Board of Directors

29 January 2020, 12:00 to 14:00
The Boardroom, Trust HQ, Royal Albert Edward Infirmary, Wigan Lane, Wigan

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 the previous meeting

2 minutes
Approval

Robert Armstrong

Minutes - P1 board - 27 Nov 2019.pdf (12 pages)

5
Patient story

8 minutes
Discussion

Helen Richardson

6
Staff story

10 minutes
Discussion

Alison Balson

7
Chair and Chief Executive's report

5 minutes
Information

Robert Armstrong/Silas Nicholls

Chief Executive's report.pdf (4 pages)

8
Assurance and governance:

60 minutes

8.1
Committee chairs' reports, including the board assurance framework

Information

Committee Chairs

8.2
Performance report

Discussion

Helen Richardson/Mary Fleming/Sanjay Arya

Trust Board Performance Report December 2019.pdf (12 pages)

8.3

Finance report

Discussion

Rob Forster

Finance report.pdf (6 pages)

8.4

Safe staffing report

Discussion

Helen Richardson

Report - safe staffing.pdf (19 pages)

8.5

Biannual staffing review

Discussion

Helen Richardson

Biannual staffing review - Jan 2020.pdf (15 pages)

8.6

Workforce plan prioritisation

Decision

Alison Balson

Workforce Plan report January 2020 - final.pdf (7 pages)

8.7

Update on review of committee arrangements

Information

Paul Howard

Update on committee review.pdf (4 pages)

9

Update on effectiveness of plans relating to pressure ulcers, SHMI and C.difficile

10 minutes

Discussion

Helen Richardson/Sanjay Arya

Pressure Ulcer Assurance Paper TB January 2020 FINAL (4).pdf (5 pages)

C diff update.pdf (4 pages)

SHMI.pdf (1 pages)

10

Mortality report

10 minutes

Information

Sanjay Arya

Mortality Q2 2019-20.pdf (4 pages)

11

CQC post-inspection feedback letter

2 minutes

Discussion

Silas Nicholls

CQC post-inspection feedback letter.pdf (3 pages)

12

Consent agenda:

12.1

Approval of changes to the constitution

Approval

Changes to the constitution.pdf (2 pages)

12.2

Risk appetite statement

Approval

Risk appetite statement 2020-21.pdf (4 pages)

12.3

Inclusion and diversity annual report

Information

I&D annual report 2018-19.pdf (40 pages)

12.4

7-day service self-assessment

Approval

7 day service assurance.pdf (8 pages)

12.5

Statement of responsibilities within the foundation trust

Approval

Statement of responsibilities.pdf (5 pages)

13

Questions from the public

5 minutes
Discussion

Robert Armstrong

14

Resolution to exclude 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 27 NOVEMBER 2019, 12.00 NOON

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

Part 1

Members' attendance record:

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

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

In attendance:

Mr P Howard	Company Secretary (minutes)
Mrs J Barrett	Director of Nursing, Surgery (to minute reference 176/19 only)

8 governors, 1 member of the public and 2 representatives from the Care Quality Commission were also in attendance.

172/19 Chair and quorum

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

The Chair opened by reminding those present that a General Election would be taking place on 12 December 2019 and that pre-election guidance recently issued by the NHS Chief Executive required Board meetings to avoid discussing matters of future strategy in public session until such a time as a new government is formed.

173/19 Apologies for absence

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

174/19 Declarations of interests

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

175/19 Minutes of the previous meeting

The minutes of the previous meeting held on 25 September 2019 were **APPROVED** as a true and accurate record.

176/19 Staff story

Mrs J Barrett addressed the Board and summarised her professional journey over her 20 years as a member of the foundation trust's staff. She recollected the support that was provided to her by her mother who had inspired her to pursue her dream of becoming a nurse and acknowledged the support of many people in the organisation, including from around the board table, as she had progressed through the organisation to her current role as Director of Nursing for the Division of Surgery. She also noted that, regardless of her role, she had always been eager to provide the best possible care to patients and described her mantra as being to treat everyone how she would wish to be treated herself. Mrs Barrett's story highlighted the benefits of identifying and developing talent and the Board noted that a more structured approach had recently been agreed and that further details would be shared with the Workforce Committee at its next meeting.

The Chief Executive noted that he had recently spent an afternoon working with Mrs Barrett and had been struck by the warmth of the relationships on display. He commended her on role modelling compassionate leadership and demonstrating the values and behaviours of the organisation on a daily basis. The Chief Nurse endorsed this view and described her as an excellent senior leader in the organisation.

The Board received and noted the staff story.

Mrs J Barrett left the meeting.

177/19 Patient experience video

The Chief Nurse presented a patient experience video which highlighted the specialist Macmillan physiotherapy service and charted the experiences of a patient with neuropathy as a result of chemotherapy.

In response to a question from the Chief Operating Officer, the Chief Nurse noted the need to raise the profile of alternative therapies and confirmed that this will be one of the tasks of the recently appointed Chief Allied Health Professional once she has taken up post.

The Board received and noted the patient experience video.

178/19 Chair and Chief Executive's report

The Chair opened by welcoming colleagues from the Care Quality Commission who were observing the meeting as part of an inspection of the well-led key line of enquiry. He also welcomed the Chief Executive to his first meeting since taking up post and briefed the Board on the stakeholder engagement activities that had taken place over the past month relating to the development of the new organisational strategy.

The Chair also noted the recent opening of the "Allscripts@WWL" experience which had been funded by Allscripts and which is intended to showcase the organisation as an exemplar site. He also summarised recent discussions with the Chair of the Greater Manchester Health and Social Care Partnership Board, Lord Peter Smith, around the foundation trust's bid for research.

The Chief Executive presented a report which had been circulated with the agenda to highlight a number of matters for the Board's attention. He drew particular attention to the section of the report relating to Healthier Wigan Partnership and noted the foundation trust's support for the system-wide, place-based approach and reminded the Board of the shared focus on ensuring the best use of the Wigan pound. The Chief Executive also highlighted the section of the report relating to pensions and noted recent developments on a national scale. He also paid tribute to those who had been successful at the annual Recognising Excellence Awards as well as those who had recently achieved national success.

Prof T Warne thanked the Chief Executive for his report and commented on the usefulness of the revised format.

The Board received the report and noted the content.

179/19 Risk escalation: McKinley T34 syringe drivers

The Director of Strategy and Planning presented a report which had been circulated in advance of the meeting to escalate a risk to the Board. He noted that the risk assessment had been approved by the Risk and Environmental Management Committee ("REMC") on 21 November 2019 and had immediately been escalated to the Board due to the fact that it had received the highest possible risk score of 25. He also confirmed that the matter had been escalated via the Strategic Executive Information System and that a

task and finish group had been established to ensure appropriate oversight of the mitigating actions that are being taken to reduce the risk to patients.

The Chief Nurse explained the purpose of a syringe driver and noted that, in line with Medical Device Alert MDA/2019/038 issued on 29 October 2019, the foundation trust had stopped using third edition models of the McKinley T34 syringe drivers pending receipt of updated instructions for use and software from the manufacturer. In conjunction with other factors, this had resulted in challenges in ensuring that a sufficient number of syringe drivers are available for use. Confirmation was provided that mitigating actions had been put in place and that five syringe drivers were currently available for use and the Chief Executive noted that the fact the manufacturer is the sole supplier in the UK had further compounded the problem.

In response to a question from the Chief Executive, the Chief Nurse advised that it is not known when it is likely that the national prohibition on use would be lifted and, in response to a supplementary question, the Medical Director confirmed that he had discussed the matter with the Consultant in Palliative Care who was confident that the matter was being addressed appropriately. Dr S Elliot highlighted the difference that delivering medication via syringe driver in preference to administering bolus doses can make in end of life care and expressed some concern that the foundation trust had only been able to secure three refurbished devices. In response, the Chief Nurse advised that all available devices had been purchased and noted that all NHS organisations would be seeking to mitigate the issue in a similar way. She also confirmed that a review of syringe driver numbers would be undertaken once the restriction on ordering has been lifted.

In response to a question from Mr I Haythornthwaite, the Director of Strategy and Planning explained how the risk had been scored and the Chief Nurse noted the clear impact on patients in the event that the equipment is not available. Prof C Austin highlighted the importance of identifying wider learning around the management of medical devices.

The Chair summarised the mitigations that had been put in place and noted the intention to purchase additional devices once the national restriction is lifted. The Board requested that the Quality and Safety Committee monitors the mitigating actions to ensure that they deliver as intended.

ACTION: Quality and Safety Committee

The Board received the report and noted the content.

180/19 Board assurance framework and committee chairs' reports

The board considered the four board assurance framework dashboards and received verbal reports from the following committees which had met since the previous meeting of the board:

(a) Audit Committee, held on 1 October 2019;

(b) Quality and Safety Committee, held on 16 October 2019 and 13 November 2019; and

(c) Finance and Performance Committee, held on 23 October 2019 and also immediately prior to the meeting.

Board assurance framework: patients

Prof T Warne summarised the work of the Quality and Safety Committee and noted that two risks had been escalated to the committee at its last meeting. The first related to the potential to misinterpret cardiotocographs and the committee had been assured that an IT solution had been identified and implemented. As a result, the committee noted that it is likely that the risk score would be reduced on its next review by REMC. The second risk escalated to the committee was regarding the availability of Tier 4 Child and Adolescent Mental Health beds and the committee had acknowledged the national scale of the issue whilst gaining some assurance around the process for assessment and acknowledging a more effective escalation process.

During the meeting, the committee had gained assurance around the number of staff who have undertaken appropriate safeguarding training and had received a briefing on the Quality Champions programme. As a result a review had been commissioned into how the programme can become more mainstream within the organisation without losing any of its entrepreneurial nature. The committee had also received confirmation that all "must do" and "should do" actions from the last Care Quality Commission inspection had been completed and that progress with discharge letter improvements and the deep clean programme are on track.

The committee had not been sufficiently assured around the work of REMC given that there were 91 risks on the corporate risk register and a number which have scored 20 for a significant period of time. As a result the executive team had been tasked to develop the organisation's risk appetite statement and to consider the future role of REMC.

Following receipt of a report on an incorrect prosthesis incident, the committee would be requiring the divisional leadership triumvirate to attend the next meeting to outline its plans to address the issue. The committee had also noted the wider review of the committee structure that was being led by the Company Secretary and recognised that its work at a recent away day would be helpful as part of this process.

With regard to the board assurance framework for patients, the committee recommended a delivery confidence of amber. This recommendation was informed by the fact that whilst some progress had been made in relation to the management of sepsis in the Emergency Department, the pace of improvement had been slower than hoped. Additionally, the unfortunate rise in the Summary Hospital-level Mortality Indicator ("SHMI") was of concern, as was the number of matters reported to the Strategic Executive Information System in October.

Board assurance framework: people

Mrs L Lobley noted that the Workforce Committee had not met since the previous Board meeting and was scheduled to meet on 5 December 2019. Notwithstanding, she provided a summary of the board assurance framework for people and highlighted a

number of positive developments, including the recent recruitment event which had resulted in offers of employment being made to 18 registered nurses and podiatrists, and the international nurse recruitment programme which was progressing well. Mrs L Lobley also highlighted the multidisciplinary approach to the development of the workforce plan and noted that it incorporated new models of working. Additionally, a new direct engagement system for temporary staffing had been introduced with NHS Professionals and note was also made of the launch of both the just culture and civility campaigns. The national pension issue was highlighted as a concern, although the positive impact of the subcontracting model in orthopaedics was acknowledged.

Mrs L Lobley noted that Go Engage had received three national awards earlier in the month and reminded the Board of the seminar later that day by Professor Michael West around compassionate leadership. She invited the Director of Workforce to summarise the proposed leadership and education strategy which is to be presented at the December Workforce Committee and invited the Medical Director to give an update on the recent medical recruitment exercise in India.

The board assurance framework for people had been prepared by the Director of Workforce and contained a recommended delivery confidence of amber-red, although Mrs L Lobley expressed some optimism that this position may improve following a review by the committee at its next meeting and when results demonstrate improvements.

Board assurance framework: performance

Mr M Guymer summarised the Finance and Performance Committee's business and noted that no new risks had been escalated to the committee and that it had considered four business cases which had been developed to address previously-identified risks. Three of the business cases – relating to a refresh of the picture archiving and communication system (PACS), maternity emergency theatre provision and nurse recruitment and retention – had been approved by the committee and the fourth had been recommended to the Board for approval as it exceeded the committee's delegated authority limit.

The committee had also acknowledged the positive use of private providers in areas where particular challenges are experienced and had committed to ensuring that an update on this issue is given to the Council of Governors early in the New Year.

ACTION: Chief Operating Officer

The committee had been encouraged by the positive work around pressure ulcers and SHMI but had noted that management of demand remained challenging. With regard to the business cases it had considered, the committee had acknowledged the essential nature of the items but had also recognised that they also added to the financial challenges of the organisation going forward.

The committee had considered the board assurance framework for performance and recommended a red delivery confidence in line with previous months. This recommendation was based on a number of factors including A&E challenges, workforce

issues and the overall financial position. The Chief Executive supported this approach but noted the need to consider A&E performance in the wider context as well as the baseline metrics. He noted that all NHS organisations are experiencing challenges with A&E performance and the Chief Operating Officer advised that bi-weekly conference calls across Greater Manchester are held, at which the feedback on the organisation's performance had been positive.

Board assurance framework: partnerships

The Board considered the board assurance framework for partnerships which had been prepared by the Director of Strategy and Planning and noted the recommendation that the delivery confidence be retained as amber-red. The Chair reminded the Board of the ongoing work around Healthier Wigan Partnership and noted the potential impact on the Secondary Care Transformation Board whose role and remit is currently under consideration. The intention to work with the Partnership to define the foundation trust's contribution to the overall scheme was acknowledged and the Chief Executive informed the Board that the Chief Officer of the Health and Social Care Partnership had recently announced that he would be standing down following his appointment as Chief Executive at Telford and Wrekin Council.

Other committees

Mr I Haythornthwaite provided a verbal summary of the business transacted at the Audit Committee meeting held on 1 October 2019. He advised that the committee had considered new and follow-up internal audit reports and noted that the full board assurance framework would be presented to the committee at its next meeting for a holistic review.

The committee had received assurances arising from a follow-up audit of payroll as well as being updated on actions taken to ensure that actions arising from a mortality audit are embedded. The Medical Director had given assurances to the committee around consultant job planning following an earlier audit and an update report would be provided to the committee's next meeting.

With regard to areas where assurances had not been received, Mr I Haythornthwaite noted that there was some concern over the ability to recruit to the Medical Examiner role which is mandated from April 2020 and the Medical Director had briefed the committee on the steps that were being taken to address this. There had also been some concern expressed at the findings of an internal audit relating to staff appraisals, and in particularly the availability of documentation to evidence completion, and note was made of the fact that a further update would be provided to the committee at its next meeting.

Mr I Haythornthwaite also informed the Board that the committee had approved an amendment to the internal audit plan for FY2019/20 to incorporate an audit of patient record access following the inappropriate access incident reported to the Information Commissioner's Office earlier in the year.

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

181/19 Performance report

The Chief Nurse opened this item by noting that many of the areas she would wish to bring to the Board's attention had been discussed during the previous agenda items. She highlighted the fact that the majority of patient experience measures had been rated as green, with a clear plan of action around the amber metric relating to the number of patients who know who their consultant is. She drew the Board's attention to the foundation trust's *C. difficile* performance and confirmed that the national trajectory had been exceeded whilst recognising that the number of cases attributable to lapses in care remained low.

The Medical Director noted the renewed focus on SHMI in preference to the Hospital Standardised Mortality Ratio and confirmed that he had recently met with the Chair of Wigan Borough Clinical Commissioning Group to introduce a process to review deaths in the community on a randomised sample basis, aligned to individual Service Delivery Footprints.

The Chief Executive noted the need to consider how the new Medical Examiner role will be utilised and emphasised the need to seek to incorporate value-added elements to the role, to the mutual benefit of the organisation and the post holder. The Chair noted that there are three quality metrics of current concern, those being pressure ulcers, SHMI and *C. difficile*, and acknowledged that action plans are in place to address each. An update report to the next meeting on the effectiveness of these plans was requested.

ACTION: Chief Nurse and Medical Director

With regard to the operational metrics, the Chief Operating Officer highlighted the unusually poor performance against three of the key metrics shown on page 2 of the report and cautioned that the foundation trust would not be in a position to deliver the national mandate to ensure that the size of waiting list in March 2020 is less than the size of the list in March 2019. She noted the need for something fundamentally different to be done in order to address the waiting list size and confirmed that private providers are used where it is considered that the patient's interests would best be served by a shorter waiting time. The Chief Operating Officer did, however, highlight the fact that the Division of Community Services had achieved 100% performance against all of its key operational metrics.

Dr S Elliot commended the foundation trust for achieving the 2-week standard for symptomatic breast patients which he noted is challenging across Greater Manchester but expressed some concern at the long-term trend of the 62-day cancer target. In response, the Chief Operating Officer noted that the organisation usually achieves its cancer targets across all domains and reminded the Board that, as the size of the patient cohort covered by the targets is relatively small, a slight increase in the number of breaches can have a significant impact on overall performance.

With regard to A&E performance, the Chief Operating Officer advised that the foundation trust was reporting a year-to-date performance of 85.73% as at 26 November 2019 and a month-to-date performance of 78.13% as at the same date. She noted that the former ranked the organisation as the best performing in Greater Manchester and that the latter placed it as the second-best in Greater Manchester. An increase in attendances from both in-area and out-of-area patients was noted, although the Chief Operating Officer reminded the Board that the foundation trust had the lowest number of super-stranded patients across the region. Confirmation was provided that all deflection and admission avoidance schemes would be proactively reviewed at the meeting of the Urgent and Emergency Care Board on 5 December 2019 to assess their effectiveness and to determine whether any additional steps could be taken.

The Chair summarised this agenda item by noting that the A&E 4-hour wait, the 18-week referral-to-treatment and all cancer targets remain challenging. He suggested that it would be appropriate for the executive team to consider this further and in particular to review the plans in place and to incorporate these within wider workforce discussions. The Chief Executive acknowledged this suggestion and noted the importance of understanding the role of demographics in driving additional activity.

The Board received the performance report and noted the content.

182/19 Financial position as at 31 October 2019

The Director of Finance presented a report which had been circulated with the agenda to summarise the foundation trust's financial position as at 31 October 2019. He noted that the control total for Q1 and Q2 2019/20 had been achieved but reminded the Board of the challenging nature of the plan associated with the second half of the financial year. He also reminded the Board that a recovery plan had been produced and shared with NHS England and Improvement and, whilst formal feedback had not yet been received, the plans had begun to be implemented. The Director of Finance noted that capital expenditure was behind plan but advised that this was partly due to national instructions issued at the start of the year around the use of capital.

The Chair summarised this item by noting that the Board was fully sighted on the underlying structural deficit and recognised the importance of delivering the recovery plan.

The Board received the report and noted the content.

183/19 Safe staffing report

The Chief Nurse presented the regular safe staffing report which provides a summary of staffing levels on all in-patient wards across the foundation trust and across community services. She noted that separate reports had been provided for September and October 2019 and advised of the intention to provide single reports covering a two-month period in the future. Particular note was made of the fact that the organisation continues to experience significant registered nurse vacancies with particular challenges in scheduled care and the Division of Community Services. The Chief Nurse also highlighted the fact that the registered nurse staffing levels are below the national average benchmark.

The Chief Nurse highlighted the reduction in vacancies in September and October as a result of a proactive approach to working with new registrant nurses and students, and confirmation was provided that fill rates in both months had exceeded 91% which she noted is a relatively consistent position.

The Chief Nurse briefed the Board on the use of daily safer staffing huddles, led by the Deputy Chief Nurse, using the Safe Care module of the electronic rostering system. She also noted that roster challenge and support meetings had commenced, alongside a review of the funded nursing establishment.

Mrs L Lobley acknowledged that staff are moved around the organisation in response to regular risk assessments but noted that frequent moves could have a negative impact on staff's perception of working for the organisation. The Chief Nurse acknowledged this and noted the need to move to a position where staff moves do not occur as frequently. She advised that the daily safer staffing huddles look to identify gaps some 24 hours in advance, to allow early intervention to take place.

Prof C Austin highlighted the introduction of alternative workforce models such as the use of Pharmacy Technicians in ward environments and asked whether any impact had been observed. In response, the Chief Nurse advised that this was still being assessed and would be included in the biannual staffing review report to the Board at its next meeting. She did note, however, that some immediate improvements had been reported on the Medical Assessment Unit, particularly in relation to the administration of medication.

The Board received the report and noted the content.

184/19 Care Quality Commission unannounced inspection feedback letter

The Chief Nurse presented a report which had been circulated with the agenda to share the initial feedback received from the Care Quality Commission following its unannounced inspection which took place during the period 22 to 24 October 2019.

The Board received the report and noted the content.

185/19 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 2019 Emergency Preparedness, Resilience and Response self-assessment report be noted; and

2. THAT the Board's cycle of business be **APPROVED**, subject to a number of amendments that were outlined.

186/19 Questions from the public

A member of the public enquired why the 2-week cancer target is considered more important than the 62-day target, to which the Chief Operating Officer replied that all

targets have equal importance. Notwithstanding, she noted that the 2-week target is often seen as a proxy for an organisation's ability to deliver the 62-day target and can receive greater attention as a result.

A staff governor enquired whether the proposed leadership and education strategy described by the Director of Workforce within minute reference 180/19 would apply equally to non-clinical staff and confirmation was provided that it would.

187/19 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.

188/19 Date, time and venue of next meeting

The next meeting of the Board of Directors will be held on 29 January 2020, 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
27 Nov 2019	179/19	Risk escalation: syringe drivers	Monitor delivery of mitigating actions	Quality and Safety Committee	Ongoing	Update provided to Q&S in January 2020.
27 Nov 2019	180/19	Board assurance framework	Provide an update to the Council of Governors on the use of private providers to support operational delivery	Chief Operating Officer	21 Jan 2020	Completed on 21 January 2020.
27 Nov 2019	181/19	Performance report	Provide update report on efficacy and efficiency of plans to address pressure ulcers, SHMI and C. difficile	Chief Nurse and Medical Director	29 Jan 2020	On agenda.

REPORT

AGENDA ITEM: 7

Wrightington, Wigan and Leigh NHS Foundation Trust

To:	Board of Directors	**Date:**	29 January 2020
Subject:	Chief Executive's report		
Presented by:	Chief Executive	**Purpose:**	Information

Executive summary

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

Risks associated with this report

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

Link(s) to The WWL Way 4wards

☐	Patients	☐	Performance
☐	People	☐	Partnerships

The WWL Way

1. INTRODUCTION

1.1. This report sets out some of my activities and other matters of note since the last meeting of the board on 27 November 2019.

2. CARE QUALITY COMMISSION INSPECTION

2.1. Colleagues will recall that the last meeting was observed by the Care Quality Commission (CQC) as part of its well-led inspection of the organisation, which followed an unannounced inspection in October 2019 and which was reported to the board in November.

2.2. The well-led inspection is based on a shared framework between the CQC and NHS England and Improvement and assesses the leadership, management and governance of the organisation to ensure it is providing high-quality care based around individual needs, that it encourages learning and innovation and that it promotes an open and fair culture.

2.3. After each inspection, the CQC sends a post-inspection letter which summarises its key findings in advance of the inspection report being provided. A copy of this letter has been included later in the agenda for the board's consideration.

2.4. Last week we received the draft inspection report from the CQC and, as is usual practice, we are in the process of reviewing this draft so that we can provide feedback on its factual accuracy. Once this process is complete, the CQC will publish the report on its website.

3. LEADERS' FORUM

3.1. In November we launched our new Leaders' Forum which is an opportunity for leaders from across the organisation to come together and receive a briefing from members of the executive team as well as discussing key issues. Held across a number of sites, at least one member of the executive team is in attendance to welcome all middle and senior managers and to facilitate a two-way discussion. We will be rolling these out on a monthly basis with a view to improving the flow of communication – both to and from the executive team – as well as allowing executive directors to be visible within the organisation.

4. DIRECTOR OF FINANCE

4.1. Colleagues will be aware that Rob Forster has been appointed as Chief Finance Officer/Deputy Chief Executive at Liverpool University Hospitals NHS Foundation Trust. Rob's last working day with us will be 31 March 2020 and I know that the board will wish to join me in congratulating Rob on his new appointment. We will be working with Saxton Bampfylde in the search for Rob's replacement and the recruitment process will commence imminently.

4.2. We have taken the opportunity to review a number of matters relating to the role and wider portfolios. As a result, we will be renaming the role to Chief Finance Officer to reflect contemporary nomenclature. The Director of Finance's current portfolio includes Information Management and Technology and this has been removed, and replaced with Estates and Facilities which currently sits under the Chief Operating Officer. Responsibility for the current IM&T portfolio will be transferred to the Chief Operating Officer except for those areas relating to external reporting which will fall under the Director of Strategy and Planning's purview.

5. CHIEF INFORMATION OFFICER

5.1. The board will also wish to note that we have recently appointed a Chief Information Officer. Malcolm Gandy, who is currently the Chief Information Officer at St Helens and Knowsley Teaching Hospitals NHS Trust. I am very much looking forward to welcoming him to the team.

6. FINANCE AND CONTRACTING 2020/21

6.1. The draft standard contract for FY2020/21 has been published and is currently subject to consultation. We have reviewed the proposed changes and are working to assess any impact that they may have.

6.2. The executive team has also held a number of sessions to formulate the proposed budget for FY2020/21 and we will present this to the Finance and Performance Committee for further discussion next month.

7. ORGANISATIONAL VISITS

7.1. Since the last meeting of the board, I have taken the opportunity to undertake a number of visits to areas of the organisation. Such visits are an excellent way to gain an understanding of how the business operates and staff always welcome the opportunity to showcase their work and to have a discussion. I would recommend that colleagues around the board table also take the opportunity to undertake visits into the organisation and we have scheduled these into our board workshop sessions.

7.2. I have undertaken pre-arranged visits to the following areas:

- IM&T teams at Buckingham Row;
- Respiratory department, Royal Albert Edward Infirmary;
- Education Centre, Royal Albert Edward Infirmary;
- Community teams;
- Clinical coding teams at Royal Albert Edward Infirmary;
- Fertility Unit at Wrightington Hospital; and
- Prosser White Dermatology Unit at Leigh Infirmary.

7.3. In addition, I undertake a weekly walkabout which takes me to different areas of the organisation and I am usually accompanied by either or both of the Chief Nurse and Medical Director.

7.4. One visit of particular note was on 27 December 2019, when Alison Balson, Mary Fleming and I were treated to a performance of Aladdin on our paediatric inpatient ward, Rainbow, by the fabulous Starlight theatre company. In what has become a regular event, the aim is to bring happiness and fun to those children who need to stay in hospital over the Christmas period. The photos overleaf show everyone having a great time.

8. TEENZONE

8.1. I was equally delighted to be invited to open the brand new Teen Zone on Rainbow Ward earlier this month. Feedback had been that the ward area was more geared towards younger children and that our teenage patients had nowhere age-appropriate available to them. The team put together a fundraising campaign through our charity, Three Wishes, and as you will see from the photographs below we were able to provide our teenagers with a great area for them to use.

8.2. My particular thanks go to Ellie Pugh, shown above, who regularly attends the ward for treatment and who cut the ribbon and became the first patient to cross the threshold.

9. FLU VACCINATION UPDATE

9.1. Our flu vaccination performance currently stands at 65%. Levels of flu are higher in the North West than elsewhere in the country and there have been over 130 confirmed cases, so continuing with our vaccination programme remains a priority.

9.2. Work continues to reconcile the data between completed vaccination forms and local intelligence and more sessions are planned to encourage a further increase in uptake. We are also looking at options for additional incentives and ways of increasing uptake further.

