Board of Directors

24 June 2020, 13:30 to 15:00
By videoconference

Agenda

1. Chair and quorum

Information

Robert Armstrong

2. Apologies for absence

Information

Robert Armstrong

3. Declarations of interest

Information

Robert Armstrong

4. Minutes of previous meeting

Approval

Robert Armstrong

- Minutes - Board - May 2020.pdf (8 pages)
- Minutes - P2 Board - May 2020.pdf *(Not included in the public bundle)* (4 pages)
- Minutes - P2 Board - 5 Jun 2020.pdf (3 pages)

5. Committee chairs' updates

15 minutes

Information

Verbal item:

- Audit Committee, 5 June 2020
- Pandemic Assurance Committee, 10 June 2020

Ian Haythornthwaite/Tony Warne

6. Update from executive team

15 minutes

Information

Verbal item

Silas Nicholls

7. COVID-19 mortality

10 minutes

Information

Sanjay Arya

- COVID-19 mortality.pdf (21 pages)

8. Transformation in recovery

20 minutes

Discussion

Chris Knights

- Transformation in recovery.pdf (20 pages)

9. Performance report

10 minutes

Discussion

Chris Knights

- Performance report.pdf (18 pages)

10. Review of COVID-19 risk appetite statement

For approval

Paul Howard

Review of COVID-19 risk appetite statement.pdf (4 pages)

11. Consent agenda

1 minutes

11.1. Changes to committee arrangements

Approval

Changes to committee arrangements.pdf (1 pages)

11.2. Hot debrief feedback

Information

Hot debrief feedback.pdf (5 pages)

11.3. Finance report

Information

Finance report.pdf (4 pages)

11.4. Register of Clinical Ethics Group referrals

Information

Register of CEG cases received.pdf (2 pages)

12. Resolution to exclude press and public

Approval

Robert Armstrong

13. Date, time and venue of next meeting

29 July 2020, 1.30pm, by videoconference

Information

Robert Armstrong

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

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

HELD ON 27 MAY 2020, 1.30PM

BY VIDEOCONFERENCE

Present:	Mr R Armstrong	Chair (in the Chair)
	Dr S Arya	Medical Director
	Prof C Austin	Non-Executive Director
	Mrs A Balson	Director of Workforce
	Lady R Bradley DL	Non-Executive Director
	Dr S Elliot	Non-Executive Director
	Ms M Fleming	Chief Operating Officer
	Mr M Guymer	Non-Executive Director
	Mr I Haythornthwaite	Non-Executive Director
	Mrs L Lobley	Non-Executive Director
	Mr R Mundon	Director of Strategy and Planning
	Mr G Murphy	Acting Chief Finance Officer
	Mr S Nicholls	Chief Executive
	Ms H Richardson	Chief Nurse
	Prof T Warne	Non-Executive Director
In attendance:	Mrs N Guymer	Deputy Company Secretary
	Mr P Howard	Company Secretary
	Mrs L Sykes	Public Governor (observer)

Part 1

57/20 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.

58/20 Apologies for absence

No apologies for absence were received.

59/20 Declarations of interest

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

60/20 Minutes of the previous meeting

The minutes of the previous meeting held on 29 April 2020 were **APPROVED** as a true and accurate record.

61/20 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 terms of reference for the Pandemic Assurance Committee be **APPROVED**.

2. THAT the Scheme of Reservation and Delegation be **APPROVED**.

3. THAT the Board Diversity Policy be **APPROVED**.

4. THAT the Board's self-certification against provider licence conditions G6 and FT4 be **APPROVED**.

5. THAT the Remuneration Committee terms of reference be **APPROVED**.

6. THAT the finance report be received and noted.

7. THAT the financial governance report be received and noted.

8. THAT the register of directors' interests be received and noted.

9. THAT the summary of directors' fit and proper person checks be received and noted.

10. THAT the summary of referrals to the Clinical Ethics Group be received and noted.

With regard to the financial governance report, the Acting Chief Finance Officer drew the Board's attention to the fact that national guidance continues to be developed and released and confirmed that this would be shared with directors once published. Mr Haythornthwaite noted the importance of ensuring that the Audit Committee remains sighted on relevant national guidance.

62/20 Chair and Chief Executive's opening remarks

The Chair advised that he had recently attended a briefing with the NHS England and Improvement Regional Director and noted that the Chief Executive would brief the Board on this more fully later in the agenda. He noted that the session had been very informative.

The Chief Executive commented that the initial response to COVID-19 had now been undertaken and that the focus was shifting towards recovery and preparing for any second wave of infection. He confirmed that the regional intention was to focus on stabilisation over the coming six-week period and then to look at a longer-term approach which is expected to last until the end of the current financial year. He suggested that the next phase in the response is likely to be more complex than the initial response as efforts are made to reinstate urgent care activities when possible and to address the backlog of elective cases at an appropriate point in time, taking into account the likely impact of introducing elective work on stocks of personal protective

equipment and other resources such as haemofiltration equipment and anaesthetic drugs. The requirement to run separate COVID-19 and non-COVID-19 services and to ensure an 80% bed occupancy rate across both services was also highlighted.

Given the reduction in activity currently, the Chief Executive noted that members of staff were likely to begin to reflect on the initial response to the pandemic and on the cases they have personally dealt with, and suggested that this could result in an increased demand for the psychological support mechanisms that have been put in place. He confirmed that he would be ensuring that he remained visible and accessible to staff and would be making a particular effort to visit areas of high acuity in the hospital to support the staff involved.

The Chief Executive commented that the time appeared right to begin to review the organisation's corporate governance arrangements in response to the pandemic. He commented that the establishment of the Pandemic Assurance Committee had served a real purpose in ensuring oversight of matters of concern but noted that the current challenges are likely to remain until the end of the financial year. Whilst a return to the pre-COVID arrangements was unlikely to be appropriate at this time, he nonetheless suggested that a hybrid approach would be beneficial to ensure a focus on safety and clinical risk as well as wider organisational matters. The Company Secretary agreed to prepare some suggestions for discussion with directors outside the meeting.

ACTION: Company Secretary

With regard to wider business as usual considerations, the Chief Executive described his desire to begin to set objectives for himself and the remainder of the executive team and suggested that it would be more appropriate to consider the setting of behavioural objectives for FY2020/21 rather than more traditional objectives linked to the organisational strategy.

The Chief Executive iterated the importance of reinstating performance reporting as soon as possible and committed to ensuring that a report is available to the next meeting. He noted the likely need to move away from sequential waiting lists and towards risk-based timetabling but acknowledged the importance of the Board receiving sufficient information on this matter to obtain assurance on the way in which waiting lists are being managed. The Director of Strategy and Planning confirmed that he would be taking this forward.

ACTION: Director of Strategy and Planning

Finally, the Chief Executive noted the significant change in decision-making at regional level in recent months. He reminded the Board that the pandemic had been declared a level 4 incident in accordance with NHS England's National Incident Response Plan and that NHS England's national command and control arrangements had been put in place. As a result, NHS England, in collaboration with local commissioners at the tactical level, were coordinating the NHS response. Locally, the NHS response was being coordinated on a Greater Manchester footprint and the Chief Executive noted that this would likely impact on all organisations' ability to determine their own capital expenditure and he advised that it is hoped for the Greater Manchester Provider Federation Board to move

towards operating on a regional basis in the medium term under delegated authority from individual foundation trusts. He commented that it is also likely that some services will be identified as being required on a regional basis rather than at local level, and note was made of the impact that some of these developments may have on clinical commissioning groups.

Mrs Lobley noted the regional governance arrangements and requested that any background documentation might be shared. The Director of Strategy and Planning agreed to provide this outside the meeting.

ACTION: Director of Strategy and Planning

Mr Guymer suggested the need to ensure that arrangements are put in place to ensure that the Board has access to decisions taken on behalf of the region under delegated authority. The Chief Executive agreed to discuss how this might best be achieved with the Director of Strategy and Planning and the Company Secretary.

ACTION: Chief Executive/Director of Strategy and Planning/Company Secretary

In response to a question from the Chief Operating Officer, the Chief Executive advised that the decision-making arrangements, including any ability to challenge decisions, were currently being developed.

Mr Haythornthwaite questioned whether any of the statutory responsibilities of foundation trust boards would be affected by the proposals, to which the Chief Executive responded that the detail had yet to be considered. He summarised a number of approaches but iterated that nothing had yet been agreed.

The Board received and noted the verbal update.

63/20 Committee chair's report from the Pandemic Assurance Committee

Prof Warne provided a verbal summary of the business transacted at the Pandemic Assurance Committee meeting held on 13 May 2020 and noted that the draft minutes of the meeting had been circulated to directors for information.

Prof Warne supported the proposed evolution of corporate governance arrangements as described earlier in the meeting and noted that much assurance had been obtained at the meeting, particularly around workforce modelling, and that the committee had welcomed the information it had received around staff health and wellbeing, both now and in the future. The work of the Clinical Ethics Group had been discussed at the meeting and the committee were pleased to see that the group was available to support clinical decision-making.

Prof Warne confirmed that the committee had received assurance around the provision of personal protective equipment and diagnostic testing within care homes and had received a report on COVID-19 mortality.

In response to a question from the Chair, the Medical Director iterated the importance of following the government advice on social distancing and in limiting travel in accordance with the regulations that are currently in force.

The Board received and noted the verbal update.

64/20 Update from the executive team

The Chief Executive opened this item by summarising the current operating position within the hospital. He then went on to note that the north west region has one of the highest numbers of COVID-19 in-patients across both intensive care and general medical beds and noted that the numbers in the Wigan area are slightly above the regional average.

With regard to restarting the elective programme, the Chief Executive confirmed that a risk-based approach to scheduling would be adopted. He also cautioned that the impact of any relaxation of social distancing guidance was not yet known.

The Chief Operating Officer provided an operational update and confirmed that national cohorting arrangement for patients had been adopted within the foundation trust as well as briefing the Board on the impact that this can have on patient flow. The Chief Operating Officer also confirmed that recent weeks had seen an increase in the number of patients presenting at the Accident and Emergency department, with a high level of acuity amongst non-COVID-19 cases being noted. She confirmed that the department had achieved performance in excess of 95% for the month and commented that this acts as a proxy for the resilience of the arrangements in place. The intention to introduce an appointment booking system within the department in the coming months was also acknowledged.

With regard to the elective programme, the Chief Operating Officer advised that the current focus is on scheduling planned patient care according to a risk stratification system based on Royal College and specialist societies' guidance. She confirmed that new ways of working, including virtual pre-operative consultations, were being used and outlined the plans to reintroduce cardiology elective patients on the Royal Albert Edward Infirmary site, endoscopy elective patients on the Leigh Infirmary site and elective day case and inpatients on the Wrightington Hospital site in the coming weeks. The full elective programme would be rolled out in a phased approach, in parallel with Greater Manchester using the equality of access principles where possible.

In response to a question from Prof Warne, the Chief Operating Officer confirmed that sufficient stocks of personal protective equipment are available to allow the intended elective procedures to recommence but noted that the matter is kept under constant review and reminded the Board of the phased approach to reinstating elective activity to allow this to be taken into account. The Chief Executive summarised the mutual aid arrangements that are in place across Greater Manchester but acknowledged the increased amounts of equipment that will be required as elective activity increases across the region.

The Medical Director cautioned that the number of patients with non-COVID-19 symptoms are increasing which will reduce the amount of medical staff available for redeployment in the event of a second wave, as they will be required to remain in their own specialties and to care for the patients already in hospital. He also described how useful the virtual outpatient appointment arrangements have been and commented on how medical staff had embraced the use of remote working arrangements.

The Medical Director also noted that there had been an increase in the number of patients discharged from the hospital with COVID-19 and highlighted in particular the fact that three such patients had been discharged from the intensive care unit.

The Chief Nurse gave an overview of the development of Bryn Ward which she reminded the Board forms part of the organisational and regional surge capacity plan. She noted that the ward has the capacity to accommodate 50 patients, with 27 beds having the capability to care for ventilated patients if required as well as clarifying that the ward is used for patients who are COVID positive and is now fully operational. She confirmed that reviews of learning are currently being undertaken and examples of initial lessons learned were shared. A further learning event was scheduled to take place in the coming week, and patient feedback on the ward had been very positive to date.

The Chief Executive confirmed that the vacuum insulated evaporator on the Royal Albert Edward Infirmary site had been upgraded to increase the amount of oxygen that can be provided at any time. Note was also made of the fact that staff in high intensity and demanding posts were being rotated to allow for some respite.

The Chief Nurse also paid tribute to the work of the community nursing teams and the way in which they have changed the way they work for the benefit of patients. Examples of such changes include the use of technology to see patients and to engage with digital ward rounds, working with the care home sector around swabbing and providing training to care home staff, as well as improving the end of life care pathway.

The Director of Workforce summarised the psychological support work that had been undertaken to date, which included 24/7 access to an employee assistance programme, completion of manager training around debriefing and the sharing of wellbeing and resilience applications. Over 250 staff had visited the SOS rooms since the beginning of April 2020, with over 85% of people surveyed highlighting the need for this provision to continue. The Director of Workforce reminded the Board that the foundation trust's approach to psychological support had been designed by occupational psychologists which she noted had been extremely beneficial in ensuring the appropriateness of interventions as well as ensuring appropriate training and supervision.

Confirmation was provided that a 12-month proof of concept investment had been agreed to ensure that it is possible to continue to provide services without relying on redeployed staff into the longer-term. The intention to consider extending the offer available across the Wigan borough was also highlighted. At the suggestion of the Chair, the Director of Workforce agreed to liaise with Lady Bradley around her experiences within the third sector.

ACTION: Director of Workforce

In response to a question from Mrs Lobley, the Director of Workforce noted that discussions were taking place across numerous forums to ensure that those who have volunteered to support the NHS are able to continue to do so. The Chief Nurse advised that a proactive approach had been taken within the foundation trust to offer permanent contracts of employment to all student nurses who had opted to enter the temporary nursing register prior to formal completion of their studies.

With regard to communications, the Director of Workforce noted that the pandemic had created an impetus for the organisation to communicate in different ways and staff feedback had been positive, particularly around the online leadership briefings that have been offered. Over 1,500 members of staff had elected to join a closed Facebook group which helps to share information and "communications cascaders" had been identified in local areas to ensure reliable sharing of information.

The Board received the report and noted the content.

65/20 Looking to the future

The Director of Strategy and Planning provided a verbal update on the planning work that has been undertaken in relation to the remainder of the financial year. He noted that much of the work had already been shared with staff as part of the online briefing sessions.

Note was made of the development of a recovery plan for the organisation and in particular the fact that recovering is often more complicated that responding to an incident, particularly around demand modelling in the recovery phases. He confirmed that the organisation's planning is based on a reasonable worst-case scenario which is considered to be a prudent approach and is not necessarily a forecast of the actual levels of demand that will be experienced.

The Board received the report and noted the content.

66/20 Review of COVID-19 risk appetite statement

The Board confirmed that the COVID-19 risk appetite statement remains appropriate.

67/20 Resolution to exclude members of the press and the 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.

68/20 Date time and venue of the next meeting

The next meeting of the Board of Directors will be held on 24 June 2020, 1.30pm by videoconference.

