive about the leadership and the plans for a midwifery led unit.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to NHS Improvement.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

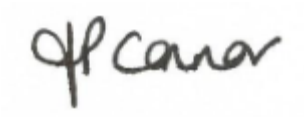
If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely



Judith Connor

Head of Hospitals Inspection

c.c. Robert Armstrong - Chair

Pauline Bradshaw - NHS Improvement/NHS England

David Fryer - CQC regional communications manager

REPORT

AGENDA ITEM: 10

Wrightington, Wigan and Leigh NHS Foundation Trust

To:	Board of Directors	**Date:**	27 November 2019
Subject:	2019 EPRR Core Standards Self Assessment Outcome		
Presented by:	Mary Fleming Mary.Fleming@wwl.nhs.uk	**Purpose:**	Information

Executive summary

This paper sets out the draft outcome of the annual EPRR (Emergency Preparedness, Resilience and Response) core standards self-assessment and the actions required for standards where the Trust is not currently compliant. Based on the submission made the Trust is "Substantially Compliant" although confirmation of this is awaited from the CCG and from GM (no issues are anticipated). The Board is asked to note the current position and the actions required.

Risks associated with this report

At present the Trust is not fully compliant with the EPRR core standards and this potentially creates a risk concerning the preparedness of the organisation. However, plans are in place to address these and the overall assessment is "substantially compliant" so the risk is considered to be low.

Link(s) to The WWL Way 4wards

☒	Patients	☒	Performance
☒	People	☒	Partnerships

Introduction

The Emergency Preparedness, Resilience and Response (EPRR) self-assessment is an annual exercise where the Trust is required to measure itself against the National Core Standards. Locally this is managed through the Greater Manchester Health and Social Care Partnership and is also reviewed by Wigan Borough CCG. The self-assessment requires a response of fully compliant, partially complaint or non-compliant and a list of evidence. An action plan is generated for any areas which are not fully compliant along with an overall compliance level. In 2019 the self-assessment results in the Trust declaring itself "substantially compliant" overall with 5 areas of partial compliance and 0 of non-compliance. This is out of a total of 84 relevant standards covering 10 domain areas along with a deep dive into "Severe Weather Response" and "Long Term Adaptation Planning". It is not easy to draw direct comparison with previous years as the areas of deep dive change but overall the Trust has achieved the same level of compliance (substantial). It should be noted that at the time of this report confirmation has not been received that our self-assessment has been accepted but no issues or changes are anticipated. The remainder of this paper sets out the areas of partial compliance and the actions associated with improving these. The full self-assessment and action plan is included at Appendix 1.

EPRR Core Standards

The standards are divided into 10 areas and the outcome against each is summarised below

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	12	2	0
Command and control	2	2	0	0
Training and exercising	3	3	0	0
Response	7	7	0	0
Warning and informing	3	3	0	0
Cooperation	4	4	0	0
Business Continuity	9	9	0	0
CBRN	14	14	0	0
Total	64	62	2	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Severe Weather response	15	14	1	0
Long Term adaptation planning	5	3	2	0
Total	20	17	3	0

Areas of Partial Compliance

a. Mass Countermeasures (Duty to Maintain Plans Domain) - EPRR leads across GM agreed to mark this as partially compliant as the requirements are not fully defined and would be dependent on national policy and guidance at the time of such a significant large scale incident. No specific WWL actions have been noted on this basis but the EPRR lead will continue to work with GM colleagues. This is the same position as in 2018.
b. Shelter and Evacuation (Duty to Maintain Plans Domain) – Wards and departments do have plans although these are not routinely tested in all areas. A regime of testing is being implemented. In addition the Trust does not currently have a whole site evacuation plan and this will be implemented from January 2020 and tested via table top exercise in summer 2020.
c. Overheating (Severe Weather Response Domain) – there isn't a consistent automated monitoring arrangement for hot weather covering all patient and staff areas and this isn't referenced in the heatwave plan explicitly. Records are not currently centrally maintained. To address this and the other deep dive areas of partial compliance a "climate change" group will be established to draw up plans to improve readiness in light of recent guidance.
d. Building Adaptations (Long Term Adaptation Planning Domain) – the Trust has begun looking at the potential impact of climate change on existing buildings and this will be considered through the group referred to above. The Trust is mindful of Department of Health and Social Care instructions not to "over engineer" ventilation systems whether to address excessive hot or cold temperatures.
e. Flooding (Long Term Adaptation Planning Domain) - new buildings / developments typically use BREEAM (Healthcare) assessments that incorporate sustainability issues and, where funded and included as part of schemes, such or similar sustainability measures are incorporated. There are currently no formal plans to reduce the impact in relation to existing buildings but this will be considered as part of the work programme of the group referred to above.