10. RECOMMENDATION

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

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

Board Performance Report

December 2019

Your hospitals, your health, our priority

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

Top 10 Performance

Group	ID	Metric Name	Period Covered	Date Last Updated	National Top 10%	Performance	Percentile	Rank / Trusts
Safe	2	Summary Hospital-level Mortality Indicator (SHMI)	AUG-18 - JUL-19	15/01/20	Yes	115.82	2.4%	4/126
Safe	3	Safety Thermometer / Harm Free Performance	OCT-19	14/01/20	No	80.64%	93.52%	102/109
Safe	4	Cancer 2 Week Wait Performance	NOV-19	13/01/20	No	96.56%	17.97%	24/129
Safe	5	18 Week Incomplete Referral To Treatment (RTT) Performance	NOV-19	13/01/20	No	90.59%	21.6%	28/126
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	DEC-19	13/01/20	No	76.26%	49.12%	57/115
Effective	8	Diagnostic 6 Week Wait Performance	NOV-19	13/01/20	No	0.87%	40.16%	52/128
Caring	10	Friends & Family Assessment Result	NOV-19	13/01/20	No	94.17%	50.78%	66/129
Caring	11	National Patient Survey Result	JAN-18 - DEC-18	15/10/19	No	0.81	48.85%	65/132

Top 10%: 2

Top 25%: 2

Top 50%: 3

Bottom 50%: 1

Bottom 25%: 0

Bottom 10%: 1

Top 5 Performing Metrics

#	Metric Name	Rank
1	Patient-led assessments of the care environment (PLACE)	2
2	Summary Hospital-level Mortality Indicator (SHMI)	4
3	Cancer 2 Week Wait Performance	24
4	18 Week Incomplete Referral To Treatment (RTT) Performance	28
5	Diagnostic 6 Week Wait Performance	52

Bottom 5 Performing Metrics

#	Metric Name	Rank
1	Safety Thermometer / Harm Free Performance	102
2	Friends & Family Assessment Result	66
3	Accident & Emergency 4 Hour Wait Performance	57
4	National Patient Survey Result	65

Local Trust Positions

Provider Name	GM Rank	North Rank	National Rank
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	1/7	4/44	10/136
BOLTON NHS FOUNDATION TRUST	2/7	18/44	38/136
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	3/7	21/44	45/136
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	4/7	26/44	60/136
SALFORD ROYAL NHS FOUNDATION TRUST	5/7	31/44	86/136
PENNINE ACUTE HOSPITALS NHS TRUST	6/7	33/44	99/136
STOCKPORT NHS FOUNDATION TRUST	7/7	34/44	109/136

In Month

18 Weeks: Incomplete

89.03%

Target: 92.0%

Cancer 62 Day: GP Referral

85.34%

Target: 85.0%

Diagnostics: 6 Weeks

98.45%

Target: 99.0%

**A&E: 4 Hour Target

76.24%

Target: 95.0%

C. Difficile Infections

40

YTD Target: 14

Year To Date

Serious Falls

3

FY Target: 0

Never Events

3

FY Target: 0

MRSA

0

FY Target: 0

Executive Summary (December 2019)

Key Messages

Highlights

The Trust has not had a serious fall during December 2019.

In December's Real Time Patient Survey, 100% of patients reported that they were treated with compassion and had been given enough privacy when being examined, treated or discussing care.

Lowlights

In January 2020 the Board of Directors is receiving detailed reports on the learning following Hospital Acquired Pressure Ulcers and Clostridium Difficile Toxin's.

Please Note:

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

Please also see Scheduled Care Report and Unscheduled Care Report.

1.1 : Harm Free

		Latest				Previous		YTD		Sparkline - Latest 13 Months			
Metric Title	Target	Actual	Period	RAG	Trend	Actual	Period	Actual	RAG	Chart	Min. Value	Max. Value	Period
Serious Harms: Community Acquired Grade 3-4 Pressure Ulcers	**	4	Dec-19		↑	1	Nov-19	15			0	4	Apr-19 to Dec-19
Harms: Total	**	91	Dec-19		↓	93	Nov-19	743			62	94	Dec-18 to Dec-19
Serious Harms: Total	**	20	Dec-19		↑	5	Nov-19	98			4	20	Dec-18 to Dec-19
Serious Harms: Number of Never Events	<= 0	0	Dec-19	●	→	0	Nov-19	3	●		0	1	Dec-18 to Dec-19
Serious Harms: Number of Serious Falls	<= 0	0	Dec-19	●	→	0	Nov-19	3	●		0	2	Dec-18 to Dec-19
Serious Harms: Hospital Acquired Grade 3-4 Pressure Ulcers	**	6	Dec-19		↑	2	Nov-19	24			0	6	Dec-18 to Dec-19
Number of Serious Incidents	<= 0	16	Dec-19	●	↑	10	Nov-19	75	●		0	16	Dec-18 to Dec-19
Mod/Low Harms: Hospital Acquired Pressure Ulcer Grade 2	**	9	Dec-19		↑	6	Nov-19	33			0	9	Dec-18 to Dec-19
Mod/Low Harms: Number of Moderate Falls	<= 0	1	Dec-19	●	↓	3	Nov-19	11	●		0	3	Dec-18 to Dec-19
Mod/Low Harms: Safety Thermometer	>= 95.0%	98.24%	Dec-19	●	↓	98.56%	Nov-19	98.48%	●		97.38%	99.54%	Dec-18 to Dec-19
Mod/Low Harms: Settled Clinical Litigation Cases	**	1	Dec-19		↓	5	Nov-19	29			1	7	Dec-18 to Dec-19
Mod/Low Harms: VTE Assessments (% of Admissions)	>= 95.0%	95.92%	Dec-19	●	↓	95.95%	Nov-19	96.48%	●		95.67%	97.13%	Dec-18 to Dec-19

Commentary (Page Owner : Director of Nursing and Performance)

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

During the month of December 2019, the Trust has submitted 16 incidents to StEIS, an increase of an additional 6 incidents when compared with the previous month. Of the 16 incidents submitted, these consisted of 6 Hospital Acquired Pressure Ulcers and 4 Community Acquired Pressure Ulcers (where a lapse in care was identified). The Board of Directors is receiving a report on the learning following investigations into Pressure Ulcers. 4 incidents were submitted in relation to 12 Hour Decision to Admit breaches. Work is underway to ensure that the SHINE Emergency Department safety checklist is embedded across the department. Additional incidents include an Information Governance breach and a Safeguarding incident. The Board of Directors will receive quarterly serious incident reports focussing on learning. The first of these reports was presented in November 2019.

1.2 : Harm Free - Infections

	Latest					Previous		YTD		Sparkline - Latest 13 Months			
Metric Title	Target	Actual	Period	RAG	Trend	Actual	Period	Actual	RAG	Chart	Min. Value	Max. Value	Period
Infections/Bacteraemias: Total	**	17	Dec-19		↑	5	Nov-19	89			5	17	Dec-18 to Dec-19
Serious Harms: Infections: Clostridium Difficile	<= 1	10	Dec-19	●	↑	2	Nov-19	40	●		0	10	Dec-18 to Dec-19
Serious Harms: Infections: Clostridium Difficile Lapses in Care	<= 0	0	Sep-19	●	↓	2	Aug-19	6			0	2	Dec-18 to Sep-19
Infections: Catheter Associated Urinary Tract	<= 0	1	Dec-19	●	→	1	Nov-19	9	●		0	2	Dec-18 to Dec-19
Serious Harms: Bacteraemias: MRSA	<= 0	0	Dec-19	●	→	0	Nov-19	0	●		0	1	Dec-18 to Dec-19
Serious Harms: Bacteraemias: MRSA - Avoidable Cases	**	0	Dec-19	●	→	0	Nov-19	0	●		0	0	Dec-18 to Dec-19
Serious Harms: Bacteraemias: MSSA	**	1	Dec-19		↑	0	Nov-19	7			0	4	Dec-18 to Dec-19
Serious Harms: Bacteraemias: E-coli	**	3	Dec-19		↑	1	Nov-19	21			1	7	Dec-18 to Dec-19
Bacteraemias: Klebsiella	**	1	Dec-19		→	1	Nov-19	9			0	2	Dec-18 to Dec-19
Bacteraemias: Pseudomonas	**	1	Dec-19		↑	0	Nov-19	3			0	1	Dec-18 to Dec-19

Commentary (Page Owner : Director of Nursing and Performance)

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

There were 10 cases of Clostridium Difficile Toxin in December 2019 in comparison to 2 in November 2019. There has been no identified cross infection since July 2019. The Board of Directors is receiving a report on the learning following investigations into CDTs. Antibiotic prescriptions are generally appropriate and overall consumption is falling. However, side room availability remains a challenge due to admission pressures, and it has not been possible to manage the majority of patients on Pemberton Ward. The Trust has been MRSA bacteraemia free for 300+ days.

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	**	114	Dec-19		↑	110	Nov-19	916			88	128	Dec-18 to Dec-19
Hospital Crude Death Rate	**	1.79%	Dec-19		↑	1.57%	Nov-19	1.45%			1.25%	1.79%	Dec-18 to Dec-19
PFD Coroner Notifications	**	0	Dec-19	●	→	0	Nov-19	0	●		0	0	Dec-18 to Dec-19
Deaths after Readmission	**	26	Dec-19		↓	36	Nov-19	280			22	39	Dec-18 to Dec-19
HSMR (Latest Month)	<= 90	96.1	Sep-19	●	↓	103.1	Aug-19	N/A			81.1	129.0	Apr-18 to Sep-19
HSMR (Latest YTD)	*	107.0	Dec-19		↓	109.9	Aug-19	N/A			95.2	109.9	Dec-18 to Dec-19
HSMR Weekday	<= 90	103.4	Sep-19	●	↓	103.7	Aug-19	N/A			73.3	129.6	Apr-18 to Sep-19
HSMR Weekend	<= 90	75.1	Sep-19	●	↓	100.4	Aug-19	N/A			74.0	162.9	Apr-18 to Sep-19
SHMI (Rolling 12 Months)	<= 90.0	115.7	Aug-19	●	↓	116.2	Jul-19	N/A			109.1	116.2	Jun-18 to Aug-19

Commentary (Page Owner : Medical Director)

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

The total number of deaths is above the average, but typical for Winter. HSMR values are for September and comparison is made with August. Both are close to the expected of 100. SHMI is for a different time period and reflects a rolling 12 month dataset. It remains high and has risen slightly.

3.1 : Midwifery - Part 1

Metric Title	Target	Latest Actual	Latest Period	Latest RAG	Trend	Previous Actual	Previous Period	YTD Actual	YTD RAG	Sparkline - Latest 13 Months Chart	Min. Value	Max. Value	Period
Maternity: Midwife / Birth Ratio	<= 1.30	1.24	Dec-19		→	1.24	Nov-19	N/A			1.24	1.26	Dec-18 to Dec-19
Maternity: Skills drills/2 day Mandatory Training Attendance	>=	95.34%	Dec-19		↑	83.91%	Nov-19	N/A			8.09%	95.37%	Dec-18 to Dec-19
Maternity: Total monthly bookings	>= 240	217	Nov-19		↓	225	Oct-19	1,760			203	292	Dec-18 to Nov-19
Maternity: Booked by 12+6 Weeks	>= 90.0%	94.74%	Nov-19		↓	94.84%	Oct-19	N/A			85.78%	94.84%	Dec-18 to Nov-19
Maternity: Induction of Labour	<= 30.0%	38.14%	Dec-19		↓	39.11%	Nov-19	N/A			32.03%	41.05%	Dec-18 to Dec-19
Maternity: Normal Deliveries	>= 60.0%	57.22%	Dec-19		↑	56.67%	Nov-19	N/A			49.10%	61.78%	Dec-18 to Dec-19
Maternity: Water Births	>= 8	10	Dec-19		↑	7	Nov-19	101			7	15	Dec-18 to Dec-19
Maternity: Instrumental Deliveries	<= 10.0%	10.31%	Dec-19		↓	17.22%	Nov-19	N/A			7.80%	17.22%	Dec-18 to Dec-19
Maternity: Elective Caesarean Sections	<= 15.0%	13.92%	Dec-19		↑	10.00%	Nov-19	N/A			9.95%	17.34%	Dec-18 to Dec-19
Maternity: Emergency / Non Elective Caesarean Sections	<= 17.0%	18.56%	Dec-19		↑	16.11%	Nov-19	N/A			13.68%	22.84%	Dec-18 to Dec-19
Maternity: Total Caesarean Sections	<= 27.0%	32.47%	Dec-19		↑	26.11%	Nov-19	N/A			26.11%	37.07%	Dec-18 to Dec-19

Commentary (Page Owner : Director of Nursing and Performance)

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

Midwife to Birth ratio remains unchanged at 1:24, with bookings remaining lower than expected, this is impacting upon the birth rate which for the year remains below target. However, CoC has been introduced in November 2019 and this appears to be having a positive response in women choosing WWL as a place of Birth. Scoping for a stand alone Birth centre has been completed, with the aim to offer women of the borough greater choice. Mandatory Training is on track to achieve the 90% compliance by year end. Induction of labour remains high but unchanged, this is due to the acuity of women and the impact of Saving Babies Lives 2 focussing on reduced fetal movements and suspected or actual small for gestational age in accordance with National recommendations. Caesarean section rate has decreased slightly this month, however the instrumental delivery rate has increased. The normal birth rate has remained below the 60% target locally, a review of positions in labour has been undertaken and discussions have taken place with midwives around supporting normal birth where possible.

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	194	Dec-19		↑	180	Nov-19	1,882			167	234	Dec-18 to Dec-19
Maternity: Episiotomy with normal birth	<= 6.0%	8.11%	Dec-19		↑	5.88%	Nov-19	N/A			2.22%	10.07%	Dec-18 to Dec-19
Maternity: 3rd/4th degree tears	<= 3.0%	2.06%	Dec-19		↑	1.68%	Nov-19	N/A			0.47%	3.03%	Dec-18 to Dec-19
Maternity: Initiation of breastfeeding	>= 55.0%	50.00%	Dec-19		↓	52.22%	Nov-19	N/A			44.29%	54.15%	Dec-18 to Dec-19
Maternity: Average post-natal length of stay	<= 1.8	1.5	Dec-19		↓	1.8	Nov-19	N/A			1.3	2.0	Dec-18 to Dec-19
Maternity: Still Births (>24 weeks)	<= 1	1	Dec-19		→	1	Nov-19	7			0	2	Dec-18 to Dec-19
Maternal Readmissions within 30 Days	<= 5	2	Dec-19		→	2	Nov-19	19			0	5	Dec-18 to Dec-19
Maternal admissions to ICU	<= 2	0	Dec-19		→	0	Nov-19	1			0	1	Dec-18 to Dec-19
Maternity Complaints	<= 2	1	Dec-19		→	1	Nov-19	14			0	5	Dec-18 to Dec-19
Maternity: New Claims	*	0	Dec-19		→	0	Nov-19	1			0	1	Dec-18 to Dec-19

Commentary (Page Owner : Director of Nursing and Performance)

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

The Infant feeding team work to promote and support mothers to initiate breastfeeding. WWL has full Baby Friendly accreditation and Gold status which identifies that those who choose to Breast feed sustain this, however, the number of mothers who opt to breastfeed remains lower than the national average and the midwifery team continue to promote the benefits of breastfeeding to all mothers and families. The number of complaints received remains low in number. No clear trends have been identified. The content of recent complaints have been around clinical care, process and staff attitude.

4.1 : Patient Experience

Metric Title	Target	Latest Actual	Latest Period	Latest RAG	Trend	Previous Actual	Previous Period	YTD Actual	YTD RAG	Sparkline - Latest 13 Months Chart	Min. Value	Max. Value	Period
Number of Complaints Upheld by Ombudsman	**	0	Dec-19		→	0	Nov-19	0			0	0	Dec-18 to Dec-19
Number of Complaints Partially Upheld by Ombudsman	**	0	Dec-19		→	0	Nov-19	1			0	1	Apr-19 to Dec-19
Percentage of Complaints Responded to on Time	**	68.89%	Dec-19		↑	54.72%	Nov-19	63.78%			34.88%	76.60%	Dec-18 to Dec-19
Friends & Family: Decisions about Discharge Home?	>= 90.0%	92.12%	Dec-19		↑	88.44%	Oct-19	N/A			83.95%	92.12%	Dec-18 to Dec-19
Delivering Same Sex Accommodation: Mixed Sex Accommodation Breaches	*	0	Dec-19		→	0	Nov-19	9			0	5	Apr-19 to Dec-19

Commentary (Page Owner : Director of Nursing and Performance)

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

During December 2019, the rate of responses being sent within the timescales agreed with the complainant at the start of the complaints process improved in comparison to November 2019 (69%). A review into the quality of the Trusts complaints responses is underway. In December 2019 the main theme was Clinical Treatment followed by Values and Behaviours and Communication. No requests for records were received from the Ombudsman and the Trust did not receive any partially upheld or upheld complaints.

4.2 : Patient Experience Survey

	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 Q1: Staff Introduction	>= 90.0%	91.74%	Dec-19		↓	94.93%	Nov-19	92.01%			88.51%	96.53%	Dec-18 to Dec-19
Patient Survey Q2: Worries and Fears	>= 90.0%	85.95%	Dec-19		↓	89.86%	Nov-19	89.70%			85.71%	93.89%	Dec-18 to Dec-19
Patient Survey Q3: Pain Control	>= 90.0%	95.04%	Dec-19		↑	94.93%	Nov-19	94.11%			89.61%	96.53%	Dec-18 to Dec-19
Patient Survey Q4: Family and Doctor	>= 90.0%	86.78%	Dec-19		↓	90.58%	Nov-19	91.73%			86.78%	97.14%	Dec-18 to Dec-19
Patient Survey Q5: Decisions about Care and Treatment	>= 90.0%	80.17%	Dec-19		↓	84.78%	Nov-19	85.56%			78.38%	91.45%	Dec-18 to Dec-19
Patient Survey Q6: Food Choice	>= 90.0%	96.69%	Dec-19		↓	98.55%	Nov-19	97.13%			94.74%	99.05%	Dec-18 to Dec-19
Patient Survey Q7: Healthy Food	>= 90.0%	88.43%	Dec-19		↑	88.41%	Nov-19	91.45%			86.96%	97.22%	Dec-18 to Dec-19
Patient Survey Q9: Know Consultant	>= 90.0%	76.03%	Dec-19		↓	84.06%	Nov-19	81.85%			73.28%	90.28%	Dec-18 to Dec-19
Patient Survey Q10: Enough Privacy	>= 90.0%	100.00%	Dec-19		↑	99.28%	Nov-19	98.74%			94.81%	100.00%	Dec-18 to Dec-19
Patient Survey Q11: Call Bell	>= 90.0%	96.69%	Dec-19		↑	94.93%	Nov-19	96.29%			92.99%	98.08%	Dec-18 to Dec-19
Patient Survey Q12: Compassion	>= 90.0%	100.00%	Dec-19		↑	99.28%	Nov-19	97.90%			96.62%	100.00%	Dec-18 to Dec-19
Patient Survey Q13: Given Required Care	>= 90.0%	97.52%	Dec-19		↓	97.83%	Nov-19	97.27%			94.90%	99.31%	Dec-18 to Dec-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:
In December 2019 every patient responded positively to the following two questions “During your stay have you been treated with compassion by hospital staff?” and “Have you been given enough privacy when being examined treated or discussing your care?”. There was a decrease in results for patients reporting that they knew their consultant and that they had been involved in decisions about care and treatment. The Medical Director is presenting a report outlining actions in relation to these two questions to the Trust's Executive Team in January 2020.

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	£ 639 k	Dec-19			£ 880 k	Nov-19	£ 2,306 k			£ -233 k	£ 1,276 k	Dec-18 to Dec-19
Friends & Family Test - Recommendation as place to work	>= 75.0%	66.49%	Oct-19			69.56%	Jul-19	N/A			61.94%	71.59%	Jan-19 to Oct-19
Clinical & Non Clinical Overall Vacancy Rate	<= 3.5%	8.91%	Dec-19			9.45%	Nov-19	10.13%			7.05%	10.87%	Dec-18 to Dec-19
Sickness absence - Total	<=	5.21%	Nov-19			4.79%	Oct-19	4.63%			4.19%	5.21%	Dec-18 to Nov-19
Quarterly Engagement Score	>= 4.00	3.95	Oct-19			3.95	Jul-19	N/A			3.90	4.01	Jan-19 to Oct-19
Appraisals over rolling 12 months	>= 90.0%	86.34%	Nov-19			83.79%	Sep-19	N/A			83.79%	89.45%	Jan-19 to Nov-19
Friends & Family Test - Recommendation as place for treatment	>= 80.0%	78.43%	Oct-19			78.56%	Jul-19	N/A			76.11%	79.42%	Jan-19 to Oct-19
Mandatory Training over rolling 12 months	>= 95.0%	95.32%	Nov-19			93.68%	Sep-19	N/A			90.12%	95.32%	Jan-19 to Nov-19
Agency vs NHSI Ceiling	<=£ 0 k	£ 732 k	Dec-19			£ 983 k	Nov-19	£ 6,120 k			£ 101 k	£ 983 k	Dec-18 to Dec-19

Commentary (Page Owner : Director of Workforce)

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

Rolling 12-month sickness from Dec 18 - Nov 19 increased to 4.64% (compared to 4.52% last reported). The in-month sickness also increased to 5.21% (compared to 4.79% in Oct 19). Temporary spend decreased by £61k to £2,226k (compared to £2,287k in Nov 19). There were increases in Locum, Bank NHSP, Bank Internal, Cost per Case, Bank and Zero Hour Contracts (increased by £143k, £30k, £17k, £9k, £5k and £1k respectively). There were decreases in Agency, Overtime and Additional Sessions (decreased by £252k, £8k and £7k respectively). Overall, the results of the Oct 19 Staff Engagement Quarterly Pulse Check highlight a moderate level of engagement within the Trust. The overall engagement score for Oct 19 is 3.95, no change from Jul 19. Trustwide there are 206 job plans at the following stages: 17 (Discussion), 29 (1st sign off), 4 (2nd sign off), 156 (fully signed off). Please note that these figures relate only to Consultant job plans.

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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%	76.24%	Dec-19		↓	78.15%	Nov-19	84.83%			75.11%	94.76%	Dec-18 to Dec-19
Access: 18 Weeks Referral To Treatment Incomplete Pathway	92.0%	89.03%	Dec-19		↓	90.59%	Nov-19	91.51%			89.03%	93.06%	Dec-18 to Dec-19
Diagnostics: Patients waiting over 6 weeks	99.0%	98.45%	Dec-19		↓	99.16%	Oct-19	98.97%			98.17%	99.42%	Dec-18 to Dec-19
Two week wait from referral to date first seen: all urgent cancer referrals (cancer suspected)	93.0%	96.43%	Nov-19		↑	95.59%	Oct-19	94.19%			89.39%	96.60%	Dec-18 to Nov-19
Two week wait from referral to date first seen: symptomatic breast patients (cancer not initally suspected)	93.0%	97.69%	Nov-19		↑	94.59%	Oct-19	95.81%			91.24%	98.57%	Dec-18 to Nov-19
All Cancers: 62 day wait for first treatment from urgent GP referral to treatment	85.0%	85.34%	Nov-19		↓	85.71%	Oct-19	85.58%			80.13%	94.29%	Dec-18 to Nov-19
All Cancers: 62 day wait for first treatment from consultant screening service referral	90.0%	100.00%	Nov-19		↑	96.08%	Oct-19	95.88%			90.91%	100.00%	Dec-18 to Nov-19
Serious Harms: Infections: Clostridium Difficile	1	10	Dec-19		↑	2	Nov-19	40			0	10	Dec-18 to Dec-19
Serious Harms: Infections: Clostridium Difficile Lapses in Care	0	0	Sep-19		↓	2	Aug-19	6			0	2	Dec-18 to Sep-19
Community: % IAPT Patients beginning treatment within 6 weeks	75.0%	100.00%	Nov-19		↑	97.00%	Oct-19	97.21%			95.57%	100.00%	Apr-19 to Nov-19
Community: % IAPT Patients beginning treatment within 18 weeks	95.0%	100.00%	Nov-19		→	100.00%	Oct-19	99.92%			99.15%	100.00%	Apr-19 to Nov-19

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

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

Finance Report

Month 09 ending 31st December 2019

The WWL Way

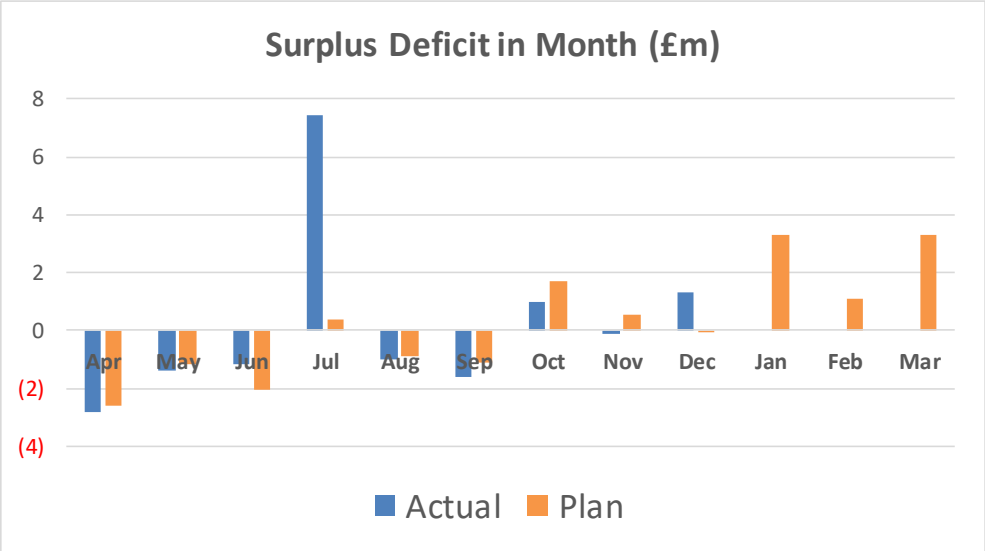
Contents

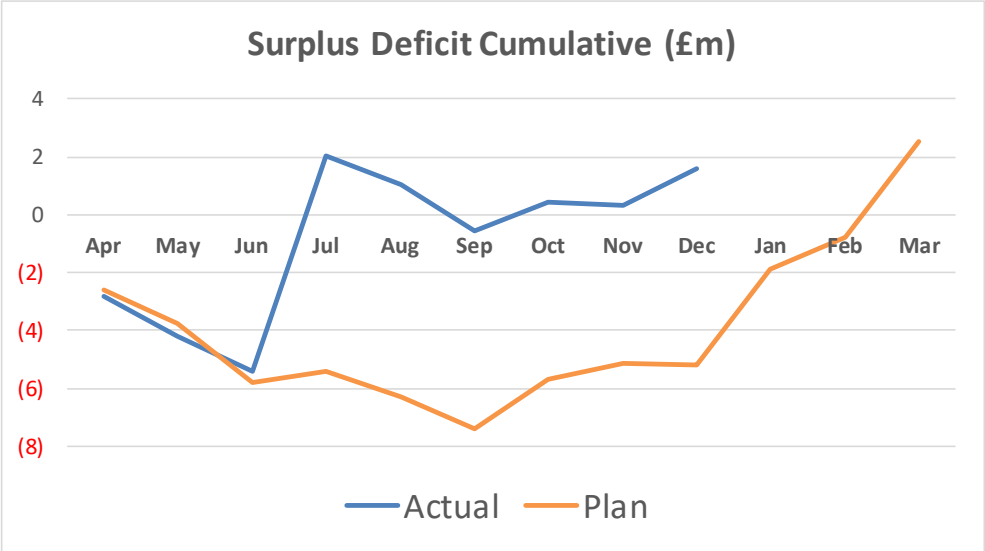
Performance on a Page

	In Month			Year to Date		
	Actual £000's	Plan £000's	Var £000's	Actual £000's	Plan £000's	Var £000's
Income	32,856	30,473	2,383	277,957	274,517	3,440
Expenditure	(30,563)	(29,506)	(1,057)	(273,590)	(270,744)	(2,846)
Surplus / Deficit	1,302	(28)	1,330	1,614	(5,181)	6,795
Cash Balance	49,954	12,199	37,755	49,954	12,199	37,755
Capital Spend	387	827	440	4,752	8,622	3,870
UOR	3	3	0	3	3	0

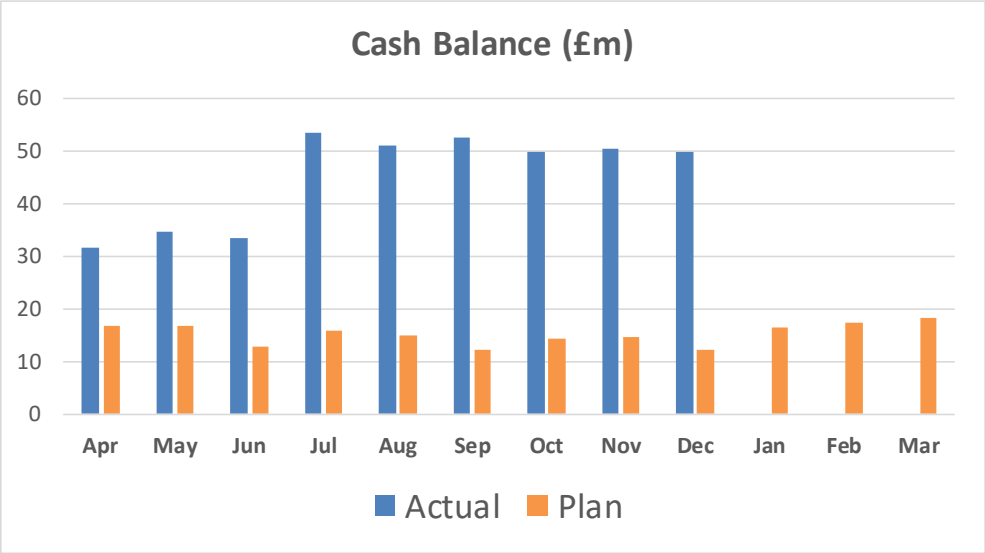
- Trust reporting a £1.6m surplus year to date which is £6.8m better than plan. This includes £7.9m for transfer of assets from Bridgewater Community Services and losses from asset impairments of £1.4.m. This is a non-trading transaction therefore the underlying trading position year to date is a £4.9m deficit.
- Cash is £37.8m better than plan.
- Capital is underspent by £3.9m.