Action log

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
27 May 2020	62/20	Chair and Chief Executive's opening remarks	Prepare suggestions as to revised corporate governance arrangements	Company Secretary	24 Jun 2020	On the agenda.
27 May 2020	62/20	Chair and Chief Executive's opening remarks	Ensure performance report presented to next meeting	Director of Strategy and Planning	24 Jun 2020	On the agenda.
27 May 2020	62/20	Chair and Chief Executive's opening remarks	Provide Mrs Lobley with supporting documentation around regional governance	Director of Strategy and Planning	ASAP	Verbal update to be provided.
27 May 2020	62/20	Chair and Chief Executive's opening remarks	Consider how best to share information on decisions taken at regional level	Chief Executive/Director of Strategy and Planning/Company Secretary	24 Jun 2020	Verbal update to be provided.
27 May 2020	64/20	Update from the executive team	Liaise with Lady Bradley around her experiences within the third sector (relating to psychological support)	Director of Workforce	24 Jun 2020	Verbal update to be provided.

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

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

HELD IN PRIVATE ON 5 JUNE 2020, 11.15AM

BY VIDEOCONFERENCE

Present:	Mr R Armstrong	Chair (in the Chair)
	Prof C Austin	Non-Executive Director
	Mrs A Balson	Director of Workforce
	Lady R Bradley DL	Non-Executive Director
	Dr S Elliot	Non-Executive Director
	Ms M Fleming	Chief Operating Officer
	Mr M Guymer	Non-Executive Director
	Mr I Haythornthwaite	Non-Executive Director
	Mrs L Lobley	Non-Executive Director
	Mr R Mundon	Director of Strategy and Planning
	Mr G Murphy	Acting Chief Finance Officer
	Mr S Nicholls	Chief Executive
	Ms H Richardson	Chief Nurse
	Prof T Warne	Non-Executive Director
In attendance:	Mr P Howard	Director of Corporate Affairs (minutes)

76/20 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.

77/20 Resolution to exclude members of the press and public

The Board RESOLVED that representatives of the press and other members of the public be excluded from the meeting, having regard to the confidential nature of the business to be transacted. In reaching this decision, the Board noted the requirement within the Foundation Trust Annual Reporting Manual issued by NHS England and NHS Improvement that the content of the documentation to be considered by the meeting may not be published until such time as it has been laid before Parliament.

78/20 Apologies for absence

Apologies for absence were received from Dr S Arya, Medical Director.

79/20 Declarations of interest

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

80/20 Year-end documentation

The following documents had been circulated to the Board in advance of the meeting:

(a) draft annual report text;

(b) draft annual accounts; and

(c) draft management representation letter.

The Board noted that these documents had been subject to detailed scrutiny by the Audit Committee immediately prior to the meeting and Mr I Haythornthwaite, as Chair of the Audit Committee, confirmed that the Audit Committee had recommended the documents for approval.

To support its decision, the Board had also been provided with the auditor's report on the audit of the annual report and accounts (ISA260) and confirmation from Mr I Haythornthwaite that the auditors had provided their audit report during the meeting of the Audit Committee and that a clean audit opinion was being issued.

Following due consideration, the Board RESOLVED as follows:

1. THAT the annual report text and the annual accounts be **APPROVED** as presented;

2. THAT the Director of Corporate Affairs be AUTHORISED to make any minor typographical amendments that do not change the overall meaning of the documents;

3. THAT the Chief Executive be authorised to sign the management representation letter on its behalf;

4. THAT, in accordance with the guidance issued by NHS England and NHS Improvement in response to the COVID-19 pandemic, use of electronic signatures by the relevant signatories in lieu of wet signatures shall constitute formal signature of the documents; and

5. THAT the documents be submitted to NHS Improvement and, following design work, laid before Parliament.

81/20 Date time and venue of the next meeting

The next meeting of the Board of Directors will be held on 24 June 2020, 1.30pm by videoconference.

Action log

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
5 Jun 2020	80/20	Year-end documentation	Ensure documentation is submitted to NHS Improvement by the stipulated deadline of 25 June 2020	Director of Corporate Affairs	25 Jun 2020	Documents submitted on 16 June 2020
5 Jun 2020	80/20	Year-end documentation	Submit final designed version of the annual report and accounts for laying before Parliament by the stipulated deadline of 6 July 2020	Director of Corporate Affairs	6 Jul 2020	Final version subject to final proofread and intended to be submitted on or before 24 June 2020

REPORT

AGENDA ITEM: 7

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

To:	Board of Directors	**Date:**	24 June 2020
Subject:	Covid-19 mortality report		
Presented by:	Medical Director	**Purpose:**	Discussion

Executive summary

Covid-19 is a clinical disease caused by a novel beta-coronavirus, named SARS-CoV-2. Although for most people COVID-19 causes only mild illness, it can make some people critically ill requiring hospital admission with a high risk of mortality. As of 16 June 2020, there have been 8,345,995 cases (448,719 deaths) worldwide, 299,000 cases (42,153 deaths) in the UK and 1,991 deaths in Greater Manchester. Wigan borough has had 317 deaths (12/6/20) of which 240 have died at WWL.

NW Mortality cell has done initial analysis which shows that WWL is an outlier in terms of number of deaths per COVID positive patients. The analysis was discussed in detail at the WWL Mortality group (which included Dr Foster's representative) and subsequently at the Wigan Borough Mortality meeting (which included Wigan Public Health Consultant and GMHSP representatives) on 17 June 2020. Several hypothesis and explanations were offered.

The paper is being presented to the Board of Directors for information as the analysis is still ongoing due to the complex nature of the issue and the contradictory statistics.

Risks associated with this report

It is recommended that Covid-19 is placed on the risk register along with HSMR and SHMI, which are also areas of concern, though recent data shows some improvement.

Link(s) to The WWL Way 4wards

☒	Patients	☒	Performance
☐	People	☐	Partnerships

The WWL Way

WWL position compared to GM and UK

- It would be very difficult to compare mortality with other organisations: (a) are we comparing the same cohort of patients and (b) are we taking factors such as deprivation, age, co-morbidities etc. into account?
- Wigan is one of the most deprived boroughs in Greater Manchester with a high incidence of heart and lung disease, a high prevalence of smoking and fastest ageing population.
- It has the smallest bed base/1000 population in GM
- Data from NW Mortality cell and ONS are contradictory to each other
- There are no official comparative figures available for mortality in each Trust, on each Medical ward or in Critical Care settings
- There is variability in Covid swab testing/re-testing across various organisations
- Role of MEs in reviewing COVID-19 deaths: Every death has been reviewed and certified by the 5 Medical Examiners on a rolling rota – our data more accurate in terms of cause of death
- Role of Martin Farrier in learning from COVID-19 deaths: No concerns have been raised around the management of patients

Please see the attached slides for further discussion.

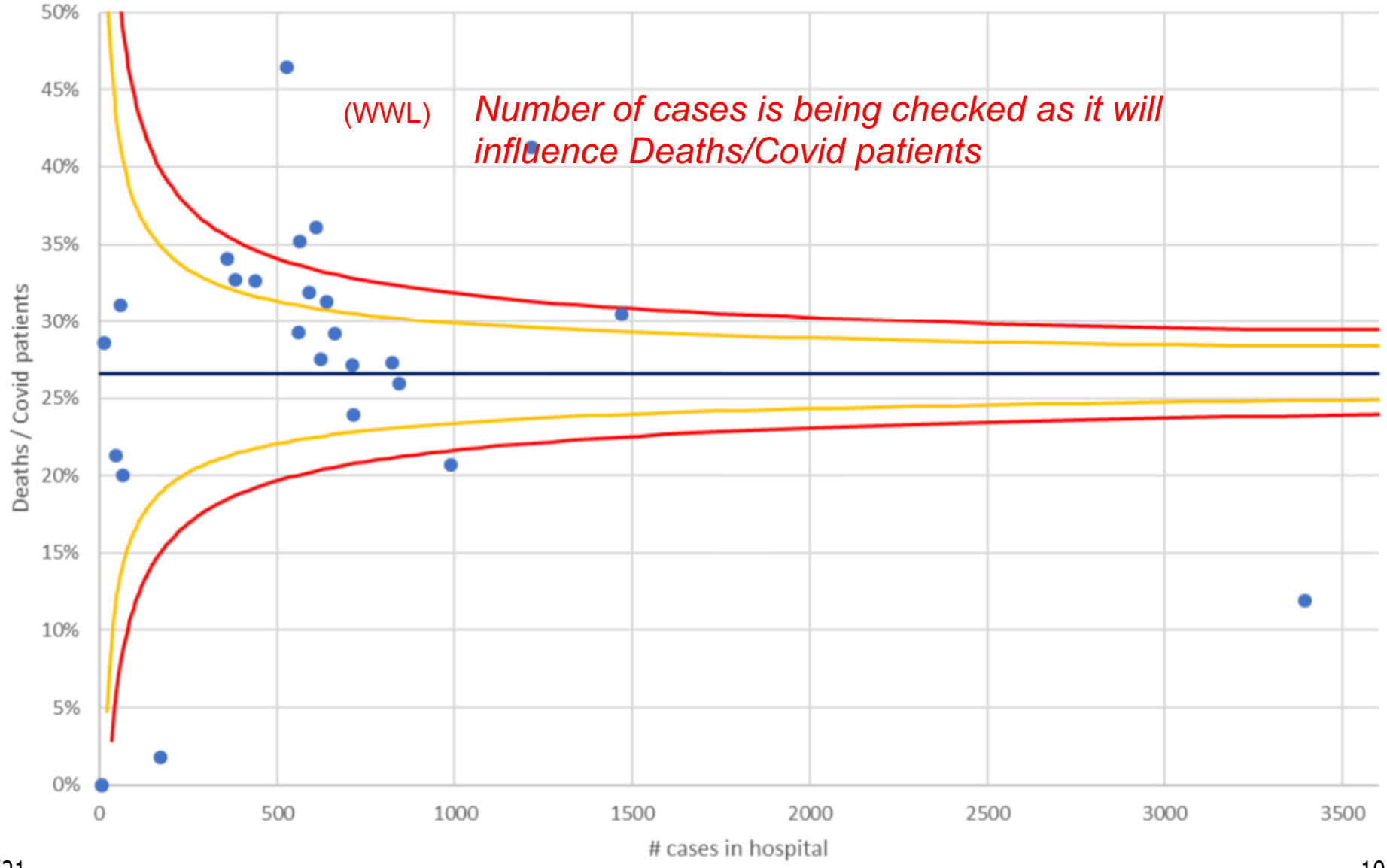
NHS
Wrightington, Wigan and
Leigh Teaching Hospitals
NHS Foundation Trust

NW Mortality Cell Charts

12/06/2020

The WWL Way

NW Mortality Cell : Funnel plot for NW acute trusts of rate of Covid deaths against cases



NW Mortality Cell : Comments

Please Note:

- NW Mortality cell contact advised that the funnel charts have been produced to identify variation, are not to be used in isolation but to be reviewed in conjunction with other information presented
- WWL rate from submitted figures as at 2.6.20 is 44.6%; but would still show as an outlier.

	WWL	NHS I/E
Cumulative Deaths:	237	242
Number of inpatients diagnosed with COVID-19 in last 24 hours (Total)	473	459
Number of patients admitted with COVID-19 in last 24 hours (Total):	58	58
Rate	44.6%	46.8%

- Some concerns have been shared around the charts;
    - More testing of patients with any symptoms will result in more incidental cases, did we test any differently from other Trusts?
    - Taking into account variation in testing practices could widen the tolerances
    - Suggested alternative chart: number of deaths against the number of patients tested (whether positive or negative) or against the deaths from all causes against total acute admissions
    - Do we have any other suggestions? Excess deaths?

ONS Excess Deaths

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

12/06/2020

The WWL Way

Greater Manchester - Excess deaths

Select LA(s):
Wigan

285 Excess Deaths	19% More Deaths than Average	317 COVID-19 Deaths

Wigan Borough

Cumulative % Excess deaths in all places by LA

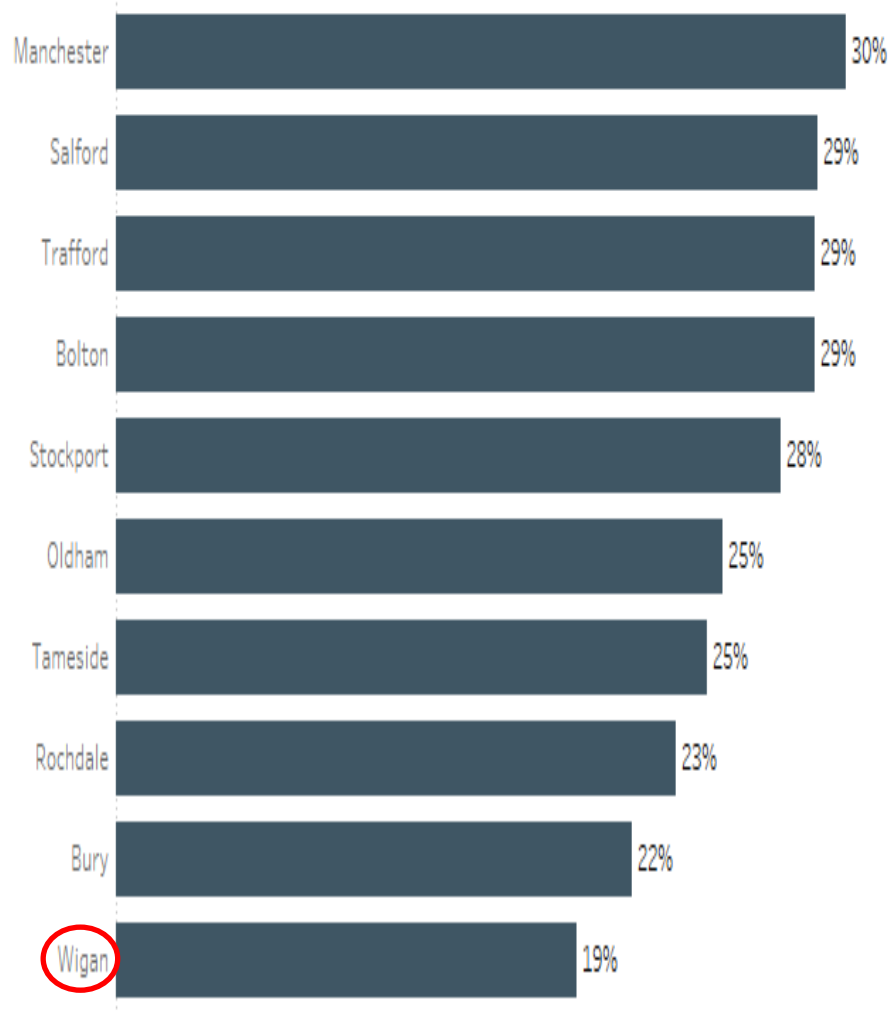


Table of cumulative excess deaths in all places by LA

	% Excess deaths	Excess deaths	COVID-19 deaths	COVID-19 deaths per 100,000	Number of all causes deaths	Five year average all cause deaths
Manchester	30%	483	357	65	2,068	1,585
Salford	29%	298	301	116	1,314	1,016
Trafford	29%	266	199	84	1,178	912
Bolton	29%	344	294	102	1,524	1,180
Stockport	28%	345	312	106	1,591	1,246
Oldham	25%	241	235	99	1,196	955
Tameside	25%	261	236	104	1,318	1,057
Rochdale	23%	218	193	87	1,152	934
Bury	22%	179	195	102	1,010	831
Wigan	19%	285	317	96	1,769	1,484
Grand Total	26%	2,920	2,639		14,120	11,200

