Board of Directors

31 July 2019, 12:00 to 16:00
Boardroom, Trust HQ, 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

Approval

Robert Armstrong

Minutes - P1 board - 29 May 2019.pdf (7 pages)

5. Patient experience video

Discussion

Pauline Law

6. Chair and Chief Executive's report

(To follow)

Discussion

Robert Armstrong/Andrew Foster

7. Launch of Rainbow Badge initiative

(Presentation)

Discussion

Debbie Jones/Jo O'Brien

8. Risk escalations:

8.1. Maternity theatres

Discussion

Pauline Law

8.1 Maternity theatres.pdf (9 pages)

9. Assurance and governance:

9.1. Committee chairs' reports

Verbal item

Information

Committee chairs

9.2. Performance report

Discussion

P Law/M Fleming/S Arya

9.2 Performance report.pdf (12 pages)

9.3. Finance report

Discussion

Ged Murphy

Finance report - P1.pdf (6 pages)

9.4. Safe staffing report

Discussion

Pauline Law

9.4 Safe staffing report.pdf (14 pages)

9.5. Bi-annual staffing review

Discussion

Pauline Law

9.5 Final bi-annual staffing review.pdf (19 pages)

9.6. Maternity staffing review

Discussion

Pauline Law

9.6 Maternity staffing review.pdf (6 pages)

9.7. Q4 2017/18 mortality report

Discussion

Sanjay Arya

9.7 Q4 mortality report.pdf (13 pages)

9.8. Board assurance framework

Approval

Robert Armstrong

BAF Patients - July 2019.pdf (2 pages)

BAF People - July 2019.pdf (3 pages)

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

BAF - Partnerships - Jul 2019.pdf (2 pages)

10. Consent agenda:

10.1. Seven day services report

Approval

10.1 Seven day services report.pdf (8 pages)

10.2. Changes to Standing Financial Instructions

Approval

10.2 Changes to SFIs.pdf (6 pages)

10.3. Corporate strategy

Approval

10.4. Modern slavery statement

Approval

10.4 Modern slavery statement.pdf (3 pages)

10.5. Freedom To Speak Up Guardian's report 2018/19

Information

10.6 FTSU annual report 2018-19.pdf (8 pages)

10.6. Guardian of Safe Working's report

Information

Guardian of Safe Working Annual Report.pdf (4 pages)

10.7. Medical revalidation and appraisal report

Information

10.7 Medical appraisal and revalidation report.pdf (7 pages)

11. Questions from the public

Discussion

Robert Armstrong

12. Resolution to exclude the press and public

Approval

Robert Armstrong

WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST

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

HELD ON 29 MAY 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	27/09/2019	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	✔						
Mrs A Balson	Director of Workforce	✔	A						
Dr S Elliot	Non-Executive Director	A	✔						
Mrs M Fleming	Chief Operating Officer	✔	✔						
Mr R Forster	Director of Finance and Informatics	✔	✔						
Mr A Foster	Chief Executive	A	A						
Mr M Guymer	Non-Executive Director	✔	✔						
Mr I Haythornthwaite	Non-Executive Director	✔	✔						
Mr J Lloyd	Non-Executive Director	A	✔						
Mrs L Lobley	Non-Executive Director	✔	✔						
Mrs P Law	Chief Nurse	✔	✔						
Mr R Mundon	Director of Strategy and Planning	A	✔						
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:

Mr P Howard	Company Secretary (minutes)
Mrs V McManus	Deputy Director of Human Resources
Mr G Murphy	Deputy Director of Finance
Ms H L'Estrange-Snowdon	Picker (for item 92/19 only)

5 governors and 1 member of staff were also in attendance.

88/19 Chair and quorum

The Vice-Chair, Prof T Warne, 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. He also welcomed Prof C Austin to her first meeting, following her recent appointment as a non-executive director.

89/19 Apologies for absence

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

90/19 Declarations of interests

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

91/19 Minutes of the previous meeting

The minutes of the previous meeting held on 27 March 2019 were agreed as a true and accurate record. Confirmation was provided that the board had now commenced a revised cycle of meetings, with formal board meetings being held on a bi-monthly basis and informal workshop sessions taking place on alternate months.

92/19 Picker inpatient survey 2018

Ms H L'Estrange-Snowdon delivered a presentation to summarise the findings from the 2018 inpatient survey and the board discussed the key areas of success and the areas for further focus in the coming year. Of particular note was the fact that there had been no areas of surprise within the findings and the board was pleased to note that it had been sighted on all key issues during the year.

The Medical Director joined the meeting.

The need for further focus on complaints and the discharge process was acknowledged and the Chief Nurse advised that this had been incorporated within the draft corporate objectives for 2019/20. The Deputy Director of Human Resources commented that analysis of the various results demonstrated the compassion of the workforce which was extremely pleasing to see.

The board received the presentation and noted the content.

93/19 Patient experience video

The Chief Nurse presented the regular patient experience video which this month highlighted a patient with Lyme disease; a bacterial infection that is not particularly common in the UK. The patient's story highlighted the need for patients to be considered holistically and for test results to inform decision-making rather than being the basis for decision-making and diagnosis. The board commended the patient's wife for her efforts to raise awareness of the condition and requested that the Chief Nurse and Medical Director consider how awareness could be improved within the organisation and across the borough, in conjunction with the Director of Public Health at Wigan Council.

ACTION: Chief Nurse/Medical Director

The board received and noted the patient experience video.

94/19 Deputy Chief Executive's report

The Deputy Chief Executive, Mr R Forster, presented a report which had been circulated in advance of the meeting to summarise the foundation trust's most up to date performance against a number of performance metrics and to brief on a number of strategic items. Confirmation was also provided that the annual report and accounts for FY2018/19 had been approved by the board on 22 May 2019 and the Deputy Chief Executive thanked all involved for their hard work and high quality submissions which had been noted by the auditors.

With regard to the narrative around the transfer of community services, the Deputy Chief Executive advised that the foundation trust had entered into an arbitration process with Bridgewater Community Healthcare NHS FT, facilitated by NHS Improvement, surrounding a number of outstanding legal and financial matters. He confirmed that this had not impacted on the operational transfer of staff and services into the foundation trust which had progressed well, with reports of high staff satisfaction and morale within the new staff cohort.

The board received the report and noted the content.

95/19 Committee chairs' reports

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

(a) Audit Committee, held on 2 April 2019 and 22 May 2019;

(b) Quality and Safety Committee, held on 10 April 2019 and 15 May 2019;

(c) Community Services Committee, held on 15 April 2019 and 20 May 2019; and

(d) Finance and Performance Committee, held on 24 April 2019 and also immediately prior to the meeting.

Mr I Haythornthwaite provided a summary of business transacted by the Audit Committee, noting that the April meeting had received a limited assurance report following an audit of sharps management and that, as a result, a follow-up report had been provided to the May meeting to provide the committee with assurance that the recommendations within the report were being addressed. The April meeting had also approved the internal audit plan and counter-fraud work plan for 2019/20 as well as the accounting policies for the 2018/19 accounts.

The May meeting of the Audit Committee had received a detailed internal audit progress report and had received the Head of Internal Audit Opinion for 2018/19 which had provided substantial assurance that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. The meeting had also considered the draft annual report, financial statements and quality report for 2018/19 along with the foundation trust's management representation letter and supporting documentation from the auditors, such as their report to those charged with governance and their report on the quality account, and had

recommended the relevant documents to the board for approval. The strong performance of the foundation trust, particularly in its financial management, was noted.

Prof T Warne presented a summary of the business transacted by the Quality and Safety Committee, and advised that a number of risk escalations had been considered by the committee. He noted in particular that the committee had received a report on the new arrangements for the attribution of *C. difficile* infections and the associated objectives for 2019/20, and had received a copy of a letter sent by the Chief Nurse to Public Health England to outline the organisation's concerns. He also drew the board's attention to the risk surrounding the availability of maternity theatres and that the committee had been provided with assurance that estates and facilities will undertake a further options appraisal to seek to address issues. Notwithstanding, the committee had noted that there was a risk to the foundation trust's potential to obtain a rebate on part of its Clinical Negligence Scheme for Trusts contribution if this element is not resolved. Prof T Warne concluded by noting that the most recent meeting had received a report from the local Trauma Audit and Research Network and had received the report of a recent leadership safety walkabout.

In the absence of the committee chair, the Director of Strategy and Planning gave an overview of the two Community Services Committee meetings, and reminded the board that the committee is intended to be time-limited and to provide a strategic overview of the transfer process rather than to address detailed issues which remained within management's purview. He noted that regular updates had been provided to the board since the transfer.

Mr M Guymer confirmed that the Finance and Performance Committee had received an update on the foundation trust's financial position at its April meeting and had considered the capital prioritisation process for 2019/20. It had also reviewed the budget setting principles relating to pay and agency expenditure. At its May meeting, the committee had received the first of a series of presentations from divisions to provide assurance around its financial position and overall performance, presented by the Division of Medicine. A report had also been considered in relation to two 52-week breaches of the referral-to-treatment time back stop that had been identified; one of which had resulted from a coding error and one due to a structured query language (SQL) reading error in the data warehouse. Confirmation was provided that full analysis of the two breaches had been completed to identify lessons for the future and also to ensure that there were no other breaches that had not yet been identified.

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

96/19 Performance report

The Chief Nurse opened this item by drawing the board's attention to the highlights and lowlights outlined on page three of the report and commented in particular on the fact that the foundation trust continues to compare favourably in relation to care hours per patient day both nationally and in comparison with its peers. With regard to the lowlights, the Chief Nurse advised that 7 instances of *C. difficile* had been reported for the year-to-date and reminded the board of its earlier discussions around the letter that had been sent to share the organisation's concerns around the new arrangements. She also noted that there had been 3 incidents reported via the Strategic Executive Information System;

two of which were the result of grade 3 hospital-acquired pressure ulcers and one due to the incorrect placement of a patient with carbapenamase-producing enterobacteriaceae resulting in the closure of a ward bay.

The Chief Operating Officer noted that the majority of operational highlights had been included within the Deputy Chief Executive's earlier report but drew the board's attention to the fact that the foundation trust was currently ranked 24th in the country for cancer waiting times and 23rd in the country in relation to 18-week referral-to-treatment performance. She also noted the work that is being undertaken as part of the Service and Value Improvement programme to address theatre effectiveness and confirmed that the model which is in place at Wrightington Hospital had been extended to other sites and had resulted in fewer patients with on-the-day cancellations. Mrs L Lobley suggested that the board should maintain oversight of this issue in addition to the detailed work undertaken by the Quality and Safety Committee.

The Chief Operating Officer highlighted A&E performance as an area of concern, noting that a significant shift in activity had been experienced, with a 12% increase in the number of attendances. The intention to move to a more streamlined performance report over the coming months was also acknowledged.

The board received the performance report and noted the content.

97/19 Financial position as at 30 April 2019

The Deputy Director of Finance presented a report which had been circulated with the agenda to summarise the foundation trust's financial position as at 30 April 2019, noting that detailed discussions on the financial performance had been held at the Finance and Performance Committee immediately before the meeting and drawing the board's attention to the revised format of the report which seeks to summarise the key performance metrics on one page. He noted that the foundation trust was reporting a deficit of £2.8m which represented an adverse variance of £0.2m against the planned position, but was reporting a favourable variance in cash position of £15.1m before year-end bonus payments.

The board received the report and noted the content.

98/19 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, as well as highlighting the inclusion of community services staffing information following the transfer of services with effect from 1 April 2019. She also noted that the foundation trust is now able to review patient acuity in escalated areas as well as ward areas.

The board discussed the challenges around the recruitment of health visitors and, whilst the Chief Nurse advised that a number had recently been appointed, the Chief Operating Officer noted the historic vacancy factor amongst this staff group and the need to understand how these have previously been covered.

The board received the report and noted the content.

99/19 Board assurance framework

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

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

100/19 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 occasions on which the common seal has been applied during financial year 2018/19 be noted AND THAT attestation of the use of the common seal by any two directors shall represent use of the seal under authority given by the board; and

2. THAT the proposed amendments to Standing Financial Instructions as outlined in the covering report be **APPROVED**.

101/19 Questions from the public

Two questions from the public were received; one surrounding ambulance handovers in Accident and Emergency and one surrounding the outstanding elements of the transfer of community services.

102/19 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.

103/19 Date, time and venue of next meeting

The next meeting of the Board of Directors will be held on 31 July 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
29 May 2019	93/19	Patient experience video	Consider how the foundation trust (and the wider borough in consultation with the Director of Public Health) may be better informed about Lyme disease.	Chief Nurse/Medical Director	ASAP	Verbal update to be provided.

REPORT

AGENDA ITEM: 8.1

Wrightington, Wigan and Leigh NHS Foundation Trust

To:	Board of Directors	**Date:**	31 July 2019
Subject:	Maternity theatres update		
Presented by:	Chief Nurse	**Purpose:**	Discussion

Executive summary

The purpose of this report is to provide the Board of Directors with information regarding the progress towards undertaking all elective maternity surgery within a dedicated elective theatre and not within the maternity emergency theatre as recommended by:

- NICE (2015) in its guidance for 'Safe midwifery staffing for maternity settings'; does not include the deployment of midwives to theatre, as the scrub practitioner, following the Department of Health (2010) recommendation that "operating theatre support" is not an "effective use of midwifery time",
- The RCOG (2016) published 'Providing Quality Care for Women - A Framework for Maternity Service Standards', which recommends that;

  "There must be separate provision of staffing and resources to enable elective work to run independently of emergency work, in particular to prevent delays to both emergency and elective procedures and provision of analgesia in labour."
- Midwifery 2020. recommends that;
  There should be a move away from skilled midwives acting as 'scrub nurses 'within theatres. An appropriate perioperative workforce including, for example, nurses or operating department assistants, will be necessary to ensure that the midwife's role focuses on caring for the woman's holistic needs.

In addition the CQC in their November 2017 inspection they identified as a must do action that the risk escalation document that has been monitored by the Quality and Safety Committee is attached to. The plan includes a number of actions related to the following:

- Scoping for availability of increasing maternity lists within the main theatre suite as sessions become available
- Revisit the option of developing a second maternity theatre within the Delivery Suite and obtain costings
- Development of a business plan in relation to staffing changes required to meet the challenges of Midwifery 2020

The WWL Way

Risks associated with this report
The Corporate Risk Register includes the following key risk: • Only 1 Maternity theatre available for both elective and emergency cases.

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

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Corporate Risk (Score of 20-25) Escalation Report Template

Risk Descriptor:	Only 1 Maternity theatre available for both elective and emergency cases.							
Ref No.:	SDel 109	**RAG & Score: 20**	**Oct18**	**Nov18**	**Dec19**	**Jan19**	**Feb19**	**Mar19**
Executive Lead:			**Apr19**	**May19**	**June17**	**July19**	**Aug19**	**Sept19**
Risk Owner:	Cathy Stanford. Head of Governance Maternity and Child Health.							

Where a Board Assurance Framework risk has remained static or rising in terms of its score (consequence x likelihood using the 5 by 5 matrix) it should be escalated from the monitoring Committee to either the Audit Committee or the Trust Board on the following basis:

- *If the risk is 'Red' for three consecutive months it should be escalated to the Trust Board*
- *If the risk is 'Amber' for six consecutive months it should be escalated to the Trust Board*
-

Care should be taken to consider 'red' risks in consecutive months over the financial year threshold

Delivery Suite has one emergency theatre and currently on 4 days per week elective Caesarean Sections are performed within the maternity emergency theatre. There is currently only one session per week allocated to maternity to undertake elective Caesarean Sections within the general main theatre suite at WWL.

There is the additional risk that during out of hours (evenings/nights/weekends) periods when no elective work is being undertaken in the maternity theatre: an emergency may already be in progress in the maternity theatre and the main theatre suite emergency theatres may be in use, resulting in a delay in the delivery which may have a catastrophic outcome for either the mother or baby.

In addition when Caesarean sections either elective or emergency are being undertaken the staffing on the Delivery Suite is reduced as 2 Midwives and a HCA are redeployed to theatre.

National recommendations state:

- The RCOG (2016) published 'Providing Quality Care for Women - A Framework for Maternity Service Standards', which recommends that; "There must be separate provision of staffing and resources to enable elective work to run independently of emergency work, in particular to prevent delays to both emergency and elective procedures and provision of analgesia in labour."

- NICE (2015) in its guidance for 'Safe midwifery staffing for maternity settings'; does not include the deployment of midwives to theatre, as the scrub practitioner, following the Department of Health (2010) recommendation that "operating theatre support" is not an "effective use of midwifery time",

- Midwifery 2020. recommends that;
  There should be a move away from skilled midwives acting as 'scrub nurses 'within theatres. An appropriate perioperative workforce including, for example, nurses or operating department assistants, will be necessary to ensure that the midwife's role focuses on caring for the woman's holistic needs.

- Anaesthetic Clinical Services Accreditation (ACSA) Standards
  Standard 1.2.4.6. Where there are elective caesarean section lists there are dedicated obstetric, anaesthesia, theatre and midwifery staff.

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Key controls (at the time of undertaking the risk assessment)	*Internal Threat*	*External Threat*	*Internal and External Assurance Source*	*Actions agreed*	*Status*
Scoping for availability of increasing maternity lists as sessions become available	Delay may occur when a women requiring an emergency Caesarean Section or instrumental delivery has to be transferred to general theatre due to the emergency theatre within Delivery Suite being in use.	Can result in a catastrophic outcome for either mother and or baby, with the potential for an adverse medico-legal case and damage to the Trusts reputation	Aim to undertake all elective cases in General Theatre	Develop robust communication process during out of hour's periods between theatre and maternity teams to identify theatre use. Identify number of sessions required and preferred options	**February 2019 Update** Theatre utilisation review in progress **May 2019 Update** The Division is committed to coming up with an interim agreement however this will have an impact on other specialties within the Division. Short term measures are high on the Divisions agenda with all possible options being reviewed Review of lists within specialities is ongoing and initiatives such as weekend working are being explored to free up sessions for Maternity. **July 2019 Update.** **The division has identified addition sessions for maternity cases and are currently awaiting the outcome of relocating breast surgery to the Wrightington site.**

All elective cases to be undertaken in a non-emergency Theatre in line with National recommendations	Lack of available theatre sessions to meet requirements	Non-compliance with National recommendations	Lists to be performed 2-3 days per week once sessions identified	Options being explored for increased activity within Leigh Theatres which would free up sessions with Wigan theatres.	**May 2019 Update** **Longer term plans** include relocation of Breast Surgery to the Wrightington site which will free up 4.5 sessions per week, but this is dependent on a successful business case for guidewire localisation. **July 2019 Update** **Plans remain in place to commence the elective lists x2 weekly w/c 22 July 2019 with 3 cases per session being booked. Electronic booking templates are available and now in use.** **Additional staffing will be available on elective theatre days to assist the flow and keep to schedule.**

Revisit the option of developing a second maternity theatre within the Delivery Suite and obtain costings	Financial costs Loss of Recovery area Loss of delivery rooms	The loss of a recovery area would be deemed detrimental to the existing theatre arrangement leaving the existing theatre derogated from the Health building notes (HBN).		Conversion of the existing theatre recovery area in maternity to be converted into a theatre for Caesarean sections. RAEI - No.2 Maternity theatre.pdf	**February 2019 Update** The proposal to provide an additional maternity theatre utilising the existing recovery area is not feasible. The reason for this is the constraints in place from NHS England Health Building notes does not allow for the required accommodation to provide this service in the manner recommended by the notes. The best the space could be used for is a treatment room, but due to the nature and invasiveness of the surgery, a full sterile environment and theatre would be required. This is not achievable in this proposal. **May 2019 Update** Further option being reviewed to utilise a delivery room along with the recovery area which may then be compliant with Building regulations in regards to size and sterile environment. Meeting to take place early May with E&F to review these options. However this will require substantial capital investment **July 2019 Update** **No further update on reviewing/scoping possibilities for a second theatre within the Delivery suite footprint as currently the plan is to utilise general theatre for all elective cases going forward.**

Development of a business plan in relation to staffing changes required to meet the challenges of Midwifery 2020	Financial costs for additional staffing required to provide 24/7 dedicated maternity theatre team	Non-compliance with National recommendations	Identify additional staffing requirements	An appropriate perioperative workforce which includes, nurses or operating department assistants, will be necessary to ensure that the midwife's role focuses on caring for the woman's holistic needs.	May 2019 Update Business case in development once options have been agreed **July 2019 Update** **Business case for theatre staffing will be developed by the surgical management team once the required staffing model has been agreed by the Clinical Heads of Service.**

Please provide a short narrative outlining how the risk will be mitigated appropriately (to Amber or Green from Red or Amber) and what the timescale for this is, please describe why this has been problematic to date and what lessons can be learnt from the difficulties experienced:

February Update

Options for the development of an additional theatre within Delivery suite are no longer feasible due to space being non-compliant with building regulations. The suggested alternative option of utilising the recovery area and delivery rooms to convert into a theatre suite would greatly reduce the capacity for labouring women and would increase the risk of the unit being closed frequently due to capacity issues.

Identifying additional theatre sessions within the main theatre suite is at present the only option available however this relies on other specialties being relocated to Leigh theatres or additional sessions identified from the theatre utilisation work which remains ongoing.

Time scales for completion need to be expedited due to the risk of failing to meet the national recommendations within Midwifery 20/20. In addition WWL does not comply with the service specifications and standards for the provision of maternity care set out in the RCOG 2016 Providing Quality Care for Women - 'A Framework for Maternity Service Standards'.

MAY 2019 Update.

The 10 safety actions outlined by the NHS Resolution Maternity incentive scheme following Year 2 (NHSR December 2018), states that where there are elective caesarean section lists there are dedicated obstetric, anaesthesia, theatre and midwifery staff. Whilst the Division will not be fully compliant with this element they are committed to providing an interim solution to ensure that elective Caesarean sections are carried out in a dedicated theatre that is not the Maternity emergency theatre. Long term solutions continue to be explored but these are dependent on several other factors and will require substantial capital investment.

July 2019 Update

2 elective Caesarean section list will commence on 22July 2019. Meeting to be held with theatre team to identify robust pathway for out of hours when 2 emergency cases required at the same time. Additional 3rd session is still awaiting confirmation following relocation of other specialty to Wrightington. .

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Board Performance Report

June 2019

Your hospitals, your health, our priority

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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-18 - MAR-19	12/07/19	No	97.96	34.38%	45/129
Safe	2	Summary Hospital-level Mortality Indicator (SHMI)	JAN-19 - MAR-19	12/07/19	No	101.77	44.96%	59/130
Safe	3	Safety Thermometer / Harm Free Performance	JAN-19	14/02/19	No	92.49%	74.55%	83/111
Safe	4	Cancer 2 Week Wait Performance	MAY-19	11/07/19	No	95.44%	28.46%	38/131
Safe	5	18 Week Incomplete Referral To Treatment (RTT) Performance	MAY-19	11/07/19	Yes	93.05%	9.38%	13/129
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	JUN-19	11/07/19	No	83.78%	60.77%	80/131
Effective	8	Diagnostic 6 Week Wait Performance	MAY-19	11/07/19	No	1.00%	32.56%	43/130
Caring	10	Friends & Family Assessment Result	MAY-19	11/07/19	No	94.00%	62.31%	82/131
Caring	11	National Patient Survey Result	JAN-17 - DEC-17	19/07/18	No	0.84	14.93%	21/135

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

Top 5 Performing Metrics

#	Metric Name	Rank
1	Patient-led assessments of the care environment (PLACE)	2
2	18 Week Incomplete Referral To Treatment (RTT) Performance	13
3	National Patient Survey Result	21
4	Cancer 2 Week Wait Performance	38
5	Diagnostic 6 Week Wait Performance	43

Bottom 5 Performing Metrics

#	Metric Name	Rank
1	Safety Thermometer / Harm Free Performance	83
2	Friends & Family Assessment Result	82
3	Accident & Emergency 4 Hour Wait Performance	80
4	Summary Hospital-level Mortality Indicator (SHMI)	59
5	Hospital Standardised Mortality Ratios (HSMR)	45

Local Trust Positions

Provider Name	GM Rank	North Rank	National Rank
BOLTON NHS FOUNDATION TRUST	1/7	3/44	7/136
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	2/7	8/44	18/136
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	3/7	12/44	26/136
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	4/7	31/44	94/136
SALFORD ROYAL NHS FOUNDATION TRUST	5/7	34/44	105/136
STOCKPORT NHS FOUNDATION TRUST	6/7	39/44	114/136
PENNINE ACUTE HOSPITALS NHS TRUST	7/7	44/44	130/136

In Month

18 Weeks: Incomplete
92.45%
Target: 92.0%

Cancer 62 Day: GP Referral
80.13%
Target: 85.0%

Diagnostics: 6 Weeks
99.26%
Target: 99.0%

**A&E: 4 Hour Target
83.78%
Target: 95.0%

C. Difficile Infections
12
YTD Target: 5

Year To Date

Serious Falls
1
FY Target: 0

Never Events
1
FY Target: 0

MRSA
0
FY Target: 0

Executive Summary (June 2019)

Overall infection rates remain low.
There is an improving trend regarding the number of Serious and Moderate Falls.
The Trust has not received any PFD Coroner notifications for 20 months.
Over all fill rate for registered nurses within the safe staffing report for May is 90.4% which is a slight improvement from the month of April.
There has been a reduction in registered nurse vacancies reported by the acute trust within month (May).