Surplus Deficit

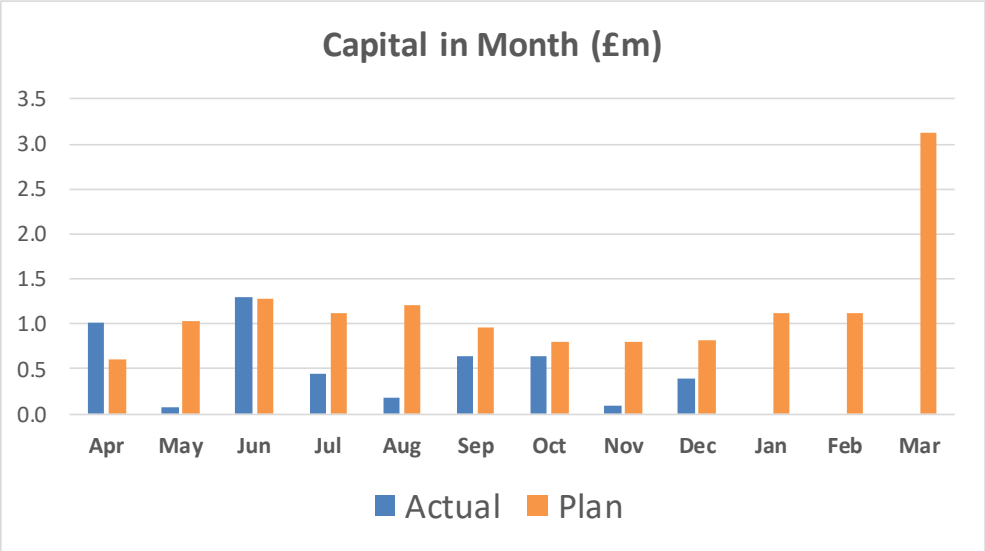


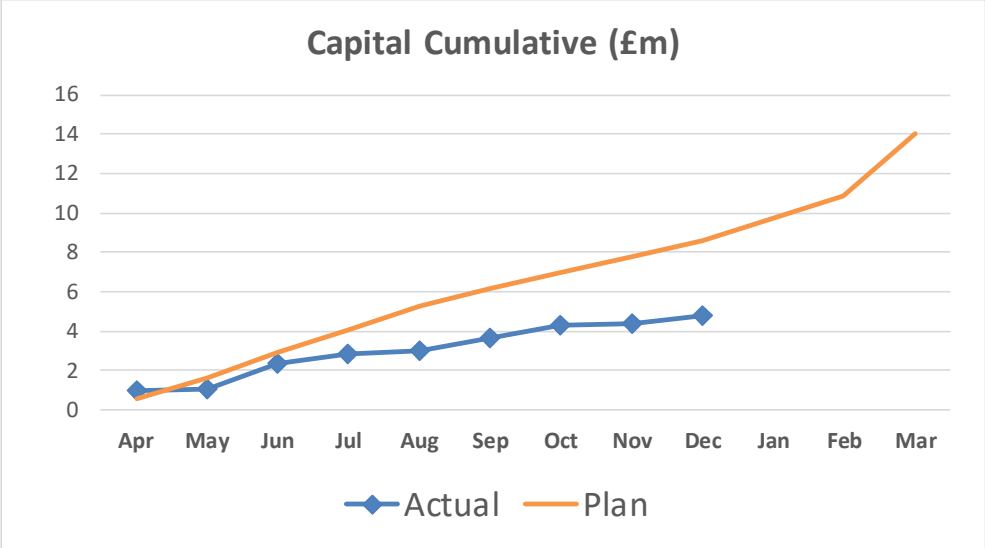


Cash Balance



Capital Spend





REPORT

AGENDA ITEM: 8.4

Wrightington, Wigan and Leigh NHS Foundation Trust

To:	Board of Directors	**Date:**	29 January 2020
Subject:	Safe Staffing Report		
Presented by:	Chief Nurse	**Purpose:**	Information and assurance

Executive summary

The purpose of this report is to provide a monthly summary of Nurse Staffing on all in-patient wards across the Trust when compared to current funded establishments. The report includes exception reports related to nurse staffing levels, related incidents and red flags which are then triangulated with a range of quality indicators.

The Board are asked to note;

- The overall nursing fill rate against the current funded establishment was 107.6% in November 2019 and 99.4% in December 2019; the overall fill rate for registered nurses was 95.2% and 98.8% respectively. This includes the deployment of additional temporary staff to support unfunded escalation areas.
- Registered nurse CHPPD remains below peer and national average and this is a reflection of the dilution in skill mix and reliance on unregistered staff.
- There is coloration of avoidable harms occurring where there have been shortfalls in Nursing workforce and dilution in skill mix most notably in the development of category 3 HAPU's.
- There has been a reduction in the reporting of Nursing red flags in the reporting period which reflects the continued redeployment of staff, the commencement of the registered nurse incentive in November 2019 and the increased use of Agency staffing.
- Within this time period there was an increase in the redeployment of staff from the Wrightington Site to support the acute site, it should be noted that whereas this action was taken to maintain safe levels of staffing across the trust bed base staff movement can adversely effects staff morale.
- Overall vacancy rates have remained relatively static within the reporting period. A second recruitment event is being planned in February 2020.
- The Bi-annual staffing review has been completed and a report is being presented to board recommending adjustments to the current funded establishments.

The WWL Way

Risks associated with this report
Nurse Staffing remains a high risk on the corporate risk register. The Bi-annual staffing review has been completed and a report is being presented to board recommending adjustments to the current funded establishments

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

Safe Staffing Report – November and December 2019

1.0 INTRODUCTION

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

2.0 SAFER STAFFING EXCEPTION REPORT

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

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

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

3.0 CURRENT POSITION – November and December 2019

The overall nursing fill rate for the Trust was 107.6% in November 2019 and 99.4% in December 2019; the overall fill rate for registered nurses was 95.2% and 98.8% respectively. Divisional fill rates for registered nurses were 90.9% Division of Medicine, 96.8% Specialist Services Division and 97.8% Division of Surgery in November; Decembers fill rates were 90.1% Division of Medicine, 90.05% Specialist Services and 92.3% Division of Surgery. For overall fill rates the Trust would be rated as green, registered nurse fill rates remain amber when considered against current funded establishments.

November and December 2019 have continued to see a reduction in the number of areas flagging red for registered nurse fill rate (Appendix 2, Table 1). The Board should note, however, that the fill rates provided are based on the current funded establishment levels and do not reflect the staffing required or the skill mix shortfall, particularly within Scheduled Care, that has been highlighted to the Board in the Biannual Staffing Review Report. The Board should also note that fill rates have been improved in part from the relaunch of the internal registered nurse incentive scheme and in part due to an increase in registered nurse shifts being undertaken by agency staff.

Appendix 2, Table 2 provides details of the vacancies across the inpatient wards and community services for October. Community figures include vacancies for nursing and Allied Health Professionals. The overall number of vacancies reported within the Trust has remained relatively static within the reporting period. There has been an increase in the number of unregistered nurse vacancies reported however in December; this is reflected also in unregistered staffing fill rates reported in Appendix 1. Of particular concern are the vacancies reported within District Nursing Services, 14.5 WTE. 3 WTE have been recruited to and are scheduled to commence in post in January and February 2020.

The benchmarking of District Nurse Caseloads continues to progress within the community division. The Division has actively sought to fill gaps with additional hours and temporary staffing to mitigate the risk. A listening event with District Nurses was held in November with the senior nursing team to provide the opportunity for staff to raise concerns and provide solutions to some of the challenges faced within the service. Opportunities for the introduction of blended roles to support the team are still being explored.

5 community acquired pressure ulcers were reported to StEIS across November and December 2019. Initial review of these cases identified some staffing concerns with respect to skill mix and caseload numbers at the time these incidents were reported.

All wards are currently utilising the SafeCare tool.
For the time period of the report the redeployment function was used to record the movement of staff to support patient need (57 moves in November and 170 moves in December). From 23 December to 31 December 137 staff were redeployed, the largest number of redeployments recorded since commencement of the system. The majority of these moves were staff from the Wrightington Site to support the acute site. This included areas of escalation and A&E department.

The number of red flags reported within acute inpatient areas (Table 4) has decreased within this reporting period. As the number of areas flagging red for registered nurse fill rates has fallen this is to be expected, however the Board should note that registered nurse skill mix remains below that agreed by Trust Board as identified in the Biannual Staffing Review Report particularly within Scheduled Care and the dilution of the substantive staff numbers by temporary staffing.

Quality will continue to be monitored closely via the Matron scheduled audits.
The majority of the red flags raised relate to delays in the administration of pain medication to patients Work continues to resolve this and a further update will be provided in the next report. This delay is also reflected in the patient experience survey reports within surgical and specialist services where these flags have been raised. There have been 29 red flags raised across November and December where there have been less than 2 registered nurses available. Rapid reviews have been completed and these indicate that with the exception of Highfield Ward these initial red flags raised were mitigated with the movement of staff from other areas to provide the second registered nurse.

Maternity services reported 1 red flag in November. This related to the unit being on divert. Maternity services have undertaken a review of the diverts instigated since the start of the financial year; this indicated that a number of the diverts could have been avoided.
To mitigate this, in December the senior midwifery team have instigated an on call process to review concerns and options for safely maintaining the services without the need for a divert to be instigated. At the time of reporting the on call team have intervened and prevented 2 diverts in December 2019; mother and baby and staff safety were maintained at all times.

On considering the quality metrics contained within Appendix 1 it should be noted that there continues to be an increase in the reporting of Hospital Acquired Pressure Ulcers (HAPUs). Of particular concern are those reported as Category 3 and 4 as these result in considerable distress for patients, both pain and quality of life, and inevitably require long term intervention to assist with healing. Across November and December 8 category 3 HAPU's were reported and escalated to StEIS for formal investigation; of the 8 reported 6 occurred within Unscheduled Care, 5 of these occurred on the Elderly Care Unit. Bespoke training has been delivered to staff within this area, and the ward has instigated additional checks and safety huddles to both raise awareness for staff and mitigate risk for patients. A paper detailing all actions being undertaken with respect to pressure ulcers is included on the agenda for Trust Board. 1 fall with harm was reported on Aspull Ward in November 2019; a review of the incident has indicated that a red flag for a shortfall in nurse staffing was also raised at the time of the incident which the division and the Trust had taken all appropriate steps to address.

CHPPD data from the Model Hospital is provided in Appendix 2 Table 6; this data was refreshed in October 2019. Whilst the Trust continues to compare favourably for CHPPD for overall staffing against peers and national benchmarking data, registered nurse CHPPD is below the peer and the national average.
Registered nurse CHPPD is reduced in comparison to the July data refresh within the Model Hospital. Unregistered CHPPD continues to compare favourably with peers and the national average but this is indicative of the reduction of skill mix previously mentioned within the report and the subsequent reliance on the unregistered workforce to deliver direct care.

4.0 ACTIONS BEING TAKEN

The Bi-annual staffing review has been finalised which makes a recommendation for immediate investment in the ward establishments to address the skill mix shortfall discussed in this and previous reports.

A second recruitment event is being planned in February 2020.

A comprehensive plan has been developed to mitigate the risk of pressure ulcer development.

5.0 SUMMARY

There remain pressures across all divisions on the acute site for nurse staffing, and there is evidence of avoidable harms occurring where there have been shortfalls of staffing most notably in the development of category 3 HAPU's.

Registered nurse CHPPD remains below peer and national average and this is a reflection of the dilution in skill mix and over reliance on unregistered staff. The Bi-annual staffing review will be strongly recommending that this skill mix is addressed

There has been a reduction in the reporting of red flags within nursing which reflects the continued redeployment of staff, the commencement of the registered nurse incentive in November 2019 and the increased use of Agency staffing.

Overall vacancy rates have remained relatively static within the reporting period. A second recruitment event is being planned in February 2020.

Harms have been reported in the Division of Medicine despite the improvement in fill rates for registered nurses and there remain concerns with respect to skill mix and supervision of Agency and unregistered staff which are being addressed within the Division and overseen corporately.

A comprehensive plan has been developed to address the concerns associated with the development of HAPU's.

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

Allison Luxon: Deputy Chief Nurse

Appendix 1
SAFE STAFFING EXCEPTION REPORT – November 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 (%)	Vacancies (%) - Registered Nursing Band 5-8	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	86.1%	98.4%	2.8	138.6%	116.2%	5.6	1.88%	4.01%	15.81%	1		0/3	1/0	0/3	100.00%	100.00%
Cardio and Respiratory	81.6%	90.0%	2.6	112.1%	118.5%	4.4	6.96%	7.85%	22.44%	11		0/9		1/7	91.00%	100.00%
Coronary Care Unit	106.4%	98.3%	7.2	126.2%	0.0%	2.5	6.04%	0.00%	0.00%	4		0/0		0/0	100.00%	100.00%
Elderly Care Unit	101.0%	100.0%	2.6	146.3%	166.0%	6.2	3.66%	6.83%	8.75%	*2		0/3	0/1	0/1	100.00%	100.00%
Highfield	84.8%	72.2%	3.8	129.5%	87.0%	5.2				7		0/0		0/0		
Pemberton	80.0%	96.7%	4.4	158.9%	149.2%	6.3	5.92%	19.02%	28.71%	1		0/2		0/1		
Shevington	89.8%	86.6%	2.7	131.3%	174.4%	5.1	14.11%	13.96%	27.29%	2		0/7	1/0	0/0	100.00%	100.00%

Division of Medicine – Unscheduled Care

	Average Fill Rates (%) & CHPPD						Staff Availability			Staff Experience	Nurse Sensitive Indicators				Patient Experience % (Number surveyed)	
	RN / RM			CSW												
Ward	Day shift (%)	Night shift (%)	CHPPD	Day shift (%)	Night shift (%)	CHPPD	Sickness (%)	Vacancies (%)	Vacancies (%) - Registered Nursing Band 5-8	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	84.1%	94.5%		120.6%	136.2%		3.84%	20.94%	19.32%	1		0/4		1/0		
A&E Paeds	93.2%	102.9%					0.00%	27.25%	27.25%	0		0/0		0/0		
A&E NP's	166.2%	3.8%														
CDW	98.8%	106.7%		99.0%	105.8%		0.44%	3.55%	1.19%	2		0/1		0/1	100.00%	100.00%
Medical Assessment Unit	97.7%	83.8%		109.5%	121.0%		8.83%	7.52%	17.43%	13	1	0/9		1/2	93.00%	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 (%)	Vacancies (%) - Registered Nursing Band 5-8	Datix Incidents - related to staffing/Red Flags	CDT	Falls (Harm / No Harm)	PU (Grade 1&2 / Grade 3 & 4)	Drug Admin Errors (Harm / No Harm)	Do you think the hospital staff did everything they could do to control your pain?	Have you been given the care you felt you required when you needed it most?
ICU/HDU	89.4%	84.6%	28.6	70.8%	0.0%	2.6	6.00%	0.64%	0.96%	10		0/0	1/0	0/0		
Langtree	97.0%	100.1%	2.6	130.1%	150.8%	3.1	2.68%	0.18%	7.40%	15		0/5	3/0	0/6	100.00%	100.00%
Orrell	97.4%	100.1%	4.0	125.7%	165.2%	5.3	5.56%	0.88%	3.19%	121		0/4		0/1	75.00%	100.00%
Swinley	102.5%	100.1%	2.6	109.5%	114.6%	2.6	3.67%	2.08%	4.46%	25	1	0/1		0/2	71.00%	100.00%
Maternity Unit	102.3%	93.6%	13.6	78.2%	95.6%	3.9	0.76%	0.00%	0.00%			0/0		0/0	100.00%	100.00%
Neonatal Unit	107.4%	120.1%	13.8	90.0%	0.0%	1.3	3.38%	0.03%	0.00%			0/0		0/0	100.00%	100.00%
Rainbow	107.4%	91.5%	8.2	99.0%	91.4%	2.7	8.52%	10.00%	10.57%	1		0/0		0/1	100.00%	100.00%

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

Division of Specialist Services

	Average Fill Rates (%) & CHPPD						Staff Availability			Staff Experience	Nurse Sensitive Indicators				Patient Experience % (Number surveyed)	
	RN / RM			CSW												
Ward	Day shift (%)	Night shift (%)	CHPPD	Day shift (%)	Night shift (%)	CHPPD	Sickness (%)	Vacancies (%)	Vacancies (%) - Registered Nursing Band 5-8	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	102.6%	82.1%	3.0	147.7%	168.1%	5.04	7.46%	9.09%	23.36%	29		0/2		0/3	83.30%	50.00%
Ward A	96.9%	92.9%	3.4	94.2%	94.1%	3.50	5.79%	13.34%	16.02%	0		0/0		0/1	100.00%	100.00%
Ward B	101.5%	98.3%	3.2	95.8%	88.3%	3.16	5.43%	5.24%	2.80%	0		0/0		0/0	100.00%	100.00%
JCW	107.1%	100.2%	5.4	76.2%	106.3%	2.68	3.01%	10.76%	8.74%	0		0/3		0/0		

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

SAFE STAFFING EXCEPTION REPORT – December 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 (%)	Vacancies (%) - Registered Nursing Band 5-8	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	91.8%	100.2%	3.0	138.9%	118.8%	5.9	4.72%	0.60%	9.80%	0		0/3	1/1	0/3	100.00%	100.00%
Cardio and Respiratory	97.7%	91.7%	3.0	101.9%	107.4%	4.1	6.22%	6.81%	22.44%	5	1	0/3	3/0	1/6	86.00%	100.00%
Coronary Care Unit	112.5%	100.9%	7.8	101.6%		2.2	1.55%	2.00%	2.11%	0		0/3		0/4	100.00%	100.00%
Elderly Care Unit	97.4%	102.4%	2.6	126.3%	141.2%	5.5	3.02%	8.70%	11.69%	*1	2	0/7	2/4	0/1	100.00%	80.00%
Highfield	84.7%	85.8%	4.3	150.5%	88.7%	6.0	0.0%	0.0%	0.0%	7		0/1				
Pemberton	93.8%	104.4%	5.2	139.7%	124.5%	5.6	6.74%	6.25%	28.71%	1		0/2				
Shevington	100.4%	89.1%	3.0	121.9%	167.8%	5.0	9.40%	13.87%	32.26%	0	1	0/4		0/1	100.00%	100.00%

Division of Medicine – Unscheduled Care

	Average Fill Rates (%) & CHPPD						Staff Availability			Staff Experience	Nurse Sensitive Indicators				Patient Experience % (Number surveyed)	
	RN / RM			CSW												
Ward	Day shift (%)	Night shift (%)	CHPPD	Day shift (%)	Night shift (%)	CHPPD	Sickness (%)	Vacancies (%)	Vacancies (%) - Registered Nursing Band 5-8	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	84.1%	94.5%		120.6%	136.2%		4.94%	19.12%	20.63%	0		0/3		0/2		
A&E Paeds	93.2%	102.9%					0.72%	19.82%	19.82%	0						
A&E NP's	166.2%	3.8%														
CDW	98.8%	106.7%		99.0%	105.8%		3.54%	0.78%	0.00%	0				0/2	80.00%	100.00%
Medical Assessment Unit	97.7%	83.8%		109.5%	121.0%		8.89%	5.54%	16.07%	7	1	0/4		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 (%)	Vacancies (%) - Registered Nursing Band 5-8	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	90.7%	88.7%	30.5	74.2%	0.0%	2.8	4.28%	0.64%	0.96%	22				0/1		
Langtree	92.4%	98.1%	2.6	140.8%	169.8%	3.5	4.01%	0.00%	7.40%	0	2	0/4		1/2	100.00%	100.00%
Orrell	105.0%	119.6%	4.6	127.7%	174.8%	5.6	11.22%	0.00%	0.00%	114		0/3	2/1	0/1	100.00%	100.00%
Swinley	100.2%	97.6%	2.6	103.1%	117.5%	2.7	2.93%	0.00%	0.00%	7	2	0/1		0/1	90.00%	90.00%
Maternity Unit	100.8%	95.1%	14.1	74.5%	92.9%	3.9	6.28%	0.00%	0.00%	0					100.00%	100.00%
Neonatal Unit	102.1%	100.1%	12.8	95.2%	0.0%	1.5	11.43%	0.00%	0.00%	0					100.00%	100.00%
Rainbow	100.7%	87.0%	7.9	107.3%	73.3%	2.6	9.02%	8.42%	10.57%	3				0/1	100.00%	100.00%

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

Division of Specialist Services

	Average Fill Rates (%) & CHPPD						Staff Availability			Staff Experience	Nurse Sensitive Indicators				Patient Experience % (Number surveyed)	
	RN / RM			CSW												
Ward	Day shift (%)	Night shift (%)	CHPPD	Day shift (%)	Night shift (%)	CHPPD	Sickness (%)	Vacancies (%)	Vacancies (%) - Registered Nursing Band 5-8	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	107.2%	92.8%	3.4	129.9%	147.2%	4.57	8.77%	9.09%	23.36%	38		1/1	1/0	0/1	88.90%	100.00%
Ward A	74.8%	68.5%	2.7	69.3%	57.8%	2.44	6.52%	13.74%	20.84%	0				0/1	100.00%	100.00%
Ward B	106.0%	124.1%	3.7	93.6%	97.7%	3.37	8.87%	4.76%	2.80%	0				0/1	92.30%	100.00%
JCW	74.7%	72.3%	4.0	68.0%	87.2%	2.39	5.38%	7.67%	9.57%	0						

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

Appendix 2

	October 2019		**November 19**		December 2019	
No of areas	Red Metrics Registered Staff Days	Red Metrics Registered Staff Nights	Red Metrics Registered Staff Days	Red Metrics Registered Staff Nights	Red Metrics Registered Staff Days	Red Metrics Registered Staff Nights
24	**5**	**6**	4	5	4	4

Table 1. Red Metrics October to December 2019

	October 2019		**November 2019**		December 2019	
Specialty	**Registered**	**Unregistered**	Registered	Unregistered	Registered	Unregistered
Medicine	**41.71**	**6.97**	37.98	2.89	37.98	2.89
Surgery	**26.74**	**7.2**	31.27	12.58	25.2	10.95
Specialist Services	**16.79**	**5.72**	12.89	8.6	10.6	11.38
Community Services Adult	**39.4**	**12.69**	48.49	14.0	64.77	22.15
Community Services Children	**8.26**	**0.0**				
Total	**132.9**	**32.58**	**130.63**	**38.07**	**138.55**	**47.37**

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

Month	Registered WTE	Unregistered WTE
April 18	48.38	9.39
May 2018	55.94	13.03
June 2018	49.21	13.15
July 2018	59.44	10.48
August 2018	56.89	12.89
September 2018	50.78	8.37
October 2018	51.88	9.643
November 2018	67.28	14.83
December 2018	64.71	15.47
January 2019	70.36	7.3
February 2019	62.49	7.3
March 2019	87.17	16.68
April 2019	160.11	23.32
May 2019	149.41	22.86
June 2019	97.81*	
August 2019	186.37	34.96
September 2019	159.13	35.81
October 2019	132.9	32.58

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

Red Flag Category	No. of Incidents October 2019	No. of Incidents November 2019	No. of Incidents December 2019
Shortfall of more than 8 hours or 25% of registered nurses in a shift	174	110	85
Delay of 30 minutes or more for the administration of pain relief	81	118	100
Delay or omission of intentional rounding	1	0	6
Less than 2 registered nurses on shift	20	16	13
Vital signs not assessed or recorded as planned	3	0	1
Unplanned omission of medication	1	1	0
Total	**280**	**245**	**205**

Table 4. Nursing Red Flags October to December 2019

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

Table 5. Maternity Red Flags October to December 2019

Care Hours per Patient Day - Total Nursing and Midwifery staff	Oct 2019	8.9	8.1	8.0	
Care Hours per Patient Day - Registered Nurses & Midwives	Oct 2019	4.4	4.6	4.7	
Care Hours per Patient Day - Healthcare Support Workers	Oct 2019	4.4	3.5	3.2	
Care Hours per Patient Day - Registered Nursing Associates	Oct 2019	0.1	0.0	0.0	
Care Hours per Patient Day - Unregistered Trainee Nursing Associates	Oct 2019	0.0	0.0	0.0	
Care Hours per Patient Day - Total AHPs staff	Oct 2019	0.0	0.0	0.0	
Cost per Care Hour - Total Nursing and Midwifery staff	Q4 2018/19	£20.6	£23.6	£23.7	
Cost per Patient Day - Total Nursing and Midwifery staff	Q4 2018/19	£174.4	£195.3	£189.6	

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

REPORT

AGENDA ITEM: 8.5

Wrightington, Wigan and Leigh NHS Foundation Trust

To:	Board of Directors	**Date:**	29 January 2019
Subject:	Bi-annual Staffing Review		
Presented by:	Chief Nurse	**Purpose:**	Discussion and Approval

Executive summary

The purposes of this report is provide the board with the mandated requirement from NHS England in providing assurance of ongoing monitoring and review of adult inpatient staffing establishments and to advise the Board of any recommended changes to these establishments.

This report is produced in addition to the monthly assurance reports.

Overall funded skill mix has fallen within predominantly Scheduled care to below the Trust agreed 55:44.

Model Hospital data demonstrates that CHPPD for registered nurses for the Trust is currently below the peer average and National average unregistered CHPPD is higher than both peer and national averages.

There is coloration with areas of diluted skill mix and the number of harms captured by Nurse Sensitive Indicators (NSI's) particularly Hospital Acquired Pressure Ulcers and falls.

The acuity and dependency of patients continues to increase in line with the previous report SNCT data suggests that there is a shortfall of nursing time as outlined within the recommendations of this report.

It is recommended that:

- The skill mix for core wards is reset to 55:45.
- Medical Assessment areas skill mix is adjusted to 65:45.
- There is an uplift of the registered workforce within Coronary Care Unit and to support the Non-invasive ventilation within the Cardio-Respiratory unit.
- There is an uplift of the registered workforce to address the rise in patient acuity and address the SNCT identified requirement.

It should be noted that in implementing the recommendations a flexible approach will be taken to maximise the recruitment opportunities and use of new registered practitioner roles such as Pharmacy Technicians and AHPs within the increased registered workforce rosters.