Greater Manchester - Excess deaths by place

Select place of occurrence: Care home

Select LA(s): Wigan

134.6 Excess Deaths

52% More Deaths than Average

61 COVID-19 Deaths

Wigan Care homes

Cumulative % Excess deaths in Care homes by LA

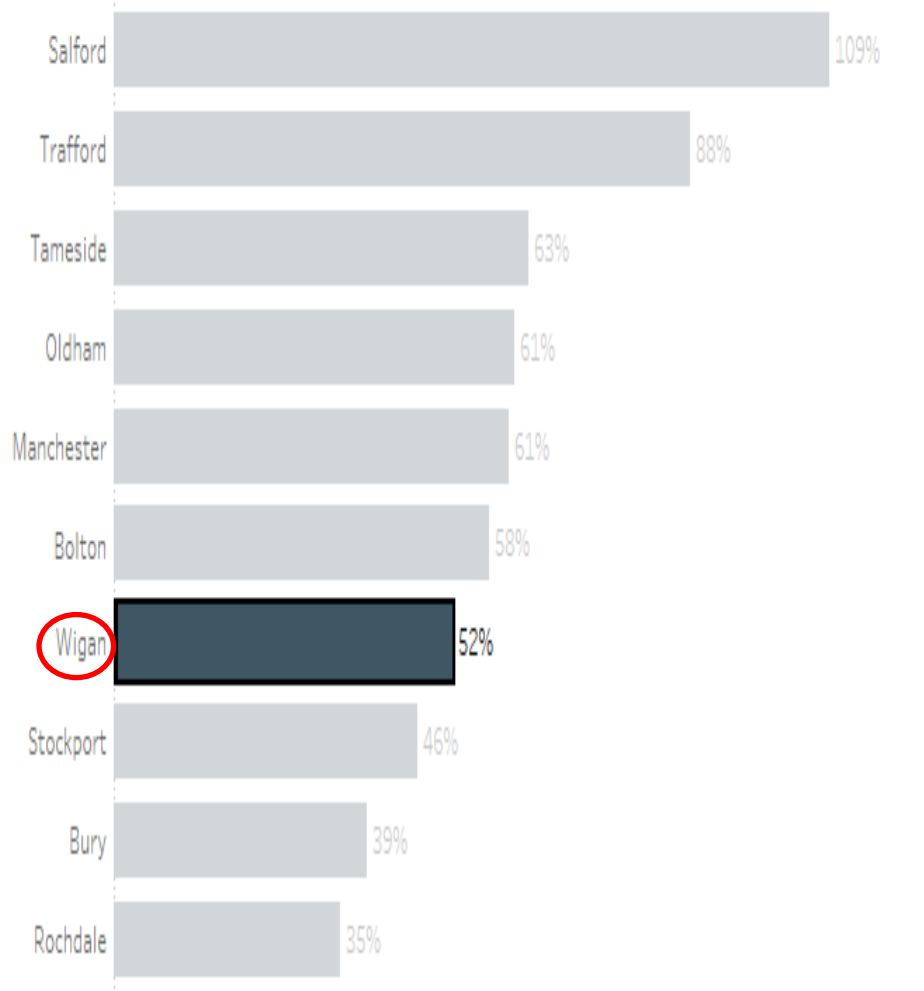


Table of cumulative excess deaths in Care homes by LA

	% Excess deaths	Excess deaths	COVID-19 deaths	COVID-19 deaths per 100,000	Number of all causes deaths	Five year average all cause deaths
Salford	109%	171	125	48	328	157
Trafford	88%	131	70	29	279	148
Tameside	63%	104	50	22	269	165
Oldham	61%	125	80	34	328	203
Manchester	61%	142	73	13	376	234
Bolton	58%	136	98	34	373	237
Wigan	52%	135	61	19	394	259
Stockport	46%	137	114	39	431	294
Bury	39%	77	55	29	277	200
Rochdale	35%	66	38	17	256	190
Grand Total	59%	1,224	764	284	3,311	2,087

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

COVID Weekly Update

10. 6. 2020

The WWL Way

Current Data – COVID positive patients

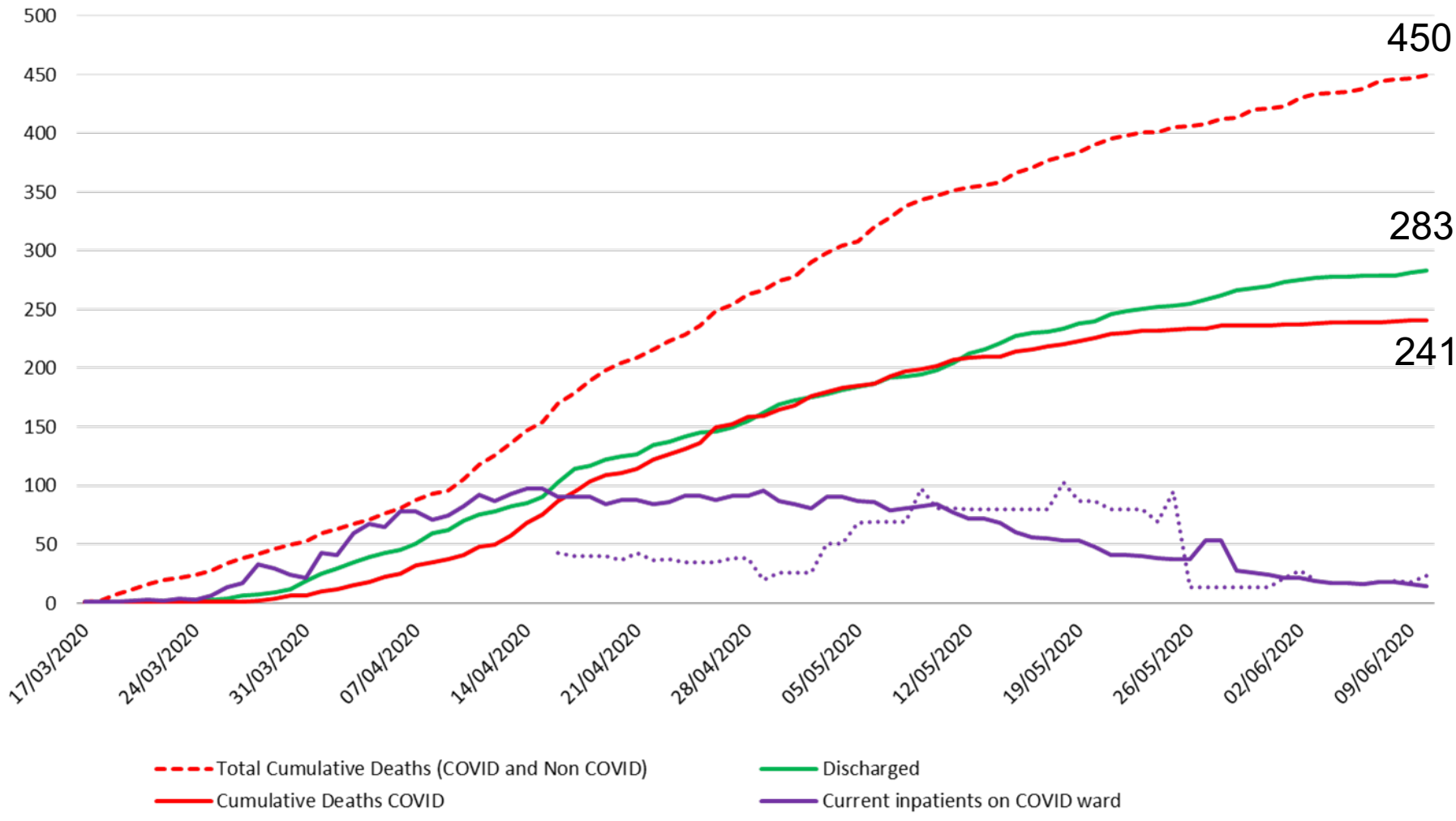
Based on patients who are admitted and have positive swab result

To midnight 10th June

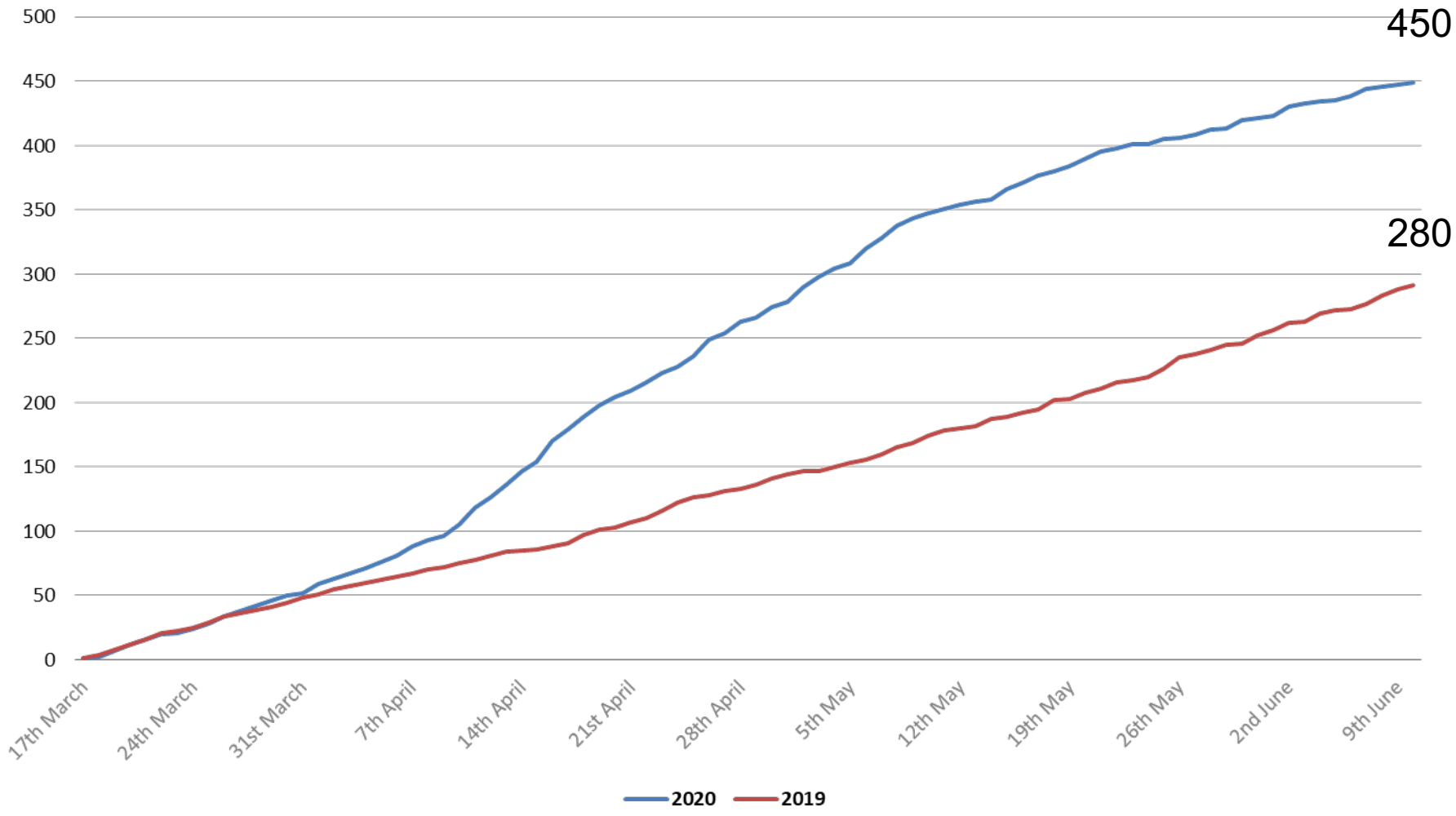
- 17th March to 10th June (Based on result date)
- 538 patients admitted
- 283 patients discharged (53%)
- 241 patients died (44%)
- 14 Current in-patients (3%)*
- 5 Patients in ICU (Total patients, COVID*, non-COVID, 9th June)

*based on patients who have had positive swab, COVID result may now be negative

Discharges, COVID deaths, total deaths, current in-patients on COVID Ward, current in-patients suspected ward
Data to 10th June



Comparison of cumulative deaths 2019 and 2020
Data to 10th June



NB: 2020 also includes COVID deaths in A&E (7 patients)

Care Home Admissions
Data to 2nd June

COVID Patients

Data from 17th March up to 2nd June

- 168/532 admissions from a care home (32% of total COVID admissions):
  - 106 patients died (63%)
  - 56 patients discharged (33%)
  - 6 patients still with us (4%)

Non-COVID Patients

(Excludes maternity and children)

Data from 17th March up to 2nd June

- 290/5111 (5.6%) non elective admissions from a care home (up to 2nd June)
  - 36/290 patients died (12%)
  - 229/290 discharged (79%)
  - 22/290 still admitted (8%)
  - 3/290 other

Critical Care (Winstanley/ITU) data to 8th June

	Non-invasive	Invasive	WWL	GM	UK
Number	29	45	74 (20%)	386	8891
Died	15	28	43 (58%)	46%	42%
Survived	14	17	31 (42%)	54%	58%

Number (12 Trusts)	20% v 9%
Mean age	61y v 58y
Male	82% v 72%
Deprivation	77% v 69%
Obesity	97% v 74%
Respiratory illness	03% v 01%
Advanced resp support	93% v 72%
Basic resp suppot	29% v 66%
Renal support	36% v 26%

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

Mortality Presentation

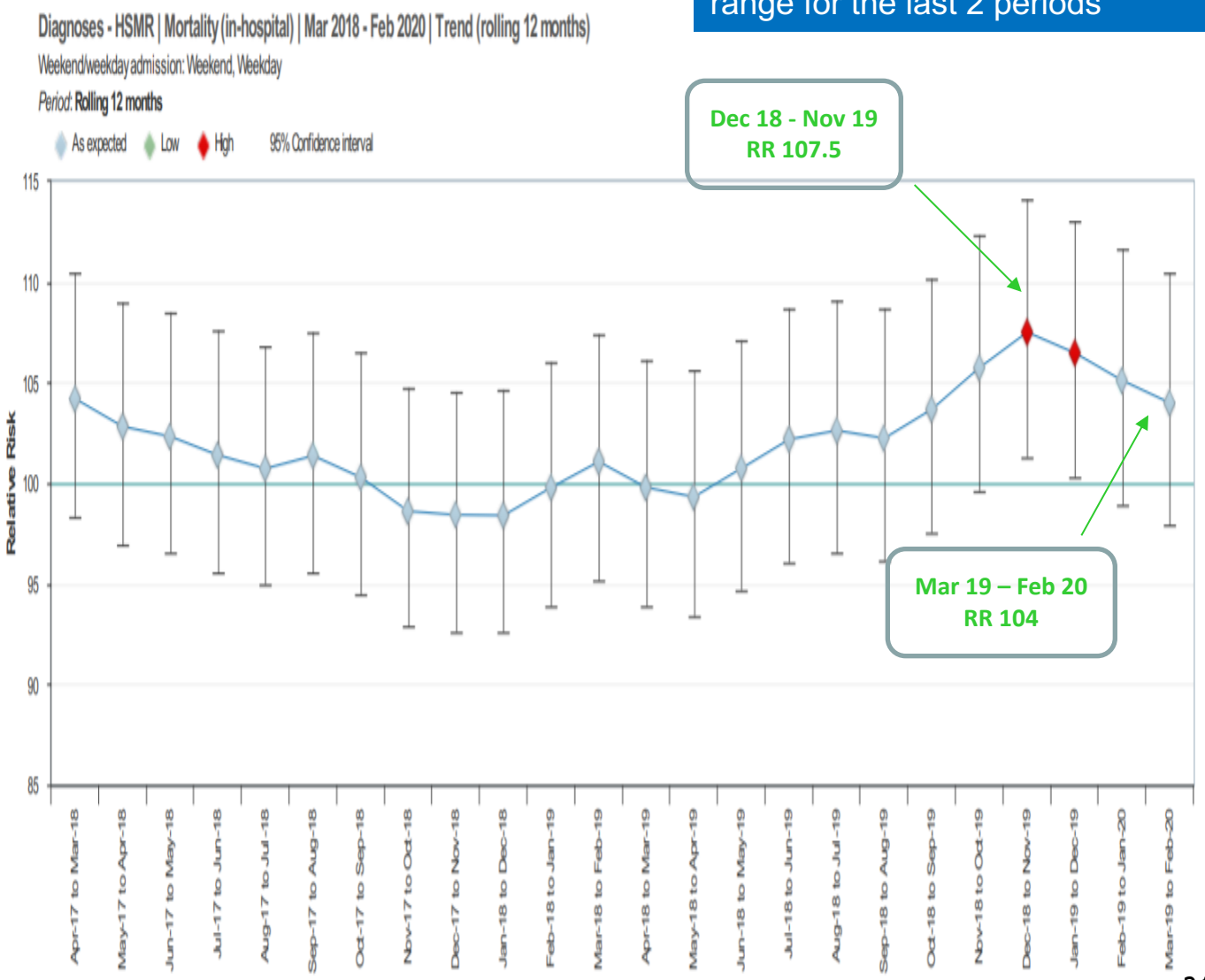
17.6.2020

The WWL Way

HSMR – Two Year Rolling 12 Month Trend
April 17 – February 2020

HSMR starting to show a decline, and has been within the expected range for the last 2 periods