The increase in Grade 3 & 4 Pressure Ulcers during the first quarter is a key concern. A Task & Finish group has been set up and a comprehensive presentation will be submitted to the September 2019 Quality & Safety Committee for discussion.
Clostridium Difficile infections also remain a concern, however, ribotyping has confirmed there have been no cases of cross infection. The new objectives in place since 1st April 2019 have impacted on the number of Clostridium Difficile infections reported.
There have been 10 StEIS reportable incidents in month, of which, 5 are StEIS reportable Pressure Ulcers from both the Hospital and the Community.
Community Acquired Grade 3 & 4 Pressure Ulcers are now included in this report.
The Trust has a higher proportion of care hours delivered per patient day by unregistered staff (4.2) than peer trusts (3.4) and the national average (3.2).
High vacancy rates are noted within the division of medicine and within the community services division impacting primarily on district nursing and health visiting services

Please also see Scheduled Care Report and Unscheduled Care Report.

1.1 : Harm Free

Metric Title	Target	Latest Actual	Latest Period	Latest RAG	Trend	Previous Actual	Previous Period	YTD Actual	YTD RAG	Sparkline - Latest 13 Months Chart	Min. Value	Max. Value	Period
Serious Harms: Community Acquired Grade 3-4 Pressure Ulcers	**	3	Jun-19		↑	2	May-19	5			0	3	Apr-19 to Jun-19
Harms: Total	**	59	Jun-19		↓	79	May-19	217			59	85	Jun-18 to Jun-19
Serious Harms: Total	**	8	Jun-19		↓	14	May-19	29			3	14	Jun-18 to Jun-19
Serious Harms: Number of Never Events	<= 0	0	Jun-19	●	↓	1	May-19	1	●		0	2	Jun-18 to Jun-19
Serious Harms: Number of Serious Falls	<= 0	0	Jun-19	●	↓	1	May-19	1	●		0	1	Jun-18 to Jun-19
Serious Harms: Hospital Acquired Grade 3-4 Pressure Ulcers	**	2	Jun-19		↑	1	May-19	5			0	2	Jun-18 to Jun-19
Number of Serious Incidents	<= 0	10	Jun-19	●	↑	4	May-19	17	●		0	10	Jun-18 to Jun-19
Mod/Low Harms: Hospital Acquired Pressure Ulcer Grade 2	**	1	Jun-19		→	1	May-19	6			0	6	Jun-18 to Jun-19
Mod/Low Harms: Number of Moderate Falls	<= 0	1	Jun-19	●	↑	0	May-19	3	●		0	3	Jun-18 to Jun-19
Mod/Low Harms: Safety Thermometer	>= 95.0%	98.07%	Jun-19	●	↓	98.09%	May-19	98.15%	●		97.21%	99.75%	Jun-18 to Jun-19
Mod/Low Harms: Settled Clinical Litigation Cases	**	2	Jun-19		↑	1	May-19	7			1	5	Jun-18 to Jun-19
Mod/Low Harms: VTE Assessments (% of Admissions)	>= 95.0%	96.34%	Jun-19	●	↓	97.00%	May-19	96.45%	●		95.67%	97.90%	Jun-18 to Jun-19

Commentary (Page Owner : Director of Nursing and Performance)

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

In June 2019, the Trust has uploaded 10 incidents to StEIS, of which 5 incidents relate to pressure damage (2 Hospital acquired and 3 Community acquired). The Safety Thermometer, the percentage of patients receiving harm free care in hospital was 93.09%.

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	**	6	Jun-19		↓	15	May-19	28			2	16	Jun-18 to Jun-19
Serious Harms: Infections: Clostridium Difficile	<= 2	5	Jun-19	🔴	↑	4	May-19	12	🔴		0	5	Jun-18 to Jun-19
Serious Harms: Infections: Clostridium Difficile Lapses in Care	<= 0	1	May-19	🔴	→	1	Apr-19	N/A			0	1	Jun-18 to May-19
Infections: Catheter Associated Urinary Tract	<= 0	0	Jun-19	🟢	↓	2	May-19	3	🔴		0	2	Jun-18 to Jun-19
Serious Harms: Bacteraemias: MRSA	<= 0	0	Jun-19	🟢	→	0	May-19	0	🟢		0	1	Jun-18 to Jun-19
Serious Harms: Bacteraemias: MRSA - Avoidable Cases	**	0	Jun-19	🟢	→	0	May-19	0	🟢		0	0	Jun-18 to Jun-19
Serious Harms: Bacteraemias: MSSA	**	0	Jun-19	🟢	↓	1	May-19	1			0	4	Jun-18 to Jun-19
Serious Harms: Bacteraemias: E-coli	**	1	Jun-19		↓	6	May-19	9			0	7	Jun-18 to Jun-19
Bacteraemias: Klebsiella	**	0	Jun-19	🟢	↓	2	May-19	3			0	2	Jun-18 to Jun-19
Bacteraemias: Pseudomonas	**	0	Jun-19	🟢	→	0	May-19	0	🟢		0	1	Jun-18 to Jun-19

Commentary (Page Owner : Director of Nursing and Performance)

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

Five inpatient cases of Clostridium Difficile infection. Two of these cases would have been assigned to the community under the pre 2019/20 rules. No apparent connection between cases but all specimens have been sent for ribotyping to determine whether a common strain is present. No other obvious features to explain this increase. Other infections remain at low levels.

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	**	104	Jun-19		↓	111	May-19	312			81	128	Jun-18 to Jun-19
Hospital Crude Death Rate	**	1.54%	Jun-19		↓	1.57%	May-19	1.52%			1.10%	1.79%	Jun-18 to Jun-19
PFD Coroner Notifications	**	0	Jun-19	●	→	0	May-19	0	●		0	0	Jun-18 to Jun-19
Deaths after Readmission	**	26	Jun-19		↓	30	May-19	84			22	38	Jun-18 to Jun-19
HSMR (Latest Month)	<= 90	101.8	Mar-19	●	↓	109.7	Feb-19	N/A			76.0	120.2	Apr-18 to Mar-19
HSMR (Latest YTD)	*	98.0	Mar-19		↑	97.6	Feb-19	N/A			95.2	98.0	Dec-18 to Mar-19
HSMR Weekday	<= 90	109.0	Mar-19	●	↓	111.1	Feb-19	N/A			66.6	121.7	Apr-18 to Mar-19
HSMR Weekend	<= 90	81.8	Mar-19	●	↓	104.7	Feb-19	N/A			75.3	125.2	Apr-18 to Mar-19
SHMI (Rolling 12 Months)	<= 90.0	113.3	Feb-19	●	↑	112.6	Jan-19	N/A			109.1	113.3	Jun-18 to Feb-19

Commentary (Page Owner : No owner assigned.)

No commentary provided for this section.

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

3.1 : Midwifery - Part 1

	Latest					Previous		YTD		Sparkline - Latest 13 Months			
Metric Title	Target	Actual	Period	RAG	Trend	Actual	Period	Actual	RAG	Chart	Min. Value	Max. Value	Period
Maternity: Midwife / Birth Ratio	<= 1.30	1.25	Jun-19		→	1.25	May-19	N/A			1.24	1.27	Jun-18 to Jun-19
Maternity: Skills drills/2 day Mandatory Training Attendance	>=	48.20%	Jun-19		↑	42.98%	May-19	N/A			8.09%	95.37%	Jun-18 to Jun-19
Maternity: Total monthly bookings	>= 240	225	Jun-19		↑	212	May-19	668			197	292	Jun-18 to Jun-19
Maternity: Booked by 12+6 Weeks	>= 90.0%	90.22%	Jun-19		↑	88.21%	May-19	N/A			84.07%	91.28%	Jun-18 to Jun-19
Maternity: Induction of Labour	<= 30.0%	39.73%	Jun-19		↑	35.32%	May-19	N/A			31.76%	41.05%	Jun-18 to Jun-19
Maternity: Normal Deliveries	>= 60.0%	60.70%	Jun-19		↑	60.27%	May-19	N/A			49.10%	67.89%	Jun-18 to Jun-19
Maternity: Water Births	>= 8	10	Jun-19		↓	13	May-19	36			7	16	Jun-18 to Jun-19
Maternity: Instrumental Deliveries	<= 10.0%	10.48%	Jun-19		↓	10.96%	May-19	N/A			9.63%	13.88%	Jun-18 to Jun-19
Maternity: Elective Caesarean Sections	<= 15.0%	13.97%	Jun-19		↑	11.42%	May-19	N/A			7.80%	17.34%	Jun-18 to Jun-19
Maternity: Emergency / Non Elective Caesarean Sections	<= 17.0%	14.41%	Jun-19		↓	17.35%	May-19	N/A			11.96%	21.08%	Jun-18 to Jun-19
Maternity: Total Caesarean Sections	<= 27.0%	28.38%	Jun-19		↓	28.77%	May-19	N/A			22.48%	36.53%	Jun-18 to Jun-19

Commentary (Page Owner : Director of Nursing and Performance)

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

Midwife to Birth ratio remains good at 1:25 which is reflective of the reducing birth rate over the last 6 months, and is in line with the downward National trend for UK born mothers. Birth rate + recommendations will be identified in the July staffing paper, which will take into account the increased level of acuity within the caseload that has been identified in the Birth-rate+ report. Additionally this has allowed 100% 1-2-1 care in labour. Attendance at Mandatory Training has dipped slightly this month but remains on target to achieve the 90% compliance by year end. Target figure for Induction of Labour across GM have been set at 35% , this month has seen a rise in inductions to just under 40% however all of which were undertaken for Obstetric reasons.

3.2 : Midwifery - Part 2

	Latest					Previous		YTD		Sparkline - Latest 13 Months			
Metric Title	Target	Actual	Period	RAG	Trend	Actual	Period	Actual	RAG	Chart	Min. Value	Max. Value	Period
Maternity: Total Births	>= 240	229	Jun-19			219	May-19	615			167	236	Jun-18 to Jun-19
Maternity: Episiotomy with normal birth	<= 6.0%	10.07%	Jun-19			9.85%	May-19	N/A			2.22%	10.07%	Jun-18 to Jun-19
Maternity: 3rd/4th degree tears	<= 3.0%	2.23%	Jun-19			0.92%	May-19	N/A			0.00%	3.20%	Jun-18 to Jun-19
Maternity: Initiation of breastfeeding	>= 55.0%	54.15%	Jun-19			53.88%	May-19	N/A			44.29%	57.35%	Jun-18 to Jun-19
Maternity: Average post-natal length of stay	<= 1.8	1.6	Jun-19			1.5	May-19	N/A			1.5	2.0	Jun-18 to Jun-19
Maternity: Still Births (>24 weeks)	<= 1	1	Jun-19			0	May-19	2			0	2	Jun-18 to Jun-19
Maternal Readmissions within 30 Days	<= 5	1	Jun-19			1	May-19	3			1	6	Jun-18 to Jun-19
Maternal admissions to ICU	<= 2	0	Jun-19			0	May-19	0			0	1	Jun-18 to Jun-19
Maternity Complaints	<= 2	0	Jun-19			2	May-19	3			0	2	Jun-18 to Jun-19
Maternity: New Claims	*	0	Jun-19			0	May-19	0			0	3	Jun-18 to Jun-19

Commentary (Page Owner : Director of Nursing and Performance)

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

Caesarean section rate overall within regional target at 28%, and Normal birth rate at 60%. Third and fourth degree tear rate remains lower than average. Initiation of breast feeding remains improved in June with the Infant feeding team continuing to work to identify opportunities to promote and support mothers to initiate breastfeeding. WWL has full Baby Friendly accreditation and Gold status. There has been one stillbirth in month which will have a full Multidisciplinary review in line with National recommendations. No complaints or legal claims have been received in June.

4.1 : Patient Experience - 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
Number of Complaints Upheld by Ombudsman	**	0	Jun-19		→	0	May-19	0			0	1	Jun-18 to Jun-19
Percentage of Complaints Responded to on Time	**	44.44%	Jun-19		↓	58.14%	May-19	60.38%			34.88%	89.13%	Jun-18 to Jun-19
Patient Survey Q1: Staff Introduction	>= 90.0%	90.08%	Jun-19		↓	92.31%	May-19	92.13%			88.51%	96.53%	Jun-18 to Jun-19
Patient Survey Q2: Worries and Fears	>= 90.0%	93.89%	Jun-19		↑	87.18%	May-19	91.24%			87.05%	94.70%	Jun-18 to Jun-19
Patient Survey Q3: Pain Control	>= 90.0%	93.13%	Jun-19		↑	92.95%	May-19	94.16%			90.16%	97.66%	Jun-18 to Jun-19
Patient Survey Q4: Family and Doctor	>= 90.0%	90.08%	Jun-19		↓	92.31%	May-19	91.46%			88.08%	96.97%	Jun-18 to Jun-19
Patient Survey Q5: Decisions about Care and Treatment	>= 90.0%	84.73%	Jun-19		↓	86.54%	May-19	85.39%			78.38%	88.19%	Jun-18 to Jun-19
Patient Survey Q6: Food Choice	>= 90.0%	95.42%	Jun-19		↓	97.44%	May-19	97.30%			93.75%	98.73%	Jun-18 to Jun-19
Patient Survey Q7: Healthy Food	>= 90.0%	93.89%	Jun-19		↑	92.95%	May-19	93.71%			88.60%	97.22%	Jun-18 to Jun-19
Patient Survey Q9: Know Consultant	>= 90.0%	73.28%	Jun-19		↓	87.82%	May-19	82.92%			73.28%	90.28%	Jun-18 to Jun-19

Commentary (Page Owner : Director of Nursing and Performance)

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

During June 2019, 12 of 27 complaint responses were sent within the timescales agreed with the complainant at the start of the complaints process (44%). 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. For Real Time Patient Survey commentary, please see overleaf.

4.2 : Patient Experience - Part 2

	Latest					Previous		YTD		Sparkline - Latest 13 Months			
Metric Title	Target	Actual	Period	RAG	Trend	Actual	Period	Actual	RAG	Chart	Min. Value	Max. Value	Period
Patient Survey Q10: Enough Privacy	>= 90.0%	100.00%	Jun-19			98.72%	May-19	99.55%			98.18%	100.00%	Jun-18 to Jun-19
Patient Survey Q11: Call Bell	>= 90.0%	97.71%	Jun-19			98.08%	May-19	97.53%			92.73%	98.08%	Jun-18 to Jun-19
Patient Survey Q12: Compassion	>= 90.0%	98.47%	Jun-19			97.44%	May-19	97.75%			96.62%	99.30%	Jun-18 to Jun-19
Patient Survey Q13: Given Required Care	>= 90.0%	98.47%	Jun-19			98.08%	May-19	97.53%			94.70%	99.31%	Jun-18 to Jun-19
Friends & Family: Decisions about Discharge Home?	>= 90.0%	84.80%	Jun-19			87.37%	May-19	N/A			83.95%	91.94%	Jun-18 to Jun-19

Commentary (Page Owner : Director of Nursing and Performance)

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

In relation to the Real Time Patient Survey, ten questions remain in the green scoring zone reaching over a 90% benchmark score. We have seen some good improvement in the question "Did you find someone to talk to about your worries and fears?". "Do you know which consultant is currently treating you?" has declined by 14.52%.

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	£ -149 k	Jun-19			£ -63 k	May-19	£ -41 k			£ -149 k	£ 1,276 k	Jun-18 to Jun-19
Friends & Family Test - Recommendation as place to work	>= 75.0%	61.94%	Apr-19			71.59%	Jan-19	N/A			61.94%	71.59%	Jul-18 to Apr-19
Clinical & Non Clinical Overall Vacancy Rate	<= 3.5%	10.50%	Jun-19			10.87%	May-19	10.72%			7.05%	10.87%	Jun-18 to Jun-19
Sickness absence - Total	<=	4.37%	May-19			4.19%	Apr-19	N/A			4.04%	5.04%	Jun-18 to May-19
Quarterly Engagement Score	>= 4.00	3.90	Apr-19			4.01	Jan-19	N/A			3.90	4.04	Jul-18 to Apr-19
Appraisals over rolling 12 months	>= 90.0%	86.19%	May-19			88.13%	Mar-19	N/A			86.19%	89.62%	Jun-18 to May-19
Friends & Family Test - Recommendation as place for treatment	>= 80.0%	76.11%	Apr-19			79.42%	Jan-19	N/A			76.11%	83.33%	Jul-18 to Apr-19
Mandatory Training over rolling 12 months	>= 95.0%	90.12%	May-19			95.28%	Mar-19	N/A			90.12%	97.25%	Jun-18 to May-19
Agency vs NHSI Ceiling	<=£ 0 k	£ 718 k	Jun-19			£ 110 k	May-19	£ 929 k			£ 101 k	£ 718 k	Jun-18 to Jun-19

Commentary (Page Owner : Director of Workforce)

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

Rolling 12-month sickness from Jun 18 - May 19 increased marginally to 4.37% (compared to 4.35% last reported). The in-month sickness rate also increased to 4.37% (compared to 4.19% in Apr 19). Temp spend in Jun 19 decreased by £580k to £1,604k (compared to £2,184k in May 19). There were decreases in Agency, Locum, Additional Sessions, Bank NHSP, Zero Hour Contract and Overtime (decreased by £385k, £55k, £50k, £49k, £39k and £20k respectively). Cost per case increased by £18k and there was zero spend on Bank in Jun 19. With respect to the Staff Engagement Quarterly Pulse Check it is noted that in Oct 18, a large shift in the results was observed, which seemingly recovered in Jan 19. In Apr 19, we see that the results have regressed once again. Over the past 12 months there has been irregularity and turbulence to the results which could be indicative of the current cultural climate. Whilst job plan compliance is at 100%, the plans are at various stages within the system. Trustwide there are 206 job plans at the following stages: 36 (Discussion), 37 (1st sign off), 18 (2nd sign off), 1 (3rd sign off), 114 (fully signed off). Please note that Speciality Doctors are now recorded on Allocate and are included in these figures along with Consultants.

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%	83.78%	Jun-19			83.07%	May-19	82.72%			75.11%	95.42%	Jun-18 to Jun-19
Access: 18 Weeks Referral To Treatment Incomplete Pathway	92.0%	92.45%	Jun-19			93.06%	May-19	92.66%			92.25%	94.16%	Jun-18 to Jun-19
Diagnostics: Patients waiting over 6 weeks	99.0%	99.26%	Jun-19			99.00%	May-19	98.81%			98.17%	99.42%	Jun-18 to Jun-19
Two week wait from referral to date first seen: all urgent cancer referrals (cancer suspected)	93.0%	95.25%	May-19			93.96%	Apr-19	94.66%			93.57%	97.95%	Jun-18 to May-19
Two week wait from referral to date first seen: symptomatic breast patients (cancer not initally suspected)	93.0%	98.61%	May-19			96.30%	Apr-19	97.22%			91.24%	100.00%	Jun-18 to May-19
All Cancers: 62 day wait for first treatment from urgent GP referral to treatment	85.0%	80.13%	May-19			83.50%	Apr-19	81.50%			80.13%	94.29%	Jun-18 to May-19
All Cancers: 62 day wait for first treatment from consultant screening service referral	90.0%	100.00%	May-19			92.86%	Apr-19	97.26%			92.31%	100.00%	Jun-18 to May-19
Serious Harms: Infections: Clostridium Difficile	2	5	Jun-19			4	May-19	12			0	5	Jun-18 to Jun-19
Serious Harms: Infections: Clostridium Difficile Lapses in Care	0	1	May-19			1	Apr-19	2			0	1	Jun-18 to May-19
Community: % Patients beginning treatment within 6 weeks	75.0%	2.33%	May-19			2.67%	Apr-19	N/A			2.33%	2.67%	Apr-19 to May-19
Community: % Patients beginning treatment within 18 weeks	95.0%	0.00%	May-19			0.00%	Apr-19	N/A			0.00%	0.00%	Apr-19 to May-19

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

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

Finance Report

Month 03 ending 30th June 2019

The WWL Way

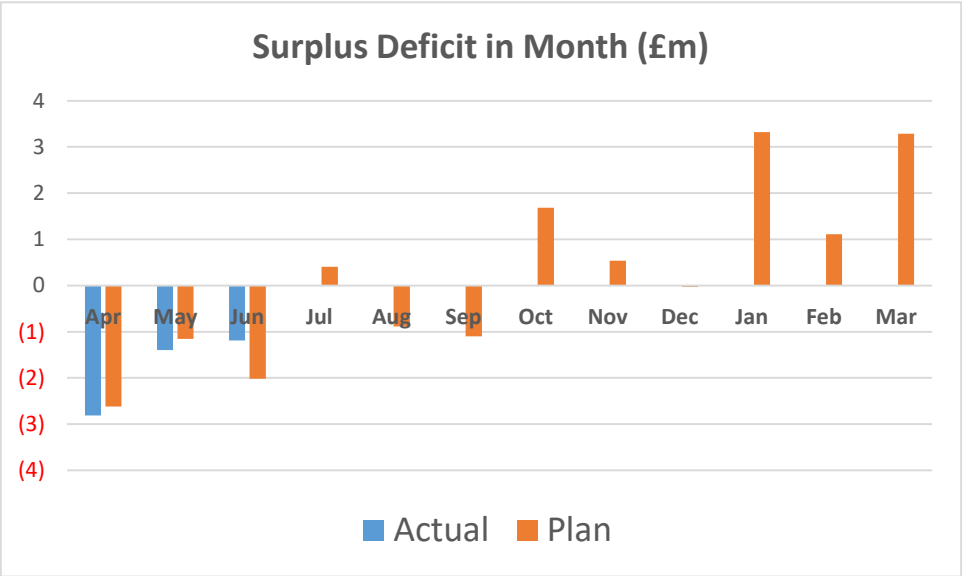
Contents

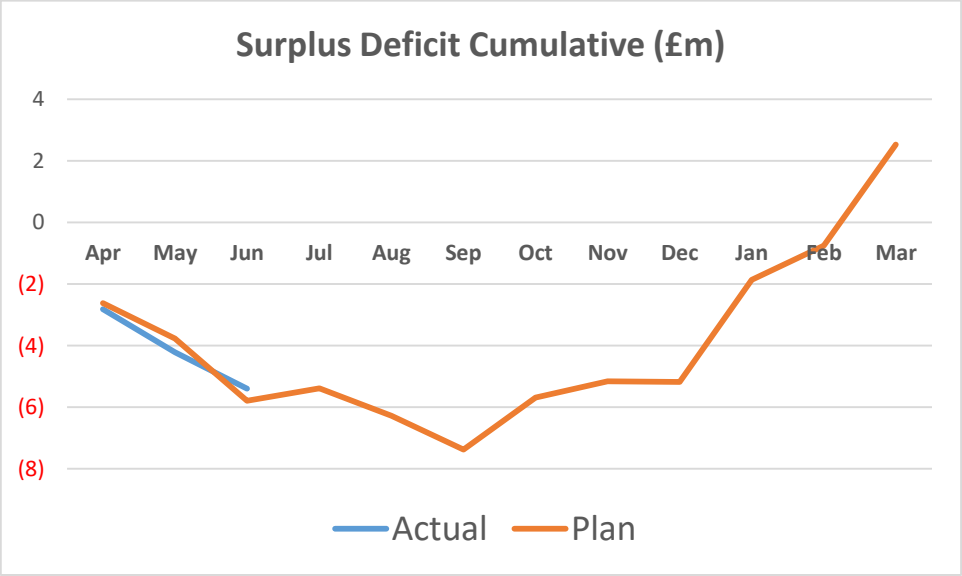
Performance on a Page

	In Month			Year to Date		
	Actual £000's	Plan £000's	Var £000's	Actual £000's	Plan £000's	Var £000's
Income	30,333	29,106	1,227	88,940	88,265	675
Expenditure	(30,532)	(30,130)	402	(91,382)	(91,072)	310
Surplus / Deficit	(1,186)	(2,019)	833	(5,396)	(5,792)	396
Cash Balance	33,599	12,836	20,763	33,599	12,836	20,763
Capital Spend	1,291	1,425	134	2,372	3,075	703
UOR	3	3	0	3	3	0

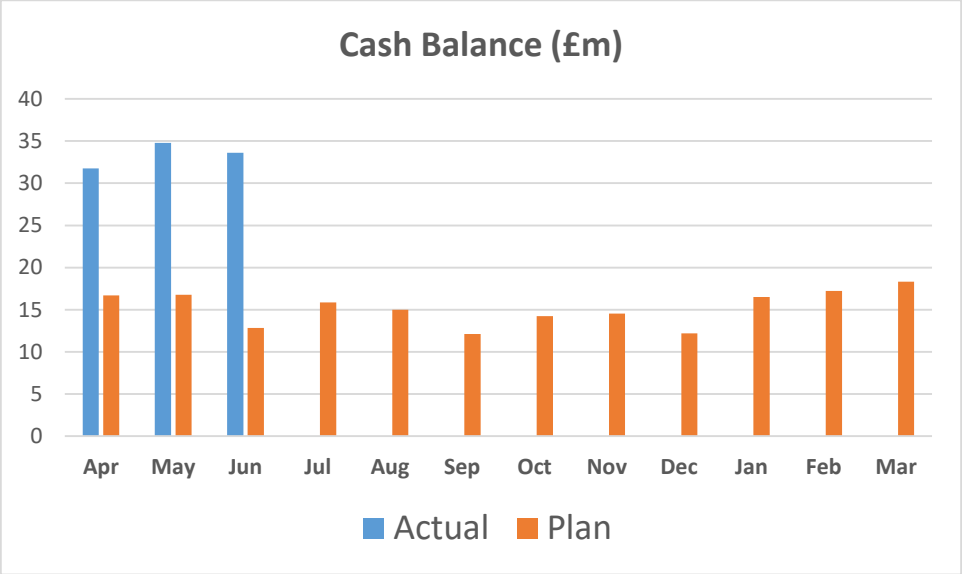
- Trust reporting a £5.4m deficit which is £0.4m better than plan.
- Cash is £21.8m better than plan (this does not include year-end bonus payments).
- Capital is overspent by £0.7m.