The total investment into the nursing budgets to address the recommendations of this report is £2.2m

The WWL Way

Risks associated with this report
Staffing levels remain a concern across clinical divisions with individual wards being noted on the Corporate Risk Register. The dilution of skill mix has had an impact on nursing care standards, patient experience and outcome

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

Bi Annual Nurse Staffing Review

Introduction

The purpose of this paper is to provide Trust Board with an assessment of the funded nurse staffing levels for inpatient areas within WWL, and to advise the Board of any recommended changes to these establishments to ensure safe care.

This report will include reference to current funded establishments, Care Hours per Patient Day (CHPPD), national guidance, acuity and dependency measures and incidents of harm which have been triangulated to formulate the recommendations within this report.

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 and that decisions made following receipt of the report to Board be documented to provide assurance of Board level accountability and responsibility for staffing levels.

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.

Developing Workforce Safeguards 2018 states each Trust must demonstrate compliance with National Quality Board guidelines with respect to workforce, and for a declaration of safety in this regard to be made within the Trust Annual Governance Statement. This should be jointly signed by the Chief Nurse and the Medical Director.

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[7]. The tool is recognised by the Quality Management

[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] Hurst, K (2012): *Safer Nursing Care Tool Staffing Multipliers (2012) – Method and Results*

Board (QMB)[8]. 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 described the Trust utilises SNCT to determine the acuity and dependency of patients within our hospital. The tool incorporates agreed multipliers for adult and paediatric inpatient and 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 Appendix 1, Table 1. Multipliers marked * represent the elevated scores associated with patients accommodated within assessment areas and acknowledges the increased workload associated with patient movement.

Quality Indicators

Data with respect to hours of time required based on acuity and dependency cannot be viewed in isolation to determine staffing levels, this 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

[8] 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.*

medicine administration errors and number of red flags reported and are usually referred to as Nurse Sensitive Indicators (NSI's).

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 Divisional Directors for Nursing and includes the agreed allowance for the uplift of staff.

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. Model Hospital data demonstrates that CHPPD for registered nurses for the Trust is currently below the peer average and National average unregistered CHPPD is higher than both peer and national averages. This demonstrates an over reliance on unregistered staff to deliver direct care and a dilution of skill mix.

**CHPPD figures Model Hospital October 2019*

Skill Mix

The RCN[9] recommends a ratio of 65:35 registered nurses/unregistered staff in inpatient areas and 70/30 for assessment areas. Following on from the last nursing establishment review in 2017 the Trust Board agreed the minimum ratio for registered/unregistered staff was to be set at 55:45.

Uplift

The RCN recommend that nursing establishments are uplifted by 23% to support study leave, annual, and sickness/absence; NHSI recommend that the uplift in staffing is 22-25%. Trust Board agreed previously that the uplift would be set at 20% and this has remained unchanged. Across Greater Manchester the average uplift is 22.5%.

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

Supervisory Ward Managers

National guidance suggests that all Ward Managers should be supervisory to practice. The Trust Board at the time of the establishment review that 50% of ward manager time should be supervisory to practice in line with national guidance; this and factored into budgeted establishment at this time.

The shortfall in registered nursing time has, however, seen clinical leadership time eroded; within Scheduled Care the average time spent on management responsibilities in these areas at the time of this review was 20-32%. The Board should note that this is insufficient time for the managers to fulfil all the requirements of their role and that this will also impact on the ability to effectively and proactively manage quality and patient experience. National evidence demonstrates that this adversely impacts on staff retention and wellbeing.

Current Position

Funded establishments were obtained from Divisional Finance Officers in September; these establishments have been verified by the Divisional Directors of Nursing; April 2019 WTE funded establishment is also provided by way of comparison. This information is provided within the Table 3.

Since the last update to Trust Board, the Nursing Associates (NA's) have registered with the Nursing and Midwifery Council (NMC); the WTE NA's employed in inpatient areas have been identified separately within this table. The NA role was introduced to bridge the gap between registered and unregistered staff. Whilst this element of the workforce is responsible and accountable for the actions and omissions and must adhere to the NMC code, they are not registered nurses, and therefore should not be considered to be a replacement for a registered nurse or allied health practitioner.

When funded establishments and SNCT data is compared it is evident that there has been an increase in acuity and dependency of patients and their care requirements highlight a need to increase funded nursing hours.

Division	Ward	Nos of Beds	Sept 19 WTE	Sept 19 SNCT	Skill Mix Budgeted
Specialist Services	Aspull	28	42.53	46.15	57:43
	JCW	16	24.48	27.99	68:32
	Ward A	28	36.59	45.17	54:46
	Ward B	24	30.59	39.43	55:45
Surgery	Langtree	28	29.7	38.37	57:43
	Orrell	26	34.01	37.93	52:48
	Swinley	26	33.05	32.22	62:38
Scheduled Care	Elderly Care	55	83.59	86.44	42:58
	ASU	22	38.35	36.36	43:57
	*CCU	8	21.04	20.02	86:14
	*Cardio Respiratory	55	85.35	84.9	47:53
	Pemberton	12	24.47	21.64	56:44
	Shevington	28	41.04	43.42	47:53
	Highfield	10	15.3	17.2	49:51
Unscheduled Care	*CDW	10	21.66	20.78	61:39
	MAU's	55	77.92	84.9	55:45
	Total	**464**	**639.67**	**682.67**	

Table 3

Application of Professional Judgment

SNCT does not always capture the requirements re national guidance and this is where Professions judgment needs to be applied

- *CCU in table based on 8 beds. 11 beds now operational and requirements contained in the recommendations reflect 11 beds and the requirement for remote monitoring of telemetry. National recommendations stipulate that CCU should have a staffing ration of 1 RN per 2 Patients this is reflected in the recommendations.*
- *CDW the model of care has changed to part bedded part ambulatory this has resulted greater level of activity which in turn impacts of nursing hours required this is reflected in the recommendations.*
- *Cardio-respiratory unit: The British Thoracic Society Guidance for the care of patients receiving Non Invasive Ventilation which specifies that patients receiving acute NIV should be cared for ration of 1 RN per 2 Patients this is reflected in the recommendations. (Please see appendix 1 table 2 re average number of level 2 NIV patients recorded as 8 patients.)*
- *ASU requires additional nursing hours for those hyper acute stroke patients who would not be transferred for Thrombolysis national guidance stipulates these patients should be cared for should be cared for ration of 1 RN per 2 Patients this is reflected in the recommendations.* (*Please see appendix 1 table 2 re average number of level 1a patients recorded as 6 patients.)*
- *Wards A and B at Wrightington: SNCT recommends an uplift in the nursing establishment of 9WTE in each area. On consideration of the peaks and troughs in operational activity in the areas and application of professional judgment the additional staffing recommended will be less as outlined in the recommendations and will provide the division with the opportunity to flex its workforce to meet operational requirements*

Within Table 3 there are 5 areas that are over the 55:45 skill mix for staffing this is due to.

- JCW and Pemberton are both areas where the bed compliment is comprised entirely of single rooms. The increased skill mix is necessary to ensure there is greater oversight of patients when direct care is being delivered.
- Aspull rostered staffing numbers include the trauma co-ordinators who do not deliver direct care to patients.
- Swinley ward holds nurse led clinics and interventions within the ward environment and additional registered staff are required to undertake this activity.
- CCU skill mix in line with national guidance.

Review of the skill mix data across all inpatient areas identifies that there has been a deviation from the Trust agreed standard for skill mix within inpatient areas and it is evident that the funded skill mix in 7 of the 16 inpatient wards does not meet the skill mix agreed by the Trust in 2016. This is more prevalent within the division of Medicine.

This information has been reviewed by the Divisional Directors for Nursing and in line with professional judgement taking into account skill mix, consideration of nursing sensitive quality indicators and patient experience, the professional recommendation is that overall staffing establishment needs to revert back to the previously agreed skill mix as a minimum as outlined within the recommendations within this report.

Position regarding acuity

Comparison of acuity and dependency data has identified a continuing shift in the care requirements of the patients (Appendix 1, Table 2). Level 1b patients remain the highest category of patients occupying inpatient beds across the Trust. These patients generally require all nursing care and in addition often have complex health and social care needs requiring oversight and scrutiny by registered staff. September has also seen an increase in the number of SNCT Level 2 patients occupying general inpatient beds. This is reflective of the age group of those admitted and the complexity of managing their multiple co-morbidities, and the increasing number of patients who are ill but do not meet the criteria for admission to HDU/ICU.

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 as a result of this dilution.

SNCT data provides evidence that there are insufficient care hours to meet the needs of our patients, therefore conversion of unregistered posts to registered posts will not address the issue of dilution, and this is will also negatively impact on nurse sensitive indicators.

It is also worthy of note that a significant proportion of SNCT Level 2 patients are those accessing NIV treatment on the cardio-respiratory ward. British Thoracic Society guidelines recommend that these patients are nursed on a 1:2 basis which is currently not funded within the ward establishment; this needs to be addressed as a priority.

In addition it should be noted that CCU is funded to provide care for 8 patients whilst 11 beds are occupied throughout the year, in addition remote telemetry is overseen on the unit. In order to maintain safety within CCU a ratio of 1:3 is required in line with national guidance and needs to be addressed by way of this paper.

Nurse Sensitive Indicators (NSI's)

NSI's are measures and indicators reflecting the structure, process and outcomes of nursing care. These measures help to reflect the impact of care that nurses working in inpatient services provide. In addition they assist in determining the link between the care provided and funded staffing establishment within the ward. NSI data is reported monthly to Board within the Safe Staffing Report.

A comparison of NSI's by Quarter for 2018/2019 and for the month of September 2019 is provided in Table 4 below.

Nurse Sensitive Indicator	Q1 2018	Q1 2019	Q2 2018	Q2 2019	Sept 2019
CDT Cases	1	12	4	11	6
Falls	71	164	135	192	62
Medication Administration Incidents	65	84	59	59	17
Pressure Ulcers	3	22	4	16	2
Nursing Red Flags	188	929	159	609	221

Table 4

The data provided in Table 4 demonstrates that there has been an increase in the number of harms in comparison to 2018.

On review of the harms data above it can be seen that there has been a high level of reported harms and red flags with an overall increase in the number of CDT cases. This is subject to a separate report to Board.

The number of inpatient falls reported by the Trust has continued to increase. Whilst the majority of the falls reported in no physical harm to the patient, the psychological impact of a fall in an elderly patient cannot be underestimated and this will inevitably impact on length of stay

The Falls Improvement Group has been reinstated to review current processes and to recommend further interventions that may assist in keeping our patients safe whilst in our care.

There has been a reduction in the number of medication administration incidents reported, however the overall trend for reporting of medication incidents remains static. This is felt to be partly attributable to the introduction of Pharmacy Technicians into some of the wards the recommendations within this report would allow that initiative to be spread across all wards.

With respect to pressure ulcer the Trust has seen an increase in the reporting of Hospital Acquired Pressure Ulcers (HAPU's) since April 2019; this is demonstrated in the run chart below (Chart 1). Chart 2 provides the run rate for the same data period in 2018. This is subject to a separate report to Board.

Chart 2 HAPU's 2018/19

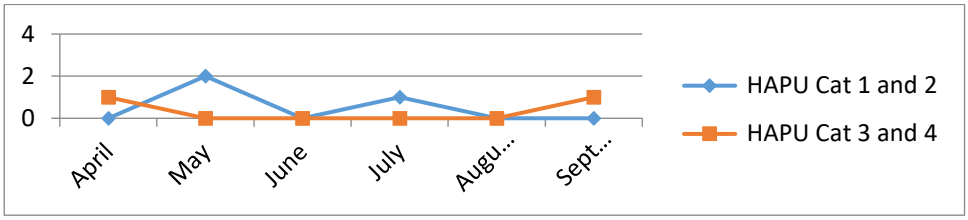
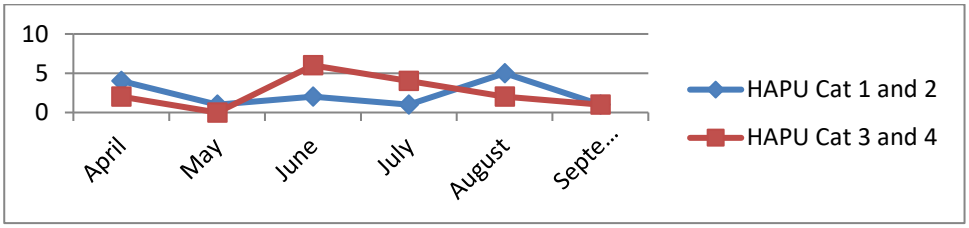


Chart 1HAPU's 2019/20



The majority of the hospital acquired pressure ulcers reported occurred within Scheduled Care; this service has also seen the greatest reduction in skill mix.

Nursing Red Flags were launched in 2014 by the National Institute for Clinical Excellence (NICE). The Red Flag events are warnings that identify when there are insufficient registered nurses to meet the needs of the patients on any particular ward. Red Flag events are currently captured on SafeCare.

The overall increase in the reporting of Red Flags. These are mainly attributed to a shortfall in registered nursing time.

The next highest reported category of Red Flag relates to delays in the administration of pain medication. This flag is intrinsically linked to staffing levels.

Mortality

Evidence suggests that there are higher levels of mortality and poor patient outcomes and experience when registered nurse staffing levels are reduced. 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. Evidence suggests that there are higher levels of mortality and poor patient outcomes and experience when registered nurse staffing levels are reduced[10]

Recommendations

It is evident from the information provided within the report that there has been deterioration in the skill mix of registered to unregistered staff. The deterioration of skill mix impacting on patient care and is reflected in the increase in avoidable harms, most notably pressure ulcers and falls.

It is therefore recommended that the Board agree with the below actions being taken;

1. The skill mix for core wards is reset to 55:45 and the skill mix for assessment areas is uplifted to 65:35 to reflect the high turnover of patients and the increasing demands and acuity on these areas.
2. To address the skill mix and SNCT requirements within Medicine the following changes are required;

- ASU require an increase of 9.71 WTE Registered staff, however this can be partly offset by the inclusion of the therapy staff based permanently on the ward. Therefore an overall increase of 1.21 WTE registered staff offset by a reduction of 1.22 WTE unregistered staff is required to correct the skill mix. (£16k)
- Winstanley 5.8 WTE registered with a reduction of 3.11 WTE unregistered (£149k)
- Astley 4.55 WTE registered with a reduction of 4.6 WTE unregistered (£60k)
- Standish 4.17 WTE registered with a reduction of 4.17 unregistered (£56k)
- Shevington 4.57 WTE registered with a reduction of 2.37 unregistered (£119k)
- Lowton 5.63 WTE registered with a reduction of 2.94 unregistered (£147k)
- MAU 5.88 WTE registered with a reduction of 2.94 unregistered (£ 157k)
- CDW 2.68 WTE registered (£107k)

The total cost of the skill mix adjustment is £812k

Investment in registered nurse staffing where there is an existing service which is currently unfunded

- Ince ward 10.72; this will address both the skill mix on the clinical area and provide support for NIV patients (£427k)
- CCU 5.36 WTE (additional beds and telemetry) (£214k)

The total cost of this investment is £641k

3. Address the shortfalls in staffing identified via SNCT and professional judgement

- Surgical Wards; 8.04 WTE registered (£321k)
- Aspull 2.68 WTE registered and 2.68 WTE unregistered (£178k)
- Ward A 2.68 WTE unregistered (£71K)
- Ward B 2.68 WTE registered and 2.68 WTE unregistered (£178k)

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

The total investment required addressing the shortfall in staffing identified by SNCT and professional judgement is £748k

The total investment into the nursing budgets to address the above is £2.2m

The recommendations result in an increase in registered staff of 63.97 WTE and a decrease in unregistered staff of 13.31 WTE; therefore there will be an overall increase in headcount of 50.66 WTE.

It should be noted that in implementing the recommendations a flexible approach will be taken to maximise the recruitment opportunities and use of new registered practitioner roles such as Pharmacy Technicians and AHPs within the increased registered workforce rosters.

There are a series of planned activities aimed at recruitment and improving registered practitioner fill rates across inpatient areas. Including quarterly recruitment events, a 'golden handshake' for experienced registered nurses joining the Trust, increasing bank rates of pay, and a relaunch of the Incentive Scheme, alongside this there is a comprehensive overseas recruitment programme. The nursing recruitment programme is currently ahead of trajectory in terms of the number of new recruits.

The Board is asked to;

- Note the deterioration in Registered to Unregistered staffing ratios within inpatient areas, most notably Unscheduled Care
- Note the correlation of registered practitioner staffing levels and reported increase in reported harms.
- Agree the professional recommendations contained within this report in relation to resetting of registered practitioner staffing levels and the investment required to staff the NIV service and CCU, and to address the uplift in staffing to meet SNCT requirements within Specialist Services and Surgery, and agree to support the financial investment required to be added to the budgets.

Appendix 1

Table 1.Safer Nursing Care Tool Descriptors

Level	Descriptor	Multiplier
0	**Patient requires hospitalisation and needs met by providing normal ward care eg.** Elective medical or surgical admission, underlying medical condition requiring ongoing treatment, patients awaiting discharge, post operative/procedure care – observations recorded ½ hourly initially then 4 hourly, 2-4 hourly observations, Early Warning Score within normal threshold, ECG monitoring, Fluid management, Oxygen therapy less than 35%, PCA, Nerve block, single chest drain, Confused patients not at risk, patients requiring assistance with some daily living requiring 1 person to mobilise, or one experiencing occasional incontinence.	**0.99/1.27***
1a	**Acutely ill patients requiring intervention or are UNSTABLE with GREATER POTENTIAL to deteriorate** Increased observation and therapeutic interventions, triggering on Early Warning Score and requiring escalation, post-operative care following complex surgery, emergency admissions requiring therapeutic intervention, instability requiring continual observation/invasive monitoring, oxygen therapy greater than 35% +/- chest physiotherapy 2-6 hourly, intermittent ABG, 24 hours post tracheostomy, central line, epidural or multiple chest or extra ventricular drains, severe infection or sepsis.	**1.39/1.66***
1b	**Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of the activities of daily living** Complex wound management requiring more than 1 nurse or takes more than 1 hour to complete, VAC therapy undertaken by ward nurses, patients with spinal instability/spinal cord injury, mobility or repositioning requiring 2 or more carers, complex IV drug regimes requiring prolonged preparatory/administration/post administration care, Patient/carer requiring enhanced psychological support owing to poor disease prognosis/clinical outcome; patients on end of life care pathway; confused patients who are at risk or requiring constant supervision; requires assistance with all or most ADL's; potential for self-harm and requires constant observation; facilitating a complex discharge where this is the responsibility of the ward-based nurse.	**1.72/2.08***
2	**May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated level 2 facility/unit** Deteriorating/compromised single organ system; post-operative optimisation (pre-op invasive monitoring)/extended post-operative care; patients requiring NIV/CPAP/BiPAP in acute respiratory failure; first 24 hours following tracheostomy; requires several therapeutic interventions including; • Greater than 50% oxygen continuously	**1.97/2.26***

Level	Descriptor	Multiplier
	• Continuous cardiac monitoring **AND** invasive pressure monitoring • Drug infusions requiring more intensive monitoring eg, vasoactive drugs (amiodarone, inotropes, gtn), potassium or magnesium • Pain management – intrathecal analgesia. • CNS depressed airway and protective reflexes Invasive neurological monitoring.	
3	**Patients needing advanced respiratory support and/or therapeutic support for multiple organs.** Monitoring and supportive therapy for compromised/collapse involving 2 or more organ/systems; respiratory or CNS depression/compromise requiring mechanical/invasive ventilation, invasive monitoring, vasoactive drugs, treatment of hypovolaemia/haemorrhage/sepsis or neuro protection.	**5.96**

Table 1.

Table 2 provides a snap shot comparison of acuity and dependency levels of care for inpatient. Where an * is used this demonstrates that there are assessment beds within the clinical area and a higher multiplier is used for these patients.

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
	Sept 19	8	1	20	1	0
JCW	Sept 18	12	0	1	0	0
	April 19	4	1	5	0	0
	Sept 19	7	1	10	1	0
Ward A	Sept 18	11	9	0	0	0
	April 19	8	1	12	0	0
	Sept 19	7	1	20	1	0
Ward B	Sept 18	8	0	11	0	0
	April 19	8	1	8	0	0
	Sept 19	7	1	16	1	0
Langtree	Sept 18	11	13	3	0	0
	April 19	13	2	12	0	0
	Sept	16	0	12	0	0

Ward		Level 0	Level 1a	Level 1b	Level 2	Level 3
	19					
Orrell	Sept 18	13	10	1	0	0
	April 19	4/2*	8/5*	5/1*	0	0
	Sept 19	4/2*	7/5*	4/1*	2	0
Swinley	Sept 18	21	4	1	0	0
	April 19	15	3	17	0	0
	Sept 19	15	1	9	0	0
Elderly Care	Sept 18	12	7	36	0	0
	April 19	0	2	52	0	0
	Sep 19	14	2	40	0	0
ASU	Sept 18	0	0	22	0	0
	April 19	0	4	17	0	0
	Sept 19	0	6	16	0	0
CCU	Sept 18	1	6	2	1	0
	April 19	1	4	5	1	0
	Sept 19	0	0	8	3	0
CDW	Sept 18	0/5*	0/5*	0/0	0	0
	April 19	0/0*	0/7*	0/3*	0	0
	Sept 19	0/0*	0/5*	0/6*	0	0
Cardio Respiratory	Sept 18	4	26	16	8	0
	April 19	14	19	14	4	0
	Sept 19	6	20	20	8	0
MAU's	Sept 18	0	48	2	1	0
	April 19	0/16*	0/22*	0/11*	0	0
	Sept 19	0/10*	0/29*	0/10*	0/1*	0
Pemberton	Sept 18	0	1	11	0	0
	April 19	0	0	12	0	0
	Sept 19	0	0	12	0	0

Ward		Level 0	Level 1a	Level 1b	Level 2	Level 3
Shevington	Sept 18	11	12	4	0	0
	April 19	5	12	11	0	0
	Sept 19	3	10	14	1	0
Highfield	April 19	0	0	10	0	0
	Sept 19	0	0	10	0	0
Total		**116/90/99**	**135/92/90**	**128/215/228**	**8/5/19**	**0/0/0**

Table 2

REPORT

AGENDA ITEM: 8.7

Wrightington, Wigan and Leigh NHS Foundation Trust

To:	Board of Directors	**Date:**	29 January 2020
Subject:	Workforce Plan prioritisation		
Presented by:	Director of Workforce	**Purpose:**	Approval

Executive summary

This report sets out the workforce plan prioritisation process outputs and should be read in conjunction with the bi-annual staffing paper.

The Executive Team recommends that the Board approves the process and findings as outlined in the paper:

- Phase 1a – essential investment to meet national evidence based benchmarks for safe staffing and the rota changes linked to the Doctors in Training terms and conditions (2019 amendments).
- Phase 1b – pre-approved business cases that are part of the budget setting process for 2020/21 and will be subject to review as part of the budget setting scrutiny process.
- Phase 2 – development of workforce models that uses appropriately skilled non-medical practitioners to address gaps in the medical workforce that result in high agency / temporary staffing expenditure, alongside wider workforce transformation programmes. Phase two programmes of work will be developed into individual transformation schemes.

The Board is asked to approve the immediate implementation of phase 1a, at a net increased cost of £3.37m. This workforce investment schedule should be fully incorporated into the financial planning process for 2020/21. Phase 1b, which includes previously approved business cases that have been factored into the budget setting round for 2020/21, will be scrutinised further in the budgeting process to mitigate the cost where practicable.

Phase 2 will be developed into transformation programmes during 2020/21 that include financial return on investment, quality and safety benefits and the cultural actions that are required to ensure full implementation and transformation.

Risks associated with this report

- HR84 – Ability to recruit and retain to required staffing levels (20)
- HR93 – Breaching the NHSI agency ceiling (20)
- HR104 – sickness absence above target (15)
- HR82 – Decline in safety culture
- HR115 – Organisational Staff Engagement Levels (16)

The WWL Way

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

Workforce Plan

Executive summary

It is essential that the Trust has a workforce that is able to deliver safe and effective care for our patients. Detailed work has been completed to develop a workforce plan for inpatient areas that takes into account the demand on services and the acuity of our patients. This plan has been spilt into two components:

Phase 1a – essential investment to meet national evidence based benchmarks for safe staffing and the rota changes linked to the Doctors in Training terms and conditions (2019 amendments).

We expect that this investment will result in:

- Reduction in hospital acquired pressure ulcers
- Reduction in patient falls
- Reduced CDT
- Reduced mortality measures
- Reduced complaints linked to patient experience
- Reduced sickness absence rate
- Improved staff engagement and morale
- Improved GMC survey

This mirrors the findings of the non-medical clinical bi-annual staffing review process, which uses evidence based methodology and professional judgement.

Phase 1b – pre-approved business cases that are part of the budget setting process for 2020/21 and will be subject to review as part of the budget setting scrutiny process.

Phase 2 – development of workforce models that uses appropriately skilled non-medical practitioners to address gaps in the medical workforce that result in high agency / temporary staffing expenditure, alongside wider workforce transformation programmes. Phase two programmes of work will be developed into individual transformation schemes.

Phase one is a key enabler to progress to phase two and is imperative to improving both patient safety and staff satisfaction.

The Board is asked to approve the immediate implementation of phase 1a at a net increased cost of £3.37m. This workforce investment schedule should be fully incorporated into the financial planning process for 2020/21. Phase 1b, which includes previously approved business cases that have been factored into the budget setting round for 2020/21 will be scrutinised further in the budgeting process to mitigate the cost where practicable.

Phase 2 will be developed into transformation programmes during 2020/21 that include financial return on investment, quality and safety benefits and the cultural actions that are required to ensure full implementation and transformation.

Context
The Trust Board has received presentations regarding the outputs of the clinical workforce planning process. The presentation at December's Board workshop highlighted a correlation between deteriorating patient experience and patient safety measures with deteriorating staff experience measures. These deteriorating metrics also correlate with a dilution of the clinical skill mix in inpatient areas.

Detailed work was completed during October by the Deputy Director of HR and Assistant Chief Nurse, with input from many clinical stakeholders, to identify the requirements of a clinical workforce plan that would deliver safe and effective care for our patients, taking into account patient acuity and multi-disciplinary team approaches. Crucially, this work used evidence based tools to determine its findings, supplemented by professional judgement, which is an obligation for the Trust under NHSI's Developing Workforce Safeguards.

The team considered the essential requirements to provide safe care, but also longer term opportunities for wider workforce transformation that, through upskilling and expansion of Advance Clinical Practitioner roles would enable alternative models to be implemented in areas of long standing medical vacancies, which provides opportunities for financial and quality benefits.

Prioritisation
A prioritisation process has been completed to inform financial and service planning for 2020/21.

Phase one
Phase 1a
The first phase is essential to ensure the skill mix of ward based registered to unregistered clinical practitioners is safe and fit for purpose. Additionally, it ensures that the safe staffing guidelines produced by the Royal College of Physicians can be met. It is essential that this phase is built into the financial schedules and planning for 2020/21 and whilst we expect there to be efficiency benefits, it is impossible for these to be profiled in a way which will provide financial return on investment. This workforce investment is however vital to ensure that establishments meet minimum national benchmarks and to address the deteriorating quality, safety and staff experience metrics. Some of the benefits we expect to see as a result of the implementation of phase one include:

- Reduction in hospital acquired pressure ulcers
- Reduction in patient falls
- Reduced CDT
- Reduced mortality measures
- Reduced complaints linked to patient experience
- Reduced sickness absence rate
- Improved staff engagement and morale
- Improved GMC survey

The bi-annual staffing review details the requirements for non-medical clinical practitioners and this mirrors the outputs of phase one in the prioritised workforce plan. It is important to note that the increased requirement for registered clinical practitioners does not refer only to nursing. The workforce planning process has identified opportunities for multi-disciplinary ward based teams, built around the requirements of the patients and the skills and competencies of the various registered clinical practitioner roles. This will help in terms of recruiting to the vacancies, but also in progressing workforce transformation at ward level using non-traditional workforce models. Quality Impact Assessments will be in place for each ward where a non-traditional model is proposed.