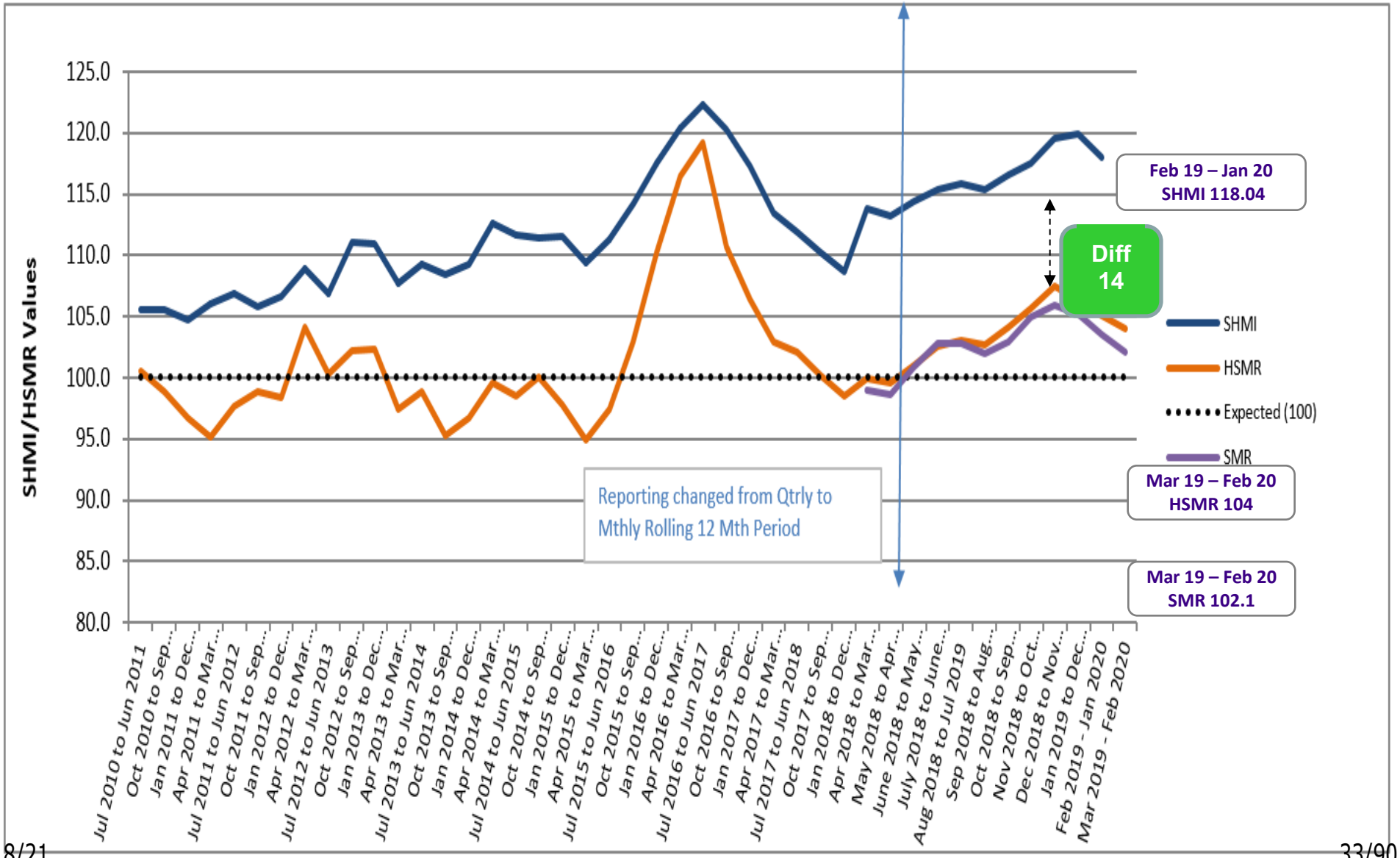
Rolling 12 Months	*Relative Risk*
Jan-18 to Dec-18	98.4
Feb-18 to Jan-19	99.8
Mar-18 to Feb-19	101.1
Apr-18 to Mar-19	99.8
May-18 to Apr-19	99.3
Jun-18 to May-19	100.7
Jul-18 to Jun-19	102.2
Aug-18 to Jul-19	102.6
Sep-18 to Aug-19	102.2
Oct-18 to Sep-19	103.7
Nov-18 to Oct-19	105.7
Dec-18 to Nov-19	107.5
Jan-19 to Dec-19	106.5
Feb-19 to Jan-20	105.1
Mar-19 to Feb-20	104.0



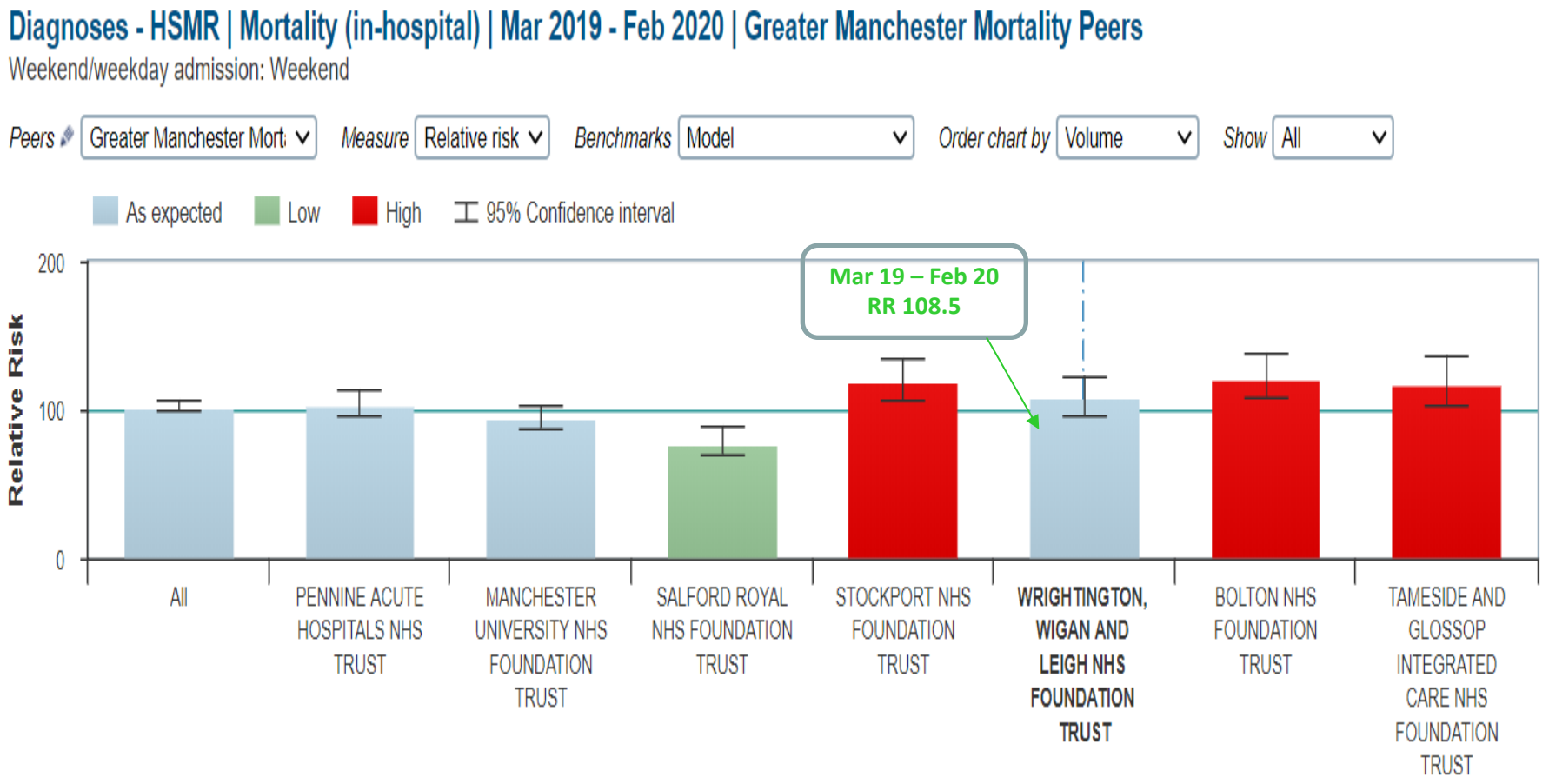
SHMI

Summary Hospital-level Mortality Indicator (SHMI), England, February 2019 - January 2020

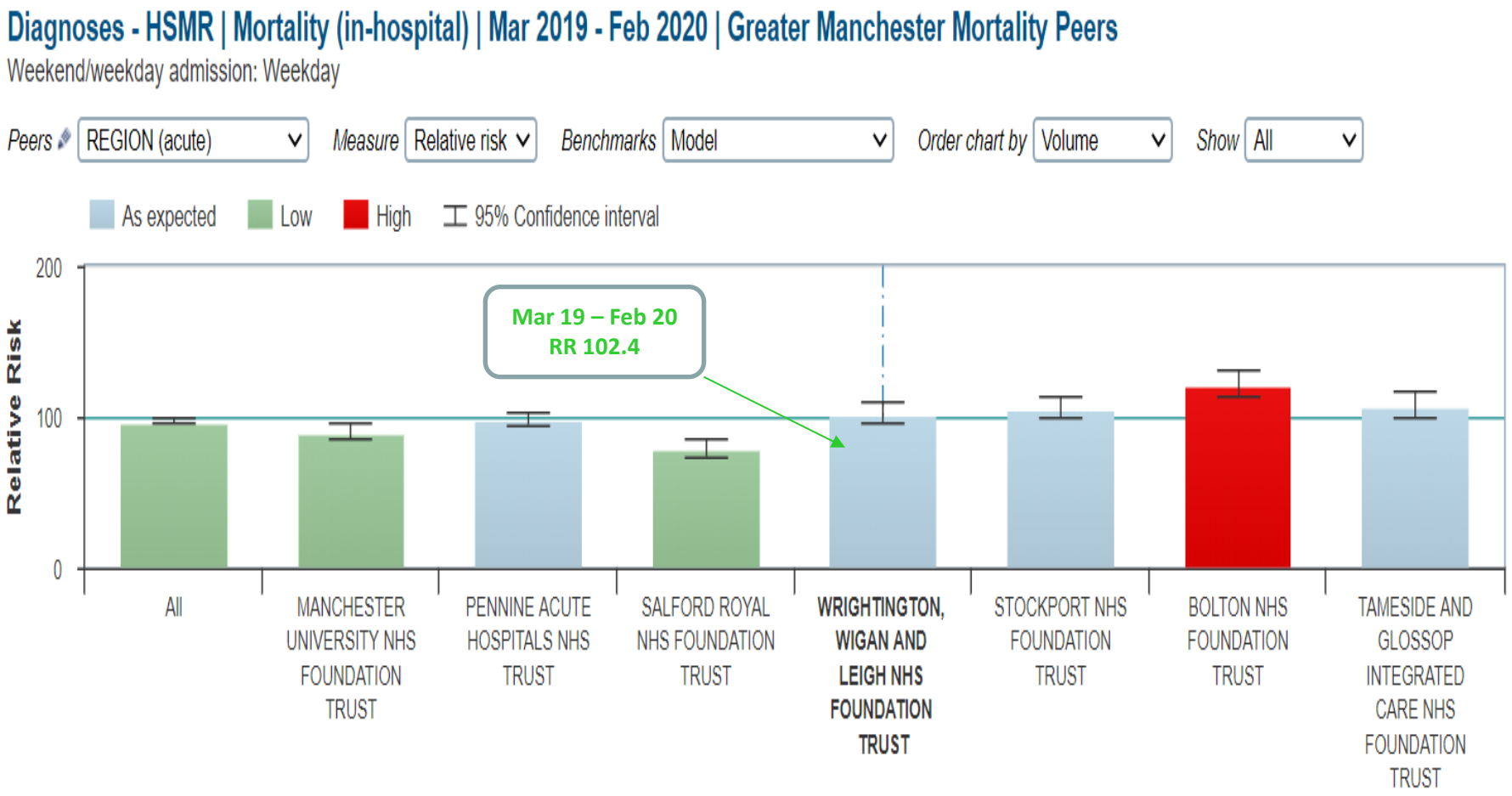
SHMI Vs HSMR – Rolling 12 Months to February 2020