Surplus Deficit

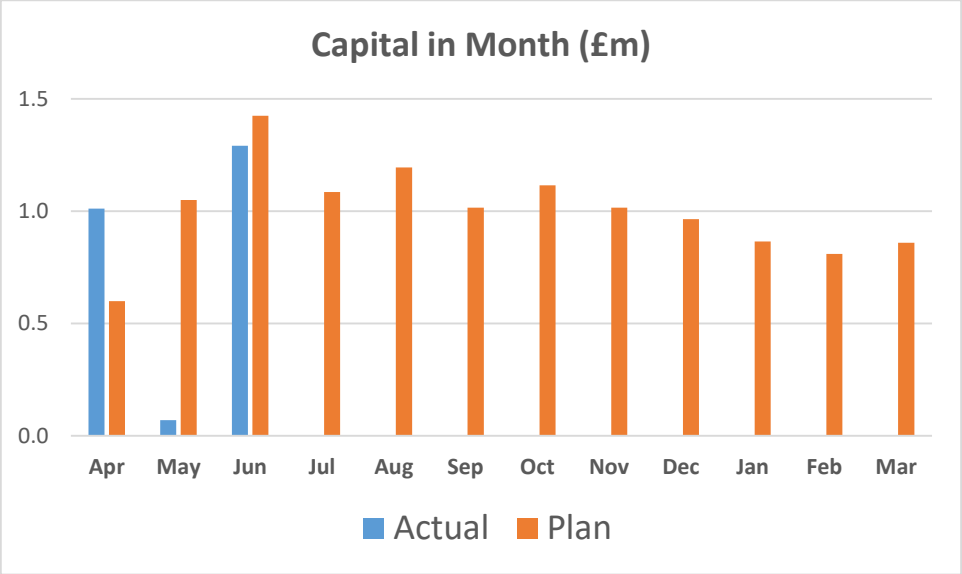


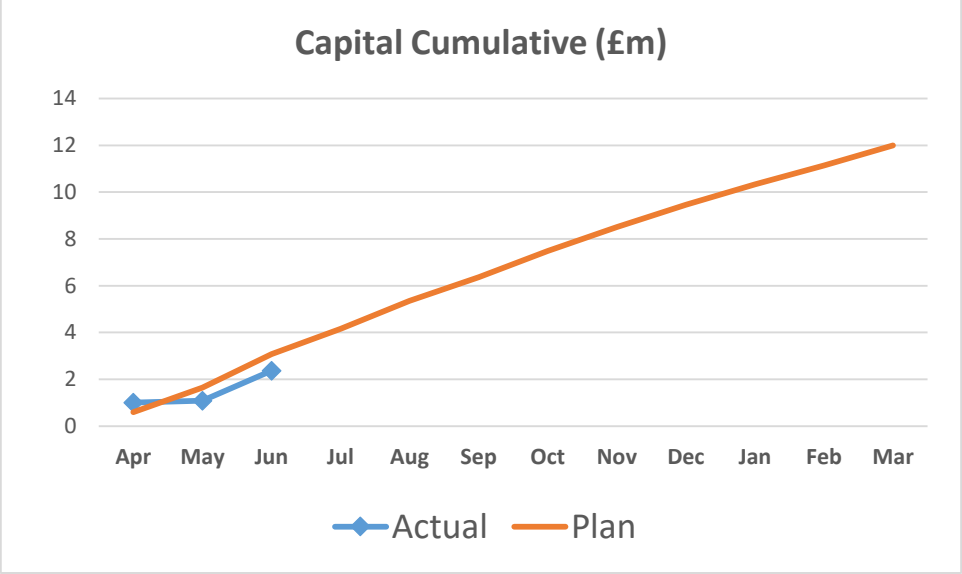


Cash Balance



Capital Spend





REPORT

AGENDA ITEM: 9.4

Wrightington, Wigan and Leigh NHS Foundation Trust

To:	Board of Directors	**Date:**	31 July 2019
Subject:	Safe Staffing Report		
Presented by:	Chief Nurse	**Purpose:**	Information

Executive summary

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

The Board are asked to note;

- The ongoing risks associated with high vacancy rates, fill rates and skill mix in Scheduled Care in the Division of Medicine
- The incidence of harm reported linked to nurse staffing levels and skill mix within Scheduled Care
- The increase in red flags associated with delays in administration of pain relief and associated deterioration of reported patient experience with respect to this metric
- The positive benchmarked position of CHPPD and nurse staffing costs with both peers and nationally
- The continued progress with the roll out of SafeCare, reporting of red flag incidents and use of redeployment functions on the system.

Risks associated with this report

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

Nurse Staffing remains the biggest risk on the risk register.

There has been an increase in the number of nurse vacancies across acute services of the Trust

The difficulties obtaining timely information with respect to staffing and safety for the community division.

The WWL Way

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

Safe Staffing Report – June 2019

1.0 INTRODUCTION

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

2.0 SAFER STAFFING EXCEPTION REPORT

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

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

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

3.0 DISCUSSION

Throughout June the Undesignated Areas paper was utilised to support escalation of areas associated with increased operational demands. Unless the areas are escalated in a planned manner movement of staff from other areas is required to support care and management of these patients which depletes planned staffing levels. The Board are reminded that the ward establishments are to safe minimum staffing levels only.

Staff who have taken advantage of the incentive scheme have been utilised to support safe staffing across these areas as required to reduce the impact on ward rostered staff. The overall fill rate for registered nurses within the report is 89.8% which is a slight decrease from the previous month.

Appendix 2 Table 1 indicates a reduction in the number of areas flagging red for registered nurse fill rates from the previous month. The pattern of red rates has, however, continued to increase for night shifts and further scrutiny of rosters is required to ensure adequate skill mix and cover during this shift period.

Tables 6 and 7 provide information from the Model Hospital for April 2019 with respect to Care Hours per Patient Day (CHPPD) and Nursing Costs. In accordance with NHSI requirements the external reporting of fill rates for registered and unregistered nursing staff has ceased and CHPPD only is being utilised as a comparator for benchmarking purposes.

As demonstrated within the data sets provided the Trust continues to compare favourably for aggregate and non-registered staff CHPPD. The overall cost of nursing staff also compares favourably. The Board should note, however, that this cost reduction is likely to be associated with the difficulties filling registered posts and an over reliance on unregistered staff to provide adequate nursing numbers to provide direct care.

Appendix 2, Table 2 provides details of the vacancies across Trust; vacancies for Adult Community Services were not provided in time for the preparation of this report and therefore like for like comparison of overall vacancies has not been possible. The Board should note there has been an overall increase in nursing vacancies across the acute site (12.89 WTE); the largest increase was seen within the division of medicine.

Embedding of the SafeCare module has continued to progress throughout June. All wards are currently utilising the system although further work is required to ensure data is captured as required, cascade training is completed and full functionality of the system is utilised. Within the month the redeployment function was used to record the movement of staff to support patient need (107 staff moves). It should be noted that the majority of these moves (69) were recorded by staff in specialist service across the Wrightington site and to support Aspull Ward. Use of these area of the system is not yet embedded into practice and therefore this figure is not representative of the total number of moves required to keep patients safe. Action is being taken to address this with Matrons and Ward Managers.

The number of red flags reported within acute inpatient areas (Table 4) has fallen for the second consecutive reporting period despite there being high levels of unfilled registered nurse time as indicated in Appendix 1. The majority of the red flags are associated with a shortfall of registered nurses within a clinical area; this shortfall is linked to the requirement to staff additional areas for escalation, short term sickness and vacancies. 30 of the red flags raised indicated that there were less than 2 registered nurses on duty at the commencement of a shift, the majority of the reports are associated with cover for night duty and require further investigation into roster practices. In month there has been an increase in the number of reported incidents relating to delays in the administration of pain relief. This is directly linked to the transfer of some analgesics to controlled medication to enable closer monitoring of use across clinical areas.

Further review of quality metrics demonstrate an ongoing link to the reduction in registered staff and patient harm. In month there have been 3 CDT and 3 Category 3 or 4 pressure ulcers reported on the Cardiorespiratory Unit (overall registered nurse full rate of 74.4%), a further 3 Category 3 or 4 pressure ulcers have been reported on Shevington Ward (overall registered nurse fill rate 79.2%). All the pressure ulcers have been escalated onto StEIS and will be subject to concise investigation in accordance with Trust processes. In addition 4 areas of the Trust are flagging red for patient experience in relation to pain management. Divisional improvement plans have been requested and will be monitored divisional governance processes.

4.0 SUMMARY

The Trust continues to compare favourably for CHPPD and for nursing and midwifery staffing costs.

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

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

Harms have been reported in Scheduled Care on the wards where fill rates for registered nurses are below 80% and there remain concerns with respect to skill mix and supervision of unregistered staff which are being addressed within the Division and overseen corporately.

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

5.0 RECOMMENDATIONS
The Board is asked to receive the paper for information and discussion.

Allison Edis: Deputy Director of Nursing

Appendix 1
SAFE STAFFING EXCEPTION REPORT – June 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	81.9%	98.6%	2.9	162.0%	132.4%	6.5	4.74%	6.87%	14		0/6			100.00%	100.00%
Cardio and Respiratory	77.4%	71.4%	2.4	125.9%	118.9%	4.7	8.06%	11.70%	15	3	0/2	0/3	0/7	100.00%	100.00%
Coronary Care Unit	102.4%	97.1%	11.1	163.4%		4.3	3.31%	0.77%	6					85.71%	100.00%
Elderly Care Unit	88.9%	99.2%	2.4	149.1%	163.2%	6.2	6.53%	9.25%	Nineteen		0/2		0/1	91.00%	91.00%
Highfield	98.8%	58.7%	4.0	107.4%	100.1%	5.3			15						
Pemberton	81.5%	96.7%	4.8	144.4%	120.0%	5.8	4.56%	19.04%	6		0/1				
Shevington	91.6%	68.6%	2.5	131.8%	158.3%	4.9	4.02%	15.63%	10		0/5	0/3	0/2	77.78%	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	88.7%	89.8%		107.3%	164.4%		2.03%	11.99%	0		0/2		1/0		
A&E Paeds	91.0%	111.4%					0.79%	11.94%	1						
CDW	93.3%	91.7%		99.1%	103.5%		6.79%	7.99%	3		0/1		0/1	100.00%	100.00%
Medical Assessment Unit	85.9%	83.2%		107.4%	105.5%		10.89%	5.36%	37		0/8	2/0	0/2	100.00%	100.00%

Division of Surgery

	Average Fill Rates (%) & CHPPD						Staff Availability		Staff Experience	Nurse Sensitive Indicators				Patient Experience % (Number surveyed)	
	RN / RM			CSW											
Ward	Day shift (%)	Night shift (%)	CHPPD	Day shift (%)	Night shift (%)	CHPPD	Sickness (%)	Vacancies (%)	Datix Incidents - related to staffing/Red Flags	CDT	Falls (Harm / No Harm)	PU (Grade 1&2 / Grade 3 & 4)	Drug Admin Errors (Harm / No Harm)	Do you think the hospital staff did everything they could do to control your pain?	Have you been given the care you felt you required when you needed it most?
ICU/HDU	93.3%	89.3%	32.0	99.0%		5.5	4.36%	1.83%	42						
Langtree	86.3%	100.0%	2.5	118.9%	155.1%	3.0	1.10%	9.87%	7	1	0/2		0/2	75.00%	87.50%
Orrell	94.0%	94.2%	4.0	127.9%	156.9%	5.3	5.06%	3.68%	29		0/1		0/1	77.78%	100.00%
Swinley	96.8%	101.1%	2.8	98.5%	111.1%	2.6	6.49%	2.64%	9	1			1/0	100.00%	100.00%
Maternity Unit	98.2%	96.9%	12.3	73.3%	92.1%	3.3	0.61%	0.00%	0					100.00%	100.00%
Neonatal Unit	90.3%	99.0%	13.3	99.7%		1.9	2.89%	7.64%	1				1/0	100.00%	100.00%
Rainbow	94.3%	71.2%	10.0	98.1%	79.7%	4.0	9.61%	13.68%	8					80.00%	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	100.2%	76.1%	3.1	123.7%	141.1%	4.16	7.97%	10.46%	49		0/2		0/2	100.00%	100.00%
Ward A	101.1%	84.1%	3.7	92.4%	87.1%	3.50	16.07%	10.92%	6				0/1	100.00%	100.00%
Ward B	103.9%	89.9%	3.6	101.5%	93.9%	3.74	4.00%	7.37%	0				0/1	100.00%	100.00%
JCW	72.2%	79.8%	7.4	58.5%	79.9%	3.85	0.48%	2.15%	0				0/1		

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

Community Childrens Services																	
	Caseload							Staff Availability		Staff Experience		Nurse Sensitive Indicators				Patient Experience % (Number surveyed)	
	Activity				% of cases												
Service	No of Active Patients	Universal	Universal Plus	Universal Partnership Plus	Universal (%)	Universal Plus (%)	Universal Partnership Plus (%)	Sickness (%)	Vacancies (%)	Datix Incidents related to staffing/Red Flags	Prescribing Errors	CDT	Falls (Harm / No Harm)	PU (Grade 3 & 4)	Drug Admin Errors (Harm / No Harm)	Do you think the community 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?
Health Visiting	17618	14367	2739	512	81.5%	15.5%	2.9%	5.14%	15.80%		NA	N/A	N/A	N/A	N/A	N/A	Not available
School Nursing	61238	59278	1656	304	96.8%	2.7%	0.5%	0.00%	21.40%		NA	N/A	N/A	N/A	N/A	N/A	Not available
Community Nursing	436	NA	NA	NA	NA	NA	NA	3.80%	14.40%		NA	NA	NA	NA	NA	Not available	Not available
Early Years	78	NA	NA	NA	NA	NA	NA	0.00%	0.00%		NA	NA	NA	NA	NA	NA	Not available
Speech & Language Therapy	1845	NA	NA	NA	NA	NA	NA	0.00%	6.00%		NA	NA	NA	NA	NA	NA	Not available
Occupational Therapy	565	NA	NA	NA	NA	NA	NA	0.00%	6.00%		NA	NA	NA	NA	NA	NA	Not available
Physiotherapy	884	NA	NA	NA	NA	NA	NA	0.00%	7.00%		NA	NA	NA	NA	NA	NA	Not available
Audiology	1174	NA	NA	NA	NA	NA	NA	0.00%	0.00%		NA	NA	NA	NA	NA	NA	Not available
NHSP	255	NA	NA	NA	NA	NA	NA	0.00%	16.60%		NA	NA	NA	NA	NA	NA	Not available

Appendix 2

	May 2019		June 2019	
No of areas	Red Metrics Registered Staff Days	Red Metrics Registered Staff Nights	Red Metrics Registered Staff Days	Red Metrics Registered Staff Nights
24	6	7	4	8

Table 1. Red Metrics May 2019/June 2019

	May 2019		June 2019	
Specialty	Qualified	Qualified	Qualified	Unqualified
Medicine	36.62*	8.89	44.86*	12.61
Surgery	17.94**	3.8	23.76**	2.36
Specialist Services	19.49	4.24	14.52	5.77
Community Services Adult	50.89	1.37		
Community Services Children	24.47	4.56	14.67	2.74
Total	**149.41**	**22.86**		

*Table 2. Nurse Vacancies May 2019/June2019 by Division (*3.86 WTE new substantively funded posts for Highfield, 8.0 WTE Cardiorespiratory Unit, 4.14 WTE Pemberton, 5.19 WTE Shevington; **6.64 WTE Rainbow ward)*

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

Table 3. Nurse Vacancies April 2018 – May 2019 (Trust Wide)

Red Flag Category	**No. of Incidents June 2019**
Shortfall of more than 8 hours or 25% of registered nurses in a shift	179
Delay of 30 minutes or more for the administration of pain relief	62
Delay or omission of intentional rounding	0
Less than 2 registered nurses on shift	30
Vital signs not assessed or recorded as planned	5
Unplanned omission of medication	1
Total	**277**

Table 4. Nursing Red Flags June 2019

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

Table 5. Maternity Red Flags June 2019

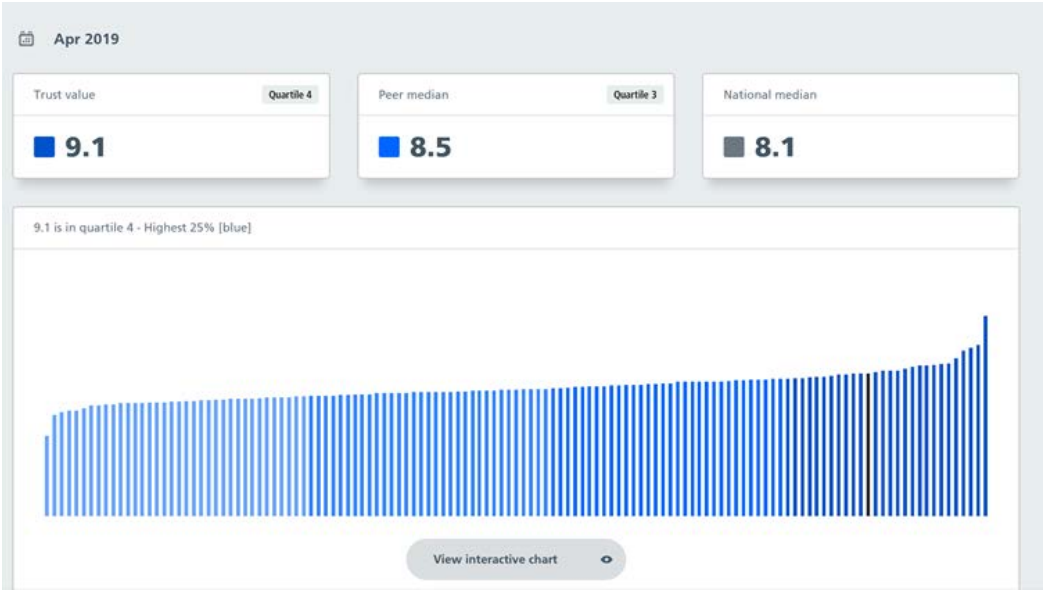


Table 6.CHPPD April 2019 (Source Model Hospital)

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	Apr 2019	9.1	8.5	8.1		
Cost per Care Hour - Total Nursing & Midwifery Staff	Mar 2019	£20.64	£23.60	£23.65		
Cost per Patient Day - Total Nursing & Midwifery Staff	Mar 2019	£174.38	£195.28	£189.65		
Average Staff Cost - All Nursing & Midwifery Staff	2016/17	£34,229	£35,565	£35,334		

Table 7. Use of resources (Source Model Hospital)

REPORT

AGENDA ITEM: 9.5

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

To:	Board of Directors	**Date:**	31 July 2019
Subject:	Bi-annual Staffing Review		
Presented by:	Chief Nurse	**Purpose:**	Assurance

Executive summary

This report is provided to the Board as a mandated requirement from NHS England to give assurance of ongoing monitoring and review of adult inpatient staffing establishments. This report is produced in addition to the monthly assurance reports already received.

Overall the Trust has sufficient budgeted nursing resource to meet the need of patients and be responsive to peaks and troughs in service demand, however the ability to readily react is impacted on by the number of vacancies within the Trust.

Consideration of SNCT data suggests there are opportunities for redistribution of staff across the Trust in response to patient need and for review of rostering practice to support more effective utilisation of the workforce across the 24 hour continuum.

There has been a change in the acuity and dependency of patients admitted to the Trust most notably an increase in the number of patients requiring Level 1b care.

Throughout the course of the last 12 months there has been a shift in the skill mix of staffing predominantly within Scheduled Care which has resulted in a dilution of the skill mix. The planned review of new workforce models requires progression in order to prevent further deterioration of this position and on quality and patient experience. There has been an increase in patient harms.

The review has highlighted a number of planned changes to services which do not appear to have been considered within business planning cycles.

The Board are asked to record all decisions made within the minutes of Trust Board as per NHSi requirements.

Risks associated with this report

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

The number of registered nurse vacancies and dilution of skill mix have the potential to impact on nursing care standards, patient experience and outcome

The lack of progression in the development of new workforce models to support registered care within inpatient wards has the potential to increase the risk of inpatient mortality and poor patient outcomes.

There is a risk to sustaining the current inpatient bed base given the vacancy situation and the patient safety and quality concerns outlined within this paper, and historical attrition trends over the summer months.

Link(s) to The WWL Way 4wards

☒	 **Patients**	☒	 **Performance**
☒	 **People**	☐	 **Partnerships**

Bi Annual Nurse Staffing Review

Background

Throughout 2012 and 2013[1][2][3][4][5] a series of reports were published describing the critical role of nurse staffing in the delivery of high quality care and excellent outcomes for patients. In 2013 it was nationally mandated that all NHS Organisations review staffing levels at least twice/year and for the findings of the review to be shared with the Trust Board. Decisions made following receipt of the Board would therefore be documented to provide assurance of Board level accountability and responsibility for staffing levels and capability.

In November 2014 NHS England published 'Safer Staffing: A Guide to Care Contact Time[6]. This report outlines further requirements to provide assurance of staffing levels and the importance of the provision of nurse to patient direct care time. The document advocates the consideration of the adoption of the following practice to provide further scrutiny of the links of nurse to patient contact time, incidence of harm and level of patient satisfaction and outlines the requirement for future Board reports to include the following information;

- Undertaking baseline assessment of nurse to patient contact utilising methodology from the Releasing Time to Care project
- Introduction of quality metrics at ward level linked to the following measures;
    - Friends and Family Test (FFT)
    - Staff FFT
    - Recording of NICE[7] red flag events
    - Introduction of locally agreed quality metrics which could be linked to the delivery of the harm free care agenda
- Temperature checks of contact time in the following circumstances;
    - Reduction of quality standards
    - If the model of care is changed
    - If there is a change in skill mix
    - Introduction of new technologies, including major IT projects.

The Board currently receives a monthly assurance report relating to safe staffing levels in Part 1 of Trust Board which incorporates the first 2 points above.

In March 2017 the Trust nursing staff participated in formal consultation to review and standardise nursing shift patterns. Following the consultation, nursing establishments were reviewed and realigned to reflect Safer Nursing Care Tool (SNCT) data and professional judgement; these establishments were signed off by the Heads of Nursing and Deputy Director of Nursing.

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[1] NHS England (2012): *Compassion in Practice*
[2] The Mid-Staffordshire NHS Foundation Trust Public Inquiry (2013): *Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry.*
[3] Prof. Sir Bruce Keogh, NHS England (2013): *Review into the quality of care provided by 14 hospital trusts in England: overview report.*
[4] Don Berwick. Department of Health (2013): *A promise to learn, a commitment to act: improving the safety of patients in England.*
[5] Cavendish, C., Department of Health (2013): *The Cavendish Review: an independent review into healthcare assistants and support workers.*
[6] NHS England (2014): *Safer Staffing: A Guide to Care Contact Time.*
[7] NICE (2014): *Safe staffing for nursing in adult inpatient wards in acute hospitals*

In October 2018 NHSi published Developing Workforce Safeguards[8] which shares best practice on workforce decision-making, including stronger board engagement and is set against existing safe staffing guidelines and resources. From April 2019 NHSi will assess all providers against their compliance with these recommendations in order to support a consistent approach to workforce decision-making.

Methodology

Since 2011 WWL has undertaken Adult nursing establishment review on a quarterly basis; March, June, September and December utilising the Safer Nursing Care Tool™ (SNCT). This tool was developed in collaboration with the Association of United Kingdom Hospitals (AUKUH) utilising the research evidence undertaken by Keith Hurst[9]. The tool is recognised by the Quality Management Board (QMB)[10]. SNCT utilises methodology to determine the staffing required to delivery care to patients within a given area dependent on actual individual patient levels of acuity and dependency. The tool also takes into consideration patient flow and nurse sensitive indicators (NSI's) in determining the appropriate level of care. Professional judgement is required to determine the skill mix of the staff employed within each area, and to assess the variability of staffing requirements which may be affected by changes in acuity and dependency levels of patients.

In January 2019 the Trust invested in SafeCare, a system that allows the measurement of the acuity and dependency needs of patients within inpatient areas to determine the hours of care required by the patient occupying the beds. This was rolled out in Q4 of 2018/19, and data from this system was used to provide the staffing recommendations within this report alongside professional judgement. Patient requirements on escalation areas, with the exception of CCU and safer placement beds, was not captured during this period of time and therefore, this report will apply professional judgement to advise on staffing required to enable the Trust to be responsive to patient need.

Safer Nursing Care Tool (SNCT)

As previously explained the Trust utilises the safer nursing care tool to determine the acuity and dependency of patients within our hospital. The tool has been expanded and now incorporates agreed multipliers for paediatric inpatient areas and for assessment areas. Descriptions of the multipliers can be found at Table 1. Staff undertake assessment of the acuity and dependency needs of patients 3 times during the course of their shift and this information, aligned with actual staffing levels on the wards, provides an indication of whether there is surplus or insufficient nursing time available to deliver care to the patients in each clinical area. Professional judgement can be applied to this depending on the ward configuration, e.g. patient need may indicate that there are surplus hours, however the ward area may have a high configuration of single rooms resulting in reduced patient visibility which warrants the additional nursing hours. Data from this census has been utilised within the report to inform staffing recommendations alongside professional judgement.

Acuity of patients as determined by SNCT classifies need against 5 descriptors with associated multipliers as demonstrated in Table 1. Multipliers marked * represent the elevated scores associated with patients accommodated within assessment areas and acknowledges the increased workload associated with patient movement.