Conclusion and Recommendations

The Board is asked to note the contents of this report and the self-assessment, particularly the draft outcome of "substantial compliance". Should there be any change to this following external review the Board will be updated. With the exception of the mass countermeasures standard an action plan has been developed with a view to ensuring compliance over the next 12 months.

Please select type of organisation: **Acute Providers**

Publishing Approval Reference: 000719

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	12	2	0
Command and control	2	2	0	0
Training and exercising	3	3	0	0
Response	7	7	0	0
Warning and informing	3	3	0	0
Cooperation	4	4	0	0
Business Continuity	9	9	0	0
CBRN	14	14	0	0
Total	64	62	2	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Severe Weather response	15	14	1	0
Long Term adaptation planning	5	3	2	0
Total	20	17	3	0

Overall assessment:	Substantially compliant

Instructions:
Step 1: Select the type of organisation from the drop-down at the top of this page
Step 2: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 3: Complete the Self-Assessment RAG in the 'Deep dive' tab
Step 4: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 5: Click the 'Produce Action Plan' button below

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual	• Mary Fleming Chief Operating Officer and AEO	Fully compliant				
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	EPRR Policy TW17-023 - Policy Statement	Fully compliant				
3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board		Fully compliant				
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes.	Y	• Process explicitly described within the EPRR policy statement • Annual work plan	EPRR Policy Statement and Work Plan	Fully compliant				
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	• EPRR Policy TW17-023 - Policy • Assessment of roles undertaken • TOR including description of role for EPRR Staff • There are organisational structures • Internal Governance process in place and actioned	Fully compliant				
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement	• Clearly define process for capturing and learning from incidents and exercises to help develop future EPRR arrangements - Lessons learned	Fully compliant				
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	• EPRR risks are considered and montiored as part of the EPRR Group. • Any EPRR risks are identified and are recorded on the Corporate Risk Register	Fully compliant				
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	• EPRR risks are considered and monitored as part of REMC (Risk and Environmental Management Committee) This is referenced in the EPRR Policy	Fully compliant				
9	Duty to maintain plans	Collaborative planning	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Y	Partners consulted with as part of the planning process are demonstrable in planning arrangements	Wigan Borough Resilience Forum Collaborative planning is actioned and maintained with GM Council and CCG Other NHS Providers	Fully compliant				
11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	• Major Incident Plan inlcuding the Crtical Incident Plan is updated in line with current national guidance and risk assessments. • It is tested in line with GM and internally.	Fully compliant				
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	• Major Incident Plan is updated in line with current national guidance and risk assessments. • It is tested in line with GM and internally.	Fully compliant				
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The local WWL Summer Resilience Plan is update against current National Guidance, this is approved and signed off as appropriate. Risk assessments are undertaken as appropriate. Staff have access to the Emergency Planning section of intranet which has details of the Summer Resilience Plan and 'How To' keep cool and safe. Regular external comms during periods of hot weather	Fully compliant				
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The local WWL Winter Resilience Plan is update against current National Guidance, this is approved and signed off as appropriate. Risk assessments are undertaken as appropriate. Staff have access to the Emergency Planning section of intranet which has details of the Winter Resilience Plan and 'How To' keep warm and safe. Regular externalm comms during periods of cold weather	Fully compliant				
15	Duty to maintain plans	Pandemic influenza	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	• The local WWL Influenza Pandemic Plan is update against current National Guidance, this approved and signed off as appropriate. • Risk assessments are undertaken as appropriate. • Staff have access to the Emergency Planning section of which has details of the Influenza Pandemic Resilience Plan and 'How To' keep avoid and prevent infection. Closing working relationship between EPRR team and infection control team	Fully compliant				
16	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases such as Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3 and PPE trained individuals commensurate with the organisational risk.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	• There is a Wigan Borough Document Plan - overarching guidance led by the Wigan Council • Internal SOP's for Infectious Disease - led by WWL Infection Control Team, these are: •TW10-042 SOP 12 - Control of outbreaks of infectious conditions within the hospital. • TW10-042 SOP18 - Isolation of Patients with Infectious Conditions • TW10-042 SOP15 - Diarrhoea (Infectious) - Infection Prevention and Centre	Fully compliant				