Greater Manchester Peer comparison
HSMR Weekend Admissions

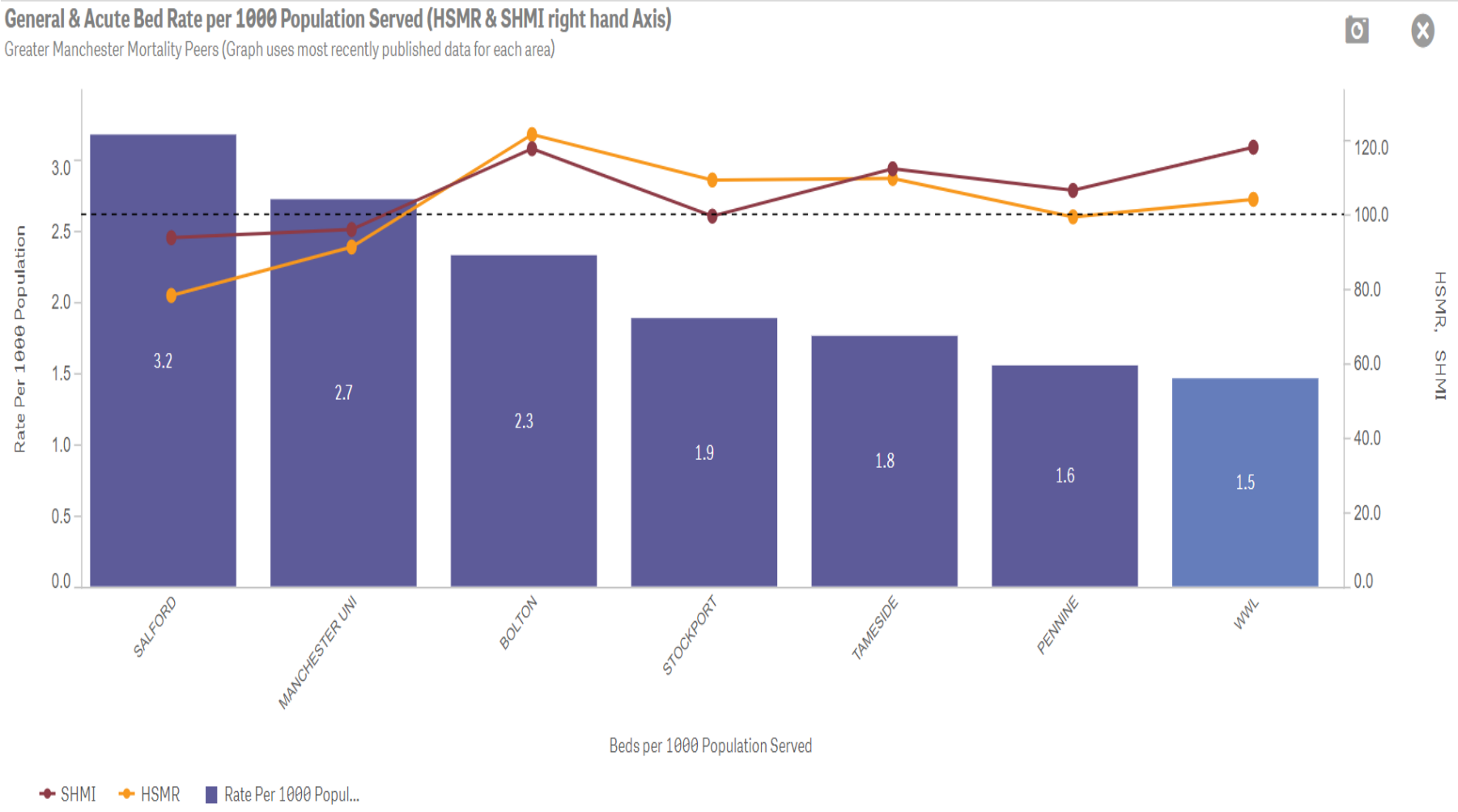


Greater Manchester Peer comparison
HSMR Weekday Admissions



General & Acute Available Beds

When looking at Beds per 1000 population, WWL has the lowest at 1.5 per 1000 patients. Whereas Salford has 3.2 beds per 1000 patients served.



REPORT

AGENDA ITEM: 8

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

To:	Board of Directors	**Date:**	24 June 2020
Subject:	Transformation in Recovery – Locking in the Benefits		
Presented by:	Deputy Director of Strategy and Planning	**Purpose:**	Information

Executive summary

Transformation is an integral component of the Trust's recovery from COVID-19. This paper will set out the emerging national guidance and expectations around embedding positive innovations and transformations made during the crisis and give an overview of the work already underway to deliver against national expectations, support the recovery process and ensure WWL locks in the benefits for the future.

Risks associated with this report

There are no risks associated with this report for consideration.

Link(s) to The WWL Way 4wards

☒	Patients	☒	Performance
☐	People	☒	Partnerships

The WWL Way

1. Introduction - Transformation in recovery

Transformation is a key component of the NHS' recovery from COVID. There is an immediate necessity to continue delivering services differently and transform tradition models of care to support the safe re-instatement of services whilst continuing to ensure capacity for COVID-19 demand. There is also an immense opportunity and collective responsibility to build on the progress made during the crisis in rapidly transforming services and changing ways of working to chart a new course for health and social care by amplifying and embedding the most promising changes and innovations.

Locking in the benefits from changes made to services in response to COVID is increasingly and more explicitly being referenced in guidance and direction from NHSE/I. The recently shared guidance from NHSE/I North West (illustrated below) sets out the strategic framework for phase three of recovery planning. This provides clear direction for the NHS to capture, continue and build on innovation and improvement, building on the reference in the previously shared 'seven tests for recovery,' again encouraging the cataloguing of innovations made, to determine, via evaluation, those to be retained and then planned for widespread adoption.

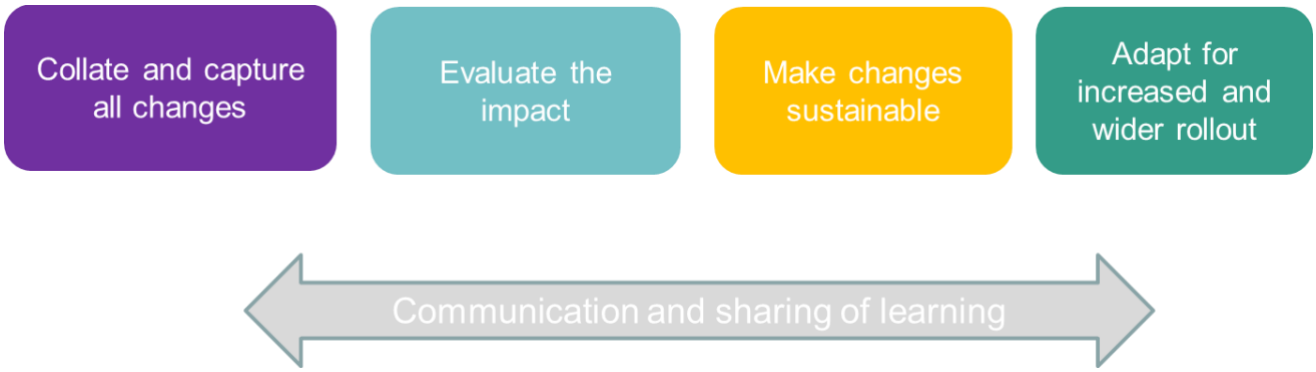
Strategic objectives	Strategic priorities
1. Continue to deliver safe, high quality health and care services for COVID management and non-COVID recovery	A. Ensure COVID-19 health and care demand is appropriately met
	B. Prioritise access to in and out of hospital services for high risk and vulnerable groups
	C. Understand and address rate limiting factors for delivering all types of care safely
2. Provide place based health and care services as a system	A. Ensure health inequality across the region does not increase
	B. Utilise independent sector and other available facilities, where necessary
	C. Ensure an equal focus on both in and out of hospital services, taking care to understand the reciprocal influences on one another
3. Deliver health and care services that are financially sustainable	A. Ensure innovation and transformation initiatives are cost effective
	B. Ensure capital investments are a balance of physical and technological infrastructure essential for the effective delivery of care
	C. Optimise resource and capacity
4. Build a resilient and supported health and care workforce	A. Develop robust workforce management tools to ensure there is capacity to deliver safe, high quality care
	B. Ensure workforce is sufficiently supported emotionally to deliver safe, high quality care
5. Capture, continue and build on innovation and transformation	A. Identify, share and embed positive transformation and improvement opportunities across the system

[1]

[1] *NHS NW COVID-19 management and NHS open for business*. Phase three planning assumptions. (NHS England and NHS Improvement, June 2020)

2. “Look back to move forward”

In determining the changes to be retained, the Trust, and indeed the NHS, needs to look back and in effect take a retrospective approach of service improvement. The simple framework to this is illustrated below.



The first stage to this is capturing and collating the rapid transformations made in a structured way and at an organisational level. This involves capturing the key enablers and conditions that supported staff at all levels and roles to make changes to services in such rapid timescales to then allow consideration of what conditions can be retained and nurtured going forward.

The Director of Transformation and Head of Resilience, using their networks and emerging good practice from national bodies, have developed a framework and agreed mechanism to jointly lead a learning from COVID programme during the second half of June and first half of July. Designed in partnership with the Deputy Director of OD and Head of OD and Engagement, an appreciative inquiry approach is be taken, centred on psychological safety to facilitate meaningful engagement and participation from staff in sharing experience and reflections of the crisis. Therefore the language, tone and approach have been carefully considered.

In summary, team level facilitated learning sessions are being held across all areas of the Trust, using a series of pre-prepared open questions across three themes to capture learning at a strategic, operational and cultural level.

From an emergency planning perspective, the learning will support preparing and making improvements for any future waves of coronavirus, pandemic and major incident planning. From a transformation aspect, the output will be used to identity changes teams and the Trust want to keep, allowing support to be directed to ensure positive changes are made sustainable and then adopted for increased and wider rollout.

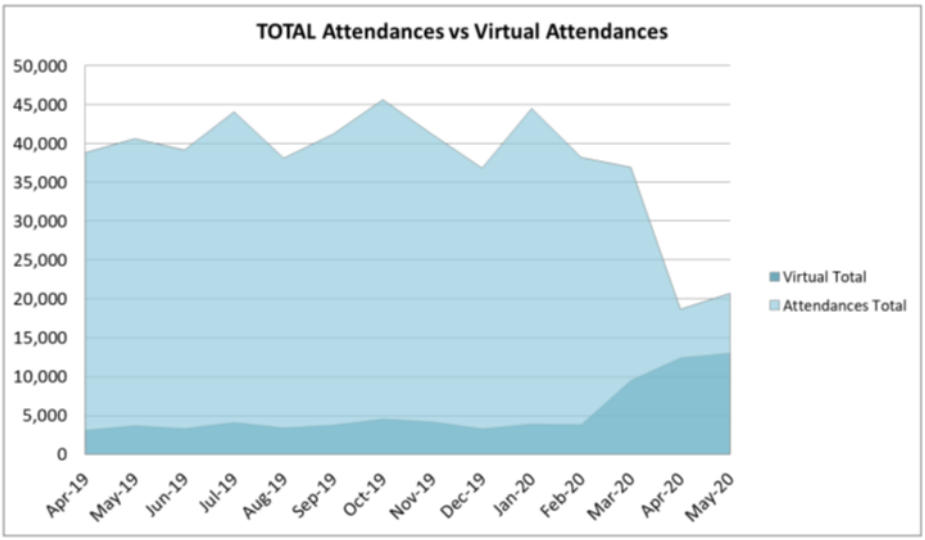
Understanding the impact of changes, particularly large scales changes, is an essential part of transformation and the look back exercise. Impact will be considered across a range of domains; patient and staff experience, access to services, resources required to support the new models of delivery (e.g. estates and staffing levels) and the efficiency and productivity of new models of service delivery.

3. Transformation to support phase 3 capacity assumptions

Positive changes to services that have already been determined for retention and are essential for the Trust's phase 3 capacity plan are already receiving support, focusing on actions required to ensure their sustainably and long-term embedment, and building plans for wider rollout and benefit. These changes are virtual clinics and the newly launched Better @ Home model, as briefly detailed below.

Virtual Clinics

The Trust has led the way across GM with introducing virtual clinics during the pandemic. The requirement now is to as a minimum maintain the level of outpatient and community activity being delivered virtually as more activity returns. The graph below demonstrates the significant increase in the proportion of outpatient attendances delivered via virtual clinics. Whilst the number of attendances reduced to c. 50% of previous levels, 63% of this activity was delivered via non-face to face consultations. The majority of these were telephone consultations, accounting for 59% or activity, and 4% from video consultations.



Supporting the objective and capacity assumptions set by GM of continuing to deliver 60-70% of outpatient activity via virtual methods, is a number of workstreams to ensure sustainability and spread:

- Work is ongoing to review and improve the administrative process for virtual clinics, capturing best practice internally and externally to finalise, rollout and embed the Standard Operating Procedure.
- Working to complete the implementation of digital appointment letters, considering additional functionalities of the new system to enhance communication with patients.
- Mapping and defining the operating model for outpatients when 60-70% of attendances are delivered virtually, understanding the impact on physical estates (outpatient rooms), workforce, productivity for example.
- Working with locality partners to communicate with patients about the change to outpatient models and support patients in adjusting to consultations increasingly being done in a virtual way.

Better @ Home

The second major transformation, again determined and required for embedment during phase 3 of recovery, is the Better @ Home model. This is the discharge to assess model and is a key enabler to reducing LOS and DTOC levels, as per the capacity assumption for phase 3. This is a significant change in practice for staff working in the acute sites, therefore vital for requiring deliberate nurturing and building in the months and years to come so new ways of working continue.

Karlyn Forrest
Director of Transformation

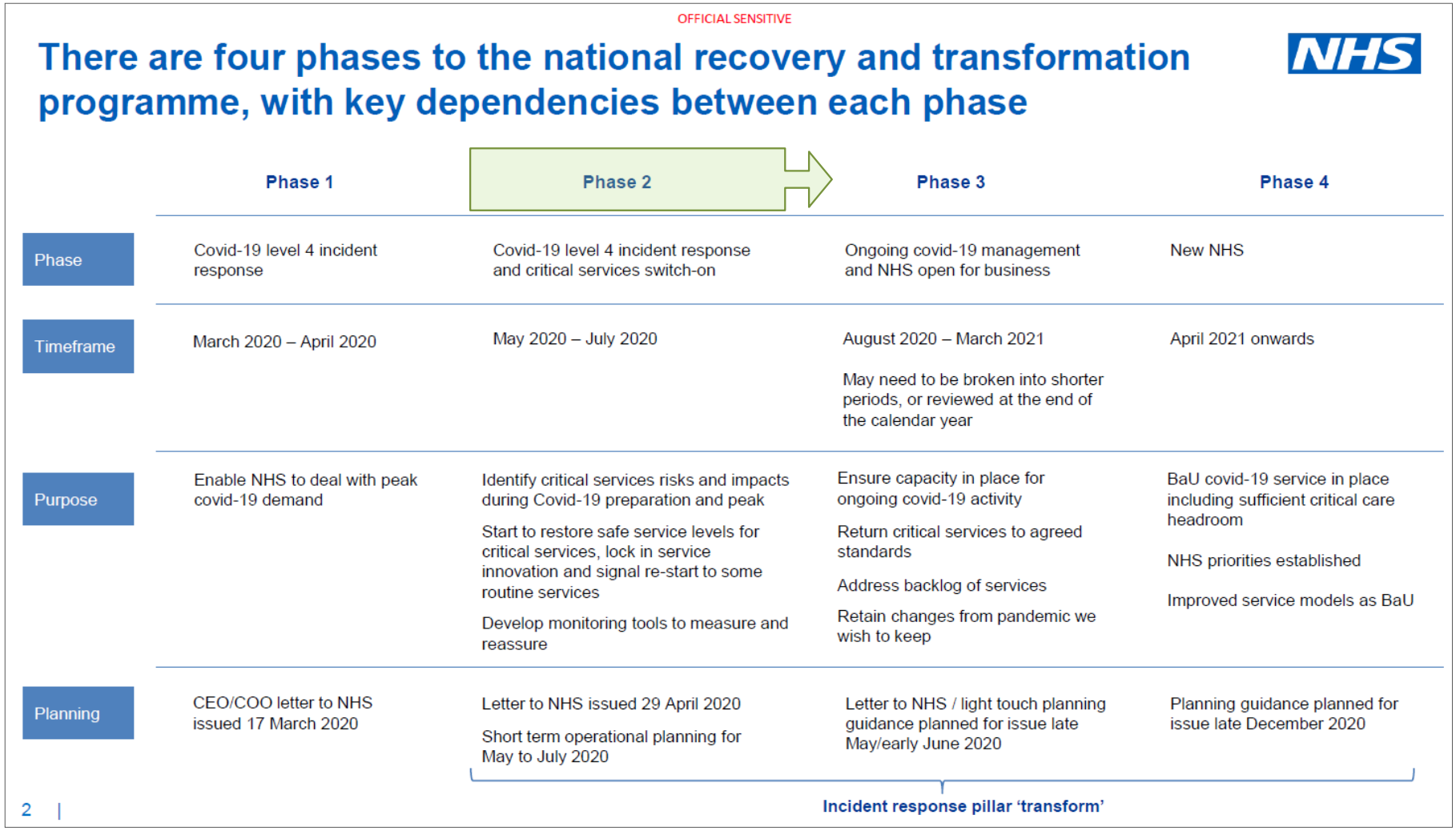
NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