[8] NHSi (2018): *Developing Workforce Safeguards.*
[9] Hurst, K (2012): *Safer Nursing Care Tool Staffing Multipliers (2012) – Method and Results*
[10] Quality Management Board (2013): *How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing, midwifery and care staffing capacity and capability.*

Level	Descriptor	Multiplier
0	Normal patients who can be cared for on a general ward	0.99/1.27*
1a	Acutely ill patients who can be cared for on a general ward	1.39/1.66*
1b	Stable patients with an increased dependency on nurses	1.72/2.08*
2	Patients in ward areas awaiting transfer to or receiving HDU care	1.97/2.26*
3	Patients in ward areas awaiting transfer to Intensive Care	5.96

Table 1

Quality Indicators

Data with respect to hours of time required based on acuity and dependency cannot be viewed in isolation to determine staffing levels, they must be viewed alongside quality metrics, which provide an indication of outcomes and avoidable harms that occur within our clinical areas. These are reported monthly to the Trust Board within the performance report and also within the safe staffing report. These metrics are CDT rates, number of falls, number of pressure ulcers, number of medicine administration errors and number of red flags reported.

Professional Judgement

Allied to the use of SNCT is the use of Professional Judgement to confirm appropriate staffing levels. This is a bottom up approach to the determination of staffing levels based on the judgement of experienced nurses to agree and determine the number and grade of staff required to provide care on a specific ward. This is agreed with Senior Nurse Managers and includes the agreed allowance for the uplift of staff. The formula utilised is as follows;

$$\frac{\text{No. of nurses x No. of days x shift length + 20\%}}{37.5}$$

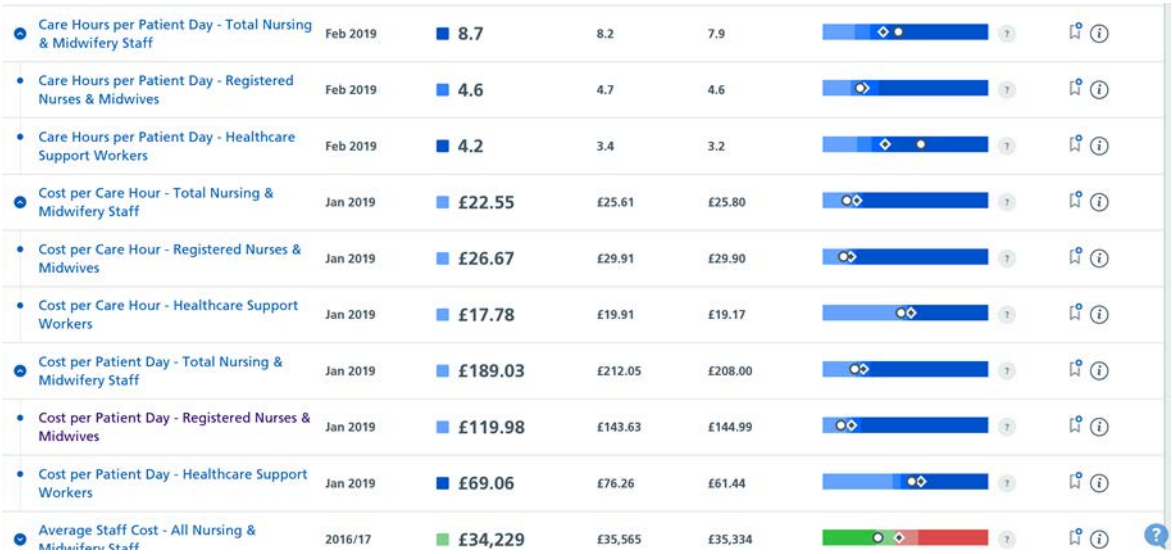
As well as considering the acuity and dependency of the patients normally cared for by the ward specialty other factors can affect staffing requirements including;

- Design and layout of the clinical area – multiple single rooms and bays
- Number of house keepers and other support staff
- Patient throughput
- Provision of supervisory time for the Ward Manager.

Care Hours Per Patient Day (CHPPD)

The CHPPD calculation (Care Hours Per Patient Day), measures the combined number of hours of care provided to a patient over a 24-hour period by both nurses and healthcare support workers. From

September 2018 this measure has been used to provide assurance externally of staffing levels and is published monthly on NHS Choices website. Between September 2018 and February 2019, the Trust has compared well against peer group median and national median figures. This comparison data is provided monthly within safe staffing reports.



Care Hours per Patient Day - Total Nursing & Midwifery Staff	Feb 2019	8.7	8.2	7.9	
Care Hours per Patient Day - Registered Nurses & Midwives	Feb 2019	4.6	4.7	4.6	
Care Hours per Patient Day - Healthcare Support Workers	Feb 2019	4.2	3.4	3.2	
Cost per Care Hour - Total Nursing & Midwifery Staff	Jan 2019	£22.55	£25.61	£25.80	
Cost per Care Hour - Registered Nurses & Midwives	Jan 2019	£26.67	£29.91	£29.90	
Cost per Care Hour - Healthcare Support Workers	Jan 2019	£17.78	£19.91	£19.17	
Cost per Patient Day - Total Nursing & Midwifery Staff	Jan 2019	£189.03	£212.05	£208.00	
Cost per Patient Day - Registered Nurses & Midwives	Jan 2019	£119.98	£143.63	£144.99	
Cost per Patient Day - Healthcare Support Workers	Jan 2019	£69.06	£76.26	£61.44	
Average Staff Cost - All Nursing & Midwifery Staff	2016/17	£34,229	£35,565	£35,334	

Table 1: Source Model Hospital data for WWL

Although the Trust performance with CHPPD is favorable, there is variability in CHPPD across the Trust. This is more apparent with registered nurses; CHPPD being higher within Surgery and Specialist Services and lower within Scheduled Care. This is evidenced in the skill mix information provided within the report.

Skill Mix

The RCN[11] recommends a ratio of 65:35 registered nurses/unregistered staff. Following on from the last nursing establishment review this ratio was reduced to 55:45. There was no reduction in the number of registered nurses within the ward environments, however there was a recognition that the number of elderly patients with basic care needs had increased and that this care could be delivered under the supervision of a registered nurse rather than directly by them. The Trust has increased its registered workforce with the engagement of 19 registered Nursing Associates following completion of their training with the Trust and these staff are deployed across the organisation within all specialties. Skill mix can also be affected as a consequence of staff turnover, when the experience of staff becomes diluted.

Supervisory Ward Managers

National guidance suggests that all Ward Managers should be supervisory to practice. The Trust agreed level is for 50% of their time to be clinical; this is factored into the staffing requirements for each of the ward areas detailed above. The shortfall in registered nursing time has, however, seen management time eroded especially within Scheduled Care and Surgery and the average time spent on management responsibilities in these areas is at the time of the review was 20-32%. The Board should note that this is insufficient time for the managers to fulfil all the requirements of their role.

[11] RCN (2010): *Guidance on safe nurse staffing levels in the UK*

Overall Results for Inpatient Areas

The overall ward nursing establishment has increased since the last staffing review was undertaken by 28.36 WTE; 15.3 WTE of this increase is associated with Highfield ward which is now a substantive ward area (Table 2). SNCT data for the inpatient wards indicated that WTE required to meet the needs of the patients is 604.35 WTE resulting in a surplus of 31.39 WTE; it should be noted that this surplus is within the Unregistered Workforce. Although there is an overall apparent surplus of funded staff, this should be taken against a backdrop of 69.15 WTE vacancies across these inpatient areas, 42.86 WTE of which are registered nurse vacancies. The Trust has ongoing active recruitment to these vacancies and initiatives, e.g Local Pay Variation (LPV) and Nursing Incentive Scheme, and medium and long-term strategies to mitigate the risk, however these shortfalls do not permit the Trust to be as responsive as it needs to be to increased demand for services.

Ward	Nos of Beds	July 17 WTE	Dec 17 SNCT	April 19 WTE	April 19 SNCT	Skill Mix (worked)
Aspull	28	38.97	44.73	41.62	41.73	47:53
JCW	16	21.05	13.55	24.34	13.95	63:37
Ward A	28	34.4	28.03	36.57	29.71	50:50
Ward B	24	28.67	26.7	30.59	23.07	51:49
Langtree	28	29.57	30.3	29.7	36.29	48:52
Orrell	26	35.38	34.66	33.88	36.6	44:56
Swinley	26	33.6	27.41	33.05	31.06	56:44
Elderly Care	55	80.64	75.82	80.46	92.22	38:62
ASU	22	37.63	34.98	38.35	34.8	34:66
CCU	8	18.82	13.25	21.04	17.12	71:29
CDW	10	20.16	15.13	21.66	17.68	55:45
Cardio Respiratory	55	83.32	78.36	82.39	72.23	36:64
MAU's	55	80.64	83.55	80.87	79.72	52:48
Pemberton	12	24.19	19.61	24.7	20.64	42:58
Shevington	28	40.32	36.88	41.22	40.33	30:70
Highfield	10			15.3	17.2	25:75
Total	**464**	**607.38**	**562.96**	**635.74**	**604.35**	

Table 2

Worked skill mix is provided with the appendices of the report. The Trusts current skill mix is below the recommended levels of 65/35 following the staffing review in July 2017. The rationale for this was the increasing dependency of patients and requirements for enhanced observation to mitigate the risks of harm following lapses in care and falls. Data provided within the Appendices of the report indicates the Trust intended skill mix of 55:45 is not being maintained across clinical areas. This is in part as a consequence of vacancies, but can also be attributed to the increase in Band 6 nursing posts which has been funded from registered nurse vacancies therefore, further reducing available registered nurse hours. In addition, due to recruitment difficulties some areas would appear to have converted registered nursing posts into unregistered posts which have not been subject to Quality Impact Assessments (QIA) and therefore a more robust divisional process is required to ensure compliance with NHSi requirements when there are amendments to staffing. The drop in skill mix is particularly apparent within Scheduled Care and has been referenced in monthly Safe Staffing reports.

Consideration of the data within SafeCare indicates that the majority of inpatient areas have a surplus of hours available in the morning, however there are shortfalls following the lunchtime and night time census. As the total hours funded for nursing time is in excess of those required, this

would indicate that staff could be redistributed throughout the 24 hour continuum to improve and manage patient safety and potentially the flow of patients.

Staffing levels are reviewed on a daily basis utilising assessment of actual staffing v planned staffing levels, and with consideration of the acuity and dependency of patients on the ward. The planned staffing levels are the agreed minimum staffing levels for each in patient area and are based SNCT, professional judgement and nationally approved ratios of registered nurses to patients and skill mix.

Table 3 proves detail relating to the average numbers of patients by acuity level on each of the inpatient areas. September 2018 data is provided in red.

Ward		Level 0	Level 1a	Level 1b	Level 2	Level 3
Aspull	Sept 18	7	4	16	0	0
	April 19	0	1	20	0	0
JCW	Sept 18	12	0	1	0	0
	April 19	4	1	5	0	0
Ward A	Sept 18	11	9	0	0	0
	April 19	8	1	12	0	0
Ward B	Sept 18	8	0	11	0	0
	April 19	8	1	8	0	0
Langtree	Sept 18	11	13	3	0	0
	April 19	13	2	12	0	0
Orrell	Sept 18	13	10	1	0	0
	April 19	4/2*	8/5*	5/1*	0	0
Swinley	Sept 18	21	4	1	0	0
	April 19	15	3	17	0	0
Elderly Care	Sept 18	12	7	36	0	0
	April 19	0	2	52	0	0
ASU	Sept 18	0	0	22	0	0
	April 19	0	4	17	0	0
CCU	Sept 18	1	6	2	1	0
	April 19	1	4	5	1	0
CDW	Sept 18	0/5*	0/5*	0/0	0	0
	April 19	0/0*	0/7*	0/3*	0	0
Cardio Respiratory	Sept 18	4	26	16	8	0
	April 19	14	19	14	4	0
MAU's	Sept 18	0	48	2	1	0
	April 19	0/16*	0/22*	0/11*	0	0
Pemberton	Sept 18	0	1	11	0	0
	April 19	0	0	12	0	0
Shevington	Sept 18	11	12	4	0	0
	April 19	5	12	11	0	0
Highfield	April 19	0	0	10	0	0
Total		**116/90**	**135/92**	**128/215**	**8/5**	**0/0**

Table 3 (* denotes assessment areas multiplier applies)

Comparison of acuity and dependency data has identified a shift in the care requirements of the patients. As can be seen above, on average the majority of the patients occupying inpatient beds are categorised as Level 1b patients, where as in September 18 the highest category of patients' were 1a, i.e. stable patients with an increased dependency on nurses This is reflective of the age group of those admitted and the complexity of managing their multiple co-morbidities.

Table 4 provides a comparison from April 2018 to April 2019 of Nurse Sensitive Indicators. This information is broken down by clinical division within the appendices of this report.

Quality Indicator	April 2018	April 2019
CDT Cases	1	3
Falls	68	57
Medication Administration Incidents	31	31
Pressure Ulcers	1	6
Nursing Red Flags	82	356

Table 4

When considering staffing skill mix and harms to patients, it can be demonstrated that there has been an increase in harms to patients from pressure ulcers in the year on year comparison. The number of falls have reduced, however the severity of the harms experienced by patients has increased. There has been no reduction in the number of medication administration errors reported however in a similar way the level of harm to patients has increased. The majority of the hospital acquired pressure ulcers reported occurred within Scheduled Care; this service has also seen the greatest reduction in skill mix and has the highest number of vacancies. There has been an increase in the reporting of nursing red flags. This is in part as a result of the promotion of the reporting, and reporting of incidents has been made quicker following the introduction of SafeCare.

In April 2018 95.9% of red flags reported were relating to a shortfall in registered nurse time; April 2019 accounted for 84.7% of red flags raised. There were no red flags raised with respect to there being less than 2 registered nurses in April 2018, however this accounted for 12.8% of the red flags raised in April 2019. It should be noted that throughout April 2019 the Trust continued to have additional areas escalated which required redeployment of staff from inpatient areas to support the delivery of care.

Evidence suggests that there are higher levels of mortality and poor patient outcomes and experience when registered nurse staffing levels are reduced[12]. Whilst this is not apparent within mortality data currently, the Board should note the potential for this risk and consider nurse staffing and skill mix as part of the mortality reviews within specialty services.

Inpatient areas are currently budgeted to deliver a 55:45 skill mix. The Board should note that when considering worked ratios there are no core wards within Scheduled Care that achieve this standard. Registered staff are essential in the planning, co-ordination, supervision and delivery of care, and the reduced performance in the quality metrics detailed within the report indicate that the care being provided is being compromised when this skill mix is diluted. It is essential that alternative workforce models are expedited over the course of the next quarter within the Trust to prevent further deterioration of these standards which impact significantly on patient safety, outcome, experience and length of stay.

It is evident that there remains considerable pressures on nursing within inpatient areas, particularly across the registered nurse workforce that have not been fully addressed via the short term initiatives agreed by the Trust. The Trust medium and long term plans associated with the Nursing Pipeline have yet to fully come into fruition, although the first cohort of Registered Nursing Associates commenced in post in February 2019. It can be seen that these pressures are impacting on patient care, and there has been an increase in harms reported. Consideration of advancing the pace of the introduction of new workforce models is required in order to address the shortfalls in registered nurse staffing.

[12] P Griffiths (2019): *Registered nurse and HCA staffing levels: the effects on mortality.* Nursing Times; January 2019/Vol 115 Issue 1

Historically the Trust has seen a pattern of increasing vacancies over the summer months. Should this pattern continue the Trust will need to agree a plan that mitigates the risks articulated, including harm to patients, which may involve closure of a ward in a planned manner to support patient and staff safety.

Appendix 1 provides further information relating to planned changes within clinical areas that will impact on staffing requirements throughout the course of the year. These include and will be subject to business case approval:

- The new staffing model for A&E to support ECIST recommendations to improve flow and ambulance turnaround (3 Registered, 3 unregistered)
- Additional IDA beds at Wrightington (5 registered)
- CDW additional B6 nurse
- NIV Bay 10.76 WTE
- Expansion of SAL services 7.61 WTE
- Increase Aspull unregistered staffing 5.37 WTE
- Monitoring of telemetry CCU 6.14 WTE
- Supernumery shift leader ICU 5.37 WTE

The Trust is sighted on the risks associated with registered nurse vacancies and, since this review was undertaken, has already commenced work with the clinical divisions to consider alternative workforce models. These include the introduction of patient flow assistants to undertake administrative duties to support discharge, appointment of pharmacy technicians to ward based teams, and exploration of the appointment of Allied Health Professionals to ward teams to provide direct care and increase leadership opportunities for the workforce. To this end the Trust is considering the development of an Associate Director of Allied Health Professionals role to provide leadership, develop a strategy and advise of workforce modelling.

Recommendations and Next Steps

The Board is asked to;

- Discuss the contents of this report with particular reference to the correlation of registered nurse staffing levels and reported increase in harms to patients.
- Discuss the acceleration of the programme of work associated with the establishment of new workforce models.
- Discuss and agree the safety parameters that would necessitate the closure of a ward due to skill mix and vacancy levels.
- Note the divisional plans referenced within the report with respect to service development and professional judgement and agree actions required with respect to these.
- Note the assurance provided within the paper of the ongoing monitoring of adult inpatient staffing areas.
- Note the favourable overall comparison of CHPPD recorded within the report for the Trust with the caveat that this is highly variable across clinical divisions.
- Ensure all decisions made are captured within the minutes of Trust Board as per NHSi requirements.

Appendix 1

Scheduled Care

Scheduled care provides the inpatient base for medical services and comprises 181 inpatient beds. Throughout the data capture period additional beds were escalated on CCU. Highfield became a substantive inpatient area in October 2018.

Clinical Area	Budget WTE	Actual WTE	SNCT	Difference	Skill Mix (worked)	Vacancy WTE	Sick Leave	Bed occupancy
ASU	38.35	27.91	34.8	+3.55	34:66	2.42	13.3 %	95.6%
Cardiorespiratory	82.39	58.89	72.23	+10.16	36:64	10.26	4.11 %	97.4%
CCU	21.04	15.07	17.12	+3.92	71:29	1.37	3.43 %	83.7%
Elderly Care	80.46	62.52	92.22	-11.76	38:62	5.46	6.04 %	99.1%
Pemberton	24.7	13.68	20.64	+4.06	42:58	7.03	3.84 %	89%
Shevington	41.22	30.43	40.33	+0.89	30:70	4.19	1.45 %	96.9%
Highfield	15.3	8.28	17.2	-1.9	51:49	7.02	No data	95.2%
TOTAL	303.46	216.78	294.54	+8.9		37.75		93.8%

Table 1

There are high vacancy levels within Scheduled Care the majority of which are registered nursing posts. Worked skill mix within the division is significantly lower than the Trust established 55:45 with the shortfall in hours being taken up by unregistered staff. 4 areas are of significant concern, Pemberton, Cardio-respiratory, Shevington and Highfield Ward; the registered nurse vacancies on Pemberton Ward represent 62% of the registered nurse workforce. Overall bed occupancy is high across the clinical areas and exceeds the optimal occupancy levels to deliver safe care.

Care Hours Per Patient Day

Clinical Area	**Combined**	**Qualified**	**Unqualified**
ASU	7.14	2.46	4.68
Cardiorespiratory	5.9	2.34	3.56
CCU	9.14	7.0	2.15
Elderly Care	6.42	2.43	3.99
Pemberton	10.2	4.61	5.59
Shevington	6.94	2.57	4.36
Highfield	8.46	3.71	4.75

Table 2

Overall CHPPD and costs per day for nursing compare favourably with peer and national figures across all inpatient areas within the division, however care hours provided by registered staff is significantly lower than peers and the national average. The reduction of registered nurse time to deliver and oversee direct patient care has negatively impacted on nurse sensitive indicators and there has been an increase in the level of harm experienced by patients

Nurse Sensitive Indicators

Quality Indicator	April 2018	April 2019
CDT Cases	1	2
Falls	6	27
Medication Administration Incidents	10	5
Pressure Ulcers	0	5
Nursing Red Flags	11	132

Table 3

Nurse sensitive indicators have declined from April 2018, and the level of harm experienced by patients has increased. This is an indication that there are inadequate levels of care provision within the division and targeted work is required to address the shortfall in registered staffing.

Professional Judgement

As stated within the report urgent action is required to address the shortfall of registered staff within the division and the deterioration of standards of care. The division has plans to create a NIV bay on Ince ward which will require an increase in establishment of 10.76 WTE registered staff to support the co-ordination and delivery of safe care.

There have been 2 serious incidents within the last 12 months where it was established that telemetry on CCU was not being overseen by a registered nurse at all time. This is in part attributable to the escalation of beds within this area to support patient flow and the pressure this places on the funded registered establishment. It is recommended that CCU's registered establishment is increased by 6.14 qualified staff to ensure there are sufficient qualified staff to oversee patients requiring telemetry across the Trust.

Unscheduled Care

Unscheduled Care incorporates Adult and Children's A&E services and inpatient assessment areas for the Division of Medicine (61 beds). Throughout the course of the year there have been a number of changes within the working practices of A&E and the development of a second Majors area on the emergency floor. Minor injuries and the walk-in centre relocated to Christopher Home. Initiatives to reduce delays in A&E have resulted in the development of new ways of working that were supported by Winter Pressures Monies provided by the CCG; these now require substantive funding in order to sustain and continue to make improvements.

Clinical Area	Budget WTE	Actual WTE	SNCT	Difference	Skill Mix (worked)	Vacancy WTE	Sick Leave	Bed Occupancy
MAU	80.87	71.56	79.72	+1.15	52:48	9.31	3.79 %	90.55%
Bed Management	7.0	6.14	N/A	N/A	N/A	0.86	0.0%	
AAA	10.48	10.38	N/A	N/A	78:22	0.10	0.0%	
Adult A&E	91.19	87.88	N/A	N/A	76:24	3.31	3.2%	
PECC	13.76	11.0	N/A	N/A	100:0	3.76	1.44 %	
CDW	21.66	20.29	17.86	+3.8	60:40	1.37	1.25 %	85.7%
TOTAL	224.96	207.25	229.21	4.95		18.71		88.13%

Table 1

Bed occupancy levels are high within Unscheduled Care. Sickness/absence is well managed within the division. Overall skill mix worked is above or near to the Trust established levels.

Care Hours Per Patient Day

CHPPD is not routinely captured for these inpatient areas.

Nurse Sensitive Indicators

Quality Indicator	April 2018	April 2019
CDT Cases	**0**	**0**
Falls	**6**	**18**
Medication Administration Incidents	**6**	**12**
Pressure Ulcers	**1**	**0**
Nursing Red Flags	**20**	**97**

Table 2

There has been an increase in the number of harms reported in the year on year comparison. The severity of the harm to patients has also increased.

Professional Judgement

SNCT indicates that there is a minimal surplus of staff within the area, however this is warranted due to the layout of CDW and the fluctuation in activity levels across the assessment areas. Although

staffing levels are appropriate it should be noted that there has been a high turnover of staff in year across the inpatient areas. This has resulted in dilution of experience within the registered nursing workforce across all direct care areas and additional support for preceptorship and development of staff is required in order to improve retention and job satisfaction.

In response to the changes across the emergency floor an additional 3 qualified and 3 unqualified staff will be required to support the provision of 24 hour direct patient triage. An additional B6 is also required on CDW to support the provision of 24/7 leadership within this assessment area.

Surgical Division

Clinical Area	Budget WTE	Actual WTE	SNCT	Difference	Skill Mix (worked)	Vacancy WTE	Sick Leave	Bed Occupancy
Boston House	10.44	10.44						
EPAU	5.19	5.19						
Fertility	4.94	4.96						
ICU	53.36	56.07						
Langtree	29.7	26.8	36.29	-6.59	48:52	2.9	0.81	93.9%
Max Fax	9.67	9.73						
Neonatal Unit	35.33	35.04						
Orrell	33.88	31.7	36.6	-2.72	44:56	2.18	1.52	85.2%
Pre-op Surgery	6.56	6.43						
Pre-op WTN	23.87	22.84						
Rainbow	42.72	35.84	28.46	+14.26	76:24	6.88	10.26	78.6%
SAL	12.15	11.84	19.05	-6.9	45:55	0.31		
Swinley	33.05	29.56	31.06	+1.99	56:44	3.49		95.5%
Urology	23.87	22.84						
WHU	9.73	9.34						
Total	334.46	318.62	334.42	0.04				89.3%

Table 1

From September 2018 additional beds were provided to the Division of Medicine to support inpatient demand. These beds were provided on Swinley and Langtree Wards; the number of patients admitted to these beds was greater on Langtree than Swinley. This has resulted in a change in the acuity and dependency of patients admitted into surgical wards and is reflected in the recommended numbers of staff required through SNCT data. Vacancy levels are within expected ranges with the exception of Rainbow Ward. Bed occupancy remains above optimal within adult inpatient areas. Capacity pressures have also seen an increase in the number of times that the Surgical Assessment Unit (SAU) has been bedded and not able to function. Surgical Assessment Lounge has seen an increase in the number of patients admitted, cared for and discharged in response to capacity pressures.

Care Hours Per Patient Day

Clinical Area	Combined	Qualified	Unqualified
ICU	**29.2**	**26.21**	**2.99**
Langtree	**5.11**	**2.48**	**2.63**
Orrell	**9.03**	**4.38**	**4.65**
Rainbow	**14.52**	**11.5**	**3.01**
Swinley	**5.32**	**2.67**	**2.65**
Neonatal	**15.56**	**13.05**	**2.51**

Table 2

Combined CHPPD within the core wards is below peer and national average with the exception of ICU, Rainbow and Neonatal Unit.