17	Duty to maintain plans	Mass countermeasures	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including arrangement for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. CCGs may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	WWL would follow instructions provided in the event of this being necessary but does not maintain its own specific plans	Partially compliant	Continue to work with GM and other colleagues and follow advice/guidance as required	Helen Salvini	Ongoing	
18	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	• Have NHS England Document - Concept of Operations for Managing Mass Casualties. • Collaboration with GM • Follow Major Incident Plan	Fully compliant				
19	Duty to maintain plans	Mass Casualty - patient identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Policy in place - reviewed and updated in last 12 months in line with CAS alert	Fully compliant				
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has ward and department level plans but not a whole site plan.	Partially compliant	Testing programme to be introduced for 2020	Helen Salvini	To be introduced as a rolling programme in 2020	
21	Duty to maintain plans	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	• TW15-004 - Lockdown Policy (2018)	Fully compliant				
22	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Visits to the trust by Celebrities: • VIP's - TW16-011 - Major Incident Plan Page 36 Section 3.9	Fully compliant				
23	Duty to maintain plans	Excess death planning	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	• TW14 - 007 SOP 33 - Mortuary - Providing Additional Body Storage SOP • Major Incident Plan • On-Call Pack	Fully compliant				
24	Command and control	On-call mechanism	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	SMOC & EXOC Training Undertaken Major Incident Plan - Action Cards On-Call Pack	Fully compliant				
25	Command and control	Trained on-call staff	On-call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf of the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	Y	• Process explicitly described within the EPRR policy statement	SMOC & EXOC Training Undertaken Major Incident Plan - Action Cards On-Call Pack	Fully compliant				
26	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Y	• Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	EPRR Policy TW17-023 - Policy Statement EPRR Agendas/Minutes/Action matrix/TOR EPRR Induction Leaflet EPRR Induction Poster Local and GM Exercises	Fully compliant				
27	Training and exercising	EPRR exercising and testing programme	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as	Y	• Exercising Schedule • Evidence of post exercise reports and embedding learning	Major Incident Plan Business Continuity Testing Table Top Exercising - Local and GM Communication Testing - Switchboard	Fully compliant				
28	Training and exercising	Strategic and tactical responder training	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Y	• Training records • Evidence of personal training and exercising portfolios for key staff	Senior Managers On Call and Execs On Call have opportunites via excercising.	Fully compliant				
30	Response	Incident Co-ordination Centre (ICC)	The organisation has a preidentified Incident Co-ordination Centre (ICC) and alternative fall-back location(s). Both locations should be annually tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Y	• Documented processes for establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards	SMOC & EXOC Training Undertaken Major Incident Plan - Action Cards On-Call Pack Power & Water Outage Documents	Fully compliant				
31	Response	Access to planning arrangements	Version controlled, hard copies of all response arrangements are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and hard copies	All EPRR Documents Major Incident Plan - Action Cards On-Call Pack and BCP's etc are on intranet and paper copies are available should this be necessary	Fully compliant				
32	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans	Review of Local/Departmental BCP's has been undertaken Audit undertaken has revealed areas for improvement, these have been raised with BCP owners and Managers and a plan is in place to support improvements	Fully compliant				
33	Response	Loggist	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents. Key response staff are aware of the need for keeping their own personal records and logs to the required standards.	Y	• Documented processes for accessing and utilising loggists • Training records	The Trust has trained loggists	Fully compliant				