COVID-19 Recovery Plan

24th June 2020

The WWL Way

NHS Recovery - Phases 1-4



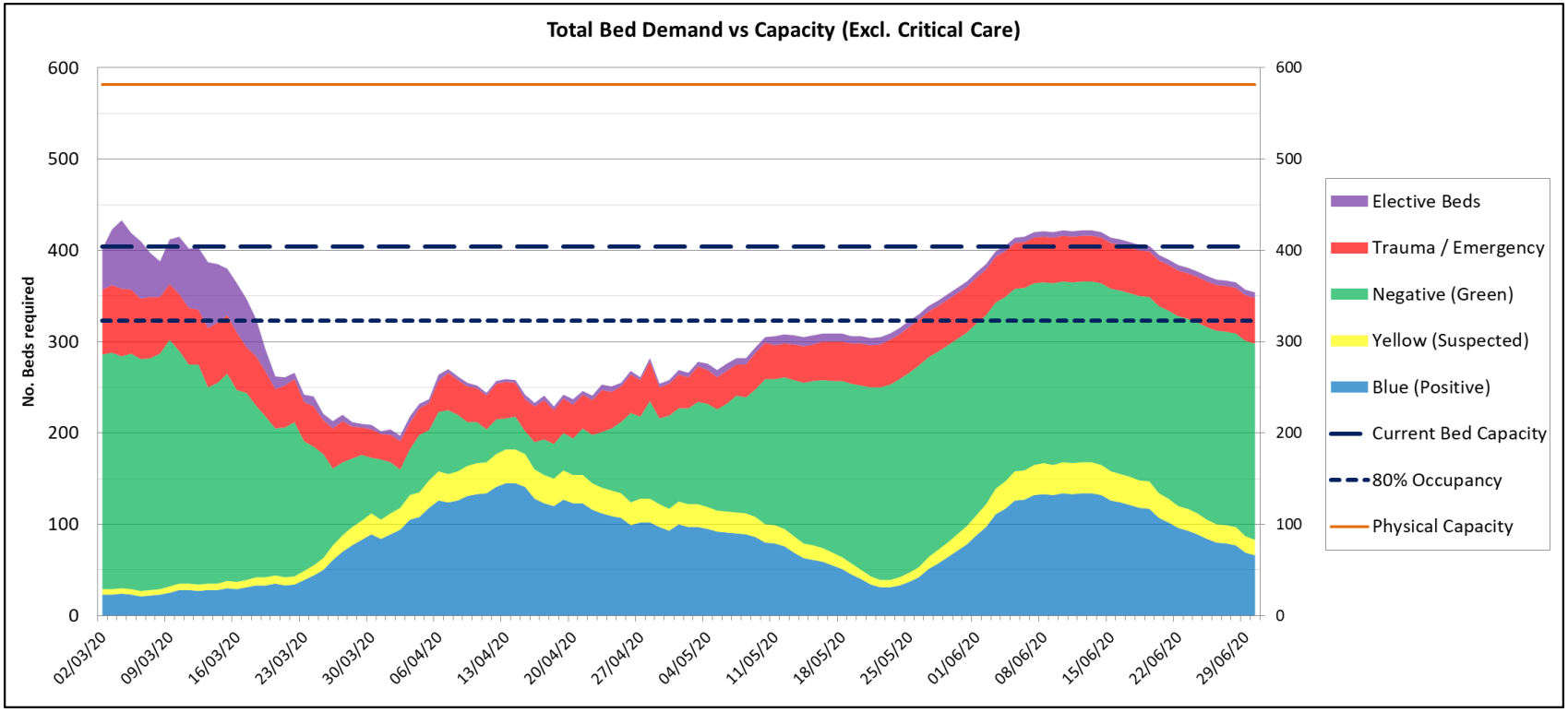
WWL's 10-step recovery sequence in action

Phase 1	1) Modelling of Covid-19 demand to plan immediate response; followed by layering of other demand as we saw the first evidence of Covid-19 stabilisation
Phase 2	2) Early recovery planning - prioritising most urgent elective demand 3) Understanding internal constraints and limitations to resuming elective activity 4) Ongoing modelling and sequencing of priority elective activity taking emerging planning assumptions into account 5) Create internal mechanisms to forecast potential increased Covid-19 or non-elective demand and flag requirements for implementation of escalation plan; and where that might compromise continued safe delivery of elective care 6) Liaison with partners and providers in GM to plan system recovery and design collective solutions
Phase 3	7) Clinically-led internal prioritising of non-urgent elective activity 8) System-level planning for entering Phase 3 of recovery – establishing plans for GM until March 2021 9) Establishing estates adjustments and capital requirements to deliver new 'business as usual' 10) Capture learning from Covid-19 response and required changes in practice. **Lock-in improvements**
Phase 4	TBC

COVID Modelling – G&A Beds (2nd Peak Model 07.05.20)

In order to support operational planning for both WWL and Greater Manchester, demand modelling has been undertaken in response to potential scenarios. These models include the Physical Bed capacity as well as the available bed capacity which is based on the workforce capacity. An 80% occupancy level is required, as per GM guidance.

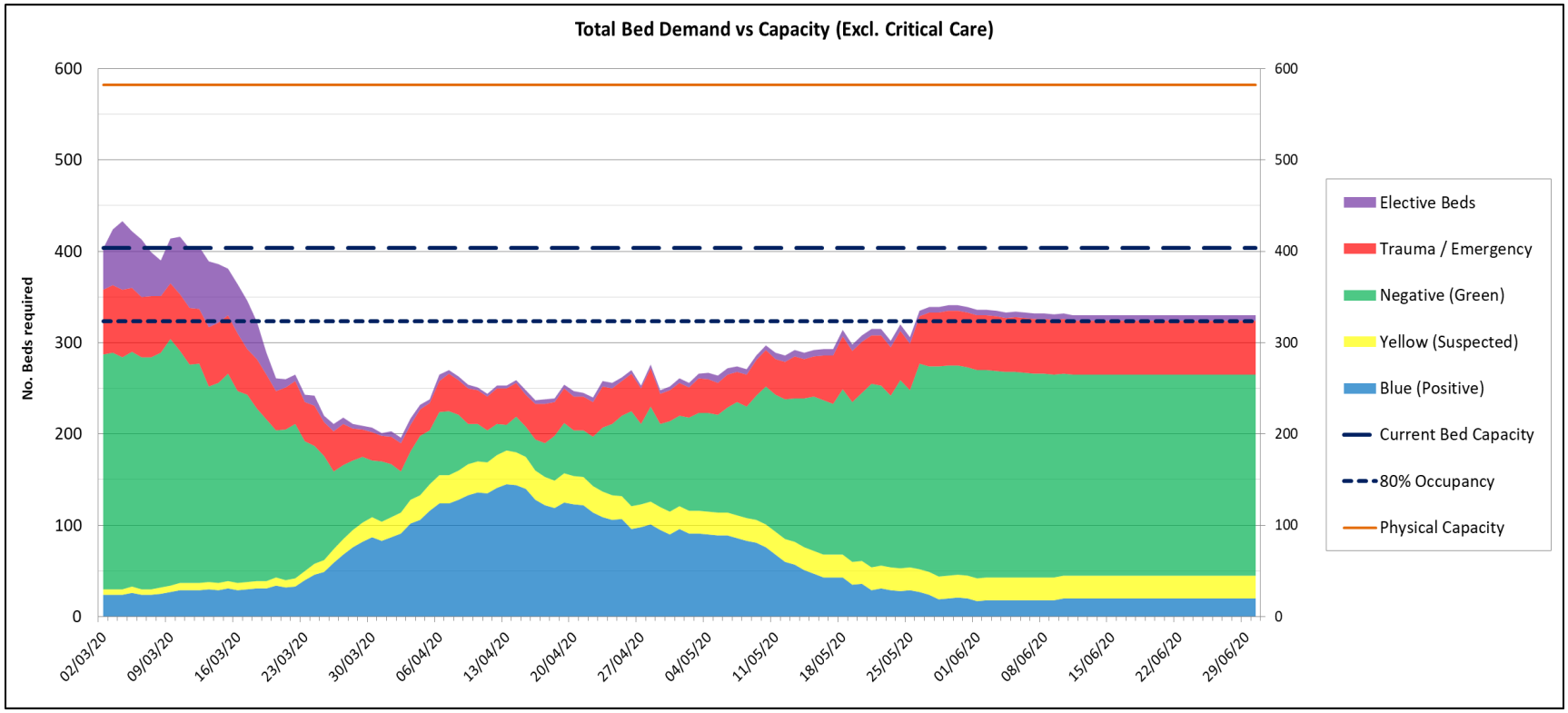
The first model shows the potential demand had a 2nd peak occurred in the aftermath of the initial outbreak:



COVID Modelling – G&A Beds (Stabilisation Model 03.06.20)

The second model shows a stabilisation scenario – maintaining the demand levels at the end of May '20.

Further modelling will continue to take place as additional information becomes available. The next model is anticipated to be undertaken by end of June '20 to cover the period until March '21 as per national requirements – this model will include the plans for Priority 2, 3 and 4 elective patients.



Elective Procedures

For the emergency response to COVID-19, the NHS provided only Emergency Surgical / Trauma procedures only (1a & 1b).

WWL has used Royal College of Surgeons' (RCoS) guidelines to prioritise its elective waiting list. Services are currently being resumed to deliver Priority 2 procedures where possible. Work is ongoing as a system in GM to plan the safe delivery of procedures for patients in the Priority 3 & 4 categories.

Clinical Prioritisation: Clinical guide to surgical prioritisation during the coronavirus pandemic (Royal College of Surgeons)			
Priority Level	**Timescale**	**Description – provided by RCoS**	**Current Status**
1a	Emergency (within 24 hours)	Emergency - Operation needed within 24 hours	Continued to provide the highest priority care through Covid-19 surge
1b	Urgent (within 72 hours)	Urgent - Operation needed with 72 hours	
2	Within 4 weeks	Surgery that can be deferred for up to 4 weeks	Services being resumed incrementally
3	**Up to** 3 months	Surgery that can be delayed for up to 3 months	Next phase of planning
4	**More** than 3 months	Surgery that can be delayed for more than 3 months	

Elective Procedures

All patients have been clinically risk stratified based on the RCoS guidance. The breakdown of these procedures is listed below:

Division & Specialty	Day Case			Day Case TOTAL	Inpatient			Inpatient TOTAL	ALL PATIENTS			TOTAL
	Priority 2	Priority 3	Priority 4		Priority 2	Priority 3	Priority 4		Priority 2	Priority 3	Priority 4	
Cardiology			11	11					0	0	11	11
Gastroenterology	305	4	510	819					305	4	510	819
Respiratory	17		7	24					17	0	7	24
Medicine Sub-total	**322**	**4**	**528**	**854**					**322**	**4**	**528**	**854**
Rheumatology			3	3					0	0	3	3
Trauma & Orthopaedics	34	533	1,182	1,749	35	226	1,154	1,415	69	759	2,336	3,164
Specialist Services Sub-total	**34**	**533**	**1,185**	**1,752**	**35**	**226**	**1,154**	**1,415**	**69**	**759**	**2,339**	**3,167**
Breast Surgery	20	15	10	45			1	1	20	15	11	46
Colorectal Surgery	93	5	179	277	6	27	12	45	99	32	191	322
ENT	9	46	237	292	6		4	10	15	46	241	302
General Surgery	49	61	444	554	5	11	67	83	54	72	511	637
Gynaecology	13	23	76	112	17	12	60	89	30	35	136	201
Ophthalmology		26	396	422					0	26	396	422
Oral Surgery (Inc. Paeds Dentistry)	16	4	913	933	1		4	5	17	4	917	938
Paediatrics			4	4					0	0	4	4
Pain Management	6	39	97	142					6	39	97	142
Urology	50	75	242	367	17	68	9	94	67	143	251	461
Vascular Surgery	3	1	98	102					3	1	98	102
Surgery Sub-total	**259**	**295**	**2,696**	**3,250**	**52**	**118**	**157**	**327**	**311**	**413**	**2,853**	**3,577**
TOTAL	**615**	**832**	**4,409**	**5,856**	**87**	**344**	**1,311**	**1,742**	**702**	**1,176**	**5,720**	**7,598**

Elective Procedures

Using the clinically prioritised waiting lists along with work to understand the wider constraints (e.g. workforce, equipment and inpatient beds), decisions have been made about how to best facilitate the re-commencement of elective activity. The phased recommencement of activity is outlined below:

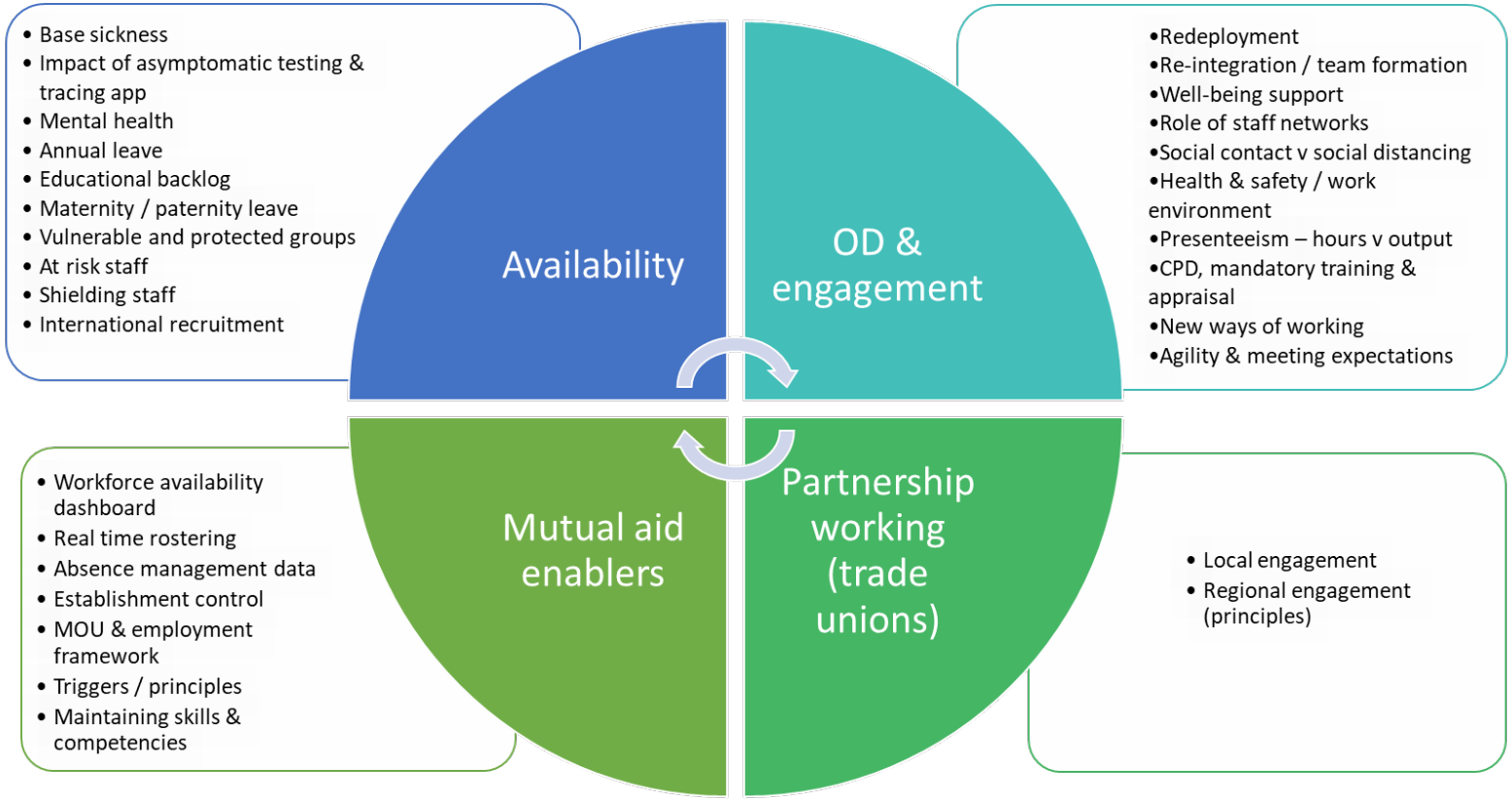
1. **Priority 2 Procedures – June & July 2020 (and continuing as further patients listed)**