Nurse Sensitive Indicators

Quality Indicator	April 2018	April 2019
CDT Cases	**0**	**1**
Falls	**12**	**6**
Medication Administration Incidents	**6**	**12**
Pressure Ulcers	**1**	**1**
Nursing Red Flags	**19**	**71**

Table 3

There has been an increase in the number of harms reported year on year and the level of harm has also increased. The CDT cases have been within surgical patients. Falls, medication incidents and pressure ulcers have occurred within medical outliers on these wards. SNCT data suggests that available staffing hours has been insufficient to meet the needs of the patients. Nursing red flags are predominantly associated with a shortfall in registered nursing time.

Professional Judgement

Pre-Operative Services Wrightington - A service review was undertaken in 2017/18. This requires revisiting to determine whether the recommended staffing model remains appropriate. Further review is planned in 2019/20

Max Fax – Extra weekend activity has taken place on a number of weeks resulting in overspends on 2018/19 budgets. A service review is currently being undertaken.

Pre op Surgery - A new pre op telephone service is to be implemented this year and movement of the dental pre op clinic out of max fax will allow standardisation of the pre op service. The leadership structure is being reviewed as there are planned retirements in the service.

SAL - WTE increased in the latter half of year due to Vascular OPD activity being moved from TLC and Leigh to RAEI however budget transfer was insufficient to cover the staffing costs. Additional weekend lists are regularly provided within the service. A business case is being developed to support the increase in activity Monday to Friday of elective patients, trauma patients and ward discharges with a proposed budget increase of 7.61 WTE which will provide ward clerk cover, pharmacy support, transfer nurse and nursing staff to work till 10pm.

Ward 3 – A new review of theatre template is presently underway to increase activity planned for this year.

Since consultation in 2017/18, where staffing was reduced to match changes to activity, the operational team have gradually added other activity with no extra staffing placed in the budget. This includes theatre lists and an additional OPD Pain clinic running through the ward area.

Since 1/4/19 ward 3 team have also started pre TCI ring round service for Pain patients which had already shown a reduction in cancellations. This has been undertaken by recognising that because the unit is an isolated ward and there can be periods of down time, staffing can be utilised to undertake additional work to support the elective admission process.

Boston House – A staffing review has been undertaken 2 x 0.53 band 2 roles were created to support the nursing service. A further review of registered staff posts will be undertaken following agreement of the leadership structure for the service.

The Division recognises the challenges with recruitment and retention and plan to utilise slippage monies to appoint 2.64 WTE practice educator posts to support preceptorship and staff development within inpatient areas.

ICU – There is currently no supernumery shift leaders within the service which is a requirement for Guidelines for the Provision of Intensive Care Standards (GPICS). To achieve this there would need to be further investment of 6.14 B7 staff.

Specialist Services Division

Clinical Area	Budget WTE	Actual WTE	SNCT	Difference	Skill Mix	Vacancy WTE	Sick Leave	Bed Occupancy
Aspull	41.62	36.69	41.73	- 0.11	47:53	4.93	5.06%	91.5%
IDA	16.64	14.2	13.52	+3.12	74:26	2.44	11.09%	
JCW	24.34	23.02	13.95	+10.39	63:37	1.32	6.25%	
Ward 1	10.26	10.06	9.19	+1.07	55:45	0.2	0.02%	
Ward A	36.57	32.36	29.71	+6.86	50:50	4.21	6.57%	72.9%
Ward B	30.59	28.9	23.07	+7.52	51:49	1.69	1.6%	75.0%
D ward	18.26	10.18	22.32	- 4.06	56:44	8.08	6.7%	
Theatres	134.56	123.52	NA	NA	65:35	11.04	7.03%	
Ward 7	8.92	8.26	NA	NA	40:60	0.66	4.55%	
OPD TLC	27.91	26.72	NA	NA	33:66	1.19	4.37%	
OPD WTN	15.68	15.15	NA	NA	63:37	0.53	1.85%	
OPD Leigh	18.69	18.69	NA	NA	24:76		2.91%	
OPD Dermatology	10.24	10.15	NA	NA	56:44	0.09	6.34%	
Fracture Clinic	14.38	14.38	NA	NA	NA	0.00	1.23%	
Radiology	2.87	2.87	NA	NA	NA	0.00	Not avail	
Total	408.52	375.15	383.73	+24.79				79.8%

Table 1

Historical Information

The Wrightington site continues to see a change in patient cohort with an increase in complex and varied co morbidities. The skill set to manage these care needs has required support in providing education from other specialist teams and the utilisation of SIM training following the formation of a facility on site. A structured Education programme has commenced in early 2019 which, with the positive feedback already received, will support the retention of experienced staff.

There are a high proportion of side rooms on the Wrightington site and professional judgement is executed in line with safe care reporting which is also an important consideration in the variable activity on the Wrightington site.

Staffing for theatres is in line with Association of Perioperative Practice (AfPP) guidelines. A rotation and education programme has commenced within theatres between scrub, anaesthetic and recovery which will continue in a staged process (6 month timeline). National standards for surgical first assistants and the AfPP guidelines are utilised to look at effective use of resources and roles.

An OPD Nurse staffing review was undertaken. This review was limited and was unable to demonstrate any cost improvement within the nursing establishment. The nursing establishments and skill mix in each department support the current level of clinic activity and has grown in response to the constant growth of outpatient activity. Recommendations included a restructure of the nursing establishment at Leigh to achieve a higher level of qualified to unqualified, address administrative support, and further work to compare Wrightington against another specialist Orthopaedic OPD.

Care Hours Per Patient Day (CHPPD)

CHPPD and costs per day for nursing compare favourably with peer and national figures across all inpatient areas within the division. Temporary staffing costs are well maintained and on average also compare favourably against the peer and national position.

Clinical Area	Combined	Qualified	Unqualified
Aspull	**9.1**	**3.65**	**5.44**
JCW	**11.1**	**7.15**	**3.96**
Ward A	**7.56**	**3.6**	**3.96**
Ward B	**7.06**	**3.65**	**3.4**

Table 2

Nurse Sensitive Indicators

Quality Indicator	April 2018	April 2019
CDT	**0**	**0**
Falls	**5**	**6**
Medication Administration Incidents	**5**	**2**
Pressure Ulcers	**0**	**0**
Red Flags	**32**	**56**

Table 3

The number of reported harms from falls has increased alongside the severity of the falls. The majority of the falls reports has been on Aspull Ward. Red flags reported mainly relate to a shortfall in registered nursing time.

Professional Judgement

Overall SNCT indicates that there are excess hours required to deliver the care required which equates to 24.79 WTE; this excess is identified across inpatient and day case areas on the Wrightington site. This does not take into consideration the additional staffing requirements for the escalation of D ward to support activity or consideration of side room numbers across the site where increased staffing is required for observation and patient safety. The site also requires additional staff to support site management, fire and emergency bleep calls due to lack of supportive infrastructure. Therefore the author does not propose a reduction in staffing across this site.

There are plans on the site to increase the number of IDA beds from 4 to 8 to enable the support of more complex patients on the site and reduce the number of patients with long waits for surgery. IDA staffing ratios are for 1 registered nurse for 2 beds; to support this an additional 5 WTE nurses would be required.

Aspull ward has experienced issues with staff turnover over the course of the past 12 months. Reasons cited for leaving including workload and associated pressures, and frequent movement of staff to other areas. Although SNCT demonstrates the need for an additional 0.11 WTE staff, review of usage of ENSIGN and additional staff use for cohorting of patients would support the increase of staff within the area by 5.37 WTE B2.

REPORT

AGENDA ITEM: 9.6

Wrightington, Wigan and Leigh NHS Foundation Trust

To:	Board of Directors	**Date:**	31 July 2019
Subject:	Maternity Staffing Review		
Presented by:	Chief Nurse	**Purpose:**	Assurance

Executive summary

This report is provided to the Board as a mandated requirement from NHS England to provide assurance of ongoing monitoring and midwifery staffing establishments.

The Board are asked to ;

- Note the Birth Rate Plus review findings
- Note the risks to compliance with Midwifery 2020 and completion of the 'Must Do' action from the CQC associated with the provision of theatre services and the priority within the division to address the risk and re-evaluate progress.
- Note the divisional plans to develop the role of a Perinatal Mental Health Midwife this is not currently within existing resources
- Note the division plans to extend the role of the Safety and Quality Midwife role this is not currently within the existing resources
- Note the division plans to apply a 90/10% skill mix to the maternity service
- The division request an uplift from 20 to 22% this is not currently in existing resources

Risks associated with this report

The Trust is currently non-compliant with the Department of Health guidance, 'Midwifery 2020: Delivering Expectations' (Risk S. DEL 014) with respect to theatre staffing; this is also a 'Must Do' action identified within the recent CQC inspection.

The WWL Way

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

Maternity Staffing Review

Background

Birthrate Plus is the only registered framework planning tool that is recognised by the Royal College of Midwives and the CQC. It is also a part of the CNST 10 steps for midwifery workforce planning. Birthrate plus in its review includes the case mix, the acuity and the number of midwife hours required. The Birth rate plus report is based on case mix, clinical indicators of the wellbeing of the mother prior to labour the mother and infant throughout labour and delivery, plus the ensuring one to one care in labour is maintained. Birthrate plus will determine the staffing required for antenatal, inpatient and outpatient services, postnatal care of women and babies in hospital and community care. It incorporates any women who migrate across the service to other care providers, but who receive still receive part care by WWL.

NHS England and NICE guideline NG4, Safe midwifery staffing for Maternity settings require the Trust to undertake a review of the midwifery establishment to inform and assure the Board that midwifery staffing levels are adequate to deliver safe, responsive care.

This report reviews the maternity staffing and activity for the 12 month period 2018/19, and will make recommendations for consideration of the future staffing levels that are required to meet the changing demands upon the service and the need to ensure all relevant standard are achieved.

Methodology

This report utilises the tools developed by Birthrate plus to review and determine staffing needs to enable workforce planning.

The financial year-end birth data for WWL for the past 3 years:

2016/17 – 2801 births

2017/18- 2623 births

Financial year Births to date: April 18- March 19: 2640

Three months case mix data was reviewed between September and November 2018 to formulate the Birth Rate Plus report.

The maternity service currently benchmarks against the Birthrate plus recommended maternity staffing ratio of 1:28 to support the delivery of high quality care. Currently based on the actual number of births the ratio is 1:23 births, however these ratios do not reflect the total case mix and an increase in acuity of mothers and babies being given care. Birth Rate plus found that 89% of the women fall in the moderate to high risk categories. Key contributory factors include high levels of obesity, post-partum haemorrhage, high perinatal mental health, massive obstetric haemorrhage, pre labour rupture of membranes, needing additional intervention. Increase in women with mental health issues, safeguarding and social issues. It is equally important to review the acuity of the babies that are cared for on the postnatal ward. In the monitoring of activity babies requiring additional observations and monitoring in the postnatal wards also need consideration. During the assessment period 615 babies had a longer than average stay. Postnatal re admissions also create additional workload. The maternity service in Wigan has a higher acuity than the national average. This needs to be reflected in its staffing model.

The midwife to birth ratio at WWL is calculated and reported monthly via the Maternity dashboard.

Birth rate plus tools are designed to measure the workload for midwives arising from the needs of women commencing from the initial contact in pregnancy until final discharge in the puerperium by community midwives.

The Birth rate plus tool calculates the number of WTE hospital and community midwives that are required to undertake the defined workload.

Results

Data collected September to November 2018

	Cat I	Cat II	Cat III	Cat IV	Cat V
% Case mix	2.3%	8.6%	27.8%	31.4%	29.8%

However the report does require some additional clarity around actual staffing of both midwives and support staff therefore as the newly appointed Head of Midwife I have commenced a review of the current staffing models in place. From my initial review there is a need to redesign both the community midwifery service and Antenatal services based at TLC and Leigh. Also at this current time the senior management team is still awaiting the arrival of the new community matron who is planned to commence in September 2019, she will assist with reviewing her service.

Birth rate plus has identified that we do not have the recommended 90/10 skill mix with midwives and support staff. Changing the skill mix will have a positive impact as it releases midwives to undertake their role, and releases time to care. In the current staffing model, specifically across the in-patient setting the lack of skill mix split results in lost midwifery time. The role of the Support worker within maternity is invaluable as they have a very different role and offer direct care under the supervision of the midwife and this can enhance the woman's experience. This will also be reflected in any new staffing models, once the birth rate plus report has been clarified and clinical judgement has been used with the existing staffing model across the whole service.

It should be noted that there is 3.92 WTE Midwife and 1.63 WTE Support Worker vacancy within the service according to current agreed staffing levels at the time of writing the report. The unit is proactive in its recruitment and keen to fill any vacancies.

Quality and Safety

The Trust remains non-compliant with the Department of Health guidance, 'Midwifery 2020: Delivering Expectations' which identifies that trained theatre practitioners should undertake the role of theatre scrub and that this role should not be carried out by midwives. An additional 5.38 WTE theatre practitioners will be required to cover Maternity theatre scrub 24/7 and the development of a business case from the theatre team in conjunction with main theatres will be needed in 2019/20 in order to meet this requirement. This non-compliance has been risk assessed and entered onto the risk register and is currently scored as a 20. Maternity staff involvement in theatre activity was additionally highlighted within the most recent CQC report as a 'Must Do' action. .

The CQC report also identified the need for the service to have a bereavement midwife, this post is now in place and the successful candidate commenced in the role in July 2019.

Supervisory Ward Managers

National guidance suggests that all Ward Managers should be supervisory to practice. The Trust agreed level is for 50% of their time to be clinical; this is factored into the staffing requirements for each of the ward areas detailed above. This falls below the national guidance but is safe for our current maternity service.

Challenges and Risks

The Maternity Service currently has a CQC rating of 'Requires Improvement'. One 'Must Do' action was identified within the report;

'The trust must continue to review processes, monitor and respond to staffing levels, skill mix and patient acuity in all areas, taking into consideration staff in theatre for elective and emergency caesarean sections.'

The service monitors staffing on a daily basis via safety huddles and ensures appropriate movement of staff to areas with increased pressure or where risks are identified.

The greatest risk associated with the service is highlighted in the Quality and Safety Section of the report and relates to the staffing requirements for emergency and elective theatre procedures for women accessing the service.

Plans are in place to commence a structured elective LSCS list in general theatre commencing in July 2019 and a joint MDT has been undertaken to address escalation for an emergency theatre in and out of hours. Clear process for escalation has been agreed and greater collaboration between all those involved introducing a formal brief between the theatre coordinator and DS on a daily basis have already been implemented. This allows all clinical teams to be fully aware of activity across the wider service and any potential emergencies. The Head of Nursing is reviewing the theatre staffing models and looking at any short falls. A business case may be required once this has been completed.

The current uplift of 20% does not currently cover the additional level of training that is required for all midwives. The division is asking for a 22% uplift to cover the additional training above that required for nursing staff. The additional training that is midwifery specific is required on an annual basis. This includes, CTG training, fetal growth restriction, in line with Saving Babies Lives requirements. Antenatal screening assessment training, maternity specific skills drill and MDT training learning and a breast feeding update and Adult and Children safeguarding.

Currently the Trust does not have a Perinatal Mental Health Midwife in post. This has been identified by a piece of work undertaken by the Greater Manchester Strategic Clinical Network. They reviewed 12 providers across GM and Cheshire and identified that Wigan has the 2nd largest number of women diagnosed with mental illness and does not have any such midwifery service available. There was only one other provider who did not have such a role and they had 75% less women with the same issues. Perinatal Mental health Midwives have a crucial role in the delivery of effective perinatal mental health care ensuring that women with these issues get high quality maternity care, throughout their pregnancy journey. In addition they help to develop local care pathways, provide training and advice and support other maternity staff to provide women with additional specialist support where required. Funding will be required outside the existing budget for this role.

Currently the Trust has a Safety and Quality Midwife role which is for 22.5 hours per week and within her role she also covers maternity and child health, but is funded from the maternity budget. The division is asking for an up lift of this role to a full time post, so an additional 15 hours at band 7 is required. This role is fundamental to the unit as she leads clinical risk management, service improvement, implementing safety thermometers and is the saving babies' lives champion.

Recommendations and Next Steps

The Board is asked to:

- Note the findings of the review and its current limitation due there needing to be clarity from Birth Rate Plus in their final report and that the HOM has recently taken over and is undertaking a review of the existing service
- Note the risks to compliance with Midwifery 2020 and completion of the 'Must Do' action from the CQC associated with the provision of theatre services and the priority within the division to address the risk jointly with the Head of Nursing for Surgery
- Note the divisional plans to develop the role of a Perinatal Mental Health Midwife this is not currently within existing resources
- Note the division plans to extend the role of the Safety and Quality Midwife role this is not currently within the existing resources
- Note the division plans to apply a 90/10% skill mix to the maternity service
- Note the division is asking to increase the uplift from 20 to 22% this is not currently within the existing resources.

REPORT

AGENDA ITEM: 9.7

Wrightington, Wigan and Leigh NHS Foundation Trust

To:	Board of Directors	**Date:**	31 July 2019
Subject:	Mortality Update Q4 2019-20		
Presented by:	Medical Director	**Purpose:**	Information

Executive summary

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

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

The Trust's Mortality Improvement Plan is an appendix to this report. The plan includes a number of actions related to the following:

- CCG and WWL Joint Review: Deaths after 30 days discharge.
- Further actions agreed to support improvements to mortality.
- Actions relating specifically to Pneumonia.

Risks associated with this report

The Corporate Risk Register includes the following key risk:

- Failure to achieve an improved benchmarked position for mortality.

Link(s) to The WWL Way 4wards

☒	Patients	☒	Performance
☐	People	☐	Partnerships

The WWL Way

Mortality Review
2018-19 Quarter 4

1.0 Introduction

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

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

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

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

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

2.0 Total Number of Inpatient Deaths (By Quarter 2018-19)

The total number of hospital deaths in 2018-19 Q4 was **343**, Q3 was 286, Q2 was 274, Q1 293, in comparison to 2017-18 367 in Q4, 359 in Q3, 298 in Q2 and 328 in Q1.

3.0 Deaths Subjected to Review

The Corporate Mortality Review Team, led by Dr Martin Farrier, Associate Medical Director, amended their processes for reviewing deaths at the beginning of October 2017 to reflect the recommendations from the Learning from Deaths Guidance. The Corporate Mortality Review for Q4 2018-19 concluded the following:

	Deaths			Review and Score						Learning Disability		
Quarter	Total	Reviewed	Avoidability >50%	Score 6 - Definitely not avoidable	Score 5 - Slight evidence Avoidability	Score 4- Possibly avoidable but not very likely	Score 3- Possibly avoidable	Score 2 - strong evidence of avoidabilty	Score 1 - Definitely avoidable	Total	Reviewed	Avoidability
Q4 18/19	343	119	1	108	5	3	1	0	0	4	4	0

3.1 Potentially Preventable Deaths

One death was escalated by the Corporate Mortality Review Team as potentially preventable:-

- Concerns related to a patient discharged without appropriate treatment.

3.2 Themes/Learning

The themes noted by the Corporate Mortality Review Team and shared included:

- Concerns related to cross boundary care for patients requiring tertiary services (Cerebrovascular Accident, Vascular or Dialysis);
- 'Right patient right ward' not adhered to given the pressures experienced by WWL.

4.0 Unexpected Deaths Reported to STEIS in Q4 (2018/19)

The Trust submitted 3 unexpected or potentially avoidable deaths to STEIS in Q4 (2018/19).

- 2019/2518: See above death escalated by Corporate Mortality Review Team;
- 2019/3749: Delayed diagnosis
- 2019/5352: Concerns related to post-operative treatment.

5.0 Prevention of Future Deaths Notices

The Trust did not receive a Prevention of Future Deaths (PFD) Notice from the Coroner in Q4 2018-19. The Trust did not receive a PFD in 2018-19.

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

The Trust's HSMR YTD to January 2019 (latest available data) was 95.2. The Trust's SHMI was 109.1 for a rolling 12 months from December 2017 to December 2018, an improvement from 110.3 for the previous reporting period.

7.0 Mortality Improvement Plan

The Trust has a mortality improvement plan which incorporates actions following the joint review of deaths within 30 days of discharge undertaken with Wigan Borough Clinical Commissioning Group and further actions agreed by the Mortality Group (See Appendix A).

Director of Governance and the Corporate Mortality Review Team
July 2019

Mortality Improvement Plan (Version 0.12 240519) Incorporating the following:

- **CCG and WWL Joint Review: Deaths after 30 days discharge.**
- **Further actions agreed to support improvements to mortality.**
- **Actions relating specifically to Pneumonia.**

No.	Issue Identified/ Recommendation	Actions to be taken (clear and specific identify resources where appropriate)	Lead Responsibility (Job Title)	Time Frame (date to be completed)	Risk to Completion (any risks that would prevent delivery of the action)	Progress towards Completion (include date the narrative relates to)	Date completed (RAG rate the column)	Evidence of completion
1	WWLFT to implement in full the recommendations from the National Guidance on Learning from Deaths (March 2017) and consider a more detailed analysis of trends in deaths by specialities and specific conditions.	To implement the recommendation from the National Guidance on Learning from Deaths	Associate Director of Governance, Clinical lead for Mortality	February 2018	None.	The Trust has revised its Mortality Review Framework and published it on then Trust website following approval at Trust Board in September 2017. The Corporate Mortality Review Group has revised its data collection tool from October 2017 to bring it line with the RIP Structured Judgement Tool. Consideration of the presentation of Q3 mortality data to trust Board is underway. March 2018: The Q3 Mortality Report was presented to the Board of Directors in January 2018.	January 2018	Mortality Framework published on trust Website http://www.wwl.nhs.uk/about_us/mortality_review_framework.aspx Q3. Mortality report to Trust board. Mortality Update Q3 2017-18 FINAL 2301

No.	Issue Identified/ Recommendation	Actions to be taken (clear and specific identify resources where appropriate)	Lead Responsibility (Job Title)	Time Frame (date to be completed)	Risk to Completion (any risks that would prevent delivery of the action)	Progress towards Completion (include date the narrative relates to)	Date completed (RAG rate the column)	Evidence of completion
2	WWLFT to review Clinical Coding practices to ensure they align with other Trusts in Greater Manchester. WWLFT to review Coding practices to ensure they align with other Trusts in Greater Manchester (cont.)	The Trust has aligned Clinical Coding for AAA with other Trusts in Greater Manchester	Clinical Lead for Mortality	Complete	None	October 2017. This is complete but will take some time to reflect in the Trusts Mortality data. November 2017. The results of the National Clinical Coding Audit demonstrated 96% accuracy in primary diagnosis for WWL.	September 2017	Possible improvements to mortality data  Wigan Wrightington Leigh NHS Foundatic
3	WWLFT to consider widening membership of the weekly deaths review group to include additional clinicians from other Divisions such as Medicine and Surgery and Primary Care to allow from additional clinical challenge.	The Medical Director has invited a Consultant Haematologist, Elderly Care Consultant and Surgeon to join the Corporate Mortality Review Team. Responsibilities for the new team members will be defined. The Trust is happy to include a GP nomination from the CCG. Previously 3 GP's have attended the review, however they haven't participated long term.	Medical Director	December 2017 Update: August 2018	-Engagement - Time commitment - sustainability	October 2017. Invitation issued by Medical Director May 2018 There are further actions required. WWL Medical Director is seeking support from Primary Care. The risks to the completion of this action are recognised as it is a weekly commitment. May 2019 An allocated GP now supports the Corporate Mortality Review in relation to primary care elements of patients care and treatment. The CCG provide support if concerns are raised regarding care in Nursing Homes. If the Corporate Review Team highlights concerns with a death the detailed are shared with the relevant specialty for their consideration.		Attendance of new Corporate Mortality Review Team. Membership and input into reviews.