34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps • Evidence of testing and exercising	SitReps are completed, signed off and submitted	Fully compliant				
35	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	Guidance is available to appropriate staff either electronically or hard c	Paper and electronic copies available in A&E	Fully compliant				
36	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y	Guidance is available to appropriate staff either electronically or hard c	Paper and electronic copies available in A&E	Fully compliant				
37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	Emergency Communications are in place and are made by: switchboard / work mobile phones / 'e' mail via the Senior Manager/Exec On-Call as per Major Incident Plan Social Media Policy TW18 - 021 Social Media SOP TW18 - 021 SOP 1 in conjunction with the Information Security Policy TW14 - 039 Major Incident Plan Page 24 Section 2.9 Press Office for official press releases. There are plans to use Resilience Direct and other platforms in the event of a power, email or cyber incident	Fully compliant				
38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	Emergency Communications are in place and are made by: switchboard, work mobile phones, e' mail, WhatsApp and Slack as per Major Incident Plan WhatsApp and Slack do not require Trust systems to be functioning Internal communications / BCP's on intranet	Fully compliant				
39	Warning and informing	Media strategy	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'	All Execs On-Call and some SMOCs have had media Training and advice and templates are available All SMOCs and EXOCs have access to Trust social media and global emails in the event of a Major Incident External Communications & PR Team are available via informal arrangements out of hours	Fully compliant				
40	Cooperation	LRHP attendance	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75% annually) Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings	The Trust is represented by NHS Acute Provider Lead and receives and acts on minutes	Fully compliant				
41	Cooperation	LRF / BRF attendance	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • Governance agreement if the organisation is represented	The Trust attends the WBRF	Fully compliant				
42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	The Trust is signed up to the GM arrangements for mutual aid and will act accordingly	Fully compliant				
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	TW10-110 SOP8 - Information Assurance Contract and Information Sharing/Access Agreement Procedure	Fully compliant				
47	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the comitmement to a Business Continutiy Management System (BCMS) in alignment to the ISO standard 22301.	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	Business Continuity Planning for the Trust is undertaken and is regularly updated and tested.	Fully compliant				
48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles	All Business Continuity Plans have been formulated using the resources from NHS England Business Continuity Planning for the Trust Business Continuity Plan Review for all departments undertaken BCP Communications undertaken	Fully compliant				
49	Business Continuity	Business Impact Assessment	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Y	Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how BA is used to support	Yearly update and review of the Business Continuity Plans, these include Business Impact Analysis.	Fully compliant				
50	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance	The Trust is compliant with DPST	Fully compliant				
51	Business Continuity	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be reviewed regularly (at a minimum annually), or following organisational change, or incidents and exercises.	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Business Continuity Planning for the Trust Business Continuity Plan Review for all departments undertaken BCP Communications undertaken Awareness Raised Audits undertaken to assess awareness	Fully compliant				
52	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers	Business Continuity Plans Board Papers Provided	Fully compliant				
53	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	EPRR Policy and BCP Policy Audit of BCP Awareness carried out and action plan completed in response	Fully compliant				
54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	Business Continuity Plans - Excel Spreadsheet - with dates of reviews and compliance	Fully compliant				
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	Each individual Ward/Departmental BCP has the details of comissioned providers / suppliers as necessary and has responsibility for gaining assurance from them	Fully compliant				
56	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	A&E (Emergency) Staff are aware of the number / process to gain access to advice through appropriate planning arrangements Staff have access and are aware of telephone numbers to Public Health England, and TOXBASE website for clinical support. The contact details and website information are contained in the following documents: 'CBRN incident: Clinical Management and health protection' guidance. WWL CBRNe And HazMat Plan March 2018 - with Action cards	Fully compliant				