Date	Service	Comments
Ongoing	Breast Surgery	Continuation of service
	Plastic Surgery	Referred to St Helens & Knowsley
01.06.20	Fertility	EPAU to move to Leigh Ward 2 to release space for Fertility Service to recommence at Wrightington
08.06.20	Endoscopy	Services to recommence at RAEI and Leigh
	Cardiology	
22.06.20	T&O	Day Case Surgery commencing with T&O Day Case in order to apply the requirements of the Operating Framework in a small cohort before rolling out to other specialties.
Jul-20 onwards	Respiratory (EBUS)	Phased roll out of services suitable to be undertaken at Wrightington Site. Day Case procedures initially due to expected inpatient occupancy. Use of Independent Sector Capacity for Colorectal and General Surgery
	Colorectal Surgery	
	ENT	
	General Surgery	
	Gynaecology	
	Urology	
	General Surgery	

2. **Priority 3 and 4 procedures - currently being scoped**

Workforce – GM considerations

There are a range of factors influencing workforce availability, as outlined below. The planning assumption across GM is that 10.4% of the workforce will be unavailable at any one time. WWL recovery planning will include modelling this at a service line level.



Escalation Triggers

A centralised dashboard is in development to monitor key metrics in order to ensure there is capacity to meet demand and that occupancy triggers are not being breached. This will also inform plans for resumption of services and site configuration.

Escalation Factors Summary

Current Position = 14/06/20

Site	ID	Escalation Factors	Metric Type	Current Position	Previous Week Position	Current Week Position	Rate of Change	Upper Limit	Lower Limit
Totals									
RAEI	1	A&E Attendances	Numerator	226	231	234	1.0%	250	200
RAEI	2	A&E COVID Attendances	Numerator	32	24	26	8.5%	35	27
RAEI	3	A&E COVID Attendances %	Percentage	14.2%	10.5%	11.3%	0.8%	20.0%	15.0%
RAEI	4	Admissions	Numerator	42	49	52	5.1%	120	100
RAEI	5	Critical Care Occupancy	Numerator	4	5	5	-14.1%	15	11
RAEI	6	Suspected COVID Bed Occupancy	Numerator	27	22	23	4.5%	25	20
RAEI	7	COVID Bed Occupancy	Numerator	8	16	9	-49.1%	100	50
RAEI	8	Non-COVID Medical Bed Occupancy	Numerator	223	188	209	10.5%	200	150
RAEI	9	Trauma / Emergency Surgery Bed Occupancy	Numerator	59	55	57	2.8%	75	
RAEI	10	Elective Bed Occupancy	Numerator	2	3	3	0.0%		
RAEI	13	RAEI Total Bed Occupancy	Percentage	78.9%	72.4%	75.5%			
RAEI	14	Discharges : Admissions	Ratio	0.7	1.0	0.9			
Wrightington	15	Wrightington Total Bed Occupancy	Percentage	68.1%	60.1%		0.0%		
Leigh	16	Leigh Total Bed Occupancy	Percentage	50.0%	27.1%	6%	%		

GM Planning Assumptions

Plans across the health and care system need to ensure that:

- Separation of COVID / Non-COVID can be supported
- A&E attends do not rise above 75% of pre-COVID levels
- General and acute bed occupancy to be at an average of 80% but no higher than 85% at any one time
- Theatre productivity is assumed to be 80%to account for IPC measures.
- Social distancing will reduce the total bed base by 10%
- Critical care occupancy is no higher than 80%
- COVID admissions at the GM level will remain at 85 per day
- A 10% conversion from COVID admissions to need for Critical Care
- Non-Elective (Non-COVID) admissions follow same pattern as pre COVID levels e.g. Length of Stay / CC conversion
- DTOC remain at May 2020 levels
- Potential for 60% - 70% outpatients to be undertaken through virtual means
- Admissions to bed based residential care remain at current low levels
- Additional capacity requirements to deal with seasonal flu will be in line with 2019/20 requirements
- 10.4% of our workforce will be unavailable at any one time

TRANSFORMATION

Capital requirements submitted to GM

In response to the GM Planning assumptions, the following Capital proposals have been put forward in order for WWL to meet the requirements of the 'new normal' for acute sites:

Capacity requirement	Brief description	Estimated capital value	Non-recurrent revenue costs	Recurrent revenue costs
Outpatients department (OPD) at Wrightington	Increase size of existing OPD dept to enable social distancing whilst maintaining operational capacity of the service	Total value = £1.8m (inc. VAT and fees) Funding required to 30/06/2020 = £300,000	N/A	N/A This work would ensure that the existing activity could be managed more safely without significantly compromising productivity. The department would essentially allow a safer provision of OPD services for the GM Regional Centre.
Additional car parking at Wrightington	The scheme would provide additional patient parking at Wrightington	£420,000	N/A	N/A
A&E Minors / Outpatients	Improve waiting capacity and flow in A&E and Outpatients departments	£81,000	N/A	TBC
Endoscopy	Professional fees to fast track the modification of the design of the RAEI Endoscopy expansion project	£350,000	N/A	N/A
Leigh Step-Down	Minor improvement works within mothballed former ward area to make it fit for use as a Step-Down facility	£404,600	N/A	£307,390
HDU at Wrightington	Create new 8-bed HDU capacity and 16-bed ward on the Wrightington site	£350,000	N/A	N/A at this stage
Specialist equipment	Purchase of new specialist equipment: • Lightweight mobile x-ray machine • Mini C arm • EUS machine for Leigh Endoscopy • 2x handheld Echo machines • 2x Echo machines for wards at Leigh	£290,000	N/A	TBC at this stage

Transformation in Recovery

Transformation is a key component of the NHS' recovery from COVID

Strategic objectives	Strategic priorities
1. Continue to deliver safe, high quality health and care services for COVID management and non-COVID recovery	A. Ensure COVID-19 health and care demand is appropriately met
	B. Prioritise access to in and out of hospital services for high risk and vulnerable groups
	C. Understand and address rate limiting factors for delivering all types of care safely
2. Provide place based health and care services as a system	A. Ensure health inequality across the region does not increase
	B. Utilise independent sector and other available facilities, where necessary
	C. Ensure an equal focus on both in and out of hospital services, taking care to understand the reciprocal influences on one another
3. Deliver health and care services that are financially sustainable	A. Ensure innovation and transformation initiatives are cost effective
	B. Ensure capital investments are a balance of physical and technological infrastructure essential for the effective delivery of care
	C. Optimise resource and capacity
4. Build a resilient and supported health and care workforce	A. Develop robust workforce management tools to ensure there is capacity to deliver safe, high quality care
	B. Ensure workforce is sufficiently supported emotionally to deliver safe, high quality care
5. Capture, continue and build on innovation and transformation	A. Identify, share and embed positive transformation and improvement opportunities across the system

NHS NW COVID-19 management and NHS open for business. Phase three planning assumptions. (NHS England and NHS Improvement, June 2020)

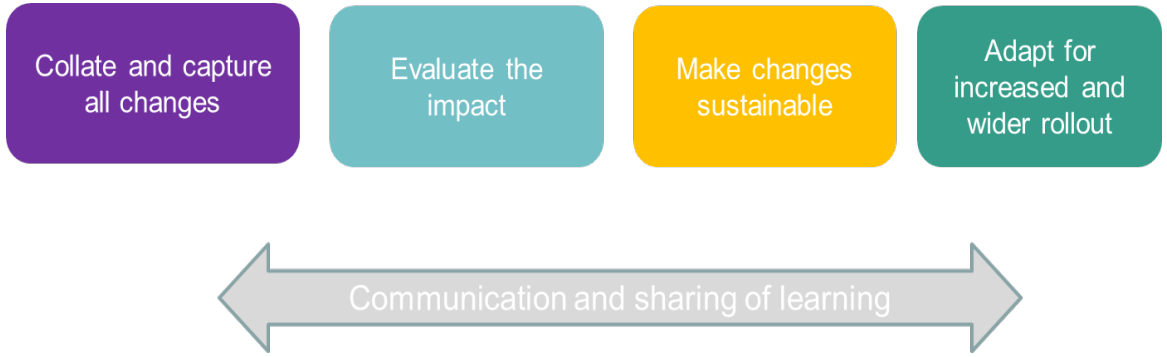
Transformation supporting the re-start of services

Immediate necessity to continue delivering services differently and transform models of care to support the safe re-instatement of services whilst ensuring capacity for COVID-19 demand.

- Support the sustainability and embedment of Better @ Home transformation to improve flow out of hospital, reduce length of stay and support the protection of hospital bed occupancy at 80%
- Protect the 'front door' through new models of care (GM Urgent Care by Appointment transformation) to positivity affect urgent care attendances to support planning assumptions of 75% A&E attends
- Embed and expand virtual outpatient models of delivery
    - Sustainability of administrative process underway
    - Continue to develop Virtual Models and build in sustainability to existing services
    - Understand any barriers and put support in place to maintain 60% virtual models as outpatient activity increases throughout phase 3
    - Define the future operating model for outpatients when 60% to 70% of attendances are delivered virtually to understand the impact on physical estates (outpatient rooms), workforce model and productivity.

Locking in the benefits of transformations

NHS must take the opportunity to identify, evaluate and agree the positive transformations and innovations that have been made to lock in the benefits for the future.



- During June and July, facilitated learning sessions with teams and departments to be held to collate and capture the rapid transformations and key enablers and conditions.
- Framework and approach shaped by emerging good practice and psychological safety evidence, taking an appreciative inquiry approach.
- Learning to ensure positive changes to services and ways of working are made sustainable and embedded for the future.

REPORT

AGENDA ITEM: 9

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

To:	Board of Directors meeting	**Date:**	24 June 2020
Subject:	Board Performance Report		
Presented by:	Deputy Director of Strategy and Planning	**Purpose:**	For information

Executive summary

Further to Pandemic Assurance Committee (PACs) suggestion of looking at reducing some of the reports that normally go to the various committees. This paper is an interim report as BI automates the production of a Balanced Scorecard – current metrics for approval, format may change to be more visual if required. RAG ratings being agreed where not already in place.

Supplementary metrics are included for Elective Care, these are for information, but could be portrayed in a condensed manner in future. Further supplementary metrics will be included in future reports for other areas as agreed. The report also shows national standards not already included earlier in the report, national quality requirements and a Covid 19 update.

Risks associated with this report

- Resource normally responsible for capturing or validating data may have been re-deployed into alterative roles therefore the information normally provided in the Trusts Board Report is currently being assessed on what we can still provide with confidence.
- The Business Intelligence team also have a large number of other COVID related and high priority projects to deliver.

Link(s) to The WWL Way 4wards

☒	Patients	☒	Performance
☒	People	☐	Partnerships

The WWL Way

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Board Performance Report Update

Business Intelligence

Prepared June 2020 (During the COVID-19 Pandemic)

Showing May data where available

The WWL Way

Contents:

Overall Trust Performance - Balanced Scorecard from 1 Apr 20 to 31 May 20

QUALITY & SAFETY

	Month	CM	RAG	YTD	RAG
Number of Serious Incidents	M2	5	●	5	●
Never Events	M2	0	●	0	●
Patient Safety Incident Reporting	M2	737	●	1290	●
National Patient Safety Alerts (CAS)	M2	0	●	2	●
Infection Prevention and Control	M2	4	TBC	10	TBC

ACTIVITY & EFFECTIVENESS

	Month	CM	RAG	YTD	RAG
Scheduled Care					
Cancer Performance (Aggregate)	M1		●		●
Diagnostics: Patients waiting over 6 weeks	M2	28.6%	●	28.6%	●
RTT Incomplete Performance	M2	63.95%	●	63.95%	●
RTT - patients waiting 52+ weeks	M2	72	●	72	●
Stroke - Stroke Patients spending 90% of their Hospital Stay on a Stroke unit	M1	74.2%	●	74.2%	●
Unscheduled Care					
Covid 19 Metrics (tbc)					
A&E performance - all	M2	96.5%	●	95.5%	●
Emergency admissions	M2	3382	TBC	6216	TBC
Number of Beddays :Super Stranded Patients	M2	1438	TBC	2651	TBC
Number of Beddays : Stranded patients	M2	2972	TBC	5060	TBC
Other					
Ward Occupancy % - all wards and sites	M2	45.6%	TBC	43.8%	TBC
Ward Occupancy % - wards reported in SITREP submissions	M2	66.9%	TBC	65.9%	TBC

WORKFORCE

Protecting Patients Metrics	Month	CM	RAG	YTD	RAG
Safe care / e-roster (nursing & AHPs) - RN	M12	97.1%	●		
Safe care / e-roster (nursing & AHPs) - Unregistered	M12	114.4%	●	23.2%	
Absence SITREP	M1	23.2%		23.2%	
Absence - Covid related	M1	12.5%		12.5%	
Mandatory Training	M2	91.6%	●	91.6%	●
Protecting Staff Metrics					
Risk stratification - Shielded					
RIDDOR reporting & investigation status					

FINANCE

Financial Position (Variance)	Month	CM	RAG	YTD	RAG
Income	M1	4,965		4,965	
Expenditure	M1	(2,749)		(2,749)	
Financing / Technical	M1	71		71	
Surplus / Deficit	M1	2,287		2,287	
Adjusted Financial Performance	M1	2,302		2,302	
Other					
SAVI	M1	(601)		(601)	
Agency Spend	M1	(774)		(774)	
Cash Balance	M1	27,627		27,627	
FRF Earned	M1	0		0	
Capital Spend	M1	(7,036)		(7,036)	

Balanced Scorecard Commentary to be included in future months.