No.	Issue Identified/ Recommendation	Actions to be taken (clear and specific identify resources where appropriate)	Lead Responsibility (Job Title)	Time Frame (date to be completed)	Risk to Completion (any risks that would prevent delivery of the action)	Progress towards Completion (include date the narrative relates to)	Date completed (RAG rate the column)	Evidence of completion
4	WWLFT may wish to undertake a review of Cardiology cases rejected by South Manchester University Hospital Foundation Trust, especially in light of their previous experiences regarding Aortic Stenosis.	WWL has been liaising closely with Central Manchester Colleagues. Individual cases are discussed between the organisations Cardiology Clinical Directors. Concerns regarding Aortic Stenosis have reduced Issues not regularly reported via the deaths audit.	Cardiology Clinical Director	Complete	None	October 2017 Complete	September 2017	Reduction in Aortic Stenosis concerns raised by mortality reviews.
5	WWLFT to review the early recognition and management of liver failure and encephalopathy.	To be reviewed by Gastroenterology Consultant	Gastroenterology Consultant (AC)	November 2017	None	October 2017: Underway November 2017: Complete	November 2017	Presented to the November 2017 Mortality Committee.
6	WWLFT to review gall bladder disease management, with a particular emphasis on waiting times for ERCP and referral to secondary care.	To be reviewed by Gastroenterology Consultant	Gastroenterology Consultant (RK)	January 2018	None	October 2017: To commence March 2018: The January 2018 Mortality Committee was cancelled. Case reviews will be presented in May 2018.	See action 15 below.	A review of ERCP delays was undertaken and an additional slot was established.
7	WWLFT to explore what further analysis or selected case review would help explain excess deaths among differing age groups from the following conditions or reassure that identified clinical themes are being appropriately addressed:							

No.	Issue Identified/ Recommendation	Actions to be taken (clear and specific identify resources where appropriate)	Lead Responsibility (Job Title)	Time Frame (date to be completed)	Risk to Completion (any risks that would prevent delivery of the action)	Progress towards Completion (include date the narrative relates to)	Date completed (RAG rate the column)	Evidence of completion
	• Lung Cancer	Case review complete	Clinical Director for Medicine (RS)	Complete	None	October 2017: Complete	September 2017	Presented to September 2017 Mortality Committee
	• COPD (45-74 years)	To undertake a case review	Respiratory Consultant (IA)	November 2017	None	October 2017: Underway November 2017: Complete	November 2017	Presented to November 2017 Mortality Committee
	• Acute renal failure	Case review complete	Medical Consultant (SG)	Complete	None	October 2017: Complete	July 2017	Presented to July 2017 Mortality Committee
	• Liver Disease (45 - 74 years)	See recommendation 5.						
	• Septicaemia	Case review complete	Consultant Anaesthetist (SN)	Complete	None	October 2017: Complete	July 2017	Presented to July 2017 Mortality Committee.
	• Parkinson's disease	To undertake a case review	Neurology Specialist Nurse (LO)	November 2017	None	October 2017: Underway November 2017: Complete	November 2017	Presented to November 2017 Mortality Committee
	• Mental retardation (Senility & Organic mental disorders)	This needs further consideration						
	• Cystic Fibrosis	This needs further consideration						
	• Aspiration Pneumonia (45-74 years)	To undertake a case review	To be discussed further with the Clinical Director of Scheduled	January 2018 Update August	None	October 2017: Discussion to occur with Clinical Director for Unscheduled Care November 2018: Aspirational	Not required	

No.	Issue Identified/ Recommendation	Actions to be taken (clear and specific identify resources where appropriate)	Lead Responsibility (Job Title)	Time Frame (date to be completed)	Risk to Completion (any risks that would prevent delivery of the action)	Progress towards Completion (include date the narrative relates to)	Date completed (RAG rate the column)	Evidence of completion
			Care.	2018		Pneumonia mortality has reduced. At the Pneumonia meeting referenced below it was noted that a focus on this at this stage was not required.		
	• Peripheral and Visceral atherosclerosis	This needs further consideration						
	• Urinary tract infection (45-74 years)	To undertake a case review	Elderly Care Consultant	November 2017	None	October 2017: Underway November 2017: Complete	November 2017	Presented to November 2017 Mortality Committee.
8	• Further actions identified to improve mortality	To establish a Mortality Committee	Medical Director, Director of Governance	June 2017	None	Complete.	June 2017	The establishment of a multi-disciplinary Committee with representation from Public Health, Wigan Borough CCG and AQUA.
9		To make coding amendment for AAA patients to bring us in line with other Trusts;	Clinical Lead for Mortality	November 2017	None	Complete.	November 2017	Coding amendment for AAA complete.
10		To undertake a case review for Alcoholic Liver Disease (ALD)	Gastroenterology Consultant (AC)	May 2018	None	Complete	May 2018	Presentation to May 2018 Mortality

No.	Issue Identified/ Recommendation	Actions to be taken (clear and specific identify resources where appropriate)	Lead Responsibility (Job Title)	Time Frame (date to be completed)	Risk to Completion (any risks that would prevent delivery of the action)	Progress towards Completion (include date the narrative relates to)	Date completed (RAG rate the column)	Evidence of completion
								Committee.
11		To undertake an End of Life Care Audit.	Palliative Care Consultant (KB)	May 2018	None	Complete	May 2018	Presentation to May 2018 Mortality Committee.
12		To undertake a case review for diagnostic imaging of heart.	Cardio-respiratory & Catheter Laboratory Service Manager (JS)	May 2018 Update: August 2018	None	May 2018 This review was completed in time for the May 2018 Mortality Group as agreed; however, due to the discussions at the committee time did not allow this to be presented. The review will be presented at the August 2018 Mortality Committee.	August 2018	Presentation to August 2018 Mortality Committee.
13	• Further actions identified to improve mortality (cont.)	To undertake a case review for Cardiac Arrest and Ventricular fibrillation	A&E Consultant (SN)	August 2018 Update: October 2018	None	May 2018 Underway August 2018 To be presented to October 2018 Mortality Committee February 2019 To be presented at the March 2019 Mortality Committee	No longer required	Presentation to March 2019 Mortality Committee
14		To undertake a case review for Heart Failure	Cardiology Consultant (AS)	August 2018 Update: October 2018	None	May 2018 Review underway July 2018 To be presented at the October 2018 Mortality Committee February 2019 To be presented at the March 2019 Mortality Committee. For	March 2019	Presentation to March 2019 Mortality Committee

No.	Issue Identified/ Recommendation	Actions to be taken (clear and specific identify resources where appropriate)	Lead Responsibility (Job Title)	Time Frame (date to be completed)	Risk to Completion (any risks that would prevent delivery of the action)	Progress towards Completion (include date the narrative relates to)	Date completed (RAG rate the column)	Evidence of completion
						information this is no longer 'triggering' on Dr Foster mortality data as a risk.		
		To undertake a case review for Cancer of the Ovary and Cervix	Obs and Gynae Consultant (JD)	October 2018	None	July 2018 Review underway. To be presented at the October 2018 Mortality Committee	December 2018	Presentation to December 2018 Mortality Committee
15		A review of delays for ERCP at the Trust	Gastroenterologist CD	February 2018	None	Complete. The Gastro Team has increased the number of ERCP slots available and the number of days that the service is available.	February 2018	The review has been completed and additional slots allocated.
16	• Further actions identified to improve mortality (cont.)	To undertake a further review of patients who died within 30 days of discharge (for November 2017). The previous project was undertaken jointly with the CCG.	Clinical Lead for Mortality	May 2018 Update: August 2018	None	May 2018 Review underway but not complete.	July 2018	Presentation to August 2018 Mortality Committee
17		To invite a relevant/appropriate representative from Tameside to attend our Mortality Group to share their learning.	Medical Director	May 2018 Update: June 2018	None	Update April 2018: Medical Director at Tameside to attend Clinical Advisory Board (CAB) in June 2018.	June 2018	Attendance at CAB in June 2018
18		To review Sepsis coding with Public Health support (action from Wigan Borough Mortality Summit).	Coding Lead for Mortality	May 2018	None	Complete: An audit of Death Certificates and Sepsis Coding has been completed.	May 2018	Presentation to May 2018 Mortality Committee.

No.	Issue Identified/ Recommendation	Actions to be taken (clear and specific identify resources where appropriate)	Lead Responsibility (Job Title)	Time Frame (date to be completed)	Risk to Completion (any risks that would prevent delivery of the action)	Progress towards Completion (include date the narrative relates to)	Date completed (RAG rate the column)	Evidence of completion
19		To commission an MIAA audit of Mortality Framework in the 2018-19 Internal Audit Programme.	Medical Director	April 2018	None	Complete. An audit of the Mortality Framework is on the Internal Audit Programme for 2018-19. Update July 2018: This review will focus on divisional mortality reviews. November 2018: This review is being presented to December 2018 Mortality Committee.	February 2018	
20		To undertake a Wigan Borough-wide review of warfarin in frail elderly patients who then RIP from bleeding.	Clinical Lead for Mortality	TBC	None	This is currently being explored by the CCG with input from the Trust. The Trust is also reviewing warfarin pre-op following an incident recently reported to STEIS.	TBC	TBC
21		To invite representation from Dr Foster to join the Trust's Mortality Committee.	Medical Director; Director of Governance	August 2018	None	May 2018: This action was agreed following a meeting with NHS Improvement in May 2018. Initiation to be issued.	August 2018	Dr Foster attendance at the August 2018 Mortality Committee.
22		To request an analysis of the Trusts mortality data by Dr Foster.	Analytic Services Manager, Business Intelligence	August 2018	None	May 2018: This action was agreed following a meeting with NHS Improvement in May 2018. Scoping of the analysis required is underway.	August 2018	Presentation of the analysis at the August 2018 Mortality Committee.
23	• The following actions relate specifically to Pneumonia	To establish a Pneumonia Task and Finish Group.	Medical Director; Director of Governance	June 2018 Update: October 2018	None	May 2018: This action was agreed following a meeting with NHS Improvement in May 2018. August 2018: A meeting is scheduled on the 4th October 2018, chaired by the Medical Director to review work undertaken to date and next steps.	Not required.	Minutes from the Task and Finish Group reported to Mortality Committee.

No.	Issue Identified/ Recommendation	Actions to be taken (clear and specific identify resources where appropriate)	Lead Responsibility (Job Title)	Time Frame (date to be completed)	Risk to Completion (any risks that would prevent delivery of the action)	Progress towards Completion (include date the narrative relates to)	Date completed (RAG rate the column)	Evidence of completion
	• The following actions relate specifically to Pneumonia (cont.)					November 2018: The Medical Director chaired a meeting with key stakeholders to review progress and actions taken to date (see below). The Trust has not triggered for Pneumonia mortality since June 2017. It was agreed that a T&F Group was not required at this stage. The pneumonia pathway is being relaunched by the Clinical Lead and it was agreed that an education session with Junior Doctors would be scheduled.		
24		To undertake a clinical audit of the Pneumonia Clinical Pathway.	Director of Governance; Pneumonia Lead	August 2018	None	May 2018: This action was agreed following a meeting with NHS Improvement in May 2018. Scoping of the audit is underway. August 2018: The Trust is now participating in the submission of Pneumonia data to Advancing Quality (AQ) with the support of a Specialist Nurse. AQ annual condition based reports provide Trust's with benchmarked data. November 2018: The Trusts latest Pneumonia AQ data benchmarks positively:  WWL_AQ_summary_ Sep_2018.pdf	August 2018	Trust participation in AQ.

No.	Issue Identified/ Recommendation	Actions to be taken (clear and specific identify resources where appropriate)	Lead Responsibility (Job Title)	Time Frame (date to be completed)	Risk to Completion (any risks that would prevent delivery of the action)	Progress towards Completion (include date the narrative relates to)	Date completed (RAG rate the column)	Evidence of completion
25		To request an analysis of Pneumonia Clinical Coding by Dr Foster.	Analytic Services Manager, Business Intelligence	August 2018	None	May 2018: This action was agreed following a meeting with NHS Improvement in May 2018. Scoping of the analysis required is underway. August 2018: Dr Foster has reviewed Pneumonia HSMR activity. The Trust alerted for Pneumonia in June 2017 (no alerts since) and this is still reflecting in the Trust's data (12month rolling).	August 2018	Dr Foster presentation to August 2018 Mortality Committee. Further actions to be discussed in October 2018.
26		To undertake a case review for Pneumonia	Mortality Clinical Lead and Coding Lead for Mortality	August 2018	None	July 2018: Complete	August 2018	Presentation to August 2018 Mortality Committee.

Patients:
Every patient receives the best possible care

Executive lead(s):	Director of Nursing Medical Director	**Reviewing committee:**	Quality and Safety Committee	**DELIVERY CONFIDENCE**	**WEIGHTED DASHBOARD**
Strategic importance:	Provision of safe, effective, high-quality and evidence based care is at the heart of everything we do.			**CURRENT MONTH:**	**MONTH:** 2 **YTD:** 2.5
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:** June 2019, May 2019, April 2019, Mar 2019	**ROLLING TREND:** June 2019: 2.85, May 2019: 1.96, April 2019: 2.15, Mar 2019: 2.04

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
Risk of injury/equipment failure/fire cause by failure of celling pendants in ICH/HDU, as a result of excessive weight, beyond safe	16	Pendants have been installed and both areas are now fully operational	20
Failure to identify the root cause and lessons learned from never events reported during 2017-18 and 2018-19 creates a risk around patient safety, reputational damage and increased regulatory scrutiny	16	Reported to Board. Themed SIRI Panel in Mar 2019 on actions/lessons learned	16
Upgrade to Somerset cancer registry interface on PAS has potential to delay cancer diagnosis	20	Update installation was scheduled for late Feb. Interface currently being tested for supplier issues	20
Only 1 maternity theatre available for elective and emergency cases	20	New risk, further analysis being undertaken	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)	**96.4% M 96.2% Y**	≥95%	94% - 90%	89%-85%	84%-80%	<80%	**1**	1 x 1 = 1	1 x 1 = 1	Perf. Report (May 2019)
Harm free care	No. Serious Falls	**0 MTD 1 YTD**	0 (MTD)		1 (YTD)	2 or 3	>3	**2**	1 x 2 = 2	3 x 2 = 6	Perf. Report (June 2019)
Patient Safety	% of 'red sepsis' patients receiving antibiotics within 1 hour in A&E	**73.5%**	≥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 1 YTD**	0 (MTD)				1 (YTD)	**3**	1 x 3 = 3	5 x 3 = 15	Perf. Report (June 2019)
Patient Safety	100% compliance with appropriate frequency of observations	**98%**	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 (June 2019)
Infection Control	No. of C. diff Lapses in Care	**1 MTD 2 YTD**	0	1 (MTD)	2 (YTD)	3	>4	**2**	2 x 2 = 4	3 x 2 = 6	Perf. Report (May 2019)
Patient Experience	% of patients recommending WWL for care	**92.8%**	≥95%	94% - 90%	89%-85%	84%-80%	<80%	**2**	2 x 2 = 4	---	Monthly FFT (May 2019)
Patient Experience	% of patients feeling involved with decisions about their discharge	**84.8%**	≥95%	94% - 90%	89%-85%	84%-80%	<80%	**1**	3 x 1 = 3	---	Perf. Report (June 2019)
Patient Experience	% of complaints responded to within the timescale agreed with the patient	**44.4% M 60.4% Y**	≥95%	94% - 90%	89%-85%	84%-80%	<80%	**1**	5 x 1 = 5	5 x 1 = 5	Perf. Report (June 2019)
Mortality	HSMR	**101.5% M 98% Y**	≤100 (YTD)	101-105 (MTD)	106-110	111-115	>115	**3**	3 x 2 = 6	1 x 3 = 3	Perf. Report (March 2019)
Mortality	SHMI	**112.6%**	≤100	101-105	106-110	111-115	>115	**1**		4 x 1 = 4	Perf. Report (Jan 2018)
Mortality	No. of PFDs	**0**	0	1	2	3	>4	**2**	1 x 2 = 2	1 x 2 = 2	Perf. Report (May 2019)
Medicines Management	% of critical medicines prescribed within 24 hours of admission or before the patient is transferred to a new area	**78%**	100%	99-95%	94-90%	89-80%	<80%	**1**	5 x 1 = 5	---	Pharmacy (Jun 2019)
Medicines Management	% of completed medicines reconciliation within 24 hours	**81%**	100%	99-95%	94-90%	89-80%	<80%	**2**	4 x 2 = 8	---	Pharmacy (Jun 2019)
Total									(52/26)	(45/18)	
Average									2	2.5	

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. Safe and effective workforce to meet service needs 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:**	
				Jun 2019	May 2019	Apr 2019	Mar 2019	
								
							4.00	3.25	3.25	3.25
							Jun 2019	May 2019	Apr 2019	Mar 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
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
HR110 – Impact of tax/pension threshold on the senior medical workforce	16	Exploring the use of alternative approaches such as pay flexibilities, alternative benefits and third party LLP contracting; lobbying around pension reform nationally; exploration of alternative workforce models; potential to recruit substantive consultants in specialties where there are no shortages.	16

HR82 – Declines in safety culture and staff confidence in reporting errors, near misses and incidents.	16	Plans to build this into the Just Culture programme of work that is being undertaken; plans to build into the FTSU action plan.	16
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
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
HR06 – 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

NARRATIVE

The weighted dashboard overleaf has been updated and the month to which data relates has been included.

Risks escalated to REMC for inclusion on the corporate risk register: Quality of Appraisals; Inclusion of voluntary OT in holiday pay; and Equality and Diversity were not accepted onto the risk register but remain on the workforce directorate risk register. Risks around Staff Engagement levels and NHSI Developing Workforce Safeguards to be presented at REMC in July.

Divisional your voice surveys have been or are in the process of being run to provide more granular detail in relation to divisional engagement. Action plans are in place to address findings. Plans are being developed to progress the Just Culture work programme, starting with a civility saves lives campaign. This will incorporate issues linked to IG and will build on the behaviour framework. Progress is also being made in relation to the triage and frameworks to manage employee relations matters in a manner consistent with Just Culture.

The focus of listening events is being changed to support more input on gaining staff input to solving issues. The first of these was held successfully for AHP's in July, with lots of positive ideas being generated.

WWL is looking to become part of the cohort 5 retention programme, which is now being extended to cover Nursing & AHP's.

Plans are in place to significantly increase the number of apprentices, enabling us to utilise our entire levy pot in 2019/20.

HEE upskilling allocations have been confirmed and we are now in the process of prioritising training and development requirements. The new learning hub has been introduced, which improves functionality and accessibility of the e-learning modules and supports prospective centralisation of training records.

Progress is being made with alternative workforce models following the workforce summit. Progress is monitored through the SAVI scheme and will also form part of the Workforce Committee Away Day in September, alongside the development of the Trust's workforce plan.

Work is progressing with IT to implement an interface between Active Directory and ESR in addition to work that aims to remove the need for any login to Wally. This will fully mitigate the Wally access risk when completed and will have numerous additional benefits in terms of messaging and access to information.

Two proof of concept bids were successful at Dragons' Den that will help with the reduction of sickness absence. These are a sickness absence management system and a health and well-being app that incentivises staff to make healthy choices e.g. health screening and flu vaccinations alongside physical activity.

Progress is being made in relation to the implementation of a new Direct Engagement system through NHSP that will support agency reduction plans, alongside the workforce transformation.

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	8.80%	≤8%	8.01-8.5%	8.51-9%	9.01-9.9%	≥10%	1	3 x 1 = 3	3 x 1 = 3	Workforce team
Employment Essentials	Leavers with less than 12 months' service	14.5%	≤10%	11-14%	15-20%	21-24%	≥25%	1	2 x 1 = 2	2 x 1 = 2	Workforce team
Route Planner	PDR completion	86.2%	≥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:** 2.74 **YTD:** 3.04
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:** Jun 2019, May 2019, Apr 2019, Mar 2019	**ROLLING TREND:** Jun 2019: 3.47; May 2019: 3.43; Apr 2019: 1.66; Mar 2019: 2.04

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

NARRATIVE

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

PERFORMANCE: WEIGHTED DASHBOARD

Performance data as at: **30 JUNE 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	83.83% M 83.25% Y	≥95%	94.9-90%	89.9-80% M & YTD	79.9-70%	≤70%	2	3 x 2 = 6	3 x 2 = 6	BI (Jun 2019)
12-hour operational standard	No patient requiring emergency admission will wait 12 hours in A&E	0 M 0 Y	0 Mth & YTD				1	2	1 x 2 = 2	1 x 2 = 2	BI (Jun 2019)
Ambulance handover standard	All handovers between ambulance and A&E must take place within 15 mins with none waiting >60m	4 > 60m M 49 > 60m Y	≤ 15 mins	15-30 mins		30-59 mins	>60 mins (M & Y)	1	5 x 1 = 5	5 x 1 = 5	BI (Jun 2019)
Cancer treatment times	85% should wait no more than 62 days from urgent referrer to first definitive treatment	80.13% M 81.50% Y	≥85% Mth & YTD				≤84.9%	2	5 x 2 = 10	5 x 2 = 10	BI (May 2019)
18-week RTT	92% on incomplete RTT pathways (yet to start treatment) should wait no more than 18 weeks	92.45% M 92.66% Y	≥92% Mth & YTD				≤91.9%	1	1 x 1 = 1	1 x 1 = 1	BI (Jun 2019)
52-week RTT	Zero tolerance for patient waits over 52 weeks on an incomplete pathway	1 M 1 Y	0				≥1 (M & Y)	2	5 x 2 = 10	5 x 2 = 10	BI (Jun 2019)
Diagnostic waiting times	99% of service users waiting for a diagnostic test should receive it within 6 weeks of referral	99.26% M 98.81 Y	≥99% (Mth)				≤98.9% (YTD)	1	1 x 1 = 1	5 x 1 = 5	BI (Jun 2019)
Paper switch off programme	By 1 Oct 2018, NHS E-referral will be used for all relevant consultant-led first OPD appointments	Complete	100%				≤99.9%	1	1 x 1 = 1	1 x 1 = 1	Complete
Control total achievement	Forecast position: Achieve finance control total before PSF	Forecast 1 quarter	Achieve 4 quarters	3 quarters	2 quarters	1 quarter	0 quarters	4	3 x 4 = 12	3 x 4 = 12	Forecast
Control total achievement	Forecast position: Achieve A&E control total trajectory	No longer applicable	Achieve 4 quarters	3 quarters	2 quarters	1 quarter	0 quarters	2	---	---	Forecast
Use of resources risk rating	Forecast position: Achieve use of resources risk rating as per plan	Forecast 1 quarter	Achieve 4 quarters	3 quarters	2 quarters	1 quarter	0 quarters	4	3 x 4 = 12	3 x 4 = 12	Forecast
Transformation	CIP delivery against target	(44%) M (44%) Y	Achieved (mth)	Fail by <10% (Y)	Fail by 10-20%	Fail by 20-30%	Fail by >30%	3	1 x 3 = 3	2 x 3 = 6	Finance report
IT	Completion of agreed IT priorities in line with plan	2019/20 plan not yet agreed	100%	90-99%	80-89%	70-79%	≤70%	2	---	---	IT department
Total								27	63(/23)	70(/23)	
Average									**2.74**	**3.04**	

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:** 2.96 **YTD:** 2.96
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:** May 2019, Apr 2019, Mar 2019, Feb 2019	**ROLLING TREND:** 3.08 (May 2019), 2.92 (Apr 2019), 2.92 (Mar 2019), 2.92 (Feb 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

NARRATIVE

Delivery confidence remains as last month at amber-red. The community services transfer is now supported by a signed Business Transfer Agreement but financial pressures remain. Re-engagement with Bolton on a strategic alliance has taken place. Concerns about the ISC (Theme 3) impact on Wigan have been raised, particularly in terms of hollowing out DGH services.

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	Mild problems	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	Ahead of target	Target complete	Ahead of target	On track	Off target	Way off target	1	1 x 1 = 1	1 x 1 = 1	R&D report
Bolton partnership	Progress on 8 key projects	Mod. concern	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	3	4 x 3 = 12	4 x 3 = 12	Self-assessment
Locality partnership	Locality plan performance matrix	Mild concerns	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	2	3 x 2 = 6	3 x 2 = 6	Self-assessment
Locality partnership	Transformation of hospital care	Mild concerns	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	3	3 x 3 = 9	3 x 3 = 9	Self-assessment
Locality partnership	Healthier Wigan partnership score	Almost on track	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	2	4 x 2 = 8	4 x 2 = 8	Self-assessment
Locality partnership	Community services transfer	Moderate concerns	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	3	4 x 3 = 12	4 x 3 = 12	Self-assessment
NW Sector p/ship	Highlight report for NWSP	Major 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	Mild 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	Almost 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
Total								24	71	74	
Average									**2.96**	**2.96**	

REPORT

AGENDA ITEM: 10.1

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

To:	Board of Directors	**Date:**	31 July 2019
Subject:	7 Day Service Assurance		
Presented by:	Medical Director	**Purpose:**	Approval

Executive summary

The national Seven Day Services programme, covering ten clinical standards, commenced in 2013 and through an audit process performance against several of them has been submitted by provider organisations over the last 3 years. This report details the latest findings from the review carried out in June 2019 which shows an improvement from the last submission in February 2019 when the Trust was compliant with all but one of the clinical standards (requirement to have a Consultant review within 14 hours). The Trust was fully compliant with all the standards (based on 90% achievement for the 4 priority standards across all days of the week) in June 2019 and this report sets out the current position.

Risks associated with this report

The results are based on a sample audit and this is the first time that the Trust has fully achieved so sustainable improvement will only be evidenced once the next series of audits are completed (expected to be Autumn 2019)

Link(s) to The WWL Way 4wards

☒	Patients	☒	Performance
☐	People	☐	Partnerships

The WWL Way

Seven Day Services Assurance Process

Introduction

The national Seven Day Hospital Services (7DS) Programme was developed to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency.

Ten 7DS clinical standards were originally developed by the Seven Days a Week Forum in 2013. Providers have been working to achieve all these standards, with a focus on four priority standards identified in 2015 with the support of the Academy of Medical Royal Colleges.

The four priority standards were selected to ensure that patients have access to consultant-directed assessment (standard 2), diagnostics (standard 5), interventions (standard 6) and ongoing review every day of the week (standard 8).

To enable providers to track their progress in achieving the four priority 7DS clinical standards, NHSI developed a self-assessment survey. This was an online tool that allowed providers to input data taken from patient case notes to measure achievement of standards 2 and 8, alongside an assessment of the availability of key diagnostics for Standard 5 and interventions for Standard 6

To achieve each standard, a provider must be able to meet this level of care for at least 90% of its patients measured across all days of week (i.e. week days and weekends)

Providers have measured their delivery of 7DS using this tool since 2016 but the significant changes and considerable improvements were not always reflected in the survey results due to the quality of source data and validation issues. The survey also placed a significant administrative burden on providers as it involved reviewing many patient case notes.

To resolve these issues and enable provider boards to directly oversee reporting on this work, NHSI replaced the survey tool with a board assurance framework via self assessment for measuring 7DS delivery. This was reflected in the previous paper submitted to the Board in February this year.

The purpose of the new self-assessment template is to ensure providers can produce a single, consistent report of their 7DS delivery, for the dual purpose of assurance from their own boards and national reporting.

As the previous submission in February was a pilot there was no requirement for a case note review and the results from June 2018 were used along with a review of wider body of evidence. For the July 2019 submission a case note audit was required using the on-line tool in addition to the broader review. The details are shown at Appendix 1.