57	**CBRN**	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	All held within A&E with specified named staff Procedures are in place for activating staff Equipment and predetermined decontamination location and facilities WWL CBRNe And HazMat Plan March 2018 - with Action cards Major Incident Plan	Fully compliant				
58	**CBRN**	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	• Impact assessment of CBRN decontamination on other key facilities	If CBRNE incident occurred within WWL, a Major incident would be declared as the amount of staff needed to facilitate the decontamination would inpact significantly on the daily running of the ECC department. WWL CBRNe And HazMat Plan March 2018 - with Action Cards	Fully compliant				
59	**CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y	Rotas of appropriately trained staff availability 24 /7	Trained staff on every rota	Fully compliant				
60	**CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material:	Y	Completed equipment inventories; including completion date	Monthly equipment inventories are completed and all equipment is tested every other month. EPRR Suit Tracker	Fully compliant				
61	**CBRN**	**PRPS availability**	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	Y	Completed equipment inventories; including completion date	Inventory and schedule of revalidation/replacement in place. PRPS available in decontamination storage room for immediate deployment if necessary.	Fully compliant				
62	**CBRN**	**Equipment checks**	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y	Record of equipment checks, including date completed and by whom.	Decontamination tent is erected bi-monthly as part of A&E major incident teaching. Checking of alll features is included as part of this by the Trust CBRN leads - any defects are reported to the supplier immediately for repair/renewal.	Fully compliant				
63	**CBRN**	**Equipment Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place fo the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y	Completed PPM, including date completed, and by whom	Annual servicing of decontamination tent and associated equipment by supplier (GRS) who is also responsible for all repairs as necessary PRPS are covered by wider procurement programme which includes servicing/extending and new suits.	Fully compliant				
64	**CBRN**	**PPE disposal arrangements**	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	Organisational policy	Included within waste management policy	Fully compliant				
65	**CBRN**	**HAZMAT / CBRN training lead**	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y	Maintenance of CPD records	CPD records of individual training leads (Paul Bolton and Louise Fletcher)	Fully compliant				
66	**CBRN**	**Training programme**	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training	Decontamination tent is erected bi-monthly as part of A&E major incident teaching. Checking of alll features is included as part of this by the Trust CBRN leads - any defects are reported to the supplier immediately for repair/renewal.	Fully compliant				
67	**CBRN**	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y	Maintenance of CPD records	CPD records of individual training leads (Paul Bolton and Louise Fletcher)	Fully compliant				
68	**CBRN**	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination techniqu	All held within A&E with specified named staff Training is given to staff following the IOR principles, Hazmat/CBRNE Guidance and Public Health England Guideance in-house for A&E Staff	Fully compliant				
69	**CBRN**	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y		Staff are fitted and tested for FFP3 wear in accordance with local guidelines. Training for fitters is on-going Equipment available and tested	Fully compliant				

Ref	Domain	Standard	Detail	Evidence - examples listed below	Organisation Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
17	**Duty to maintain plar**	**Mass countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including arrangement for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	WWL would follow instructions provided in the event of this being necessary but does not maintain its own specific plans	Partially compliant	Continue to work with GM and other colleagues and follow advice/guidance as required	Helen Salvini	Ongoing	
20	**Duty to maintain plar**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has ward and department level plans but not a whole site plan.	Partially compliant	Testing programme to be introduced for 2020	Helen Salvini	To be introduced as a rolling programme in 2020	
1	**Severe Weather response**	**Overheating**	The organisation's heatwave plan allows for the identification and monitoring of inpatient and staff areas that overheat (For community and MH inpatient area may include patients own home, or nursing/care home facility)	The monitoring processes is explicitly identified in the organisational heatwave plan. This includes staff areas as well as inpatient areas. This process clearly identifies relevant temperature triggers and subsequent actions.	The local Divisions monitor temperatures within their own areas as standard clinical practice. Recording is not automated by Estates BMS across RAEI, however it is automated across Wrightington and Leigh. Estates therefore report on areas that reach the 26C ERIC threshold either via direct BMS data or data calculated using historic weather data for RAEI.	Partially Compliant	Central monitoring arrangements to be reviewed	Helen Salvini / Estates	31st March 2020	
18	**Long term adaptation planning**	**Building adaptations**	The organisation has in place an adaptation plan which includes necessary modifications to buildings and infrastructure to maintain normal business during extreme temperatures or other extreme weather events.	The organisation has an adaptation plan that includes suggested building modifications or infrastructure changes in future	DoH Estates guidelines "prohibit" the expensive "over engineering" of ventilation systems to include for all temperature eventualities (either exceptionally high or low)	Partially Compliant	Planning/Modificaiton arrangements to be reviewed and updated as necessary	Helen Salvini / Estates	31st March 2020	