Additional support for Junior Doctors was also prioritised in phase one of the plan, with the introduction of 14 Foundation Year 3 doctors in Medicine and 2 Foundation Year 3 Doctors in Surgery. This helps to address some of the issues identified by our Doctors in Training in the GMC survey.

Since the Board presentation in December, the impact of the phased implementation of the Doctors in Training Contract agreement (2019) has been implemented in the rota design software. This has resulted in the requirement to increase medical cover in A&E by 4 Foundation Year 2 / Core Trainee 1 doctors. The Trust has no option but to make this change in order to reduce the weekend frequency within that department to comply with the new terms and conditions. Failure to do so would result in exception reporting fines and could risk the continued allocation of trainees to WWL in this specialty. This has therefore been added to the requirements under the essential phase 1 plan.

Phase 1b – pre-approved business cases that are part of the budget setting process for 2020/21 and will be subject to review as part of the budget setting scrutiny process.

Phase two

Phase two of the workforce plan aims to focus on significant workforce transformation, with the development of workforce models that uses appropriately skilled advanced non-medical practitioners to address gaps in the medical workforce that result in high agency / temporary staffing expenditure, alongside wider workforce transformation programmes. This phase requires significant preparatory work and lead in time, as well as a shift in the organisational culture. Getting the workforce to the right size and skill mix, through phase one implementation is a key enabler to phase two. Phase two activities will be worked into transformation and SAVI schemes in 2020/21, with clear return on investment profiles.

Given the training and associated lead in time for Advanced Clinical Practitioners, opportunities for externally funded training programmes will be utilised when they become available, where relevant to the phase two plans. These would subsequently be prioritised in the transformation programme.

Financial impact

£000s	19/20	20/21	21/22	22/23	23/24
Seeking Approval					
Nurse Skill Mix	2,197	2,197	2,197	2,197	2,197
Junior Doctors	1,172	1,172	1,172	1,172	1,172
Recruitment & Retention					
Phase 1a	**3,369**	**3,369**	**3,369**	**3,369**	**3,369**
Already Approved (to be reviewed)					
Nurse Skill Mix					
Junior Doctors					
Recruitment & Retention	225	1,465	599	599	599
Advanced Clin. Practitioners					
Divisional - Alternative W.force	1,720	2,730	2,730	2,730	2,730
General	107	107	107	107	107
Physician Associates					
Professional Practice					
Phase 1b	**2,052**	**4,303**	**3,436**	**3,436**	**3,436**
Future Review / Approve					
Advanced Clin. Practitioners	836	1,127	1,350	1,402	1,428
Divisional - Alternative W.force	3,879	3,927	3,927	3,927	3,927
General					
Physician Associates	97	97	97	97	97
Professional Practice	605	808	364	402	402
Phase 2	**5,417**	**5,960**	**5,738**	**5,828**	**5,854**

People impact

Workforce metrics have been deteriorating (most notably in the last 18 months – 2 years), correlating with a diluted skill mix, increased vacancies and reduction in staff engagement. Implementing phase one of the workforce plan will see improvements in multi-disciplinary team approaches and skill mix. This should impact positively on staff engagement, morale, sickness absence, turnover and temporary staffing. Phase two of the workforce plan provides opportunities for professional development and CPD to implement wider workforce transformation, which should further improve morale and stability.

WTEs	19/20	20/21	21/22	22/23	23/24
Seeking Approval					
Nurse Skill Mix	50.7	50.7	50.7	50.7	50.7
Junior Doctors	20.0	20.0	20.0	20.0	20.0
Recruitment & Retention					
Phase 1a	**70.7**	**70.7**	**70.7**	**70.7**	**70.7**
Already Approved (to be reviewed)					
Nurse Skill Mix					
Junior Doctors					
Recruitment & Retention					
Advanced Clin. Practitioners					
Divisional - Alternative W.force	40.5	66.1	66.1	66.1	66.1
General	2.8	2.8	2.8	2.8	2.8
Physician Associates					
Professional Practice					
Phase 1b	**43.3**	**68.9**	**68.9**	**68.9**	**68.9**
Future Review / Approve					
Advanced Clin. Practitioners	16.0	22.0	25.0	25.0	25.0
Divisional - Alternative W.force	82.3	83.3	83.3	83.3	83.3
General					
Physician Associates	2.0	2.0	2.0	2.0	2.0
Professional Practice	24.0	33.0	15.0	15.0	15.0
Phase 2	**124.3**	**140.3**	**125.3**	**125.3**	**125.3**

(NB This is before any substitution is factored in and benefits linked to transformation programme)

Risk

Workforce is identified as the most significant risk for the Trust and we are not currently meeting national evidenced based expectations around safe staffing establishments. Phase one of the workforce plan will address this risk. Phase two of the plan provides the career progression and CPD opportunities that will further mitigate the workforce risks and should provide mechanisms in the longer term to improve efficiency, reduce cost and reduce temporary staffing expenditure. By ensuring the skill mix meets nationally recognised standards, we expect that the patient safety measures highlighted in this report will also improve.

Risk appetite statement

- We have **NO** appetite for risks which materially have a negative impact on patient safety.
- We have a **LOW** appetite for risks that may compromise the delivery of outcomes without compromising the quality of care.

Recommendations

The Executive team has reviewed the workforce plan and the associated bi-annual non-medical clinical staffing review. There is recognition that phase one is an essential and immediate priority to ensure the Trust has safe staffing establishments. The Executive team therefore recommends immediate funding is approved to implement the essential phase one requirements.

The Board is therefore asked to approve the immediate implementation of phase 1a. This workforce investment schedule should be fully incorporated into the financial planning process for 2020/21. Phase 1b, which includes previously approved business cases that have been factored into the budget setting round for 2020/21 will be scrutinised further in the budgeting process to mitigate the cost where practicable.

Phase 2 will be developed into transformation programmes during 2020/21 that include financial return on investment, quality and safety benefits and the cultural actions that are required to ensure full implementation and transformation.

REPORT

AGENDA ITEM: 8.6

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

To:	Board of Directors	**Date:**	29 January 2020
Subject:	Update on review of committee arrangements		
Presented by:	Company Secretary	**Purpose:**	Information

Executive summary

In November 2019, the board commissioned an internal review of committee arrangements, with a particular focus on ensuring the right arrangements were in place to seek and provide assurance. The review has focused on "right sizing" the membership of committees as well as ensuring that the frequency of meetings provides the right balance of providing upward assurance and facilitating corporate oversight against facilitating time for management to deliver.

The revised arrangements set out in this report have been reviewed by both the executive team and the collective board. Directors will note that the overarching structure has not changed dramatically as it was considered to be fundamentally sound. Rather, the frequency and membership of the meetings are the key areas of change. It is proposed that these arrangements be implemented from 1 April 2020 and that a review will be undertaken in September/October 2020 to assess the effectiveness of the new arrangements.

Risks associated with this report

Clear and focused committee structures allow the board to discharge its responsibilities effectively and to have good oversight of risk. The content of this report is therefore intended to support the organisation's management of corporate risk.

Link(s) to The WWL Way 4wards

☒	Patients	☒	Performance
☒	People	☒	Partnerships

The WWL Way

Background

In November 2019, the Board of Directors commissioned an internal review of committee arrangements, with a focus on ensuring the effectiveness and efficacy of the arrangements. The review was prompted by a desire to ensure continual improvement and learning from best practice rather than any specific concerns around the existing arrangements.

As part of the review, contributions have been received from executive and non-executive directors and these views have been used to inform the changes set out below.

The intention is for the revised committee arrangements to be implemented from 1 April 2020 and a suite of associated documentation, such as revised terms of reference, will be presented to the Board in March 2020 for approval.

Underpinning principles

The overriding principle of the review was to ensure that, whatever structure is settled upon, it is clear and unambiguous with defined areas of responsibility and distinct reporting arrangements. To support this, standardised nomenclature has been used, as follows:

Board:	There is only one Board within the organisation, that being the Board of Directors. The rationale for this is to ensure clarity and avoid confusion. The board has strategic oversight and responsibility for the organisation.
Committee:	The term “committee” is reserved for Tier 2 groups which report into the board directly. It is also used for the Nomination and Remuneration Committee which is a committee that reports directly to the Council of Governors on matters relating to non-executive director remuneration, allowances and terms of office and the Trust Management Committee which will form part of a revised management reporting structure. Committees have a tactical, assurance-focused role.
Sub-Committee:	Used exceptionally, this term is used to denote an umbrella body which acts as a gate-keeper and reports into a committee.
Group:	Management-level meetings will be termed “group” by default, unless there are exceptional reasons for not doing so. These meetings have an operational focus.

The practice of all executive directors attending all committee meetings has been reviewed and under the new arrangements attendance at committees has been distributed across the team.

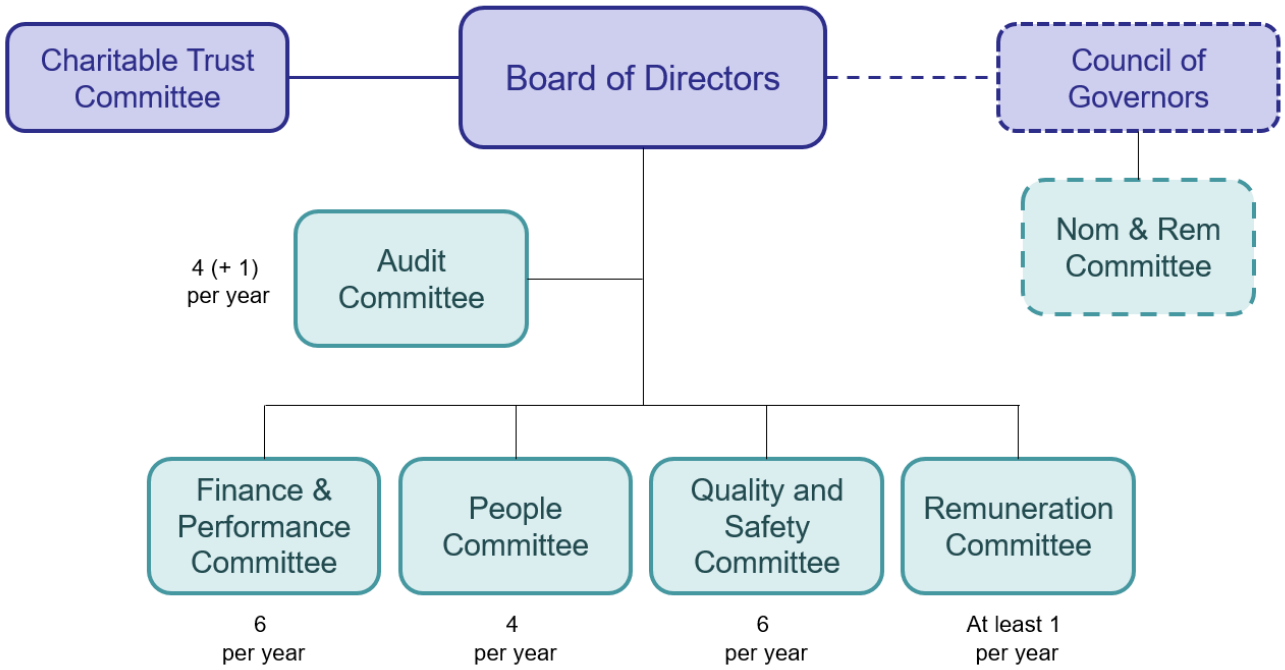
Following feedback from directors, the standard frequency of committee meetings has moved from monthly to bi-monthly. This approach is intended to allow sufficient time between meetings to allow necessary actions to be taken and reported back and, coupled with a more assurance-focused approach, is not considered to be detrimental to the overall oversight of the organisation.

Once new terms of reference have been developed, these will be used to triage agenda items to ensure that all matters to be considered by committees are relevant to their scope and responsibility. This, along with a risk-based agenda setting approach, is intended to ensure that committee meetings are covering the right topics in a timely manner.

The review at month 6/7 will be important as it will allow all directors the opportunity, having experienced the revised arrangements, to consider whether they remain fit-for-purpose or whether any amendments are required.

New structure

The new committee structure is set out in the chart below:



Purple shading indicates strategic level groups and blue shading indicates tactical, assurance-focused groups

Improved reporting

It is acknowledged that changes to the committee structure alone will not deliver significant improvements. In conjunction with the revised committee structure, it is intended to introduce a new reporting format which will help to identify key issues and introduce a standardised approach.

All reports will:

- incorporate a standardised cover sheet which includes an executive summary and a number of mandated paragraphs, with a maximum length of two pages;
- contain a report which has been tailored to the specific audience, with a maximum size of four pages;
- contain more detail in appendices if required, subject to the comments below, with a maximum size of 20 pages.

There will be some occasions where it is not possible to restrict the size of the appendices to 20 pages, however it is expected that these will be the exception rather than the rule. One such example would be where a report is presented to outline the organisation's compliance with the NHS Foundation Trust Code of Governance and the content of the Code itself exceeds 20 pages in length.

Each report will contain the following mandated paragraphs:

- risks and proposed mitigation;
- financial implications;
- legal implications;

- people implications; and
- wider implications.

The introduction of new reporting templates will be supported by the delivery of workshops for report authors to ensure an assurance-focus.

Recommendation

The Board of Directors is recommended to endorse the approach outlined above.

REPORT

AGENDA ITEM: 9

Wrightington, Wigan and Leigh NHS Foundation Trust

To:	Board of Directors	**Date:**	29 January 2020
Subject:	Incidence of Hospital Acquired Pressure Ulcers		
Presented by:	Chief Nurse	**Purpose:**	Discussion and assurance

Executive summary

This purpose of this paper is to provide Trust Board with an overview of the Trusts incidence of Hospital and Community Acquired Pressure Ulcers and the improvement actions being taken.

Trust Board are asked to note

- The increase in hospital acquired pressure ulcers reported between 2018/19 and 2019/20
- There have been 35 category 3 and 4 pressure ulcers acquired by patients whilst in our care in the current financial year to date
- The correlation of harm to patients associated with the reduced registered nurse skill mix within acute care
- Learning from review of pressure ulcers to date has identified issues with patient assessment and risk, the planning and evaluation of patient care by registered nurses, issues with electronic documentation of pressure ulcers and wound care on HIS, a lack of consistency in the categorisation of pressure ulcers and poor bed and mattress stock across the Trust
- An overarching Pressure Ulcer Strategy has been developed which is being overseen by Harm Free Care Committee
- A comprehensive action plan has been developed to address the learning identified from the reviews
- A programme of audit is in place to monitor and provide assurance of positive change.
- The productivity and cost elements associated with treating patients with category 3 and 4 pressure ulcers is £521k year to date.

Risks associated with this report

Harm to patients from the development of hospital and community acquired pressure ulcers

Registered Nurse Staffing levels and skill mix

Age and suitability of existing bed, mattress, trolley and chair stock

The WWL Way

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

Hospital Acquired Pressure Ulcer Incidence

1. Introduction

This purpose of this paper is to provide Trust Board with an overview of the Trusts incidence of Hospital and Community Acquired Pressure Ulcers and the improvement actions being taken.

A pressure is defined as;

'*..localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful.*' NHSI (June 2018).

Pressure ulcers can affect any part of the body that's put under pressure. They're most common on bony parts of the body, such as the heels, elbows, hips and base of the spine.

They often develop gradually, but can sometimes form in a few hours.

Pressure ulcer prevalence is widely regarded as an indicator of the quality of care being delivered within an organisation. It is believed that the majority of pressure ulcers can be avoided if appropriate assessment and interventions are put into place to mitigate risk; this assessment and development of the care plan and evaluation of care should be undertaken by a registered nurse or practitioner

There are 4 categories of pressure ulcer ranging from Category 1 to Category 4. All pressure ulcers across the trust should be reported internally via the Trust incident reporting system. Category 3 and 4 pressure ulcers, which are the most serious categories, are also reported to StEIS.

2. Current Situation

Throughout the course of 2018/19 the Trust reported 13 category 1&2 and 6 category 3&4 hospital acquired pressure ulcers (HAPU's).

Between April 2019 and November 2019 the trust has reported 23 Category 1&2 and 21 category 3&4 HAPU's. This information is graphically displayed in Table 1.

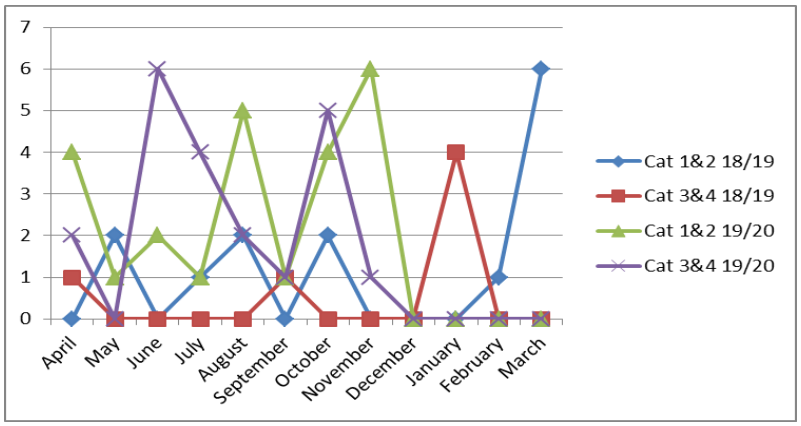


Table 1

In addition between April 2019 and November 2019 the trust has reported 14 Category 3 pressure ulcers developed in patients under the care of WWL's community services.

Therefore there have been 35 serious pressure ulcers reported across the trust Between April 2019 and November 2019.

Pressure ulcers can cause significant pain and distress for patients and can contribute to longer stays in hospital, increasing the risk of complications, including infection.

NHSi (2019) advise that the productivity and cost elements associated with treating patients who have these category of pressure ulcers is £14106; therefore the cost to date for the trust is circa £521k.

On review of these pressure ulcers the majority of those reported were found to have developed on patient's heels or sacrum/buttocks with a very small number being device related.

3. Action Being Undertaken

Reviews have been undertaken of all serious (category 3&4 pressure ulcers) reported to StEIS and key learning from these incidents has been;

- Improvement required in the assessment of the patient and the risk of pressure damage.
- Improvement required in the planning and evaluation for care to prevent and manage skin damage
- Improvement required in the electronic record system in relation to pressure ulcer prevention and management and the documentation of wound care.
- Improvement required in the consistency in the grading of the category of pressure ulcer
- Improvement required in adherence to policy with respect to the completion of body maps and medical illustration
- Improvement required in the bed, trolley and chair stock across the acute services
- Correlation of areas of pressure ulcer incidence and challenges with Registered Nurse Staffing levels and high acuity captured on SNCT

A trust wide pressure ulcer reduction strategy has been developed led by the Deputy Chief Nurse and is overseen by Harm Free Care Committee with key actions focusing on the following actions:

Education

- Targeted education of Matrons and Ward Managers to improve knowledge ownership and accountability.
- Programmed activities to raise awareness across the Trust including provision of educational sessions to front line staff linked to incidence of pressure damage**.**

Care Delivery

- Introduction of a pressure ulcer review panel chaired by the Deputy Chief Nurse; a learning and scrutiny panel for all grades of reportable pressure ulcers.

- Ensuring pressure damage prevention is embedded as a key aspect of ward board rounds and or/safety huddles twice daily.
- Strengthening of ward manager's oversight of pressure area risk and plan of care including improving the appropriate use of body maps
- A review of the application of intentional rounding and its roll in pressure ulcer prevention and nutrition and hydration support is being undertaken
- Strengthening the use of medical illustration to improve compliance with measurement of wound dimensions on the images provided
- Strengthening assessment and management of risk in A&E key element within ED safety checklist.

Documentation

- Standardising the rapid review investigation of pressure ulcers in collaboration with the patient safety team to maximise learning.
- Review of documentation associated with risk assessment, care planning, evaluation and monitoring to ensure its effectiveness in delivery of care. Action has been taken to revert back to end of bed paper skin buddle whilst the improvements electronic documentation is being actioned.

Equipment

- Review of the effectiveness and availability of pressure relieving equipment to inform the tender for a Total Bed Management System and address issues with the current bed stock, mattress provision and trolley requirements

Workforce

- A biannual review of inpatient nurse staffing has been completed and recommendations included where there is a required to uplift registered practitioner levels
- A review of district nurse activity and caseloads is ongoing
- Review of Tissue Viability Nurse capacity and structure

Audit

The following audits have been planned to provide assurance of improved patient care and compliance with policy

- Monthly MUST nutritional assessment audit
- Monthly Waterlow risk assessment audit
- Monthly audit the skin bundle and care planning
- Bi annual equipment audit

Trust Board are asked to note the actions being implemented to mitigate the risk of pressure ulcers developing for patients within our care.

REPORT

AGENDA ITEM: 9

Wrightington, Wigan and Leigh NHS Foundation Trust

To:	Board of Directors	**Date:**	29 January 2020
Subject:	*C.difficile* – Current position and actions being taken		
Presented by:	Chief Nurse	**Purpose:**	Information

Executive summary

The purpose of this paper is to provide the Board with an overview of C.difficile (C.diff) rates within our organisation and the actions being taken.

WWL's nationally set trajectory for 2019/20 for C.difficile toxin positive infections (C.diff) is 20 this is based on our performance in 2018/19, where there were11 cases in total.

To date there has been 41 new cases reported against the trajectory of 20.

It should be noted that the national definitions for cases were changed on 1st April 2019 which will in part increased the numbers reported against previous year's figures.

C.diff rates for Q1 and Q2 were close to the average for the Northwest, however, the number of new cases has risen significantly in December with 10 new cases being reported.

Comparative data provided by PHE is only available for up to the end of November but it shows that a number of similar sized Trusts were performing similarly.

All cases are subject to an in-depth review which has both executive and CCG oversight. These review have shown that to date there have been 6 'Lapses in care' to date.

All samples are sent for Ribotyping and there has been one incidence of cross infection identified to date.

A C.diff reduction plan has been developed and an external review undertaken by NHSI in September 2019 who did not identify any significant additional actions.

An extensive deep clean programme is being planned for the year ahead to address any risk of environmental loading.

Discussions with commissioners are ongoing regarding a place based approach to understanding the prevalence in the population.

Risks associated with this report

The WWL Way

The following risk assessments relate to this report:

- 'Patients at RAEI are being put at increased risk of CDI because there has been a large number of CDT infections in hospital this year compared to last year; numbers are also far higher than the trajectory set by Public Health England' – scores 20.
- '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' – scores 20
- 'Infection rates in patients are likely to rise as the Deep clean programme at RAEI will not be fully achieved in 2019/20' – scores 16.

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

1. Background

C.diff infection remains an unpleasant and potentially severe or even fatal, infection that occurs mainly in elderly and other vulnerable patient groups, especially those who have been exposed to antibiotic treatment. Patients can experience frequent watery diarrhoea, severe abdominal pain and fever, leading to dehydration and weight loss. Severe infection may cause severe intestinal inflammation, enlargement of the colon (also called toxic megacolon) and sepsis.

The NHS has made great strides in reducing the number of C.diff infections, but the rate of improvement has slowed over recent years and some infections are a consequence of factors outside the control of the NHS organisation that detected the infection.

It was felt that further improvement on the current position required greater understanding of individual causes across the healthcare system to ensure all potential learning was identified; therefore, the national objectives for cases in 2019/20 were changed on 1st April 2019 as below:

- The number of days to identify hospital associated cases was reduced from ≥3 to ≥2 days after admission.
- WWL numbers also now include cases that occur in the community when the patient has been an inpatient in our Trust in the previous 4 weeks.

The new trajectory for 2019/20 WWL was given as 20 (rate of 14.1 /100,000 bed days) based on our performance in 2018/19, where we had just 11 cases in total, our lowest ever tally.

2. Current position

Each NHS Trust is set a target number of cases per year, a trajectory. These trajectories are based on the previous year's number of reported cases.

WWL's trajectory for C.diff in 2019/20 is 20 cases.

As of the time of writing this report the trust has reported 41 new cases year to date using the new national reporting definitions.

Using last year's definitions the total would have been 26. 5 patients had a sample taken ≥2 days after admission and 10 were community-onset cases; so would not have been included in our reportable cases last year. Therefore, the change in national case definitions accounts for some of the increase but not all.

All, cases are subject to an in-depth review which has both executive and CCG oversight. These review have shown that to date there have been 6 'Lapses in care' with 11 cases still to complete a review.

All samples are sent for Ribotyping and there has been one incidence of cross infection identified to date (in July on the Acute Stroke Ward).

A C.Diff reduction plan has been developed and an external review undertaken by NHSI in September 2019 who did not identify any significant additional actions.

Overall the Trust's rates for Q1 and Q2 were close to the average for the Northwest.

However, the number of new cases has risen significantly in December with 10 cases in the month. Each case is currently undergoing a review there is currently no indication of cross infection. Ribotyping for four cases from December are all different, results for the rest are to follow.

Of note Faecal sample numbers were lower in October and November but rose significantly in December so this will partly account for the rise in new cases in December:

Comparative data provided by PHE is only available for up to the end of November but it shows that a number of similar sized Trusts were performing similarly or were in an even worse position with regard to C.diff at that point. IPC has contacted colleagues in other Trusts but there was no conclusion as to the cause for this rise being seen this year.

3. Identified learning points

- Improvement required in early isolation impeded by low number or lack of side rooms; this was exacerbated in December due to cases of influenza requiring isolation.
- Further improvement required in levels of compliance with hand hygiene, appropriate use of PPE and cleaning of equipment. There is correlation with where there are challenges with Register nursing levels.
- There is recognised correlation with infection rates and high bed occupancy.
- There is a risk of environmental loading due to the number of cases and the inability to complete full decant and 'Deep clean' this year.
- Most patients were complex with comorbidities and poly pharmacy.

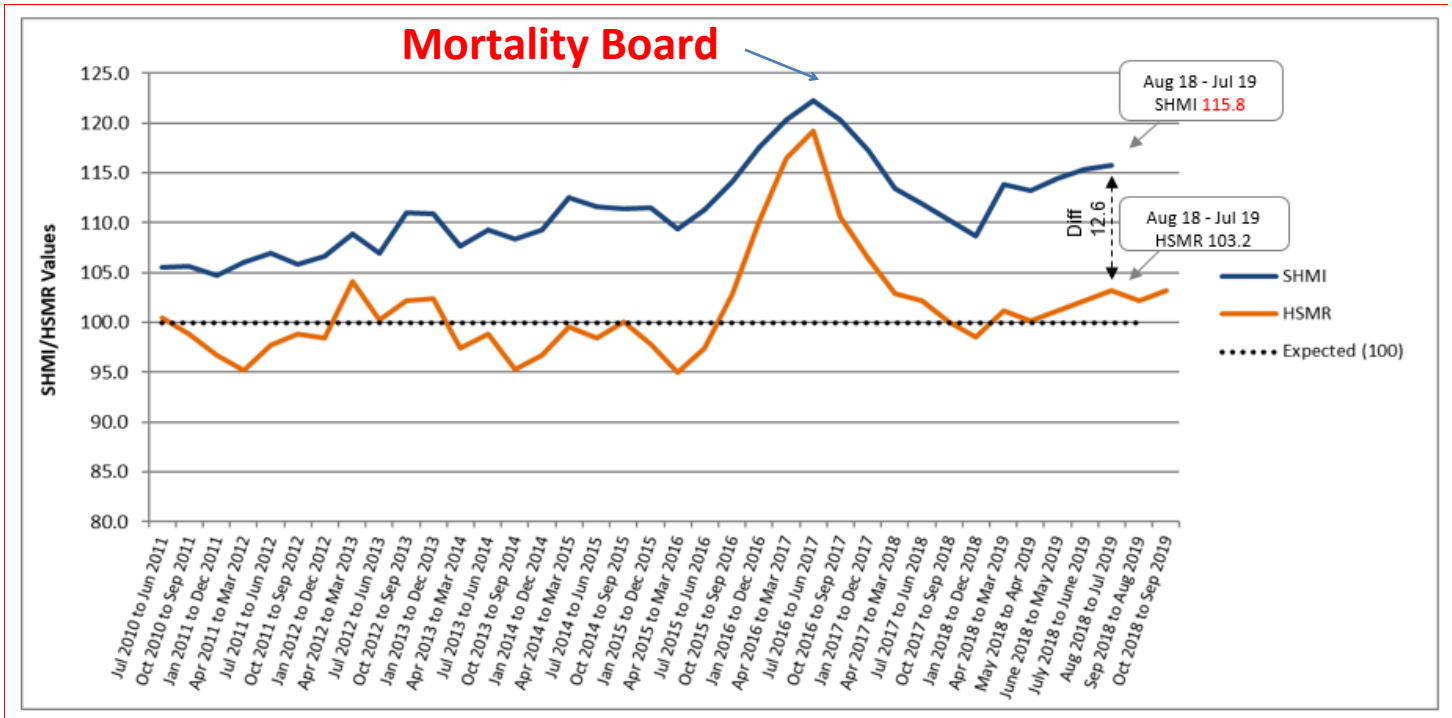
Actions being taken to reduce C.diff

- A C.diff Reduction Plan is in place monitored at the IPCC.
- Full RCAs are carried out on each C.diff case with the exception of one area no obvious similarities or conclusions with regards location, speciality and antibiotic use have been identified to date.
- Comprehensive action plans are drawn up to address any learning that results from these RCAs and progress is monitored at the IPCC.
- IPC attend bed management meetings on a daily basis and regularly review side room use to maximise appropriate use.
- IPC are reinforcing precautions including hand hygiene, use of PPE and ensuring equipment and beds are fully decontaminated between patients.
- A full IPC audit will be carried out in January on the 8 wards with the highest numbers of C.diff cases.
- A training day for Housekeepers took place in December – 41 attended with excellent evaluations; the importance of cleaning and hand hygiene for staff and patients was emphasised.
- A plan is being drawn up to ensure all general wards receive a full Deep clean in the summer of 2020 using the new ward as decant facility.
- Results from all audits fed back to clinical teams.
- Updated templates for cleaning schedules for all nursing equipment were issued in December.
- IPC Level 2 e-leaning launched in December, all staff providing direct patient care will have to complete this by the end of February.
- The mattress audit at RAEI will be repeated in January.
- Discussions with commissioners regarding a place based approach to understanding the prevalence in the population.