Four Priority Clinical Standards

The threshold for achieving compliance for all four priority clinical standards is 90% measured across each day of the week (i.e. week days and weekends combined)

Standard 2 specifies that all emergency admissions must be seen and have a thorough clinical

assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital

Standard 5 covers the availability of six consultant-directed diagnostic tests for patients within one hour for critical patients, 12 hours for urgent patients and 24 hours for non-urgent patients. The diagnostic tests are as follows

- Computerised tomography (CT)
- Ultrasound (USS)
- Echocardiography
- Upper GI endoscopy
- Magnetic resonance imaging (MRI)
- Microbiology

Standard 6 covers timely 24-hour access seven days a week to nine consultant-directed interventions. The interventions are as follows

- Critical care
- Interventional radiology
- Interventional endoscopy
- Emergency surgery
- Emergency renal replacement therapy
- Urgent radiotherapy
- Stroke thrombolysis
- Percutaneous coronary intervention
- Cardiac pacing

Standard 8 relates to the ongoing consultant-directed reviews received by patients admitted in an emergency once they have had their initial consultant assessment. The standard aims to ensure that all patient cohorts receive an appropriate number and level of reviews from consultants depending on the severity of their condition. In practice this means that patients with high dependency needs should be reviewed by a consultant twice daily. All other patients admitted in an emergency should be reviewed by a consultant once daily unless the consultant has delegated this review to another competent member of the multidisciplinary team on the basis that this would not affect the patient's care pathway

Standards for Continuous Improvement

All 10 7DS clinical standards are vital to consistently high quality care, and taken as a whole, impact positively on the quality of care and patient experience. In addition to the specific information on the four clinical standards as outlined above providers must draft a commentary on work done relating to the delivery of the remaining six in the board assurance template. These standards are as follows

- **Standard 1 : Patient Experience** - Information from local patient experience surveys on quality of care/consultant presence on weekdays versus weekends
- **Standard 3 : Multidisciplinary Team Review** - Assurance of written policies for MDT processes in all specialties with emergency admissions, with appropriate members (medical, nursing, physiotherapy, pharmacy and any others) to enable assessment for ongoing/complex needs and integrated management plan covering discharge planning and medicines reconciliation within 24 hours
- **Standard 4 : Shift Handovers** - Assurance of handovers led by a competent senior

decision-maker taking place at a designated time and place, with multiprofessional participation from the relevant incoming and outgoing shifts

- **Standard 7 : Mental Health** - Assurance that liaison mental health services are available to respond to referrals and provide urgent and emergency mental healthcare in acute hospitals with 24/7 emergency departments 24 hours a day, seven days a week
- **Standard 9 : Transfer to Community, Primary and Social** Care - Assurance that the hospital services to enable the next steps in the patient's care pathway, as determined by the daily consultant-led review, are available every day of the week
- **Standard 10 : Quality Improvement** - Assurance that provider board-level reviews of patient outcomes cover elements of care and quality that relate to the delivery of high quality care seven days a week – such as weekday and weekend mortality, length of stay and readmission ratios – and that the duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high quality, safe patient care, seven days a week

Trust Performance

Priority Clinical Standards

As outlined earlier the February 2019 submission was based on data collected in June 2018 but for this report a further case note review was carried out using the national data collection tool in June 2019

In previous surveys there wasn't a national target although in the final report there was some benchmarking with other providers. The target issued as part of the revised process is 90% as outlined above.

WWL Results	Weekday results				Weekend results			
	Standard 2	Standard 5	Standard 6	Standard 8	Standard 2	Standard 5	Standard 6	Standard 8
Mar-16	61%			100%	58%			97%
Sep-16	74%				59%			
Mar-17	81%	100%	100%	98%	84%	68%	89%	64%
Sep-17	82%				94%			
Jun-18	89%	100%	100%	100%	71%	83%	100%	100%
Jun-19	96%	100%	100%	100%	95%	83%	100%	100%

Full details of the current assurance levels and a short narrative are included in Appendix 1 but there were significant improvements in Standard 2 with the Trust now compliant both during the week and at weekends.

The only area where the Trust is not fully compliant is in relation to standard 5 where access to echocardiography remains available via informal arrangement only at the weekend. Patients who need this test urgently will have it carried out but the standard requires there to be a formal agreement to be in place. Following discussion with NHSI the Medical Director has considered whether the 24/7 Consultant cardiologist on-call provision means the Trust does meet this standard but does not believe this is an accurate assessment and therefore the position remains the same.

Clinical Standards for Continuous Improvement

At the time of the February self-assessment the Trust was compliant with all standards except for standard 1 relating to patient experience at weekends versus during the week. Since then a report has been established separating patient experience during the week versus at the weekend. Once there is sufficient data to set a baseline areas for improvement will be identified and any associated actions implemented. The Trust is therefore compliant with all six of these standards.

Conclusions and Recommendations

The Board is asked to note the contents of the report and approve the self-assessment as outlined at Appendix 1. There have been significant improvements in relation to Standard 2 although further data will be needed to confirm that this is an ongoing position. At present it is expected that the next data collection exercise will be in the Autumn and the results will be reported to this Board. If the results are not sustained a working group will be established to implement and embed any necessary changes.

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	Only 3 patients were seen outside 14 hours - one at 20 hours, one at 18 hours and one at 37 hours. All three patients have been reviewed to see if anything can be learnt from their experience Patient experience surveys now include information on Consultant presence at the weekend which the Trust will use to inform it's knoweldge of patients' perception and can be checked against staffing records In addition to the 7DS survey additional audits of senior review and the junior doctors survey also inform the level of support available to junior and middle grade doctors Wider performance metrics such as flow, length of stay and mortality are reprted monthly to the Trust Board and any reduction in performance in these would result in a review including Consultant provision	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Standard Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available off site via formal arrangement	Yes available off site via formal arrangement	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	Trust is fully compliant other than with access to echocardiography at the weekend where we are reliant on the goodwill of staff to provide the service	Echocardiography	Yes available on site	No the test is only available on or off site via informal arrangement	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available on site	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Interventional Endoscopy	Yes available on site	Yes available on site	
		Emergency Surgery	Yes available on site	Yes available on site	
	Trust is fully compliant	Emergency Renal Replacement Therapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Urgent Radiotherapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Stroke thrombolysis	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Percutaneous Coronary Intervention	Yes available on site	Yes available on site	
		Cardiac Pacing	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	The Trust is fully compliant with this standard. Plans and policies are in place to ensure that there is sufficient capacity to deliver this. The surveys and audits referred to under clinical standard 2 are also key to providing assurance regarding this along with the 7DS survey itself. The Trust escalation policy has recently been updated and changes are being made to the clinical information system to support early alerting. This is reported regularly through to the Trust Quality and Safety Committee along with the wider evidence referred to under Clinical Standard 8	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Standard Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
Clinical Standard 1 : Patient Experience - The Trust is now actively reviewing patient experience at the weekend versus during the week, so far the weekend scores are very similar to the week day ones but this will continue to be monitored Clinical Standard 3 : Multidisciplinary Team Review - The Trust is compliant with this standard Clinical Standard 4 : Shift Handover - The Trust is compliant with this standard. There is a clear handover policy in place. Clinical standard 7 : Mental Health - The Trust is compliant with this standard which is documented in the liaison policy Clinical Standard 9 : Transfer to community, primary and social care - The Trust is compliant with this standard. All the identified services are available every day (week day and weekend) and most are available 24/7 Clinical Standard 10 : Quality Improvement - The Trust is compliant with this standard. These issues are covered by the Trust Board Performance Report and associated scrutiny, the Learning from Deaths Report, thew Quarterly Mortality Report, the Responsible Officers Report and scrutiny from the internal Quality and Safety Committee and the CCG chaired Quality and Safeguarding Committee which is a sub-group of the formal Contract Monitoring Group.

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 5	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 6	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 8	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
Not applicable

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

REPORT

AGENDA ITEM: 10.1

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

To	Board of Directors	**Date:**	31 July 2019
Subject:	Changes to Standing Financial Instructions		
Presented by:	Deputy Director of Finance	**Purpose:**	Approval

Executive summary

To seek approval of proposed changes to the foundation trust's Standing Financial Instructions and Budgetary Control and Delegation Arrangements ("SFIs"), following recommendation by the Audit Committee and the Finance and Performance Committee. A copy of the proposed amendments is appended to this report and a copy of the complete SFIs is available on request.

The Board is also requested to resolve that, in order to streamline the process of reviewing SFIs, future amendments will only require the recommendation of the Audit Committee rather than the current approach of seeking the approval of two committees.

Risks associated with this report

None

Link(s) to The WWL Way 4wards

☐	Patients	☒	Performance
☐	People	☐	Partnerships

The WWL Way

Introduction

The purpose of this paper is to seek the board's approval of proposed changes to the foundation trust's Standing Financial Instructions and Budgetary Control and Delegation Arrangements.

Background

The Code of Conduct: Code of Accountability for NHS Boards issued by the Department of Health requires that each NHS organisation shall give, and may vary or revoke, Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. The Standing Financial Instructions (SFIs) are issued in accordance with the Code.

The SFIs detail the financial responsibilities, policies and procedures to be adopted by the Trust and are designed to ensure that its financial transactions are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

The SFIs incorporate the Trust's budgetary control and delegation arrangements which detail how the powers are reserved to the Board of Directors, while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures. However, the Board of Directors remains accountable for all of its functions even those delegated to committees, sub committees, individual directors or officers.

Changes

The SFIs have been updated to reflect a number of changes which have come to light following the changes that were submitted to in May. Details of these can be found in Appendix 1.

Recommendation

On the recommendation of the Audit Committee and the Finance and Performance Committee, the board is asked to approve the proposed amendments to the SFIs as presented.

APPENDIX 1

Standing Financial Instructions - summary of amendments made June 2019

Section 1 Introduction Amended Section 1.1.5 *(page 7)*

From: Failure to comply with Standing Financial Instructions can in certain circumstances be regarded as a disciplinary matter that could result in dismissal**.**

To: Failure to comply with Standing Financial Instructions can in certain circumstances be regarded as a disciplinary matter that could result in dismissal. Compliance with this document will be monitored by the Finance Department and all potential breaches of fraud reported to the Local Counter Fraud Specialist.

Added 1.1.7 *(page 7)*

Where failure to comply with this document constitutes a criminal offence it may result in a criminal investigation and criminal sanctions being applied.

Section 8.1 Non Pay Expenditure - Authorisation levels for approval of purchase orders *(page 27)*

The table on page 27 has been amended as follows:

From:	Associate Director of Finance / Deputy Director of Performance	£150,000
To:	Associate Director /Deputy Director	£150,000

Section 14.2.9 Losses and special payments *(page 38)*

The losses table has been amended

From:

Categories of losses and special payments	Approval delegated to	Delegated checklist* signatories *– for all individual losses over £1,000*
LOSSES		
1. Losses of cash (a) Theft, fraud, arson etc. (b) Overpayments of salaries, wages, fees and allowances (c) Other causes, including unvouched or incompletely vouched payments overpayments other than those included under 1b loss of cash by fire (other than arson) physical losses of cash, cash equivalents and stamps other than those covered by 1a 2. Fruitless payments and constructive losses (including abandoned capital schemes, except where work is purely exploratory) 3. Bad debts and claims abandoned (a) Private patients (b) Overseas visitors	Director of Finance up to £25,000 Chief Executive up to £50,000 Audit Committee and Board of Directors over £50,000	Director of Finance or nominated deputy and Executive Director or nominated deputy in the relevant directorate

(c) Cases other than 3a & 3b 4. Damage to buildings, their fittings, furniture and loss of equipment and property in stores and in use (a) Culpable causes e.g. theft, fraud, arson or sabotage, whether proved or suspected, neglect of duty or gross carelessness (b) Stores losses (c) Other causes e.g. weather damage or accidental fire
***Checklists are available from Finance**

To:

Categories of losses and special payments	*Approval delegated to	*Nominated deputy*
LOSSES		
1. Losses of cash (a) Theft, fraud, arson etc. (b) Overpayments of salaries, wages, fees and allowances (c) Other causes, including unvouched or incompletely vouched payments overpayments other than those included under 1b loss of cash by fire (other than arson) physical losses of cash, cash equivalents and stamps other than those covered by 1a	Director of Finance up to £25,000 Chief Executive up to £50,000	Deputy Director of Finance or Associate Director of Finance Executive Director
2. Fruitless payments and constructive losses (including abandoned capital schemes, except where work is purely exploratory)	Audit Committee and Board of Directors over £50,000	
3. Bad debts and claims abandoned (a) Private patients (b) Overseas visitors (c) Cases other than 3a & 3b		
4. Damage to buildings, their fittings, furniture and loss of equipment and property in stores and in use (a) Culpable causes e.g. theft, fraud, arson or sabotage, whether proved or suspected, neglect of duty or gross carelessness (b) Stores losses (c) Other causes e.g. weather damage or accidental fire		
***Approvals relate to all categories of losses**		

Losses and special payments *(page 39)*

The special payment table has been updated from:

Categories of losses and special payments	Approval delegated to	Delegated checklist* signatories *– for all individual losses over £1,000*
SPECIAL PAYMENTS		
5. Compensation payments made under legal obligation *(such as court order or arbitration award for personal injury, property damage or unfair dismissal)*	Director of Finance / Chief Executive up to £50,000 Audit Committee and	Not applicable

	Board of Directors over £50,000	
6. Extra-contractual payments to contractors *(such as payments for non-contractual obligations which might arguably have been upheld in court)*	Chief Executive up to £50,000 Audit Committee and Board of Directors over £50,000	Director of Finance or nominated deputy and Executive Director or nominated deputy in the relevant directorate
7. Ex-gratia payments (a) Loss of personal effects (b) Clinical negligence (negotiated settlements following legal advice) where the guidance relating to such payments has been applied (c) Personal injury claims involving negligence where legal advice is obtained and relevant guidance has been applied (d) Other clinical negligence cases and personal injury claims (e) Other employment payments (f) Patient referrals outside the UK and EEA guidelines (g) Other (h) Maladministration, such as bias, neglect, or delay	Trust Legal Department up to £10,000 Director of Nursing from £10,000 to £50,000 Audit Committee and Board of Directors over £50,000	Executive Director or nominated deputy in the relevant directorate and One other Executive Director or nominated deputy
8. Severance payments on termination of employment *(beyond contractual obligations and not including Treasury-approved MAS)* **9. Extra statutory and extra regulatory payments**	See 14.28 above.	
***Checklists are available from Finance**		

TO:

Categories of losses and special payments	Approval delegated to	Nominated Deputy
SPECIAL PAYMENTS		
5. Compensation payments made under legal obligation *(such as court order or arbitration award for personal injury, property damage or unfair dismissal)*	Director of Finance up to £25,000 Chief Executive up to £50,000 Audit Committee and Board of Directors over £50,000	Deputy Director of Finance or Associate Director of Finance Executive Director
6. Extra-contractual payments to contractors *(such as payments for non-contractual obligations which might arguably have been upheld in court)*	Director of Finance up to £25,000 Chief Executive up to £50,000 Audit Committee and Board of Directors over £50,000	Deputy Director of Finance or Associate Director of Finance Executive Director
7. Ex-gratia payments (a) Loss of personal effects (b) Clinical negligence (negotiated settlements following legal advice) where the guidance relating to such payments has been applied	Trust Legal Department up to £10,000 Director of Nursing from £10,000 to £50,000	Not applicable

(c) Personal injury claims involving negligence where legal advice is obtained and relevant guidance has been applied (d) Other clinical negligence cases and personal injury claims (e) Other employment payments (f) Patient referrals outside the UK and EEA guidelines (g) Other (h) Maladministration, such as bias, neglect, or delay	Audit Committee and Board of Directors over £50,000
8. Severance payments on termination of employment *(beyond contractual obligations and not including Treasury-approved MAS)* **9. Extra statutory and extra regulatory payments**	See section 14.2.8

REPORT

AGENDA ITEM: 10.3

Wrightington, Wigan and Leigh NHS Foundation Trust

To:	**Board of Directors**	**Date: 31st July 2019**	
Subject:	**Public Version of the 2019/24 Trust Strategy**		
Presented by:	Richard Mundon	**Purpose:**	For information

Executive summary

This paper has been drafted to give members of the Board the final public version of the Trust strategy 2019/24

The Board is asked to approve the final content

Risks associated with this report

Link(s) to The WWL Way 4wards

☒	**Patients**	☒	**Performance**
☒	**People**	☒	**Partnerships**

1.0 Introduction

This paper has been written to give members of the Trust Board the final public version of the Trust Strategy 2019-24.

Members of the Board are asked to approve the final content.

2.0 Background

The public version of the Trust Strategy 2019-24 has been developed over a number of months through a detailed consultation process with key stakeholders including the Trust Board, Council of Governors and the general public. A full management version of the document is also being prepared that will be finalised in readiness for the Trust Board meeting in September.

Subject to the approval of the Board to the public version, this document will be launched in September 2019.

3.0 Recommendation

Members of the Trust Board are asked to approve the content of the public version of the Strategy.

Appendix A – Public version of the Trust strategy 2019-24

KEY FACTS 2019:

88,769
A&E urgent care cases

We treated
45,935
inpatients
39,705
daycases

Our community response team recieve
11,000
per year, helping to avoid
8,000
unnecessary A&E visits

We spend over
£1m
per day on your healthcare

485,849
Outpatients attendances

We employ
6,109
people

2,640
babies delivered

305
vounteers working across the Trust

WORKING IN PARTNERSHIP AT **WRIGHTINGTON, WIGAN** AND **LEIGH**

WWL is fully involved in the Greater Manchester Health and Social Care Partnership. We are working together to improve the health, wealth and wellbeing of the 2.8 million people living across Greater Manchester.
We are committed to transforming our services in line with Greater Manchester health and care devolution and securing WWL's position as a leader in orthopaedics.

We are also partners in the Healthier Wigan Partnership. The NHS, Council and other partners in Wigan borough are working together in the Healthier Wigan Partnership to make health and social care services better for you and your family.
Wigan Borough Community Services transferred to WWL in 2019, Hospital services will further adapt to compliment primary and community services to support the Wigan locality agenda supporting people to start, live and age well.

t. 01942 244 000
e. patient.relations@wwl.nhs.uk
www.wwl.nhs.uk
@wwlnhs

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

OUR STRATEGY

2019 / 2024

To be outstanding in everything we do

OUR STRATEGY IN 5 STEPS:

1 AIM

To be outstanding in everything we do.

2 FOCAL POINTS

Patients and our Community are at the heart of everything we do.

3 STRATEGIC PRIORITIES

IMPROVE:
- We will provide the best possible care for our patients and community

INTEGRATE:
- We will work with our partners in Wigan and Greater Manchester to deliver fully integrated services

INSPIRE:
- We will be one of the very best health care organisations in the NHS

4 Ps

Our corporate objectives will focus on; Patients, People, Performance and Partnerships

5 BEHAVIOURS

To take us 4WARD
4ward Thinking
Working Together
Accountable
Respectful
Demonstrate Compassion

4WARD THINKING | WORKING TOGETHER | ACCOUNTABLE | RESPECTFUL | DEMONSTRATE COMPASSION

REPORT

AGENDA ITEM: 10.4

Wrightington, Wigan and Leigh NHS Foundation Trust

To:	Board of Directors	**Date:**	31 July 2019
Subject:	Modern Slavery Statement		
Presented by:	Company Secretary (Paul.Howard@wwl.nhs.uk)	**Purpose:**	Approval

Executive summary

The foundation trust is required to approve a statement under the Modern Slavery Act 2015 each year. The attached statement is provided for the board's consideration and approval.

Risks associated with this report

It is a statutory requirement to have an approved statement. Approval of the attached mitigates any risk of non-compliance.

Link(s) to The WWL Way 4wards

☐	Patients	☐	Performance
☒	People	☐	Partnerships

The WWL Way

Slavery and human trafficking statement

Wrightington, Wigan and Leigh NHS FT ("WWL") is an NHS foundation trust, providing acute hospital and community care to the population of Wigan Borough and beyond. We treat over 87,000 inpatients and over 480,000 outpatients each year, and we deal with around 94,000 attendances each year. We also provide approximately 44,000 walk-in centre appointments and deal with over 177,000 referrals from GPs. We employ over 6,000 members of staff and have an annual turnover of around £370m. Further detail about what we do can be found on our website.

Policies and initiatives

We fully support the Government's objectives to eradicate modern slavery and human trafficking and recognise the significant role that the NHS has to play in combatting it, and in supporting victims.

We are committed to ensuring that there is no modern slavery or human trafficking in any part of our business and, insofar as possible, we require our suppliers to adopt a similar approach. We are also committed to using our role as a healthcare provider and a key organisation in the borough to ensure that our staff and patients are able to access all available support and as such we are committed to the sharing of information and raising awareness.

At WWL, we:

- Comply with legislation and regulatory requirements
- Make suppliers and service providers aware that we promote the requirements of the legislation
- Consider modern slavery factors when making procurement decisions
- Develop awareness of modern slavery issues

For our workforce, we:

- Confirm the identities of all new employees and their right to work in the United Kingdom, and pay all our employees in line with national terms and conditions, such as Agenda for Change
- Have dedicated policies in relation to grievances and raising concerns and we have a good working relationship with our staff side partners which gives our employees an outlet to raise any concerns about poor working practices.

For procurement and our wider supply chain, we:

- Aim to include modern slavery conditions or criteria in specification and tender documents wherever possible
- Will evaluate specifications and tenders with appropriate weight given to modern slavery points

- Encourage suppliers and contractors to take their own action and understand their obligations under the new requirements
- Ensure that our staff will work with the procurement team when looking to work with new supplier to ensure that appropriate checks are undertaken.

The procurement team will:

- Undertake awareness training where possible
- Aim to check and draft specifications to include a commitment from suppliers to support the requirements of the Act
- Will not award contracts where suppliers do not demonstrate their commitment to ensuring that slavery and human trafficking are not taking place in their own business or supply chains.

During the financial year 2019/20, we will:

- Review our terms and conditions of business, including any specific clauses, to ensure that they reflect our obligations under the Modern Slavery Act 2015
- Upskill the procurement team on the implications of the Act in order that they can support the wider organisation on its implementation
- For those contracts deemed to be of high risk, including the specific Right to Audit against the obligations of the Modern Slavery Act 2015

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ending 31 March 2020.

The Board approved this statement at its meeting on 31 July 2019.

Signed: _____

Andrew Foster CBE
Chief Executive

REPORT

AGENDA ITEM: 10.6

Wrightington, Wigan and Leigh NHS Foundation Trust

To:	Board of Directors	**Date:**	31 July 2019
Subject:	Freedom to Speak Up Guardian's Annual Report 2018/19		
Presented by:	Director of Workforce	**Purpose:**	Assurance

Executive summary

The attached report provides an overview of FTSU activity during the year 2018/19. The report has previously been considered by the Workforce Committee.

Risks associated with this report

Risk on the Workforce Directorate risk register:

HR82: Staff not reporting incidents / near misses (including negative impact on the Trust's CQC rating if concerns are raised to an external regulator rather than internally to the Trust)

Link(s) to The WWL Way 4wards

☒	Patients	☐	Performance
☒	People	☒	Partnerships

The WWL Way

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

Freedom to Speak Up Annual Report 2018/19

The WWL Way

1. Introduction

The report provides an update from the Trust's Freedom to Speak Up Guardian (FTSUG), Claire Alexander, on national or local developments on matters considered as Speaking Up during 2018/19.

This includes a progress update on the internal action plan, which aims to promote and strengthen FTSU provision, and the most recent National Guardian's Office (NGO) case review.

Finally, the report provides a brief summary of the cases referred to the FTSUG, Fraud Specialist Manager, or HR in relation to matters that are under the auspices of Speaking Up within 2018/2019 and to provide assurance these are being managed appropriately and in accordance with the Trust's Freedom to Speak Up Policy.

2. 2018/19 Freedom to Speak Up Guardian update

In 2018/19, the FTSUG received an average of 12 contacts from staff every quarter which is a significant increase on 2017/18 which was at 4-5 contacts from staff every quarter. This can be seen as a positive effect of the promotional activity and focus over the past year. The majority of contacts have been related to attitudes and behaviours, and the impact this has on staff particularly regarding their health and wellbeing. The involvement of the FTSUG in each contact varies. An important element of the role is providing staff with support and signposting for appropriate advice.

The NGO has undertaken three case reviews since November 2017. Since the last report to the board, a review of speaking up arrangements at Derbyshire Community Health Services NHS FT has been published. The recommendations within all of the reports have been reviewed against WWL provision and any further actions required have been incorporated into the FTSU action plan. The board is reminded that Trusts or individuals can refer cases to the NGO for review if it is considered that the concerns raised were not managed appropriately.

The FTSUG continues to work closely with Union and Workforce colleagues to promote and encourage speaking up. The aim is to promote a culture where staff are comfortable raising concerns with their line manager in the first instance, as part of business as usual and part of everyday life within their informal team discussions. If staff feel unable to do this then there are other options such as via HR, the Union and the FTSU Guardian.

A focus for the coming year will be to develop a FTSU network to support ongoing promotion and signposting. This has already started with the creation of a FTSU Advocate role to support the FTSUG. The FTSU Advocate will undertake the administrative duties associated with speaking up as well as supporting the FTSUG with contacts as appropriate. This has been an agreed way forward as an add-on duty to the existing Workforce Governance Lead role. A further development will be to appoint FTSU Ambassadors across the Trust from a variety of staff groups, individuals who feel passionate around the support and resolution for concerns within their groups and whose role it will be to promote FTSU and signpost staff appropriately. These will be welcome developments given the increase in activity seen by

the FTSUG. As the FTSUG duties in the Trust are an addition to an existing job role, it will be important to monitor activity closely and identify early any issues that arise from this in terms of capacity.

Additional considerations for the coming year will be how to implement a mechanism to receive feedback from those that contact the FTSU Guardian and to share learning from raised concerns across the Trust. These are best practice recommendations from the NGO and will provide essential intelligence in terms of how the process worked for the individual and close the loop in terms of lessons learned.