19	**Long term adaptation planning**	**Flooding**	The organisations adaptation plans include modifications to reduce their buildings and estates impact on the surrounding environment for example Sustainable Urban Drainage Systems to reduce flood risks.	Areas are identified in the organisations adaptation plans that might benefit drainage surfaces, or evidence that new hard standing areas considered for SUDS	New buildings / developments typically use BREEAM (Healthcare) assessments that incorporate sustainability issues – where funded and included as part of schemes such or similar sustainability measures are incorporated	Partially Compliant	Any changes would be made in accordance with legislation/guidance at the time but climate change is not currently formally considered in terms of reviews of current estate. Policy development to be considered	Helen Salvini / Estates	31st March 2020	

REPORT

AGENDA ITEM: 10

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

To:	Board of Directors	**Date:**	27 November 2019
Subject:	Review of cycle of business		
Presented by:	Company Secretary	**Purpose:**	Approval

Executive summary

The Board's cycle of business is attached to this report for routine review.

Risks associated with this report

There are no risks associated with the content of this report.

Link(s) to The WWL Way 4wards

☐	Patients	☐	Performance
☐	People	☐	Partnerships

The WWL Way

Board of Directors
Cycle of business 2019/20

Item	Part	Purpose	Presenter	Prepared by	May 2019	Jul 2019	Sep 2019	Nov 2019	Jan 2020	Mar 2020
INTRODUCTORY ITEMS										
Chair and quorum	1 & 2	Information	Chair	Verbal	✓	✓	✓	✓	✓	✓
Apologies for absence	1 & 2	Information	Chair	Verbal	✓	✓	✓	✓	✓	✓
Declarations of interest	1 & 2	Information	Chair	Verbal	✓	✓	✓	✓	✓	✓
Minutes of the previous meeting	1 & 2	Approval	Chair	Company Secretary	✓	✓	✓	✓	✓	✓
Chair and Chief Executive's report	1 & 2	Information	Chair/Chief Executive	Chair/Chief Executive	✓	✓	✓	✓	✓	✓
Patient experience video	1	Discussion	Chief Nurse	Patient Relations/PALS	✓	✓	✓	✓	✓	✓
ASSURANCE AND GOVERNANCE										
Committee chairs' reports (verbal)	1	Discussion	Committee Chairs	Verbal	✓	✓	✓	✓	✓	✓
Performance report	1	Discussion	COO/CN/MD	Business Intelligence	✓	✓	✓	✓	✓	✓
Finance report	1 & 2	Discussion	Director of Finance	Finance Team	✓	✓	✓	✓	✓	✓
Safe staffing report	1	Discussion	Chief Nurse	Deputy Chief Nurse	✓	✓	✓	✓	✓	✓
Board assurance framework	1	Approval	Chair	Deputy Co. Sec.	✓	✓	✓	✓	✓	✓
StEIS reports	2	Information	Chief Nurse	Patient Safety Mgr	✓	✓	✓	✓	✓	✓
Serious incident annual report	2	Information	Chief Nurse	Patient Safety Mgr					✓	
Biannual staffing review	1	Information	Chief Nurse	Deputy Chief Nurse		✓			✓	
Maternity staffing review	1	Information	Chief Nurse	Deputy Chief Nurse	✓					
Mortality report	1	Information	Medical Director	Director of Governance	✓		✓		✓	