Trust Board are asked to note the content of this report and the actions being taken.

HSMR: death in Hospital

SHMI: death in hospital and within 30 days of discharge



Mortality board formed in June 2017 – Led by Medical Director & Director of Governance

- Audits carried out, clinical pathways reviewed and lessons learnt
- Coding brought in line with other NHS Trusts
- Improvement in HSMR and SHMI until April 2019, when both started creeping up
  - Significant staffing shortages - nurses, doctors. therapists, pharmacists
  - Intense pressures due to high acuity, high number of patients with End of Life care and 2nd lowest acute bed base in GM

Steps being taken to address worsening HSMR and SHMI

- Workforce plan – recruitment of additional staff -nurses, doctors , therapists, pharmacists
- Working with CCG and Primary care - looking into End of Life care & deaths in the community

REPORT

AGENDA ITEM: 10

Wrightington, Wigan and Leigh NHS Foundation Trust

To:	Board of Directors	**Date:**	29 January 2020
Subject:	Mortality Q2 2019-20 Report		
Presented by:	Medical Director	**Purpose:**	Approval

Executive summary

The purpose of this report is to provide the Board of Directors with a summary of mortality in Q2 2019-20, reflecting the requirements of the National Guidance on Learning from Deaths published in March 2017. Additions to the report this quarter includes further information regarding deaths reported externally, for example to LeDeR (Learning Disability Mortality Review Programme) and MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK)

There were **270** inpatient deaths in Q2 2019-20 which was slightly lower than Q2 2018-19 (274) and considerably lower than Q1 2019-20 (317). **2** deaths were escalated by the Corporate Mortality Review Team as potentially preventable, both of which were reported to STEIS. **2** hospital deaths and **3** community deaths to LeDeR (Learning Disability Mortality Review Programme). There was **0** maternal deaths in Q2 2019-20, **2** still births and **2** neonatal deaths reported to MBRRACE-UK.

SHMI (Summary Hospital-Level Mortality Indicator) is a concern. At the end of Q2 SHMI was 115.8 (July 2018-June 2019), which was an increase on the previous time period. Actions being taken to address this will be outlined in the Q3 2019-20 mortality report.

A standardised approach for divisional mortality reviews has been developed and piloted in Acute Medicine and Cardiology. Further consideration is required to integrate community division into the Trust-wide approach for mortality review. Triangulation of learning from deaths across the organisation will be strengthened by the introduction of the Medical Examiner role.

Focus regarding learning from deaths in Q2 2019-20 included reviews of sepsis care and fractured neck of femur. Actions were discussed at the Mortality Group and are outlined in the report.

The Trust has not received a Prevention of Future Deaths Notification from HM Coroner since November 2017.

Risks associated with this report

- BAF and Corporate Risk Register: Right Patient Right Ward
- Divisional Risk Registers: Sepsis.

Link(s) to The WWL Way 4wards

☒	Patients	☐	Performance
☐	People	☐	Partnerships

The WWL Way

Mortality Review
2019-20 Quarter 2

1.0 Introduction

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

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

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

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

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

2.0 Total Number of Inpatient Deaths (By Quarter)

The total number of hospital deaths in 2019-20 Q2 was **270** in comparison with 2019-20 Q1 312, 2018-19 Q4 343, Q3 286, and Q2 274.

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 Q2 2019-20 concluded the following:

	Deaths			Review and Score						Of which: 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 Avoidability	Score 1 - Definitely avoidable	Total	Reviewed	Avoidability
Q2 19/20	270	174	1	167	2	4	1	0	0	3	3	1

3.1 Potentially Preventable Deaths

2 deaths were escalated by the Corporate Mortality Review Team as potentially preventable related to possible delays in taking patients to Theatre. Both of the potentially preventable deaths escalated by the Corporate Mortality Review Team were submitted to STEIS as serious incidents (see section 4.0).

3.2 Themes/Learning

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

- Failure to escalate in two patients;
- Communication difficulties and issues with dialysis in patient with learning disabilities;
- Missed diagnosis of patient with duodenal ulcer and perforation;
- IV access problems;
- Concerns with NIV.

4.0 External Reporting

4.1 Unexpected Deaths Reported to STEIS in Q2 (2019-20)

In Q2 2019-20 the Trust reported 2 unexpected deaths to STEIS. As outlined above both incidents related to possible delays in taking patients to Theatre.

4.2 Deaths of patients with a learning disability (reported to Learning Disabilities Mortality Review Programme - LeDeR)

In Q2 2019-20 the Trust reported **2** hospital deaths and **3** community deaths to LeDeR. The LeDeR programme was been commissioned by NHS England to support local areas in England to review the deaths of people with a learning disability to:

- Identify common themes and learning points, and
- Provide support to local areas in their development of action plans to take forward the lessons learned.

The death of patients who are formally diagnosed with a learning disability and on the learning disability register should be referred to LeDeR. To date the Trust has not received any recommendations from LeDeR.

4.3 Maternal Deaths, Still Births and Child Deaths (reported to MBRACE-UK)

The Trust has had **0** maternal deaths in Q2 2019-20, **2** still births and **2** neonatal deaths:

- The review of the first sad still birth is complete and placental histology reports are awaited for the second sad stillbirth. Review of cases involving women with diabetes having poor outcomes has led to evaluation and improvement work to be undertaken within the Maternity Diabetes Service. It is evident as Maternity Services have increased their analysis of the cases that the increased investigation, both into the care that women are receiving and into the causes of the fetal deaths, are providing more definitive answers for the parents of babies sadly stillborn within the Maternity Service.
- The 2 sad neonatal deaths (NND's), both of which occurred at extreme pre-maturity, were pre viable gestations reported as NND's under the new rules for reporting to the Coroner where a fetus shows some signs of life.

5.0 Community Deaths

As outlined in the 2019-20 Q1 report, further consideration is required to integrate community into the Trust-wide approach for mortality review; however, there is a process in place to review deaths. Community staff are requested to report all unexpected deaths as an incident. Community staff are also requested to report child deaths, deaths of patients with a learning disability, deaths of patients under care of the Community Response Team and deaths of patients in community beds at Bedford House care home. The Trust is aiming to report further details in the Q3 2019-20 mortality report.

6.0 Prevention of Future Deaths Notices

The Trust did not receive a Prevention of Future Deaths (PFD) Notice from the Coroner in Q2 2019-20.

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

The Trust's HSMR YTD to July 2019 (latest available data) was 104.6. The Trust's SHMI was 115.8 for a rolling 12 months from July 2018 to June 2019, a decline from 114.9 for the previous reporting period. The Medical Director has met with the CCG to discuss an approach to review deaths 30 days after discharge. Further actions agreed in relation to SHMI will be outlined in the Trust's Q3 mortality report.

8.0 Mortality Group

The Trust Mortality Group, chaired by the Medical Director, met in September 2019. The Group received updates on the actions being taken in response to MIAA recommendations following their audit of divisional mortality reviews and Medical Examiner recruitment. The Trust's Lead for Sepsis presented the findings of a review into deaths from sepsis with a zero length of stay. The findings indicated that the sepsis 6 bundle had not always been fully completed. The recommendations were as follows:

- Use of NEWS2 triggered Sepsis tool on HIS, which allows completion of Sepsis tool, recording of Sepsis diagnosis, prescribing Sepsis 6 and Sepsis Order Set, the use of red flag/amber flag terminology. A meeting with the Medical Director and 'AllScripts' to progress this is scheduled in early February 2020.
- Expansion of blood cultures training;
- Use of antibiotic PGDs to be launched.

The group received a review of Fractured Neck of Femur patients and coding. Secondary diagnosis was accurately recorded in 88% of the cases (target is 90%). The review highlighted concerns in relation to ensuring patients are allocated specialist beds within 4 hours of admission. Work has been undertaken to identify and 'ring-fence' beds for patients with Fractured Neck of Femur, supported by an escalation plan.

9.0 Divisional Mortality Reviews

Following an MIAA audit of divisional mortality reviews, the Trust has piloted a framework which will triangulate with the Corporate Mortality Review process. Each sub-speciality will receive a summary of the findings from the Corporate Mortality Review for discussion within their own meetings with subsequent feedback to relevant committees. Acute Medicine and Cardiology are the pilot areas.

Director of Governance and the Corporate Mortality Review Team
December 2019

REPORT

AGENDA ITEM: 11

To:	Board of Directors	**Date:**	29 January 2020
Subject:	CQC post-inspection feedback letter		
Presented by:	Chief Executive	**Purpose:**	Information

Executive summary

Following its well-led inspection of the foundation trust in November 2019, the Care Quality Commission has provided us with an initial feedback letter in advance of the formal inspection report.

The letter contains a request for it to be discussed at the next public board meeting and a copy is therefore appended to aid this discussion.

Risks associated with this report

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

Link(s) to The WWL Way 4wards

☒	Patients	☒	Performance
☒	People	☒	Partnerships

The WWL Way

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

By email only

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

Date: 24 December 2019

Your account number: RRF
Our reference: INS2-7161639425

Dear Mr Nichols

CQC inspection of Wrightington, Wigan and Leigh NHS Foundation Trust

Following the feedback meeting with Jonathan Driscoll, Ann McCracken and I on 28 November 2019. I thought it would be helpful to give you written feedback as highlighted at the well led assessment and given to the trust leadership team at the feedback meeting.

This letter does not replace the draft report and evidence appendix we will send to you, but simply confirms what we fed-back on 28 November 2019.

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

An overview of our feedback

- We acknowledged that it was a time of change with the acquisition of community services, new leaders, a new strategy and a review of governance.
- We saw evidence of strong partnership working with other Wigan stakeholders, Edge Hill university and other stakeholders.
- There appeared to be a cohesive leadership team with a real passion for the trust.

- Leaders had an awareness of the key challenges (for example, staffing, capacity, mortality), although we noted that there may need to be some strengthening around risk escalation (for example, the issues we identified at the core service inspection)
- We saw a good use of the board assurance framework to frame board discussions.
- The trust had a strong governing body and engagement with the local community.
- The trust had acknowledged a dip in staff survey results but had plans to address the areas identified.

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

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

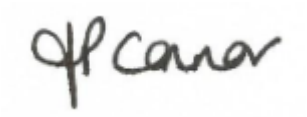
If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

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

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

Yours sincerely



Judith Connor

Head of Hospitals Inspection

c.c. Robert Armstrong - Chair

Pauline Bradshaw - NHS Improvement/NHS England

David Fryer - CQC regional communications manager

REPORT

AGENDA ITEM: 12

Wrightington, Wigan and Leigh NHS Foundation Trust

To:	Board of Directors	**Date:**	29 January 2020
Subject:	Amendments to the foundation trust constitution		
Presented by:	Company Secretary	**Purpose:**	Approval

Executive summary

The foundation trust has a strategic objective to become a teaching hospital with effect from 1 April 2020. One of the steps in doing so is to formally change the foundation trust's name. This is done by amending the "name and status" clause of the foundation trust's constitution.

Approval of changes to the constitution requires resolutions of both the Board of Directors and the Council of Governors. The Board is requested to approve the amendment of the foundation trust's "name and status" clause as set out in the attached report with effect from 1 April 2020, subject to receipt of confirmation that the approach is supported by NHS England and Improvement. No other changes to the constitution are proposed.

The Council of Governors approved the above amendment at its meeting on 21 January 2020.

Risks associated with this report

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

Link(s) to The WWL Way 4wards

☐	Patients	☐	Performance
☐	People	☐	Partnerships

The WWL Way

Background

The Board will be aware that the foundation trust has a strategic objective of becoming a teaching hospital from 1 April 2020. There are a number of steps required to become a teaching hospital and these are set out below:

Step	Update
Discuss the proposed name change with NHS Improvement	This has been actioned and no objections are anticipated
Seek approval of changes to the foundation trust constitution	This report deals with this item in relation to the Board's approval; Council approved the amendment on 21 January 2020
Amend clause 2.1 of the foundation trust's constitution to effect the change of name	Covered within this report
Appoint at least one member of the Council of Governors from Edge Hill University	This post was introduced when the constitution was last reviewed in October 2018; we have been liaising with Edge Hill and a potential candidate has now been identified

Amendment of clause 2.1

The following change to clause 2.1 is requested:

Current wording: "The name of this Foundation Trust is Wrightington, Wigan and Leigh NHS Foundation Trust."

New wording: "The name of this Foundation Trust is Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust."

The Board of Directors is recommended to approve the amendment to the constitution as shown, with effect from 1 April 2020.

REPORT

AGENDA ITEM: 12.2

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

To:	Board of Directors	**Date:**	29 January 2020
Subject:	Risk appetite statement 2020/21		
Presented by:	Company Secretary	**Purpose:**	Approval

Executive summary

Whilst risk management is a key activity for any organisation, it is not always possible or feasible to remove all risk completely. Adopting too risk averse an approach can be just as restrictive to an organisation as taking too much risk and it is therefore important to develop a considered and consistent approach to this issue.

A risk appetite statement articulates the amount and type of risk that an organisation is willing to take in meeting its strategic objectives and the Institute for Risk Management notes that a properly communicated, appropriate risk appetite statement can actively help organisations to achieve goals and to support sustainability.

The attached risk appetite statement has been developed by the Board of Directors, both at a workshop and following consideration of submitted comments, and is presented for approval.

Risks associated with this report

The content of this report is intended to support organisational risk management by articulating the foundation trust's risk appetite in a dedicated statement which will be shared within the organisation to inform decision-making.

Link(s) to The WWL Way 4wards

☒	Patients	☒	Performance
☒	People	☒	Partnerships

The WWL Way

Risk appetite statement 2020/21

Wrightington, Wigan and Leigh NHS Foundation Trust

Introduction

It is best practice for organisations to have in place an agreed risk appetite statement to direct and govern decision making at both Board and operational level. Risk appetite is defined as the level of risk that an organisation is willing to accept. An agreed risk appetite sets the framework for decision making across the organisation to ensure consistency of decisions and the embedding of an agreed organisational value base.

At Wrightington, Wigan and Leigh NHS Foundation Trust we recognise that complete risk control and avoidance is impossible but that risks can be minimised by making sound judgments and having a common understanding of the organisation's risk appetite and value set. Precise measurement of risk appetite is not always possible and we have therefore defined our risk appetite by way of a broad statement of approach, based on a matrix developed by the Good Governance Institute. A copy of the matrix is appended to this statement for information.

The table below sets out our appetite for risk, with greater tolerance of risk in some areas depending on the context of the risk and the potential losses or gains. When making decisions in line with this risk appetite statement, consideration will also be given to the counterfactual scenario, i.e. the potential consequences of not proceeding with a particular approach.

Our risk appetite

The Board of Directors has defined our organisational risk appetite for the remainder of FY2019/20 and for FY2020/21 as follows:

Quality, innovation and outcomes	We have **NO** appetite for risks which materially have a negative impact on patient safety. We have a **LOW** appetite for risks that may compromise the delivery of outcomes without compromising the quality of care. We have a **SIGNIFICANT** appetite for innovation that does not compromise the quality of care.
Financial and Value for Money (VfM)	We have a **MODERATE** appetite for financial risk in respect of meeting our statutory duties. We have a **MODERATE** appetite for risk in supporting investments for return and to minimise the possibility of financial loss by managing associated risks to a tolerable level. We have a **MODERATE** appetite for risk in making investments which may grow the size of the organisation.
Compliance/ regulatory	We have a **MODERATE** appetite for risks which may compromise our compliance with statutory duties or regulatory requirements.
Reputation	We have a **MODERATE** appetite for actions and decisions that, whilst taken in the interest of ensuring quality and sustainability of the patient in our care, may affect the reputation of the organisation.

Review

We will review this position at least annually or whenever there is a material change in the foundation trust's circumstances.

This statement was approved by the Board of Directors at its meeting on 29 January 2020.

_____

Robert Armstrong
Chair
For and on behalf of the Board of Directors

Appendix: Risk appetite matrix

RISK APPETITE: ➔	NONE	LOW	MODERATE	HIGH	SIGNIFICANT	
	AVOID *"Avoidance of risk and uncertainty is a key organisational objective"*	**MINIMAL** *"Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential"*	**CAUTIOUS** *"Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward"*	**OPEN** *"Willing to consider all potential delivery options and choose whilst also providing an acceptable level of reward and VfM"*	**SEEK** *"Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)."*	**MATURE** *"Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust"*
Quality, innovation and outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision-taking authority. General avoidance of systems/technology development.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems/technology development to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems/technology developments limited to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems/technology developments used routinely to enable operational delivery. Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to "break the mould" and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently "breaking the mould" and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Financial/ Value for Money (VfM)	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls in place). Resources allocated without firm guarantee of return – "investment capital" type approach.	Consistently focused on the best possible return for stakeholders. Resources allocated in "social capital" with confidence that process is a return in itself.
Compliance and regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliance.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.

(Acknowledgement: Good Governance Institute)

REPORT

AGENDA ITEM: 12.3

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

To:	Board of Directors	**Date:**	29 January 2020
Subject:	Inclusion & Diversity Annual Monitoring Report 2018/19		
Presented by:	Alison Balson	**Purpose:**	Consent

Executive summary

This report provides an update on the progress we have made in relation to equality, diversity and inclusion for patients and staff during the last 12 months.

This report provides a summary of headline data in relation to staff and patient demographics. This report provides assurance to the Board of how the Trust is meeting the requirements of the Public Sector Equality Duty, summarising the priorities for the year ahead.

Board of Directors are invited to receive and approve the Annual Inclusion and Diversity Monitoring Report.

Risks associated with this report

Non-compliance with Accessible Information Standard.

Link(s) to The WWL Way 4wards

☒	Patients	☒	Performance
☒	People	☒	Partnerships

The WWL Way

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

Inclusion and Diversity Annual Monitoring Report 2018/19

AUTHORS:
Debbie Jones
Joanne O'Brien

Everyone is Unique

The WWL Way

Executive Summary

TITLE:

Inclusion and Diversity Annual Monitoring Report - April 2018 to March 2019

PURPOSE OF REPORT:

This report provides an update on the progress we have made in relation to equality, diversity and inclusion for patients and staff during the last 12 months. This report provides a summary of headline data in relation to staff and patient demographics. This report provides assurance to the Board of how the Trust is meeting the requirements of the Public Sector Equality Duty, summarising the priorities for the year ahead.

EXECUTIVE SUMMARY:

Over the last 12 months, the Trust has seen notable progress in embedding inclusion, diversity and human rights into core business activity. **A number of key outcomes have been achieved over the last 12 months.**

Staff Engagement

Wigan PRIDE 2018 Slogan Competition

Living with a Disability Listening Event – Oct 18

BME Listening Event – Nov 2018

Staff Story – Living with Dyspraxia

Staff Story – Transgender Journey

Calendar of Events

Awareness of protected characteristics throughout the year:

Disability Awareness Day
Wigan PRIDE Launch Event
Wigan PRIDE 2018
LGBT History Month

Governance

Equality Impact Assessments review

Annual WRES Assessment published.

EDS 2019 Report produced.

Training

Autism Awareness Training held in April 2018.

Deaf awareness training session held July 18

Level 3 Inclusive Leadership Management Training Session designed – First session held March 2019

Supporting Trans Staff Policy updated

Partnership Working

Wigan Borough E&D Collaborative Group

Key stakeholder in planning of Wigan Pride 2018

E&D North West Forum

GM E&D Leads Forum

Patient Engagement

- BME Cancer Patient Experience Survey
- Local Mosque Patient Experience Survey
- Leigh Deaf Club
- BELONG Blind Group
- W&L People First LD Group
- Wigan PRIDE 2018

Improved Access

New Provider for BSL and Face to Face Language Interpreters.

Pagers for hearing impaired implemented in A&E.

Funding secured for further 3 year contract with AccessAble (Hospital Accessibility Checker).

Requirements of Accessible Information Standard reviewed. IT solution identified for hospital letters.

SUMMARY OF HEADLINE DATA:

SERVICE USERS

- Overall picture of patient access reflects broad similarity to local demographics.
- Over last 12 months, 0.3% decrease in total in-patients/out-patients of British White Ethnicity. 0.3% increase in patients of Black and Minority Ethnic Backgrounds. 92% British White / 4% BME. No statistical significance reported. 0.6 % decrease in those not stated.
- Over last 9 years, steady increase in % of patients of black and minority ethnicity attending A&E. **2010/11:** BME 2.5% / **2018/19:** BME 6% .
- Higher % of Black and Minority Ethnic Groups using maternity services in comparison with overall out-patient / in-patient activity. Data historical – 2.2% increase in BME maternity activity during last 12 months. British White 87.4% / BME 12%. No statistically significant difference noted. Data in line with growth in Wigan Borough migrant worker population and numbers of refugees / asylum seekers.
- Although Wigan is the least ethnically diverse borough in the County, migration has significantly changed the wealth of diversity in Wigan since the last census and there has been significant demographic change within Wigan Borough. Ethnic minority populations living in Wigan include long-term resident ethnic minority population and asylum seekers and refugees, migrants, Gypsies and Travellers, European Roma and Overseas students. Although the numbers are small compared to the size of the total population and some only stay for a short period of time, some will have specific health needs that need to be addressed.
- Top languages interpreted during last 12 months: Kurdish / Sorani, Polish, Arabic, Farsi, Romanian, Mandarin, Russian, Punjabi, Latvian, Lithuanian, Cantonese, Portuguese, Urdu, Albanian. French. Spanish. Trends show the same top languages as 2017/18. An increase in the number of interpreter requests for Romanian and Kurdish interpreters during the last 12 months noted.
- As with most healthcare services in the UK, women are more likely to use hospital services than men – 56% female out-patients during last 12 months.
- Wigan Borough's population has experienced an upward trend since 2010. Between 2010 and 2017 there has been increase of around 17,000 persons. This increase is estimated to be mainly due to an increase in our ageing population rather than migration, Wigan has seen a 19.9% increase in the 65+ population from 2010 to 2017. Almost 60% of the overall increase in population is attributable to aged 65+ population. 1 in 6 residents in Wigan are now aged over 65 years. The age of patients accessing hospital services is bias towards the older population, reflecting greater healthcare needs.
- 21.5% of Wigan residents are living with a limiting long-term illness, health problems or disability – higher than the national average 17.9%. 1 in 6 (16%) of the local population are living with hearing loss (53,000 residents). By 2020, 10,500 Wigan Residents estimated to be living with sight loss.
- Estimated 15,000 lesbian, gay and bisexual Wigan residents and 2,500 Trans residents.

STAFF

- Similar to last year, just over 90% of the workforce is of British White Ethnicity. This figure remains significantly lower than the Wigan borough figure of 95%. Similar to last year, 8% of the workforce profile is from Black & Minority Ethnic Groups, with 7.1% of Trust Board being BME.
- Whilst the split between under 50 and over 50 has remained fairly static, there has been a further slight increase in the proportion of staff aged over 60 which is leading to an ageing workforce.
- There has been slight improvment in the amount of declared data in respect of disability from 2.2% to 2.5%
- The workforce profile remains predominantly female at 79.49% whereas the local population is 50.3% female. However, this is in keeping with the gender profile of the healthcare profession in general and the NHS in particular.
- Just over 57% of staff who have disclosed their religion and belief describe themselves as Christian compared to a Wigan borough figure of 77%. However, 26.75% of Trust staff have not disclosed their religion and belief.
- Similar to last year, nearly 73.15% of staff describe themselves as heterosexual. However, just over 25% of staff have not disclosed their sexual orientation, this is slightly less than last year's rate of 27%.

POTENTIAL RISKS

Failure to actively promote equality across all protected characteristics could constitute failure to meet the requirements of Equality Legislation / Statutory Bodies. Challenge from the local community and loss of reputation and public confidence could arise as a subsequence. Non-compliance / failure to address national requirements could impact on our Care Quality Commission Scores. The key risks to the Trust therefore in terms of service delivery are non-completion of equality impact assessments, failure to provide accessible information in a patient's preferred format and the limited availability of equality information against some of the protected characteristics.

The key risks to the Trust therefore in terms of employment practice are: a higher % of white applicants continuing to be appointed following shortlisting than those from black and minority groups. Furthermore, improved levels of declared workforce data in respect particularly of sexual orientation and disability status would enable the Trust to more effectively assess whether or not its employment practices are fit for purpose moving forward.

ACTION BY BOARD: WWL Workforce Committee members are invited to receive and approve the Annual Inclusion and Diversity Monitoring Report.

Contents Page

Appendices

1. Introduction

As an employer & health service provider, WWL NHSFT takes the issues of fairness, rights and equality very seriously. Inclusion and diversity is a key part of our values and runs through everything we stand for and do. By investing in I&D we aim to improve services and patient care. We will continue to ensure that our staff and service users are in a safe, inclusive and accessible environment and that our services are accessible to all communities across the borough of Wigan.

Over the past few years we have made substantial progress in embedding inclusion and diversity into our core business activities. We will continue to make progress by ensuring these values are mainstreamed through all aspects of our service provision, and in how we work in partnership with our employees and our local communities.

Our Inclusion and Diversity Annual Report provides an update on the progress we have made in relation to equality, diversity and inclusion for patients and service users and also for our staff. Publishing this report forms part of our legal requirement under the Specific Duty in the Public Sector Equality Duty (PSED).

2. NHS Drivers & Compliance

There are a number of equality based national laws and guidelines which mandate and guide how NHS organisations should demonstrate equality These include the Legal Framework, NHS Constitution, NHS Equality Delivery System, Workforce Race Equality Standard and Disability Equality Standard. This report evidences how the Trust has delivered on these requirements during the last 12 months. **See Appendix 1 for a summary of our compliance against national standards.**

3. Key Developments 2018/19

Over the last 12 months, we have seen progress in embedding inclusion, diversity and human rights into core business activity.