A review of FTSU arrangements across the Trust forms part of the Mersey Internal Audit Agency plan for 2019/20. This review will be welcome in terms of providing an impartial assessment of the provision in place and highlighting improvements that can be made.

The FTSU Guardian also continues to attend the twice yearly National FTSU conferences and North West Network events.

3. Freedom to Speak Up action plan / NGO case reviews

As described earlier in the report, there have been three case reviews undertaken by the NGO since November 2017. The latest case review was in relation to Derbyshire Community Health Services NHS FT. The report made 13 recommendations against which the Trust has undertaken a gap analysis. As previously, the majority of the recommendations are either already encompassed within FTSU arrangements or have been picked up as part of the action plan. However, it was noted that some additional learning could be taken:

- The removal of references to raising concerns with malicious intent from the Freedom to Speak Up Policy. The NGO believe that this could act as a deterrent against staff raising concerns for fear of it being perceived as malicious;
- Provision of a confidential route for staff to contact the Non-Executive Director responsible for speaking up; and
- Ensuring that staff members are thanked in a meaningful way for speaking up.

These will be picked up as part of the action plan.

The key takeaway from our comparison review of the previous NGO reports and recommendations is that FTSU arrangements within WWL are generally good. However, there are always opportunities to improve and strengthen the arrangements in place. Anecdotal evidence has been received in the past that not all staff are familiar with the many avenues open to them to raise concerns or with the availability of the FTSUG. With this in mind, a number of actions have been undertaken over the last year to raise the profile of raising concerns in general:

- FTSU stand at the Wrightington site;
- FTSU walkabout at the Leigh site;

- Promotion across the Trust of Speak Up month;
- Articles in News Brief and banner on the intranet;
- FTSU information included in the electronic induction and Go Engage Teams information packs;
- Re-branding of the Raising Concerns Policy to become the Freedom to Speak Up Policy (currently going through the approvals process);
- Stakeholder group established to agree and implement anti-bullying and harassment training – this will have a positive impact on FTSU matters by increasing manager and staff awareness;
- Re-scheduling of the leadership masterclass with Dr Nick Harper (to take place on 27 June 2019).

There has been a huge amount of enthusiasm and support for the action plan within the Workforce Directorate with Counter Fraud, Staff Side colleagues and the FTSUG working together in partnership on delivery. Progress has been challenging, however, due to capacity across the teams and a number of timescales have been revised as a consequence.

FTSU is a standing item on the monthly Workforce Directorate Quality Executive Committee (DQEC).

4. 2018/19 Annual Update

a) Reported concerns

The recorded contacts during 2018/19 total 68 which is a significant increase on 2017/18 which amounted to 39 (as previously mentioned, this could be seen as a positive outcome to promotional activity across the Trust). These contacts are those that have been raised to the FTSUG, HR team or Fraud Specialist Manager. Within the stages of the Freedom to Speak Up Policy there is the opportunity for individuals to raise matters informally initially. This informal process has been promoted with the Trust's open culture however in terms of capturing data we are unable to report the number of concerns that are raised and resolved informally, at source, via line management or another route such as Staff Side.

It is important to note that concerns relating to bullying or harassing behaviour within employment may be raised via the Trust's Grievance process and/or via the Freedom to Speak Up process therefore may be recorded via separate methods and reported as such, however all data is held within the HR department. The Trust actively promotes the raising of all employee concerns and therefore is happy to record matters according to the process under which they are reported.

b) Formal concerns

68 matters have been recorded formally under the auspices of raising concerns during 2018/19. Of these cases 18 were referred by the Fraud Specialist Manager.

Out of the 18 that have been reported via the Fraud Specialist Manager:

- 13 individuals allegedly made false representations;
- 2 individuals allegedly did not adhere to core hours;
- 1 individual allegedly failed to disclose;
- There was an allegation of abuse of position;
- There was an allegation of retaining unlawful credit.

Of these, all matters were raised anonymously.

From these allegations:

- 13 cases were determined as not meeting the criminal standard to warrant further action from a fraud perspective – of these 5 proceeded to formal disciplinary action by the HR team;
- 5 cases remain ongoing with the Fraud Specialist Manager.

The Fraud Specialist Manager has recovered **£12,397.22** in redress monies for 2018/19. The Fraud Specialist Manager provides an annual report on matters to the Audit Committee; a bi-monthly update report to Audit Committee and monthly updates to the Director of Finance. Included within the updates and reports are outcomes from investigations; ongoing investigations; breaches of the Trust's Standing Financial Instructions; and financial redress from matters.

There are 50 remaining concerns, all of which were initially received by, or referred in the first instance to, the Trust's FTSUG.

Of these 50 concerns:

- 4 concerns related to matters that could be categorised as Service Changes;
- 12 concerns related to matters that could be categorised as Quality and Safety;
- 32 concerns related to matters that could be categorised as Attitudes and Behaviours;
- 2 concerns could not be categorised as detail was not provided by the reporter

Of these 50 concerns:

- 36 of the concerns have been closed – concerns are closed following appropriate action and follow up by the FTSUG or where the reporter declines to engage further;
- 14 of the concerns remain ongoing.

Of these 50 concerns:

- 20 matters were raised anonymously;

- 30 matters were raised by individuals who provided permission for them to be identified.

As can be seen from the above information, the majority of concerns raised can be categorised as pertaining to Attitudes and Behaviours. The Workforce Directorate has a programme of work planned which may positively impact these matters. This includes:

- The promotion and embedding of the Behaviours Framework across the organisation;
- The implementation of Anti-Bullying and Harassment training;
- The strengthening of the mediation service by training additional mediators;
- Additional compassionate and just culture training is being explored and may be defined as future leadership development from Board level down. This will link in with all critical stakeholders including staff side and the clinical governance team.

From all concerns, inclusive of those where no evidence is identified, scrutiny is given to the tightening or modifying of policies or procedures so that greater assurance is possible in order to reduce further concerns where relevant.

Where possible to give feedback to those individuals who have given contact details or a means of response, this has been undertaken in each case. Supportive mechanisms are also offered to staff where appropriate.

c) Matters raised in accordance with PIDA

Whilst the Trust's Freedom to Speak Up policy embraces but is not limited to those concerns or disclosures raised in accordance with the PIDA it should be noted which matters would qualify under this Act for the purposes of reporting. Qualifying disclosures are disclosures of information where the worker reasonably believes (and it is in the public interest) that one or more of the following matters is either happening, has taken place, or is likely to happen in the future.

- A criminal offence;
- The breach of a legal obligation;
- A miscarriage of justice;
- A danger to the health and safety of any individual;
- Damage to the environment;
- Deliberate attempt to conceal any of the above.

In this regard the Trust would report that within 2018/19 18 concerns have been reported which could qualify under the Act.

Out of all concerns reported in 2018/19 there have been no conclusions that any reports or concerns raised have been made maliciously.

5. Staff Survey Report 2018

Whilst not directly identifiable against matters reported under the auspices of Speaking Up, it is important to reflect on the outcome scores below taken from the National Staff Survey 2018:

- 92% of staff members agreed that they had reported an error, near miss or incident when they saw it. This compares less favourably against a score of 96% in 2017 and the sector average of 95%;
- 52% of staff members agreed that the organisation treats staff who are involved in an error, near miss or incident fairly. This compares less favourably against a score of 58% in 2017 and the sector average of 57%;
- 65% of staff members agreed that when errors, near misses or incidents are reported, the organisation takes action to ensure that they do not happen again. This compares less favourably against a score of 74% in 2017 and the sector average of 68%;
- 51% of staff agreed that feedback about changes made in response to reported errors, near misses or incidents was given. This compares less favourably against a score of 56% in 2017 and the sector average of 56%;
- 65% of staff members agreed that they would feel secure raising concerns about unsafe clinical practice. This compares less favourably against a score of 70% in 2017 and the sector average of 68%;
- 53% of staff agreed that they would feel confident that the organisation would address their concerns. This compares less favourably against a score of 64% in 2017 but is in line with the sector average of 54%.

The deterioration in these results is a concern and, when considered with the fact that only 12 of the matters raised with the FTSUG pertain to Quality and Safety, raises questions as to the strength of the safety and speaking up culture across the Trust. In recognition of this, the FTSU action plan and those programmes of work previously identified as planned over the next year will hope to respond to this. The Workforce DQEC is considering whether a risk assessment is appropriate for potential inclusion on the corporate risk register.

6. Conclusion

The Trust continues to maintain focus on raising concerns and key stakeholders work together to identify opportunities for improvement to the process and how to promote within the organisation.

7. Recommendations

The board is asked to consider if it continues to support the current approach being taken to maintain a culture of raising concerns and to recommend any further actions to enhance or improve the current status.

REPORT

AGENDA ITEM: 10.7

Wrightington, Wigan and Leigh NHS Foundation Trust

To:	Board of Directors	**Date:**	31 July 2019
Subject:	Guardian of Safe Working – Annual Report		
Presented by:	Director of Workforce (Alison.Balson@wwl.nhs.uk)	**Purpose:**	Information

Executive summary

The role of the Guardian of Safe Working (GOSW) is a position held by a Trust consultant, appointed internally through a formal process. The GOSW oversees and quality assures the process with regards to working hours of doctors in training. The role is a mandatory requirement under the Doctors in Training 2016 Terms and Conditions of Services in order to oversee safety-related exception reports and monitor compliance with the system, intervening and escalating where issues are not being resolved satisfactorily.

The annual summary of exception reporting is reported in the Quality Account as required by the Terms and Conditions of Service and provided to the Workforce Committee for information. We have seen the majority of exceptions raised in the Division of Medicine and specifically in General Medicine. They have largely been raised by FY1 and FY2 doctors with exceptions declining as the grade increases. This is consistent across trusts and the region.

The Trust utilises the NHSP platform for bank and agency medical staff to fill gaps left by vacancies. The data shows that the highest rate of unfilled shifts and exceptions are within the same grades and specialty indicating a pressure on staffing in this area. The Trust has recently completed a Safer Staffing project in this area looking at staffing levels and an action plan to address the issues identified.

Routinely throughout the year the trust has reviewed rotas and working patterns to improve them for service and the experience of doctors in training at the trust.

Risks associated with this report

There are several risks that should be hi-lighted as part of this report:

1. Risk of vacancies and unfilled shifts reducing the workforce available to care for patients.
2. Future loss of Training posts for doctors if issues are not addressed
3. Financial risk of fines and additional hours worked
4. Health and Safety risks around working hours for Doctors in Training

The WWL Way

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

This report is intended to illustrate the number of exception reports raised against the vacancy rate by the grade of doctor. Exceptions are raised by Doctors in Training where they are expected to work outside their scheduled rota. This may be for working extra hours, missing breaks or missing an educational opportunity they were scheduled to attend due to clinical pressures. This is a requirement under the Doctors in Training 2016 Terms and Conditions of Service, exceptions are the responsibility of the Educational Supervisor for individual doctors to review and resolve granting either payment or TOIL where extra hours are worked.

Fill rates for ad hoc shifts are provided to illustrate how successfully vacant shifts are filled from flexible staffing solutions. This section also illustrates the actions taken to mitigate the risk of having unfilled shifts and any adverse impact on the training experience of Doctors in Training whilst on rotation to WWL

High level data

Number of doctors and dentists in training (total):
194
Number of doctors and dentists in training on 2016 Terms and Conditions of Service (total):
179
Annual vacancy rate among this staff group:
5.6%

Annual data summary of exception reports raised

Specialty	Grade	Number of Exceptions Raised				Total gaps (average WTE)	Number of shifts uncovered (over the year)	Average no. of shifts uncovered (per week)
		Quarter 1	Quarter 2	Quarter 3	Quarter 4			
General Surgery	F1	17	9	4	7	0	28	1
General Surgery	F2/ST 1-2	5	2	0	0	3	50	1
General Medicine	F1	27	41	23	20	0	97	2
General Medicine	F2/ST 1-2	10	2	2	2	4	525	10
Orthopedics	F1	0	5	18	3	0	0	0
Orthopedics	F2/ST 1-2	0	1	0	0	1	77	1
Ear Nose and Throat	ST3+	0	3	0	0	0	0	0
Paediatrics	F2/ST 1-3	0	0	1	3	0	51	1

Obstetrics and Gynecology	F1	0	0	0	1	0	0	0
Obstetrics and Gynecology	F2/st1-2	0	0	0	1	0	0	0
Total		**59**	**63**	**48**	**35**	**8**	**828**	**16**

Issues arising

The Trust has seen a consistent level of vacancies across doctors in training specialties reported quarterly to the Board by the Guardian of Safe working. General Medicine remains the area being impacted on the most significantly as evidenced by the exception reporting results; however visa restrictions also resulted in a significant impact on the Orthopaedic rota between August 2018 and November 2019. This was an isolated issue and is now resolved.

The exceptions are largely as a result of additional hours being worked although no fines (as per the Terms and Conditions of Service for NHS Doctors and Dentists in Training 2016) have been applicable to date. Almost exclusively exceptions are being raised by Foundation Doctors rather than the higher grades (See Appendix 1)

Unfilled shifts are provided from the NHSP Platform used for facilitating bank and agency bookings of medical staff, it is possible that there is duplication of the system which is wholly separate from the rota system and so this may suggest some inaccuracies in the data of unfilled shifts.

Actions taken to resolve issues

The actions taken to resolve these issues were as follows:

- Quarterly Exception Reporting Forums: To discuss current levels of exceptions, trends and actions being taken
- Training for Educational Supervisors: The Trust has a training video for Educational Supervisors outlining their responsibilities with an overview of the system, administrator to support access to the system and ad hoc events held to provide the opportunity for Educational Supervisors to come along and share their experience and raise queries.
- Review of Rotas: Five rotas have been reviewed and redefined through a consultation and sign off process involving doctors in training, DME and Guardian of Safe Working. Three rotas are currently under review. The review of rotas has incorporated the considerations of best practice in line with the Rest Charter.
- NHS Professional (NHSP) Connect: The implementation and promotion of NHSP Connect as a booking platform for medical shifts and the development of the Medical Bank is facilitating the monitoring of fill rates and use of agency and bank. There is specific support in place to facilitate rota coordinators using this system effectively to prevent duplication and ensure accurate recording.
- Survey: A survey is currently ongoing to identify why doctors may be choosing to exception report or not. Communications have been issued to encourage exception reporting amongst Doctors in Training and the proactive involvement form Educational Supervisors in resolving issues.
- Safer Staffing Exercise: The Trust has commenced an audit of how the Trust meets the Safer Staffing stipulations in the Guidance produced by the Royal College of Physicians. This remains in progress.
- Expansion of Earn Learn Return Programme – The Trust has expanded the number of trust grade doctors contracted from an Earn Learn Return scheme to support the medical workforce provision in the Trust.

Summary

The Trust continues to monitor and report on vacancies via the Exception Reporting Forum and Quarterly Board Report. This analysis shows trends and peaks of exceptions raised which illustrate the impact of vacancies or workload in particular specialties. Where issues are identified they are targeted with actions or longer term strategies considered to address these issues.

Appendix 1:

Breakdown of Exceptions by Type:

Specialty	FY1	FY2/ST1-2	ST3+	Total
General Medicine	**118**	**8**		**126**
Education	32	4		36
Hours & Rest	82	4		86
Hours & Rest;Education	4			4
General Surgery	**37**	**7**		**44**
Education	11	2		13
Hours & Rest	25	5		30
Hours & Rest;Education	1			1
Obstetrics and gynaecology	**1**	**1**		**2**
Education	1	1		2
Otolaryngology (ENT)			**4**	**4**
Hours & Rest			4	4
Paediatrics		**4**		**4**
Education		4		4
Traumatic and Orthopaedic Surgery	**26**	**1**		**27**
Education	1			1
Hours & Rest	24	1		25
Hours & Rest;Education	1			1

REPORT

AGENDA ITEM: 10.7

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

To:	Board of Directors	**Date:**	31 July 2019
Subject:	Appraisal and Revalidation Report		
Presented by:	Medical Director	**Purpose:**	Information

Executive summary

This report was submitted to the Workforce Committee on 6 June 2019 for approval of the Trust's performance with regards to appraisal and revalidation of medical staff for the period April 2018 – March 2019.

Risks associated with this report

Link(s) to The WWL Way 4wards

☒	Patients	☒	Performance
☐	People	☐	Partnerships

The WWL Way

Appraisal & Revalidation Annual Report 2018/2019

Contents

1. Executive summary

Number of doctors with prescribed connection = **371**

Consultants = 177

Completed Appraisals = 175

Approved incomplete or missed appraisals = 2

Unapproved incomplete or missed appraisal = 0

Staff Grade/Associate Specialists/Speciality Doctor = 40

Completed Appraisals = 39

Approved incomplete or missed appraisals = 1

Unapproved incomplete or missed appraisal = 0

Temporary, short term contract holders = 154

Completed Appraisals = 126

Approved incomplete or missed appraisals = 28

Unapproved incomplete or missed appraisal = 0

2. Purpose of the Paper

The purpose of this report is to give and overview of appraisal and revalidation processes for the period 1 April 2017 - 31 March 2018.

3. Background

This is the 7th year of revalidation and appraisal. An Annual Organisational Audit Report was submitted to NHS England for the year 2018/2019.

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] and it is expected that the executive team/board will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can

[1]The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practice and Revalidation) Regulations Order of Council 2012'

inform the appraisal and revalidation process for their doctors; and

- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

4. Governance Arrangements

Staff supporting Appraisal and Revalidation

Responsible Officer	Dr Nayyar Naqvi (effective 1 June 2017)
Medical Director	Dr Sanjay Arya (effective 1 June 2017)
Appraisal Lead*	Professor Raj Murali
Medical Appraisal & Revalidation Manager	Mrs Kathryn Heffernan

*Prof Murali stepped down has Appraisal Lead as of 1 April 2019; he will continue to be Appraisal Lead for the MCh group of doctors. New Appraisal Lead for WWL doctors to be appointed.

Appraisal/Revalidation Process

All clinicians with a prescribed connection to WWL NHS FT are connected to WWL via GMC Connect. Doctors are added and removed from the GMC connect database either by the new designated body or by the Appraisal & Revalidation Manager. The list is updated at least on a monthly basis.

All clinicians with employment for longer than 3 months or longer are offered appraisal.

All permanent members of staff are given an appraisal ‘month (September- December) in which to undertake appraisal.

Each doctor is given the name of a trained appraiser (usually but not always specialty specific)

Prior to appraisal the RO sends details of specific untoward incidents and complaints to be discussed and documented at appraisal to the doctor and appraiser. An audit is then carried out to check that these have been included in their appraisal.

Each doctor is asked to submit an appraisal date to the appraisal manager.

All staff given reminders using an escalation policy outlined below:

- *1st - Email reminder sent on the first of the month (or nearest date) proceeding allocated month to all appraisees who have not completed their appraisal*
- *2nd - Email sent 4 weeks from 1st reminder date again to those appraisees who have still not completed appraisal*
- *3rd - Email reminder from RO sent 4 weeks from 2nd reminder date*
- *4th – Email reminder from RO sent 4 weeks from 3rd reminder to GMC ELA*

Appraisal is undertaken using a document management system available on the internet via the provider ‘Clarity’.

Each doctor is asked to undertake a peer and patient feedback at least 6-12 months in advance of their revalidation date and in advance of their appraisal. (Peer and patient feedback once per 5 year cycle is a GMC requirement for revalidation)

The number of appraisals undertaken each month is monitored by the Appraisal Manager and escalation policy as above. Appraisals are classed as complete when the documentation is received within:

1a was this in the 3 months preceding the appraisal due date; AND
1b was the appraisal summary signed off within 28 days of the appraisal date; AND
1c did the entire process occur between 1 April and 31 March?

2) Summary and output documentation is checked by RO.

4a Policy and Guidance

The appraisal and Revalidation Policy (TW12-010) is due for review in October 2019 via the LNC committee.

5. Medical Appraisal

a. Appraisal and Revalidation Performance Data

Completed Appraisals

	2018/2019	2017/2018	2016/2017	2015/2016	2014/2015	2013/2014	2012/2013
Number of Doctors	371	371	321	298	288	222	230
Consultants	175/177 (99%)	175/176 (99.4%)	161/171 (94.2%)	166/174 (95.4%)	159/170 (93.5%)	139/153 (91%)	47/158 (29.7%)
Staff Grade/Associate Specialists/Speciality Doctor	39/40 (97.5%)	33/37 (89.2%)	33/37 (89.2%)	36/38 (95%)	45/49 (91.8%)	38/39 (97.4%)	17/40 (42.5%)
Temporary,short term contract*	126/154 (81.2%)	89/158 (56.3%)	69/113 (61.1%)	64/86 (74.4%)	53/69 (76.8%)	26/30 (86.7%)	2/32 (6.3%)

* Our temporary, short term contract numbers were significantly better than last year; due to us not having as many MCh doctors employed by WWL this past year. This will change moving forward once Lead Employer status is confirmed.

b. Appraisers

80 trained appraisers are available. (Medicine -27, Surgery- 27, Specialist services- 26).
New appraisers attended approved New Appraiser training
All appraisers were asked to attend bi-annual Appraiser update meetings

c. Quality Assurance

The number of appraisals undertaken each month is monitored by Appraisal Manager and escalation policy as above.

The RO reviews all appraisal summaries.

The quality of selected summary output documentation including sign offs and PDPs is scored for each appraiser (2 per appraiser) using a 'Progress QA tool' by the RO and Appraisal Lead.

For the individual appraiser

- An annual record of the appraiser's reflection on appropriate continuing professional development. Reflection at 1:1 meeting with the RO if required.
- A certificate of attendance is sent to the appraisers confirming participation in Appraiser Update meetings (must attend one annually)
- Appraiser feedback from Clarity system (inputted by individual doctors)

For the organisation

- Audit of timelines of process of appraisal by department
- System user feedback available on Clarity
- Review of lessons learned from any complaints at Executive Scrutiny Committee.
- Review of lessons learned from any significant events at Executive Scrutiny Committee.

d. Access, security and confidentiality

All appraisals are undertaken using a secure internet based document management system, Appraisal Toolkit, provided by 'Clarity'.

Appraisal documentation printed and filed securely in locked Appraisal and revalidation office.

Access limited to Appraisal Manager/Appraisal lead/RO/ Medical Director.

No patient identifiable information has been identified within appraisal documentation.
No breaches of security have been identified.

e. **Clinical Governance**

Consultants receive data obtained by the appraisal manager prior to the appraisal meeting. This provides:

i. Activity data (Dr Foster)
ii. Data with regard to complaints (only those with the doctor's directly named); audit attendance, legal cases
iii. Study leave number of days

SUIs, significant complaints and litigation are recorded by the RO and sent to the doctor and appraiser one month prior to the appraisal meeting advising that the topic should be discussed at appraisal and a reflective review included in the appraisal documentation.

f. **Revalidation Recommendations:**

Number of recommendations between 1 April 2018 – 31 March 2019 = 65
Recommendations completed on time = 65
Not on time = 0
Positive recommendations = 62
Deferrals requests = 3
Non engagement notifications = 0

g. Monitoring Performance

All significant incidents, complaints, inquests and litigation are reviewed once weekly at the Executive Scrutiny Committee.

This committee comprises of:

Medical Director, Director of Nursing, Deputy Director of Nursing, Patient Safety Officer, Governance Lead, PALS lead, Trust Solicitor, RO

All significant events involving doctors are reviewed by RO and MD to ascertain whether there is evidence of poor or un-towards practice.

All significant episodes documented by RO and doctor advised the necessity to discuss at appraisal and include reflective documentation

h. Responding to Concerns and Remediation

The Responding to Concerns & Remediation Policy (TW13-040) is due for review at the next LNC meeting in October 2019 via the LNC committee.

i. Risk and Issues

Risks

Locum Doctors – all locums are offered the opportunity to engage in appraisal. In some instances by the time we are made aware of them working at WWL there is little time to arrange appropriate appraisal.

Issues

a) Locum Doctors – before we are aware of them they may have left WWL
b) Non training junior doctors – have poor understanding of appraisal and the need to collect appropriate documentation to support the process.

j. Corrective Actions, Improvement Plan and Next Steps

a) Help co-ordinate appraisal training session for SAS doctors with SAS Lead
b) Recruitment of additional appraisers across all specialities
c) Appoint new Appraisal Lead

Action Plan

Appraisal & Revalidation – Action Plan 2018/2019

Item	Actions	Timescale	Results
Continue recruitment of additional appraisers across all specialities	Send email to all consultants /staff grades in all specialities	12 months	Additional 3 appraisers recruited
Bring Wigan & Leigh Hospice Doctors online with our system	Responsible Officer to visit Hospice with Appraisal & Revalidation Manager to expedite	2 months	Wigan & Leigh Hospice doctors now sit under WWL Responsible Officer; but still remain their own designated body. Regular contact maintained with Hospice Medical Director
New Medical Education Structure now in place	Appraisal & Revalidation Manager has identified a member of the Medical Education Team to ensure that the knowledge, skills and expertise are retained within the department (appraisal element only)	Immediate	Staff member trained for appraisal element.

Appraisal & Revalidation – Action Plan 2019/2020

Item	Actions	Timescale	Reporting
Continue recruitment of additional appraisers across all specialities	Send email to all consultants /staff grades in all specialities	12 months	Workforce Committee: Annual Report
Appoint new Appraisal Lead	Send out expressions of interest email and interview candidates and appoint new Appraisal Lead	3 months	Workforce Committee: Annual Report
Help co-ordinate training session for SAS doctors with SAS Lead	Arrange training session to go through the appraisal process and pertinent points	12 months	Workforce Committee: Annual Report