Item	Part	Purpose	Presenter	Prepared by	May 2019	Jul 2019	Sep 2019	Nov 2019	Jan 2020	Mar 2020
Review of risk management strategy	1	Approval	Director of Governance	Director of Governance	✓					
CORPORATE GOVERNANCE										
Register of directors' interests	1	Information	Company Secretary	Company Secretary						✓
Review of committee terms of reference	1	Information	Company Secretary	Company Secretary						✓
Review of committee effectiveness	1	Information	Company Secretary	Company Secretary					✓	
Review of well-led action plan	2	Discussion	Company Secretary	Company Secretary	✓				✓	
Use of the common seal	1	Information	Company Secretary	Company Secretary						✓
Data Protection Officer's report	2	Information	Company Secretary	Company Secretary	✓		✓		✓	
NHS Improvement self-certifications	1	Approval	Company Secretary	Company Secretary	✓					
Approval of annual report and accounts *(separate meeting to be convened)*	2	Approval	Chair	Co Sec/DGov/Finance	✓					
Review of Standing Orders	1	Approval	Company Secretary	Company Secretary						✓
Review of Standing Financial Instructions	1	Approval	Director of Finance	Head of Fin. Services						✓
Internal audit plan	2	Approval	Audit Committee Chair	Internal auditors						✓
Review of cycle of business	1	Approval	Company Secretary	Company Secretary			✓			✓
QUALITY AND PATIENT EXPERIENCE										
In-patient survey results	1	Information	Chief Nurse	Survey provider	✓					
Safeguarding annual report	1	Information	Chief Nurse	Safeguarding Team			✓			
Safe, Effective, Caring (SEC) report	2	Information	Chief Nurse	Compliance Lead		✓	✓	✓		✓
Complaints annual report	1	Information	Chief Nurse	Patient Relations/PALS			✓			
PPI assurance report	1	Information	Chief Nurse	Engagement Team			✓			

Item	Part	Purpose	Presenter	Prepared by	May 2019	Jul 2019	Sep 2019	Nov 2019	Jan 2020	Mar 2020
WORKFORCE										
Medical exclusions and restrictions	2	Information	Director of Workforce	Workforce Gov Mgr	✓	✓		✓	✓	
Guardian of safe working hours report	1	Information	Director of Workforce	Responsible Officer	✓					
Freedom to Speak Up Guardian's report	1	Information	Director of Workforce	Workforce Gov Mgr		✓				
Inclusion and Diversity annual report	1	Information	Director of Workforce	I&D Leads					✓	
Gender pay gap report	1	Information	Director of Workforce	Workforce Team						✓
Staff survey report	1	Information	Director of Workforce	Staff Engagement						✓
FINANCE										
Approval of budget	2	Approval	Director of Finance	Dep Director of Finance						✓
Approval of reference costs	2	Approval	Director of Finance	Dep Director of Finance		✓				
Acceptance of control total	2	Approval	Director of Finance	Dep Director of Finance					✓	
BUSINESS CONTINUITY										
Major incident/business continuity plan	1	Approval	Chief Operating Officer	Head of Resilience		✓				
EPRR core standards report	1	Approval	Chief Operating Officer	Head of Resilience				✓		
7-day services report	1	Approval	Chief Operating Officer	Head of Resilience			✓			✓
STRATEGY AND PLANNING										
Agreement of corporate objectives	2	Approval	Dir. of Strat and Plan	Dep Dir Strat and Plan					✓	
NHSI operational plan 2020-21	2	Approval	Dir. of Strat and Plan	Dep Dir Strat and Plan						✓
Review of NHS operational plan 2019-20	2	Discussion	Dir. of Strat and Plan	Dep Dir Strat and Plan					✓	