The following table summarises:

- What we did during 2018/19
- Why we did it
- What the outcome was
- Priorities for the year ahead

3. Key Developments 2018/19

Governance			
What have we done	**Why we did it**	**What was the outcome**	**Looking ahead**
Equality Delivery System (EDS) 2019 Assessment undertaken and report produced.	NHS Contract and Department of Health requirement. Assessment enables us to assess and score our performance in collaboration with staff and local stakeholders through engagement, equality monitoring and improved patient access and experience.	Evidence used to inform EDS Action Plan 2019/20. Ensures there is a clear plan to work to.	Data and evidence will be reviewed and updated annually and progress published on Trust Website.
Annual Workforce Race Equality Standard (WRES) assessment compiled and published.	In order to demonstrate through the 9 Point metric how we are addressing race equality issues in a range of staffing areas.	WWL is performing better than many other Trusts in relation to the specific indicator relating to BME representation at Board level which is a problem area nationally.	Work with the requirements of WRES & WDES.
Reviewed requirements of forthcoming Workforce Disability Equality Standard (WDES)	Compliance with WDES requirements. To be mandated via the NHS Standard Contract in England from April 2018. First sub mission due by 1st August 2019.	First WDES submission completed.	
Implemented Schedule of Events for 2018/19 to promote / hold supporting events.	Increased staff and patient engagement.	WWL seen as fully inclusive employer and service provider. Annual Schedule of Events Summary Report.	Continue to be monitored by I&D Operational Group/I&D Champions. Schedule of Events for 2019/20 to be implemented,
Implemented 3 yearly reviews of existing Equality Impact Assessments for Medicine and Surgery.	To review all existing Equality Impact Assessments in Medicine and Surgery. Ensure Quality Assurance is implemented.	Excel Monitoring System developed. Robust review system implemented to ensure EIAs are monitored and reviewed.	Implementation of 3 yearly reviews for specialist services. On-going monitoring and review of equality Impact Assessments by I&D Service Lead.

Goal 1: Better Health Outcomes for All			
What have we done	**Why we did it**	**What was the outcome**	**Looking ahead**
Wigan PRIDE Staff Competition launched May 18. Staff encouraged to design their own WWL PRIDE Slogan. The theme for this year's PRIDE was 'Community and Growth' – staff were encouraged to include this theme within their slogan and consider how this could be tied in with the Trust's strategy (The WWL Way 4Wards and the 4Ps).	To encourage staff to get involved. A shortlist of three was agreed, and then reviewed by a panel of judges. All three shortlisted entries were displayed on placards during the Wigan PRIDE Parade and throughout the day	WWL seen as fully inclusive employer and service provider.	To continue to work together with the LGBT community to engage and improve our knowledge and understanding of LGBT service users. To continue as a key stakeholder in the planning and involvement of Wigan Pride 2019
On 25th July, the Trust showed its support for the borough's LGBTQ+ community by raising the rainbow flag and planting our very own WWL PRIDE tree outside the main entrance to the Royal Albert Edward Infirmary. Guests included members of the Trust's executive team, staff and representatives of Wigan Council's BYOU Project, which offers activities and advice for local LGBTQ+ people aged under19.	We want to work together with the local LGBT Community to improve and expand the quality of the information, knowledge and understanding we have about our LGBT service users.		
Wigan Pride returned for a third year in Wigan Town Centre on 11th August 2018, celebrating community and growth. WWL were delighted to be part of this event, working in partnership with BYOU, Wigan CCG, Wigan Council and other local providers. WWL were actively involved in Wigan PRIDE on 11th August 2018. Hosted information stand / Participated in PRIDE Parade / Undertook Engagement Survey.	To work collaboratively with local providers, promoting equality, diversity and human rights throughout the Trust and wider community to show how proud we are to be an inclusive employer and an organisation that's treats all our patients as individuals.	WWL seen as fully inclusive employer and service provider. Increased staff and patient engagement and participation. Patient Engagement Survey conducted. 63 completed surveys received. Engagement Report produced. Positive feedback obtained, Services were easily accessible; overall good care was received; they were treated with dignity and respect.	
In support of LGBT History Month in February 2019, WWL raised the Rainbow Flag on the RAEI and WNT Sites.	To show our support for LGBT History Month.	WWL seen as fully inclusive employer and service provider. Increased staff and patient engagement and participation.	

Goal 2: Improved Patient Access & Experience			
What have we done	**Why we did it**	**What was the outcome**	**Looking ahead**
Attended Leigh Deaf Club on 25th April 2018 and engaged with the local hearing impaired community.	To ascertain views and experiences of local deaf community. Historically people with disabilities report poorer access to healthcare.	Engagement summary paper produced. New provider of BSL Interpreters sourced and contract commenced. Funding sourced for pagers in A&E. Pagers implemented and trialled by hearing impaired service user on 21st Nov 18.	To continue to engage with service users. To ensure services are accessible to all.
Reviewed and implemented Deaf Awareness Training Session for A&E staff.	To increase staff awareness of some of the barriers patients with hearing impairments face when accessing hospital services.	Training session held on 10th July 18.	Dual Sensory Awareness Training to be relaunched.
Attended BELONG Blind Group on 13th November 2018 and engaged with the local visually impaired community.	To ascertain views and experiences of local visually impaired community. Historically people with disabilities report poorer access to healthcare	Engagement summary paper produced. Overall positive feedback and experience of hospital services.	To continue to engage with service users. To ensure services are accessible to all.
Attended Wigan and Leigh People First Learning Disability Group on 12th March 2019and engaged with the local learning disability community.			
BME Cancer Patient Experience Survey undertaken.	National cancer patient experience surveys report that BME cancer patient have poorer experiences of cancer services than their white counterparts. We engaged with the local BME community to ascertain their experience of WWL Cancer Services.	Questionnaire designed and forwarded to the 20 BME patients identified. 20% response rate. Report produced. Overall positive feedback obtained. Recommendations proposed.	To continue to engage with service users. To ensure services are accessible to all.
Local Mosque Patient Experience Survey undertaken.	To ascertain views and experiences of local Muslim community.	Questionnaire designed / 100 surveys circulated to local mosque. 5% response rate. Report produced. Overall positive feedback obtained.	To continue to engage with service users. To ensure services are accessible to all.

Goal 2: Improved Patient Access & Experience - Continued			
What have we done	**Why we did it**	**What was the outcome**	**Looking ahead**
Autism Awareness Training Session delivered to I&D Ops and Champions Group.	Increase staff awareness of autism.	Increased staff awareness.	To continue to work in partnership with Dawn O'Neil (Autism Advocate)
Funding secured for a further 3 year contract with AccessAble (previously DisabledGo). .	WWL can continue to provide service users with access to on-line Accessibility Checker. This free on-line resource provides patients with detailed information about the accessibility of the Trust's departments, wards and services for all of the hospital sites.	Accurate & consistent on-line information guides. Increased staff & patient awareness. Improved patient experience. Increased Provision of accessible information.	To continue to work in partnership with AccessAble during 2019 - 2021.
IT Solution identified for one aspect of Accessible Information Standard (AIS) - Ensuring all letters which are routed via Syntertec are printed in patient's preferred format. Funding secured from Patient & Public Engagement. IT Solution being progressed.	To further improve patient experience. Compliance with Accessible Information Standard.	Patient letters which are routed via Syntertec will be printed in the patient's preferred format. Further resource will be required to ensure full compliance with AIS.	On-going implementation / continuing to work in collaboration with CCG. Increased staff and patient awareness. Provides evidence that WWL is working towards • A&E registration to be amended to provide ability to collect patient's needs. • Data needs to be extracted from PAS to HIS to ensure visible in HIS Patient Header (majority of staff have access to HIS. Alert on HIS would ensure that patient needs are acted upon).
Reviewed feasibility of implementing video remote interpreting in A&E.	To ensure access to BSL Signers in emergencies / unplanned hospital attendances.	Providers reviewed. Project Mandate and Privacy Impact Assessment completed. Business Case produced.	On-going implementation. IT support required.

Goal 3: Empowered, Engaged and Included Staff			
What have we done	**Why we did it**	**What was the outcome**	**Looking ahead**
Developed ILM Level 3 & 5 I & D Training Course	To provide staff with knowledge and awareness around Trust's, Manager's and employees responsibilities in relation to I & D	Positive feedback from first session which was run in March 2019.	Planned course dates through 2019/20.
Worked in partnership with Wigan Borough Clinical Commissioning Group n on the 3rd Wigan PRIDE.	To demonstrate the Trust's support of LGBT as an inclusive employer and in terms of service delivery to the patients within the community.	Awareness was raised via all internal communication methodologies as well as social media such as Facebook and Twitter.	Work in collaboration with partners within the local area on plans for the Wigan Pride 2019. Identify and participate in other collaborative initiatives.
Programme of staff awareness / engagement activities was planned for 2018-19 as part of the WWL Way.	To schedule further engagement activities for staff to support Trust values and behaviours and the WWL way.	Awareness was raised cia all internal communication methodologies.	Build further events into the forthcoming year's schedule.

Goal 4: Inclusive Leadership at all levels			
What have we done	**Why we did it**	**What was the outcome**	**Looking ahead**
Planned regular focus groups and listening events. Visible and effective support of Chief Executive, Workforce Director and other Board members at Inclusion and Diversity events as part of the annual schedule.	To enable senior leaders to demonstrate commitment to equality, deal with feedback and embed values into core business activities.	Targeted participation in Inclusion and Diversity values at leadership level.	Annual programme of events to continue to take place.
I&D Steering Group continued to be chaired at Executive level. Members of the group continue to be senior leaders from within the Trust's management team.	To allow agenda items to be given a high priority and items escalated from the underpinning Operations Group to receive appropriate support.	Items were progressed in a timely and appropriate manner furthering the I&D agenda effectively.	Ensure that this practice remains in place moving forward.
Demonstrated senior support as follows: • Senior attendance at the targeted Focus Groups referred to above. • Visible involvement in initiatives such as Wigan PRIDE 2018.	To demonstrate senior level commitment to equality and embed values into core business activities.	Evidence was fed into the EDS assessment and fed back to Trust staff.	Continue to evidence senior level support within all I&D initiatives on an ongoing basis.
A number of further staff stories were obtained during 2018-19.	To demonstrate the level of support staff feel is in place and evidence this to the Trust as a whole as well as to key stake holders.	Stories indicate that staff appreciate the support received from the Trust in relation to I&D matters and are happy to share experiences.	Obtain and publish further Staff Stories and share these at Workforce Committee meetings whenever possible.

4. Summary of Key Diversity Events celebrated 2018/19

Autism Friends – April 2018

On 24th April, members of the I&D Operational & Champions Group took part in an Autism Awareness Session. The session was delivered by Dawn O'Neill, Autism Advocate. Dawn was diagnosed with Autism in January last year at the age of 46 and now works for Wigan Council raising awareness of Autism. Attendees found the key messages extremely thought provoking and also benefitted from Dawn's knowledge and first-hand experience as well as discussing ways to support those with Autism.

Wigan Pride Staff Competition Launched – May 2018

Staff were encouraged to design their very own WWL PRIDE Slogan. The theme for this year's PRIDE was 'Community and Growth' – staff were encouraged to include this theme within their slogan and consider how this could be tied in with the Trust's strategy (The WWL Way 4Wards and the 4Ps). A shortlist of three was agreed, and then reviewed by a panel of judges. All three shortlisted entries were displayed on placards during the Wigan PRIDE Parade and throughout the day.

Winner – Helen

Runners Up – Stephen Hand & Angela

Learning Disabilities Awareness Week – June 2018

During this week the Learning Disabilities Hospital Liaison Team hosted an information stand at the Royal Albert Edward Infirmary. The week focused on communication and reasonable adjustments within an acute Trust. A patient kindly offered to come along and help support the team during the week.

Wigan Pride Launch Event – July 2018

On 25th July, the Trust showed its support for the borough's LGBTQ+ community by raising the rainbow flag and planting our very own WWL PRIDE tree outside the main entrance to the Royal Albert Edward Infirmary. Guests including member of the Trust's executive team, staff and representatives of Wigan Council's BYOU Project, which offers activities and advice for local LGBTQ+ people aged under19.

Wigan Pride – August 2018

Wigan Pride returned for a third year in Wigan Town Centre on 11th August 2018, celebrating community and growth. WWL were delighted to be part of this event, working in partnership with BYOU, Wigan CCG, Wigan Council and other local providers.

Wigan PRIDE celebrates equality and diversity and encourages everyone to get involved in their communities, be that attending social groups, volunteering or getting involved in local projects. This year, a brand new emblem was revealed and the parade had its own theme of 'flower power'. A family-friendly fiesta of live entertainment, stalls, competitions and children's attractions celebrated the LGBTQ+ community's journey towards equality. WWL actively got involved on the day, by hosting an information stall, raising breast screening awareness and actively engaging with the local community about hospital services. Our Three Wishes Charity were busy on the day face painting and fund raising. Albert also made an appearance!

Listening Event for Staff Living with a Disability – October 2018

A listening event for Staff Living with a Disability was held on 3rd October 2018. At this event, the Trust emphasised its commitment to increasing awareness, not only to make others more aware of conditions that some of our staff live with but to also highlight the support available for others who may not feel comfortable speaking about their disability.

David Ollerton kindly agreed to share his story about working at WWL with dyspraxia.

Listening Event for BME Staff – November 2018

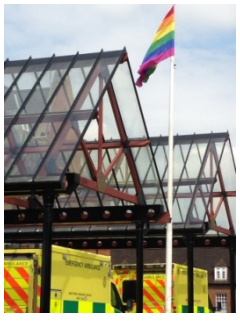
BME
Black & Minority Ethnic Network

A follow up listening event for BME Staff was held on 22nd November 2018. An array of topics were discussed, including equal opportunities for flexible working; time off for religious events in place of other bank holidays; Ablution and prayer facilities at Buckingham Row; car parking; and training opportunities. An Action Plan has been produced and is being progressed.

Patient Engagement during 2018/19: Leigh Deaf Club / BELONG Blind Group / Wigan & Leigh People First Learning Disability Group

Historically people with disabilities report poorer access to healthcare. The Head of Patient and Public Engagement (PPE) and the Inclusion and Diversity Service Lead attended the above groups to find out what their experience was of using hospital services and what further improvements could be made.

WWL flies Rainbow Flag to commemorate LGBT History Month – February 2019



Lesbian, Gay, Bisexual and Transgender History Month is celebrated in February each year. It celebrates the lives and achievements of the LGBT community in the UK. LGBT History Month also aims to promote tolerance and raise awareness of the prejudices faced by lesbian, gay, bisexual and transgender people.

Each year has a different theme. This year's theme, Catalyst, looks at the 50 years of activism, recognising the 50th anniversary of Stonewall.

Everyone is Unique

5. Headline Data

5.1 Our People (Workforce)

The following workforce data is collected routinely by the Trust:

- Age
- Disability
- Ethnicity
- Sex
- Marital Status
- Maternity
- Religion & Belief
- Sexual Orientation

For the purposes of this report, we have reviewed the data which is available to us in terms of the above protected characteristics. The Trust does not hold data on gender reassignment for its workforce profile although it does for statistics in relation to Recruitment and Selection. (See below).

5.1 Our People (Workforce)

Age

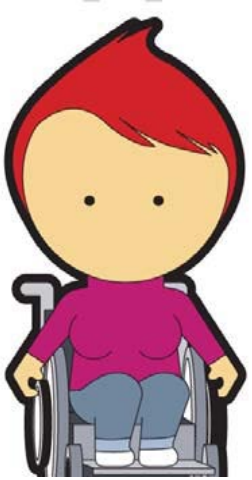
As at 31 March 2019 WWL Trust staff breakdown was:

40% Aged Under 50 **60%** Aged over 50

(Fairly Static Year on Year)

Slight decrease this year with the proportion of staff aged 60+ years. Within 2017 10.15% of staff were over 60, with 12.09% of staff being over 60 in 2018. **This year, 9.47%** of staff were over 60.

Disability



As at 31 March 2019

2.2% of the Workforce have declared that they they are living with a disability.

Although this is consistent with the 2018 figure, there is still a large amount of undeclared data although this figure is improving. (2019 figure is 29.03%, 2018 figure was 32.45%, 36.57% in 2017)

Within **Recruitment**, **5.56%** of applicants declared that they were living with a disability. This figure reduced to 5.13% of those who were shortlisted; reducing again further to those being appointment from shortlisting to 2.40%.

Ethnicity

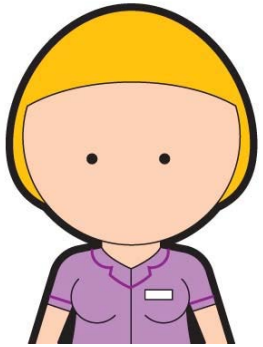
As at 31 March 2019:
90% of Staff of British White Ethnicity (Wigan Borough White representation is 95%)

8% of Staff from Black & Minority Ethnic Groups
1.08% Not Stated

7.1% of the Trust Board membership is BME.

Within **Recruitment**, White candidates shortlisted and appointed are still over representative in comparison with BME applicants, this is still a key area that requires monitoring.

Sex

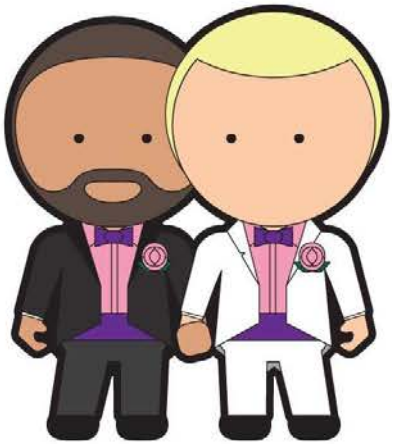


Workforce as at 31 March 2019
79.49% Female
20.51% Male
(50.3% female / 49.7% male within Wigan population)

Figure has remained relatively static over a period of several years.

47% of **Disciplinary** cases were in respect of male staff members which is not representative of the 20.51% male workforce profile. This is a significant increase from previous years data at 32% of disciplinary cases in respect of male staff members.

Marriage and Civil Partnership



As at 31 March 2019

55.17% of staff were **Married**

0.63% were in a **Civil Partnership**

31.46% single, 8.54% divorced / legally separated, 0.84% widowed, 3.34% unknown.

Figure has remained relatively static over a period of several years.

Pregnancy and Maternity

As at 31 March 2019, a snap shot from the Electronic Staff Record indicated that:

1.69% of female staff were on **Maternity Leave**

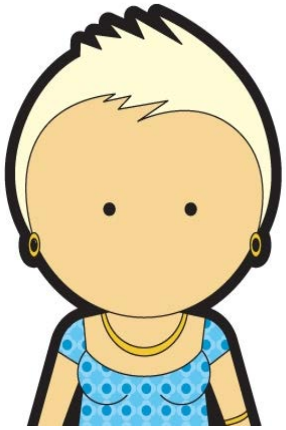
No statistically significant difference from last year.

Religion and Belief

57.1% Christian **26.75%** Unknown

Remaining staff split across a range of religions and beliefs with the highest number being in the `other` category (5.57%).
A significant proportion of staff have not declared their religion and belief. (26.75%)
(The Wigan borough figure for Christianity is 77%.)

Sexual Orientation and Gender Reassignment



Workforce as at 31 March 2019:

73.15% Heterosexual

0.77% Gay or Lesbian

25.75% did not wish to disclose.

Wigan population 8.5% Lesbian, Gay or Bisexual.

Less than **0.44%** of Job Applicants were from individuals identifying as Transgender which is less than the 2.5% Wigan population profile This figure increased to 0.52% at the shortlisting stage and to 0.74% at the appointed stage.

Transgender information for current staff is not recorded on ESR so we cannot therefore undertake workforce profile monitoring at present.

5. Headline Data

5.2 Our Service Users (Patients)

The Trust has historically only had very limited information on the protected characteristics of the people who use our services. As a consequence, it can be difficult for us to determine the extent to which we are providing services which are responsive to individual needs.

The following patient demographics are collected routinely by the Trust:

- Age
- Sex
- Ethnicity
- Religion and Belief

For the purposes of this report, we have reviewed the data which is available to us in terms of age, sex, ethnicity and religion and belief, along with local data and reports. Where we do not have sufficient data in terms of disability, sexual orientation, marriage and civil partnership, trans gender, we have used regional or national data as an estimate.

5.2 Our Service Users (Patients)

Ethnicity (Out-Patients & In-Patients)

During 2018/19

92.4% of Patients of British White Ethnicity

4.0% of Patients from Black & Minority Ethnic Groups (BME)

3.6% Not Known

During last 12 months, 0.3% decrease in patients of British White Ethnicity. 0.3% increase in patients of BME Origin. 0.6 % decrease in those not stated.

Over last 9 years steady increase in BME activity 2010/11: 2.9% / 2018/19: 4%.

Ethnicity (Accident & Emergency)

During 2018/19

92.1% of Patients of British White Ethnicity

6.0% of Patients from Black & Minority Ethnic Groups (BME)

1.9% Not Known

During last 12 months, 0.5% decrease in patients of British White Ethnicity. 0.3% increase in patients of BME Origin.

Over last 9 years steady increase in BME activity in A&E. 2010/11: 2.5% / 2018/19: 6%

Ethnicity overall reflective of local population – Latest census (2011) reported that 95% of the local population were of British White Ethnicity. In 2001 it was estimated that 97.6% of Wigan's Population was "White: British". However, since 2001 the number of residents from Black, Asian and other Minority Ethnicities has more than doubled to 7,062 (2.2% of the population).

Ethnicity (Maternity Admissions)

During 2018/19

87.4% of Patients of British White Ethnicity

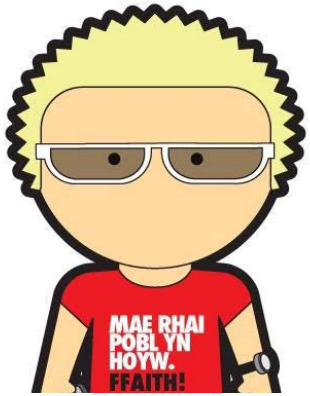
12% of Patients from Black & Minority Ethnic Groups

0.5% Not Known

2.1% decrease in patients of British White Ethnicity. 2.2% increase in patients of Black and Minority Ethnic Backgrounds.

Higher % of Black and Minority Ethnic Groups using maternity services than overall out-patient / in-patient activity. No statistically significant difference noted – data historical. Data in line with significant growth in Wigan Borough migrant worker population and numbers of refugees / asylum seekers.

Interpreter & Translation Services



During 2018/19
Top Languages Requested

Kurdish / Sorani, Polish, Arabic, Farsi, Romanian, Mandarin, Russian, Punjabi, Latvian, Lithuanian, Cantonese, Portuguese, Urdu, Albanian. French. Spanish

Trends show the same top languages as 2017/18. An increase in the number of interpreter requests for Romanian and Kurdish interpreters during the last 12 months.

During 2018/19:

16 Translations into other languages
22 Other formats - 8 Braille / 12 Large Print / 2 Audio Translations requested
This will continue to increase with the implementation of the Accessible Information Standard,

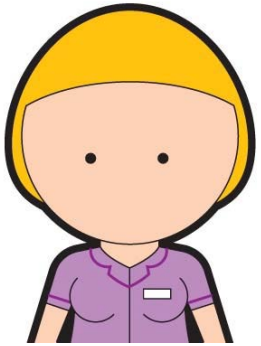
Ethnic Population in Greater Manchester

Although **Wigan is the least ethnically diverse borough** in the County, migration has significantly changed the wealth of diversity in Wigan since the last census and there has been significant demographic change within Wigan Borough.

Ethnic minority populations living in Wigan are:
Long-term resident ethnic minority population and asylum seekers And refugees, migrants, Gypsies and Travellers,
European Roma and Overseas students. Although the numbers are small compared to the size of the total population and some only stay for a short period of time, some will have specific health needs that need to be addressed.

Local Authority	White British	Mixed	Asian or Asian British	Black or Black British	Chinese
Wigan	95%	0.8%	1.3%	0.7%	0.3%
Bolton	84%	1.4%	9.6%	1.2%	0.5%
Salford	86%	1.6%	3.3%	1.7%	0.6%

Sex (Out-Patients)



During 2018/19
56% Female
44% Male

Latest census reported that 50.3% of the local population is female

As with most healthcare services in the UK, women are more likely to use hospital services than men.

Age

During 2018/19
% of patients accessing hospitals services

9% Under 18 **11%** 18-30 Years
41% 31-64 Years **39%** 65+ Years

1 in 6 residents in Wigan are now aged over 65 years.

Set to increase by 30,000 over the next 20 years

Age overall reflective of local population – Latest census reported that the % of the population aged 65 and over in the Wigan Borough was the highest seen in any census. In comparison with the UK as a whole, the population of Wigan is ageing. **The age of patients accessing hospital services is bias towards the older population, reflecting greater healthcare needs. Trends show a 4% increase in patients aged 65+ years over the last 12 months and 4% decrease in those aged 18-30 years. Needs to be monitored over longer period to establish if any statistical significant difference.**

Wigan Borough's population has experienced an upward trend since 2010. Between 2010 and 2017 there has been increase of around 17,000 persons. This increase is estimated to be mainly due to an increase in our ageing population rather than migration, Wigan has seen a 19.9% increase in the 65+ population from 2010 to 2017. Almost 60% of the overall increase in population is attributable to aged 65+ population.

Religion and Belief

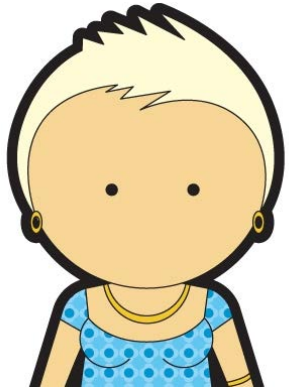
During 2018/19
% of patients accessing out-patient services

71% Christian
12% None
0.6% Muslim
16% Unknown
0.2% Hindu
0.2% Atheist
0.1% Islam

Religion overall reflective of local population – Latest census reported that 78% of the population were of Christian Belief

Trust Data affected by the high proportion of religion not known (74708 patients). 87558 not known in 2017/18

Sexual Orientation and Transgender



Based on recent research and LGBT inequalities data it is estimated that there are

15,000 Lesbian, Gay or Bisexual Wigan Residents
2,500 People who identify as trans in Wigan

Despite the relatively small numbers, the impact that gender re-assignment can have on people's outcomes is extreme.

In response to national research, NHS England is spearheading a collective drive to improve the experience of trans and non-binary people when accessing health and care services.

Disability

Latest Census reported

21.5% of Wigan Residents living with a limiting long-term illness, health problems or disability which limits daily activities at work.

Higher than national average 17.9%

The 5 most common conditions which account for 54% of DLA Claims

Arthritis; Learning Disabilities; Heart Disease; Disease of muscles, bones & joints; Hyperkinetic syndromes

1 in 4 people experience a mental health problem during their life. Having a long-term condition increases the risk that an individual will have a mental health.

The number of people who are at risk of having poor mental wellbeing in Wigan is high because of the high levels of deprivation.

Action on Hearing Loss estimate that

1 in 6 (16%) of the population are living with hearing loss.

53,000 of Wigan Residents.

Improving Health & Lives (IHAL) estimate that

1.9% (6,170 residents) have learning disabilities.

Royal National Institute for Blind People estimates that

8,680 of Wigan Residents are living with sight loss (**990** are living with severe sight loss)

By 2020, figures are expected to rise to **10,500** of Wigan Residents living with sight loss (1,250 living with severe sight loss)

The Accessible Information Standard

A law to ensure that people who have a disability, impairment or sensory loss are given information they can easily read or understand. Making information easier to understand for people living with communication and information needs.

WWL is committed to working towards meeting the core requirements of the Standard for everyone we serve.

Patients with disabilities often report barriers to using health services, in terms of transport difficulties, distance and needing someone to accompany them. Poor communication leads to non-attendance for appointments. These are issues currently being reviewed within Wigan Borough Locality Plan.

Marriage and Civil Partnership

Latest Census reported

47.4% Wigan Residents are **Married**

0.2% (482) Wigan Residents in a Registered **Same-Sex Civil Partnership**

Complaints

539 Complaints Received during 2018/19

318 Female **221** Male

523 British White Ethnicity

10 Black & Minority Ethnic Background

6 Not Stated

68% Aged 50 years or above

5 Main Subject Complaints

- Clinical treatment
- Communications
- Patient Care
- Admissions and Discharges
- Value and Behaviour

No trends in relation to protected characteristics noted

Health Inequalities – Wigan Local Authority Health Profile - 2018

Population (2015)
323,060

Projected Population (2039)
346.374

Deprivation
Wigan is ranked 85th out of 326 Local Authorities for deprivation (1 is most deprived).

Health in summary
The health of people in Wigan is varied compared with the England average. Deprivation is higher than average and about 16% (9,300) of children live in poverty. Life expectancy for both men and women is lower than the England average.

Child health
In Year 6, 21.5% (737) of children are classified as obese, worse than the average for England.

The rate of alcohol specific hospital stays among those under 18 is 54*, worse than the average for England. This represents 37 stays per year.

Levels of teenage pregnancy, breastfeeding initiation and smoking at time of delivery are worse than the average for England.

Life Expectancy
Life expectancy is 12.0 years lower for men and 9.8 years lower for women in the most deprived areas of Wigan than in the least deprived areas.

Adult health
The rate of alcohol-related harm hospital stays is 693*, worse than the average for England. This represents 2,187 stays per year. The rate of self-harm hospital stays is 277*, worse than the average for England. This represents 879 stays per year.

Estimated levels of adult excess weight are worse than the England average. The rate of hip fractures is worse than average. Rates of sexually transmitted infections, people killed and seriously injured on roads and TB are better than average. Rates of early deaths from cardiovascular diseases and early deaths from cancer are worse than average. The rate of statutory homelessness is better.

*** Rate per 100,000 population**

6. Conclusion

Over the past few years, Wrightington, Wigan and Leigh NHS Foundation Trust have made substantial progress in understanding diversity within the local population and ensuring knowledge, skills and competencies in our staff to meet the needs of service users with protected characteristics. We will continue to make progress by ensuring these values are mainstreamed through all aspects of our service provision, and in how we work in partnership with our employees and our local communities.

As this annual report identifies, there have been some notable successes:

- Holding two separate Listening Events for staff – Living with a Disability / BME.
- Living with dyspraxia staff story.
- Wigan PRIDE returned for a third year. WWL were actively involved in the planning and on the day.
- Holding a Wigan PRIDE Staff Slogan competition.
- Engaged with specific protected characteristic groups about hospital services (including Leigh Deaf Club; BELONG Blind Group; Wigan & Leigh People First Learning Disability Group)
- Several Patient Experience Surveys carried out: BME Cancer Patient Experience; Local Mosque Patient Experience; and LGBT Community.
- Autism Awareness Training Session for staff.
- Deaf Awareness Training Session for A&E staff.
- Level 3 Inclusive Leadership Management Training Session designed and first session held in March 2019.
- Pagers for hearing impaired implemented in A&E.
- Funding secured for a further 3 year contract with AccessAble.
- IT solution identified for ensuring accessibility of hospital letters.

Work around the requirements of the Equality Delivery System is enabling the Trust to further develop strong foundations that support the progression and implementation of inclusion and diversity principles into mainstream processes. This report demonstrates the commitment within the Trust to progress work around equality.

WWL has met its statutory obligations to monitor and report on workforce and patient equality and diversity issues and provides assurance that action is being taken to address issues of note.

Under current practice, there continues to be gaps within the Trust's information gathering and analysis of patient data. Only equality information in relation to a patient's ethnicity, age, sex and religion is collected routinely. At present, the Trust does not have the technology in place to capture data on disability, sexual orientation, gender re-assignment and marriage and civil partnership. The implementation of more robust equality monitoring and data analysis within service delivery continues to be addressed and is being actioned as a key priority within the Trust's Equality Delivery System Action Plan.

For the purposes of this report, we have reviewed the patient data which is available to us in terms of age, sex, ethnicity and religion and belief, along with local data and reports. Where we do not have sufficient data we have used regional or national data as an estimate. **The overall picture of access, using the best available data, reflects broad similarity to local demographics.**

In terms of workforce data, we have reviewed the data which is available to us with regards to age, disability, ethnicity, sex, marital status, maternity, religion & belief and sexual orientation. Other than in respect of Recruitment and Selection statistics, the Trust does not hold workforce data on gender reassignment.

The Trust recognises the importance of equality and human rights and the value that it adds. We will continue to build on the progress we have made to date.

7. The Year Ahead

Implementing and Monitoring EDS2

In 2019/20 the Trust will continue to embed and integrate the Equality Delivery System 2 in terms of both service provision for patients and employment practice. In line with the requirements of EDS2, the Trust will aim to continuously improve services for all service users and especially those that are categorised as having protected characteristics and underrepresented groups. This will be done in partnership with staff, service users and local interest groups.

As a Trust, we already have a culture that recognises the equality challenges we face. We capture this within our EDS Action Plan 2018/19.

Maintaining Compliance with the Public Sector Equality Duty

The Trust has and will continue to monitor compliance with the equality agenda and ensure that staff and service users are consulted with and updated on any changes and progress. This will include ensuring that there is equality for all and eliminating discrimination.

WRES and WDES

The Equality Delivery System (EDS2) and Workforce Race Equality Standard (WRES) are published on our Trust Website and help us to focus, highlight concerns and keep on track with making improvements in what we do and how we do it – for the benefit of all our service users, carers and staff. WDES will be reported on from August 2019 and published on our Trust Website again to help us to focus, highlight concerns and keep on track with making improvements in what we do and how we do it.

Engagement

We recognise the need to continue to work in partnership with staff and patients. For staff, this means continuing to raise awareness of initiatives and engaging with protected groups to ensure that all staff feel valued, respected and able to progress through the organisation. It also means the opportunity to share and build on areas of good practice whilst addressing areas for development. For patients and carers, this means being able to access our services, receive care and support and be treated as individuals with dignity.

Equality Monitoring

WWL recognises that we do not have sufficient information about the health needs and experiences of lesbian, gay, bisexual and trans people and need to continue to make our services more welcoming and inclusive.

Over the last 9 years there has been a steady increase in the percentage of black and minority ethnic patients attending A&E. By working with Wigan Clinical Commissioning Group we need to ensure asylum seekers and refugees and the migrant population are aware of the role of the GP, Hospital A&E and alternatives like the Walk-in-Centre, NHS 111 and pharmacies.

During 2018/19, the Trust continued to undertake equality analysis on all policies and practices (to ensure that any new or existing policies and practices do not disadvantage any group or individual). Equality impact assessments are embedded as part of Trust Policy Protocol. Further work however is required to ensure all new / re-designed services are assessed. The Trust needs to continue to ensure that EIAs become a core activity when reviewing / implementing new services / projects etc.

Accessible Information

We need to ensure that patients continually receive information in formats that they can understand. Patient feedback re-iterates the need for us to ensure that communication support needs are recorded and acted upon accordingly. WWL is continuing to work towards meeting the core requirements of the Accessible Information Standard. Although an IT solution has now been identified for ensuring all letters which are routed via synertec are printed in the patient's preferred format, further resource is required to ensure full compliance. Next steps include amending A&E registration so patient needs can be collected and

implementing a data extract from PAS to HIS System, so patient needs become visible on the electronic patient record.

Promotional Events

To continue to help publicise and promote events that highlight best practice in equality and diversity within the organisation. This will focus on national campaigns that are linked to the protected characteristics as well as all the various initiatives that are being undertaken at a local level.

Employment Practice

We aim to further develop the support available to managers with regard to inclusion and diversity issues and look to develop more local resources, awareness sessions and master classes.

We also aim to further reduce inequalities experienced by staff and applicants from a BME background by means of our BME Listening Events and Forum and further developing the BME Leaders module within the WWL Leadership Programme.

8. Recommendations

WWL Workforce Committee members are invited to receive and approve the Annual Inclusion and Diversity Monitoring Report. To support further progress on the Trust's Equality, Diversity and Inclusion Action Plan.

9. References – to be updated

- **Public Sector Equality Commitment Annual Report (2018/19)** – Wigan Council
- **Public Sector Equality Duty Annual Equality and Diversity Report – January 2019** Wigan Borough Clinical Commissioning Group
- **Census 2011**
- **Disability in the United Kingdom 2013 – Facts & Figures** – Papworth Trust
- **Disadvantage in Wigan in 2011 Report** – Wigan Council
- **Equality and Diversity Strategy 2016-2019** – Wigan Borough Clinical Commissioning Group
- **Gypsy and Traveller Population in England and the 2011 Census** - An Irish Traveller Movement in Britain Report (August 2013)
- **Gypsylife – From then until now Annual Report – April 2013**
- **Health and Migration in the North west of England** – An Overview: November 2008 – Public Health
- **House of Commons Migration Statistics – Seventh Report of Session 2013-14**
- **Immigration – The Rational Debate North West Focus Group Report – January 2013** – Migrant Workers North West
- **Office for National Statistics (ONS)** – Census 2011
- **Regional Economy and Job Market Immigration Report – The Rational Debate -** North West Migrant Workers Focus Group - January 2013

- **Safeguarding Vulnerable Adults & Children Annual Report 2012-2013 –** Wrightington, Wigan & Leigh NHS Foundation Trust.
- **Scope About Disability - https://www.scope.org.uk/**
- **Stonewall - http://www.stonewall.org.uk/**
- **Wigan Council – State of the Borough Report 2017**
- **Wigan Joint Strategic Needs Assessment 2011**
- **Wigan Health Profile 2018** – Public Health England
- **Wigan's information System on Dynamic Online Maps** (wisdom.wiganlife.com)
- **Wigan Locality Plan for Health and Care Reform**
- **Wigan Population Profile and Key Health Inequalities for Protected Characteristic Groups 2015 -** Bridgewater Community Healthcare NHS Foundation Trust
- **Images used with permission of Christian Tate**

10. Accessibility

This document can be made available in a range of alternative formats e.g. large print, braille and audio. For more details, please contact the Trust's Patient Information Administrator, Membership and Engagement Department on 01942 773106 or email InterpreterServices@wwl.nhs.uk

APPENDICES

Appendix 1

Compliance against National Standards - Dashboard

Equality National Standards	Requirements	Update	RAG Rating
Equality Act 2010: **Public Sector Equality Duty - General Duty**	Must provide evidence that we have given 'due regard' to the three aims of the General Duty across all 9 protected characteristics: • Eliminate unlawful discrimination, harassment & victimisation • Advance equality of opportunity • Foster good relations	Equality Impact Assessments provide evidence-based assurance of how the Trust is identifying and addressing any existing or potential inequalities across all 9 protected characteristics. I&D Strategy 2016-2020 reviewed. Consultation undertaken May/June 2016. Approved by I&D Steering Group Meeting on 27/09/16. Approved by Trust Board Dec 2016. Evidenced within Annual EDS Action Plan. Published on Trust Website.	
Equality Act 2010: **Public Sector Equality Duty - Specific Duties**	Must publish relevant, proportionate information demonstrating compliance with the Equality Duty by 31st January of each year. Must set four-year equality objectives, based on key local equality priorities. Must analyse the effect of policies and practices on equality.	I&D Annual Monitoring Report 2017/18 received by Workforce Committee and Trust Board in Nov/Dec 18. Published on Trust Website. Trust website updated regularly. Equality Objectives for 2016-2020 reviewed. Proposed Objectives approved by E&D Executive Leads. Consultation undertaken May/June 2016. Proposed Strategy & Objectives approved by I&D Steering Group on 27/09/16. Approved by Trust Board Dec 2016. Equality Impact Assessments provide evidence based assurance of how policies and practice impact on protected groups.	
Equality Delivery System (EDS2) NHS Standard Contract Requirement Embedded within CCG Assurance Framework & CQC Inspection regime.	Must comply with the Mandatory Equalities Reporting Framework for the NHS. Must undertake in partnership with local stakeholders, to review and improve performance for people from protected groups.	**When assessing and grading performance against 18 EDS Outcomes, guidance now stipulates that NHS organisations can choose to look at just one or a few aspects of their work, rather than looking across the entirety of all they do**. Given the number of services provided by the Trust and the 18 outcomes within EDS2, a phased implementation of EDS2 was agreed. 4 outcomes reviewed each year. One for each of the four goals. Equality Objectives Review & EDS Assessment 2018 published on Trust Website. **Annual EDS 2018/19 Assessment currently being reviewed. Proposed evidence and scores for Goals 1 & 2 (Service Delivery) to be reviewed by Healthwatch & local stakeholders.**	
Work Force Race Equality Standard (WRES)	Must demonstrate through the 9 Point Work Force Race Equality Standard (WRES) metric how we are addressing race equality issues in a range of staffing areas. Must demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of BME Board representation.	At present, WWL is performing better than a number of other Trusts in respect of the BME Board representation. The updated WRES return was submitted to the Department of Health at the end of August 2017, submitted to CCG and uploaded onto the Trust's internet web page. Indications are fewer BME staff reporting harassment, bullying and abuse when compared to their white colleagues. There also appear to be improvements in the percentage of BME staff who believe that WWL provides equal opportunities. 2018 WRES data appears to indicate a deterioration so this will need to form a key part of the 2018-19 Action Plan. WRES 2019 assessment is currently in development stages ready submission by end of August 2019.	

Equality National Standards	Requirements	Update	RAG Rating
Disability Work Force Equality Standard (WDES)	• A set of specific measures to enable us to compare the experiences of disabled and non-disabled staff. • Research shows that a motivated, included and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety. • Will form part of NHS Standard Contract. • WDES will enable us to better understand the experiences of disabled staff. It will support positive change for existing employees, and enable a more inclusive environment for disabled people working in the NHS. • August 2019 publication date for Trusts. • April / May 2020 publication of first national annual WDES report.	Completed – to be submitted 01/08/19	
Accessible Information Standard **(for people with a disability, impairment or sensory loss)**	From 31st July 2016 - Must ask all patients if they have any information or communication needs. Must record those needs clearly and in a set way. Must highlight or flag patient's needs and ensure their needs are met. Must share information with other services / providers. **IT Solution identified for one aspect of AIS - Ensuring all letters which are routed via Syntertec are printed in patient's preferred format.** Further resource required to ensure full compliance with AIS: • A&E registration to be amended to provide ability to collect patient's needs. • Data extracted from PAS to HIS – to ensure visible in HIS Patient Header (majority of staff have / will have access to the new Health Information System (HIS). Alert on HIS would ensure that patient needs are acted upon). • An investigation is also required to scope the capability of other standalone systems.	Trust non- compliant from 31/07/16. Risk Assessment undertaken. Registered on Corporate Risk Register April 2016. Risk Rating of 15 allocated. Raised at relevant committees. IT Systems currently unable to facilitate requirements of standard (record / alert & share patient needs). **IT Solution identified for one aspect of AIS - Ensuring all letters which are routed via Syntertec are printed in patient's preferred format.** Funding sourced via PPE for 15 days of IM&T development support £4,800. Action Plan being progressed. Further resource of £48,000 required to ensure full compliance with AIS: Cost reviewed by Business Analysis: **£12,000:** A&E registration to be amended to provide ability to collect patient's needs. Data extracted from PAS to HIS – to ensure visible in HIS Patient Header (majority of staff have access to HIS. Alert on HIS would ensure that patient needs are acted upon).Contracted resource to back fill Developer BAU work to allow time to be allocated to Reg tool amendment work & PAS look up set up. **£36,000:** Investigation required to scope the capability of other standalone systems. Funding needed to contract a Business Analysist (£1,500 per week x 6 months).	

Gender Pay Gap Reporting	In line with the Gender Pay Gap regulations, the Trust published its gender pay gap data by the 31st March 2018. The information is published on the Government website and on the Trust`s own website so that it is openly available for review. All organisations with 250+ employees are required to publish their data and there has been national press interest in the gender pay gap issue as the deadline approaches.	The Trust data has highlighted there is a gender pay gap within the Trust with women across the average, median and bonus gap being paid less than males. The Trust has analysed its data and produced a supporting report which outlines the factors which contribute to the gender pay gap and this was discussed at Workforce Committee on the 14th March 2018. . An analysis of the data has been carried out by division and actions to be included in 2019-20- Action Plan	
Sexual Orientation Monitoring Standard Published 5th October 2017.	The Sexual Orientation Monitoring Information Standard provides the mechanism for recording the sexual orientation of all patients/ service users aged 16 years and over across all health services and Local Authorities with responsibilities for Adult social care in England in all service areas where it may be relevant to collect this data. The standard acts as an enabler for the Equality Act 2010, supporting good practice and reducing the mitigation risk for organisations required to comply with the Act. All public sector bodies have a legal obligation to pay due regard to the needs of (LGB) people in the design and delivery of services, and to ensure that people are not discriminated against based upon their sexual orientation. Health and Care Organisations must review the impact of this information standard and make appropriate changes to local health IT Systems from 5/10/17 and before 31/03/19.	**This standard provides the categories for recording sexual orientation but does not mandate a collection.**All new data sets with a business requirement to collect sexual orientation data will be expected to adopt this sexual orientation monitoring (SOM) fundamental standard, and existing data sets already reporting SEXUAL ORIENTATION CODE will be required to change to the new values at their next iteration. This Change Request adds the supporting definitions and values for Person Stated Sexual Orientation to the NHS Data Model and Dictionary to support the Sexual Orientation Monitoring Information Standard. PAS Update (Patient Centre) includes a field in which sexual orientation can be recorded. **As data not already recorded routinely within the Trust, guidance stipulates not a mandatory requirement. Standard requirements to be embedded within any changes to future operational protocol.**	

Appendix 2

A detailed account of all Trust Equality Monitoring Data for 2018/19

can be accessed via our Trust Website

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

Appendix 3

A copy of the Trust's Workforce Race Equality Standard (WRES) Submission 2018-2019

and Workforce Disability Equality Standard (WDES) update

can be accessed via our Trust Website

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

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

REPORT

AGENDA ITEM: 12

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

To:	Board of Directors	**Date:**	29 January 2020
Subject:	7 Day Service Assurance		
Presented by:	Medical Director	**Purpose:**	Approval

Executive summary

The national Seven Day Working programme, covering ten clinical standards, commenced in 2013 and through an audit process performance has been submitted by provider organisations over the last 3 years. This report details the latest findings from the review carried out in November 2019 which shows a slight deterioration from the last submission in July 2019 when the Trust was compliant with all of the standards (based on 90% achievement for the 4 priority standards across all days of the week). In November the Trust was compliant with all but one of the standards (the requirement for 90% of patients to see a Consultant within 14 hours). The standard was achieved during the week (91%) but in the sample only 82% of patients saw a Consultant within 14 hours at the weekend.

Risks associated with this report

There is a risk that patients who did not see a Consultant within 14 hours may have had a longer length of stay or had suboptimal care. All patients have been reviewed by the Medical Director and no harm identified.

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 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)

The data to measure performance against the priority standards was initially measured via an on-line tool but this is now captured via a self-assessment template. The aim of this 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. 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

The standards are measured via an audit for Standards 2 and 8 and information capture for standards 5 and 6. As per the guidance the audit data was from one week in October. The

outcomes since the data collection commended in March 2016 are shown below (prior to June 2018 the number of standards data was collected on varied hence the gaps shown)

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%
Nov-19	91%	100%	100%	100%	82%	83%	100%	100%

Full details of the current assurance levels and a short narrative are included in Appendix 1 but in relation to Standard 2 at the weekend it should be noted that this is based on a small sample of patients (28) of which 5 did not see a Consultant within 14 hours. All patients have been reviewed by the Medical Director and no harm was identified. The sample was too small to identify themes and therefore a wider audit will be undertaken and the results and any associated actions will be monitored and managed through the "Valuing patients time" workstream.

In relation to standard 5 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. There are no current plans to change this.

Clinical Standards for Continuous Improvement

The Trust is 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. Performance in relation to standard 2 at the weekend is variable due to the small sample size and therefore the wider audit referred to above will be carried out and any themes and associated actions will be managed through the valuing patients time workstream. It is expected that the next self-assessment will take place in Spring 2020 and an update on any actions will be included in the report. It is also recommended that if the data collection method remains the same a larger scale audit is carried out for the next submission to give more assurance about the outcomes (although it should be noted that the sample size used for the November submission was as recommended).

7 Day Hospital Services Self-Assessment

Organisation	**Wrightington Wigan and Leigh NHS FT**
Year	**2019/20**
Period	**Autumn/Winter**

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.	6 patients did not see a Consultant within 14 hours during the week and 5 did not at the weekend. 1 patient on a short ENT pathway did not a Consultant at all during their admission. Of those patients who saw a Consultant after 14 hours the maximum time to be seen was 24 hours. The average was 17.5 hours with all but 3 patients waiting less than this. The median wait was 16:49 hours. The performance at the weekend was 82%. The cases ranged across a large number of specialties. All cases have been reviewed by the Medical Director and a task and finish group is being established to identify any trends and/or actions to improve performance, especially at the weekend.	Yes, the standard is met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not 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	
	The Trust is compliant with this standard with the exception of echocardiography for which we are reliant on the goodwill of staff. At present there are no plans in place to move this to a formal arrangement	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 mix of on site and off site by formal arrangement	
		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	
	This standard is fully met	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.	This standard is fully met	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: 12

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

To:	Board of Directors	**Date:**	29 January 2020
Subject:	Statement of responsibilities within the foundation trust		
Presented by:	Company Secretary	**Purpose:**	Approval

Executive summary

The *NHS Foundation Trust Code of Governance* ("the FT Code") is based on the standards of good practice for listed companies set out in the UK Corporate Governance Code ("the UK Code") and is recognised as best practice guidance within the NHS foundation trust sector.

The FT Code recommends that the division of responsibilities between the Chair and the Chief Executive is clearly established, set out in writing and agreed by the Board of Directors. The recently-updated UK Code now extends this recommendation to include the roles of the Senior Independent Director, the Board and its Committees.

In light of this emerging good practice from the corporate sector, a broader statement of responsibilities has been prepared and is presented for approval.

Risks associated with this report

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

Link(s) to The WWL Way 4wards

☐	Patients	☐	Performance
☐	People	☐	Partnerships

The WWL Way

Statement of responsibilities within the foundation trust

Wrightington, Wigan and Leigh NHS Foundation Trust

One of the main principles within the leadership section of the NHS Foundation Trust Code of Governance ("the FT Code") is that there should be a clear division of responsibilities at the head of a foundation trust between the chairing of the Board of Directors and the Council of Governors and the executive responsibility for the running of the foundation trust's affairs. The FT Code notes that, as part of this, no one individual should have unfettered powers of decision. The FT Code suggests that the division of responsibilities between the Chair and the Chief Executive should be clearly established, set out in writing and agreed by the Board of Directors.

The UK Corporate Governance Code ("the UK Code") published by the Financial Reporting Council sets out wider corporate governance best practice. The UK Code has recently been updated and now recommends that the responsibilities of the Senior Independent Director, Board and Committees should also be set out in writing, agreed by the Board of Directors and made publicly available. In light of this emerging best practice and in an effort to further improve transparency, these additional responsibilities have also been set out in this statement.

Responsibilities of the Board of Directors and its Committees

The Board of Directors is responsible for setting the overall strategic direction of the foundation trust. The business of the foundation trust is managed by the Board of Directors and all the powers of the foundation trust are exercisable by the Board of Directors on its behalf. The matters that the Board has reserved to itself and those which have been delegated to individual directors or committees are clearly documented within a Scheme of Delegation. The Board operates in accordance with Standing Orders and the organisation operates in accordance with financial rules agreed by the Board in Standing Financial Instructions.

The Board has established a number of committees in order to have oversight and to seek assurance in specified areas. Each of these committees has clear terms of reference which set out the scope of the committee's responsibilities and any delegated powers given to it by the Board. They report back to the Board after each meeting, providing assurance or escalating risks as appropriate.

More information on the responsibilities of each committee will be included in our annual report.

Responsibilities of the Council of Governors

The Council of Governors is comprised of 28 governors who have either been elected from amongst the various constituencies within the foundation trust's membership or appointed by one of our partner organisations. The Council of Governors has two general duties:

1. To hold the non-executive directors to account, individually and collectively, for the performance of the Board of Directors; and

2. To represent the interests of the foundation trust's members as a whole and the interests of the public.

Additionally, the Council of Governors also has a number of specific responsibilities as set out below:

- To appoint and, where necessary, remove the Chair and the other non-executive directors;
- To approve the appointment of a Chief Executive by the non-executive directors;
- To decide the remuneration and allowances, and the other terms and conditions of office, of the non-executive directors;
- To appoint or remove the external auditor;
- To appoint or remove any other external auditor appointed to review and publish a report on any other aspect of the foundation trust's affairs;
- To be presented with the annual accounts, any report of the external auditor and the annual report;
- To approve significant transactions as defined within the constitution;
- To approve an application by the foundation trust to enter into a merger, acquisition, separation or dissolution;
- To decide whether the foundation trust's non-NHS work would significantly interfere with the fulfilment of its principal purpose (which is the provision of goods and services for the purposes of the health service in England) or the performance of its other functions;
- To approve amendments to the constitution;
- To provide their views to the Board of Directors when the Board is preparing the foundation trust's forward plan;
- To prepare, and from time-to-time review, the membership strategy and the policy for the composition of the Council of Governors, and
- Where appropriate, to act collectively and through individual governors to communicate with members about developments in the foundation trust and the work of the Council of Governors.

Responsibilities of the Chair and Chief Executive

The respective responsibilities of the Chair and Chief Executive are set out in the table below:

Chair	Chief Executive
Reports to the Board of Directors.	Reports to the Chair and to the Board of Directors.
Other than the Chief Executive, no executive reports to the Chair.	All members of the management structure report, either directly or indirectly, to the Chief Executive.
Ensures effective operation of the Board of Directors and Council of Governors.	Runs the foundation trust's operation and day-to-day business.
Ensures that the Board of Directors as a whole play a full part in the development and determination of the foundation trust's strategy and overall objectives.	Responsible for proposing and developing the foundation trust's strategy and overall objectives.

Chair	Chief Executive
The guardian of the Board of Directors' decision-making processes.	Implements the decisions of the Board of Directors and its committees.
Leads the Board of Directors and the Council of Governors.	Ensures the provision of information and support to the Board of Directors and Council of Governors.
Ensures the Board of Directors and Council of Governors work together effectively.	Facilitates and supports effective joint working between the Board of Directors and Council of Governors.
Oversees the operation of the Board of Directors and sets its agenda.	Provides input to the board of director's agenda on behalf of the executive team.
Ensures the agendas of the Board of Directors and Council of Governors take full account of the important issues facing the foundation trust.	Ensures the Chair is aware of the important issues facing the foundation trust and proposes agenda items accordingly.
Ensures the Board of Directors and Council of Governors receive accurate, timely and clear information.	Ensures the provision of reports to the Board of Directors which contain accurate, timely and clear information.
Ensures compliance with the Board of Directors' approved procedures.	Ensures the compliance of the executive team with the Board of Directors' approved procedures.
Arranges informal meetings of the directors to ensure that sufficient time and consideration is given to complex, contentious or sensitive issues.	Ensures that the Chair is alerted to forthcoming complex, contentious or sensitive issues affecting the foundation trust.
Proposes a schedule of matters reserved to the Board of Directors; proposes terms of reference for each Board of Directors committee and proposes other board policies and procedures.	Provides input as appropriate on changes to the schedule of matters reserved to the Board of Directors and committee terms of reference.
Facilitates the effective contribution and the provisions of effective challenge by all members of the Board of Directors.	Supports the Chair in facilitating effective contributions by executive directors including effective challenge.
Facilitates constructive relationships between executive and non-executive members of the Board of Directors.	Supports the Chair in sustaining constructive relations between executive and non-executive members of the board.

Responsibilities of the Senior Independent Director

The Senior Independent Director is appointed by the Board of Directors, in consultation with the Council of Governors. The role of the Senior Independent Director is to:

- act as a sounding board for the Chair and to serve as an intermediary for the other directors when necessary;
- lead the performance evaluation of the Chair, within a framework agreed by the Council of Governors, taking into account the views of directors and governors;
- lead meetings of the non-executive directors without the Chair present at least annually to appraise the Chair's performance and on such other occasions as are deemed appropriate;

- report the outcomes of the Chair's appraisal to the Council of Governors;
- be available to governors if they have concerns that contact through the normal channels of Chair, Chief Executive, Chief Finance Officer or Company Secretary has failed to resolve or where such contact is inappropriate; and
- attend sufficient meetings with governors to listen to their views in order to help develop a balanced understanding of their views, issues and concerns.

This statement was approved by the Board of Directors at its meeting on 29 January 2020.

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Robert Armstrong
Chair
For and on behalf of the Board of Directors