For this month's report, drill down reports are included in the pack to provide an Elective Care Update:

Inpatient Waiting List

- Planned waiting list – routine and urgent patients past their due appointment date.
- Inpatient Waiting List – total patients including / excluding private patients
- TCI Dates, historic, no TCI, Future TCI

Outpatient Waiting List

- Total Outpatient Waiting List size – New patients
- Outpatient Cancellations (New) – Cancelled by Hospital; Cancelled by Patient
- New attendances; Face to Face; Phone, Procedures
- Total Outpatient Waiting List size – Follow up patients
- Outpatient Cancellations (Follow up) – Cancelled by Hospital; Cancelled by Patient
- Follow up Outpatient Waiting List – past due date
- Follow up attendances; Face to Face; Phone, Procedures
- New attendances by Type of Contact
- Follow up attendances by Type of Contact

RTT – Submitted Position

- Total RTT waits, RTT additions

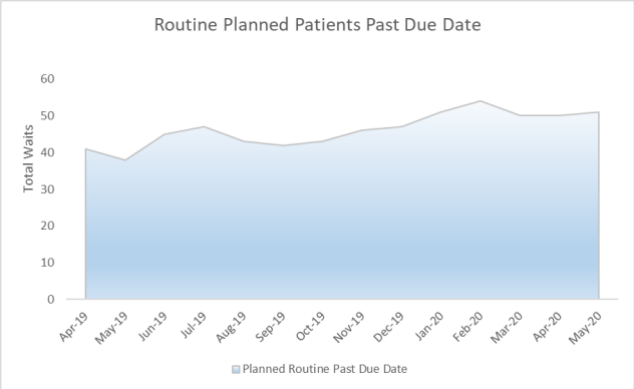
Diagnostics – waiting list size

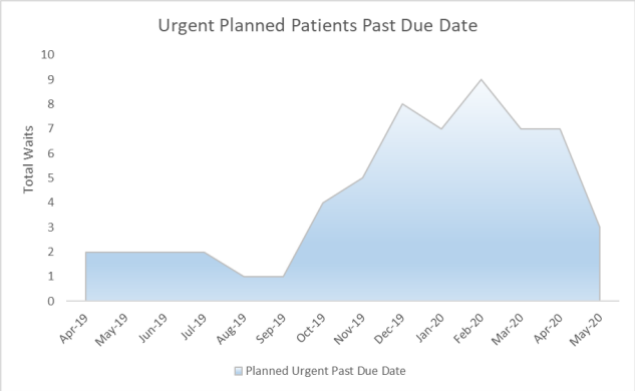
E-Referrals Management

- Total number of Appointment Slot Issues (ASI); total number over 180 days
- Rebooking and RAS (Referral Assessment Service) lists

Elective Care Update:

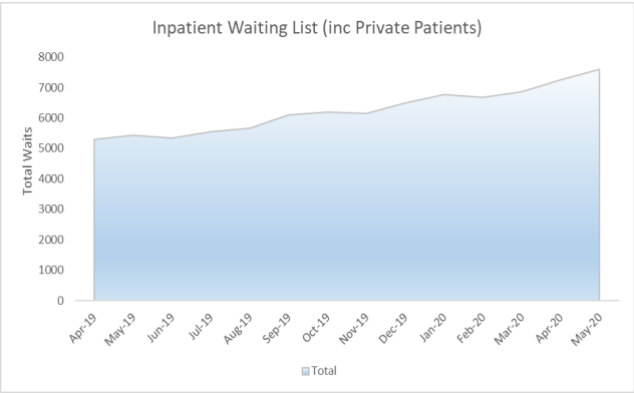
Planned Waiting list

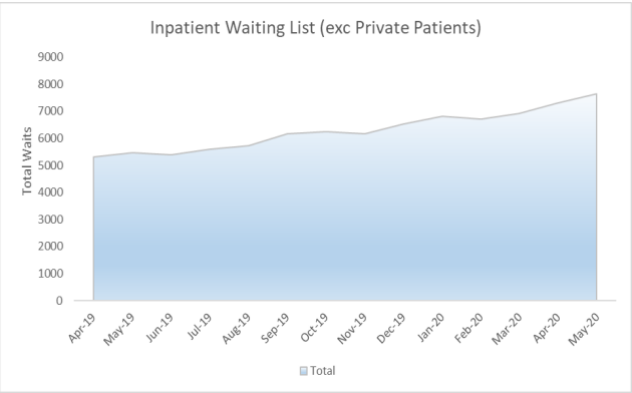




Planned WL	Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total WL Size	2019/20	4781	4843	4907	5031	5117	5138	5092	5127	5054	5100	4977	4850
	2020/21	4923	4807										
Planned Urgent Past Due Date	2019/20	2	2	2	2	1	1	4	5	8	7	9	7
	2020/21	7	1										
Planned Routine Past Due Date	2019/20	41	38	45	47	43	42	43	46	47	51	54	50
	2020/21	50	51										

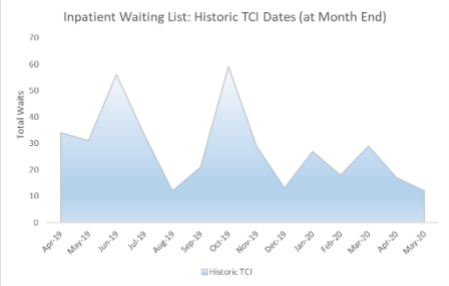
Inpatient Waiting List

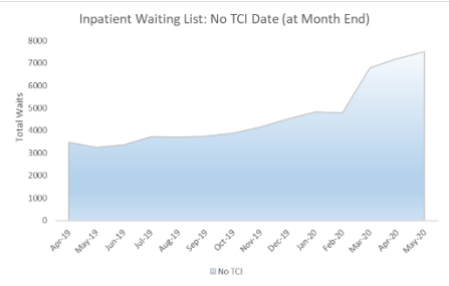


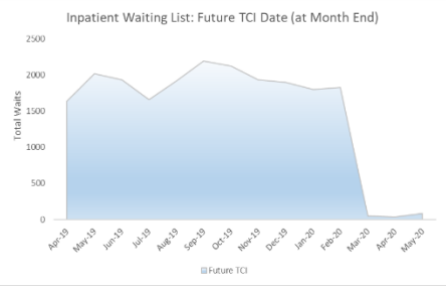


Inpatient WL	Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total IPWL Size	2019/20	5325	5473	5392	5593	5721	6157	6248	6177	6544	6829	6719	6913
	2020/21	7300	7652										
Total IPWL Size (exc Private Patients)	2019/20	5307	5433	5355	5553	5672	6105	6205	6143	6497	6774	6668	6863
	2020/21	7250	7602										
IPWL Urgency: Expedite (COVID Priority 1)	2019/20	84	91	57	64	85	97	112	88	70	127	103	69
	2020/21	92	77										
IPWL Urgency: Urgent (COVID Priority 2)	2019/20	503	528	600	598	667	654	657	692	718	784	745	685
	2020/21	757	721										
IPWL Urgency: Soon (COVID Priority 3)	2019/20	75	76	75	83	67	62	73	76	72	67	59	63
	2020/21	62	846										
IPWL Urgency: Routine (COVID Priority 4)	2019/20	4327	4596	4612	4677	4837	5121	5183	5248	5529	5629	5718	6022
	2020/21	6318	5950										

TCI Dates





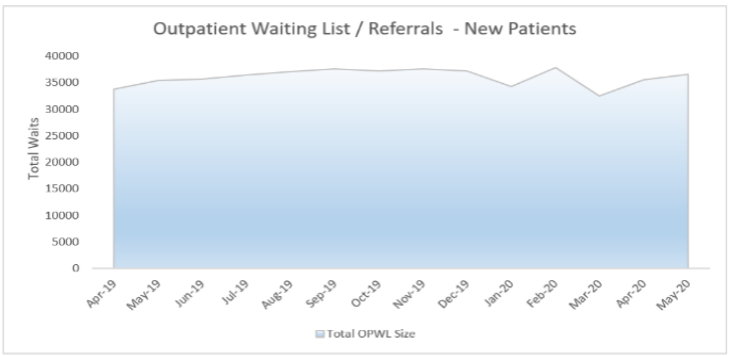


Inpatient WL	Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Historic TCI Dates	2019/20	34	31	56	33	12	21	59	29	13	27	18	29
	2020/21	17	12										
No TCI Date	2019/20	3484	3266	3360	3739	3717	3753	3888	4156	4515	4819	4787	6780
	2020/21	7192	7507										
Future TCI Dates	2019/20	1638	2015	1935	1657	1920	2192	2120	1931	1899	1802	1829	47
	2020/21	34	83										

Comment:

Outpatient Waiting List

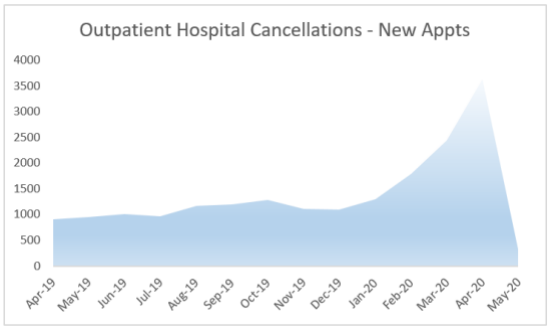
Total Outpatient Waiting List Size (New)

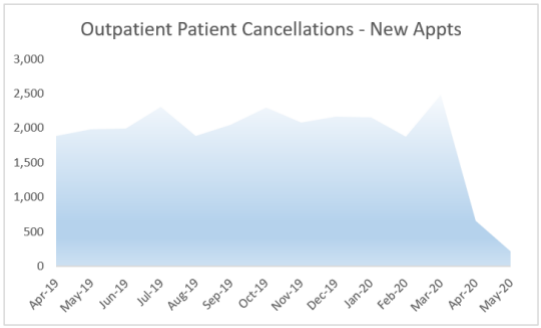


Total OPWL Size	Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2019/20	33830	35487	35717	36518	37101	37615	37231	37601	37173	34233	37826	32446
	2020/21	35607	36636										

Comment: Data includes patients waiting for a new appointment - Both on an Outpatient Waiting List & where the Trust has received a referral but the patient has not been added to an Outpatient Waiting List yet. This will include ASI & Rebooking patients as well as self-referrals etc

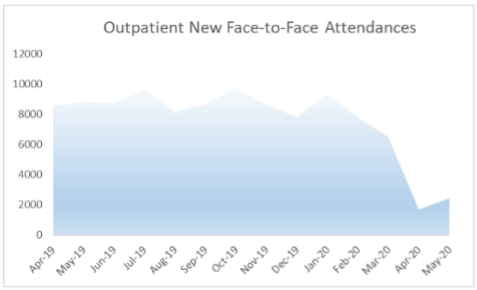
Outpatient Cancellations (New)

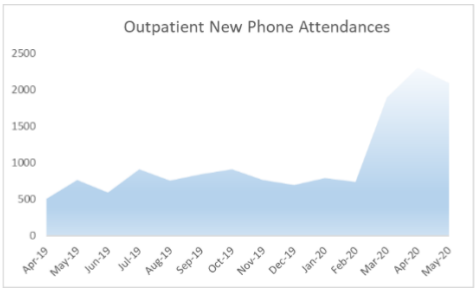


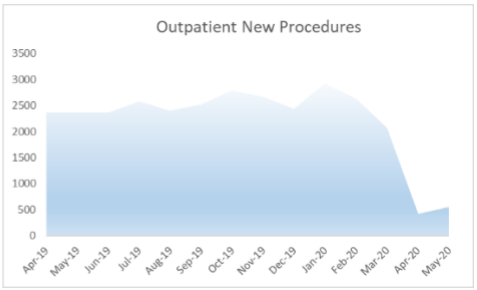


	Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Outpatient Cancellations (New Appts)	2019/20	2795	2929	3003	3270	3050	3236	3576	3189	3253	3457	3664	4920
	2020/21	4287	546										
Outpatient Hospital Cancellations (New Appts)	2019/20	911	949	1,004	964	1,166	1,191	1,281	1,107	1,091	1,297	1,788	2,446
	2020/21	3,633	331										
Outpatient Patient Cancellations (New Appts)	2019/20	1,884	1,980	1,999	2,306	1,884	2,045	2,295	2,082	2,162	2,160	1,876	2,474
	2020/21	654	215										

Historic Appointments (New Attendances)



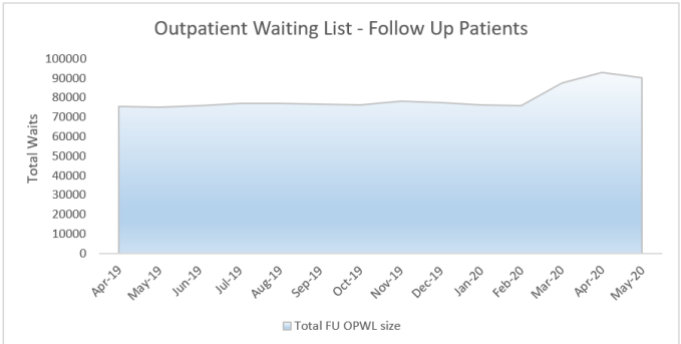




	Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Outpatient New Attendances	2019/20	11415	11938	11672	13098	11280	12006	13376	12028	10954	12996	11145	10467
	2020/21	4409	5089										
Outpatient Face-to-Face New Attendances	2019/20	8552	8805	8716	9603	8125	8639	9677	8602	7822	9288	7781	6498
	2020/21	1697	2441										
Outpatient Phone New Attendances	2019/20	505	767	594	911	759	845	912	766	695	793	742	1896
	2020/21	2295	2092										
Outpatient New Procedures	2019/20	2358	2366	2362	2584	2396	2522	2787	2660	2437	2915	2622	2073
	2020/21	417	556										

Comment:

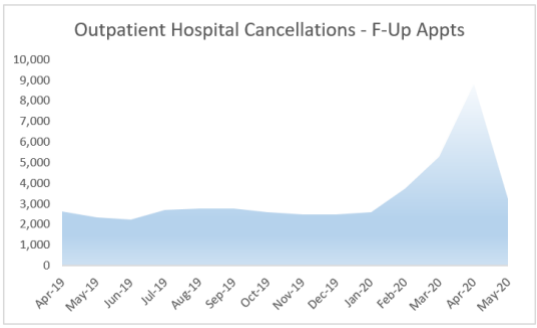
Total Outpatient Waiting List Size (Follow up)

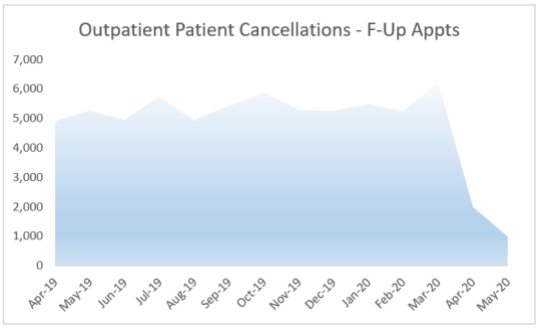


Total FU OPWL size	Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2019/20	75299	75149	75812	77048	76914	76716	76094	78038	77517	76231	75881	87346
	2020/21	92762	90032										

Comment: Data includes all patients waiting for a follow-up appointment - This will include overdue patients

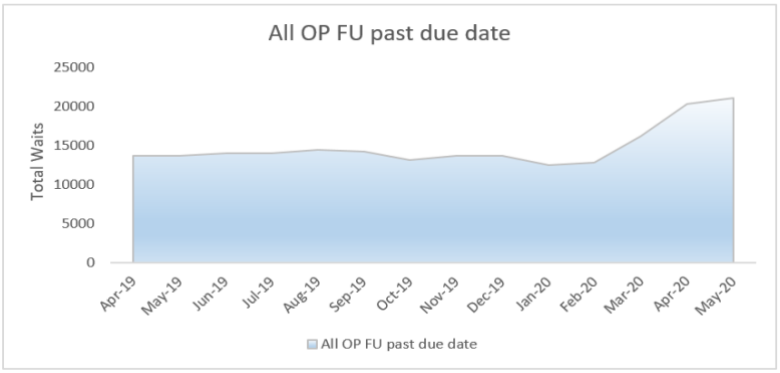
Outpatient Cancellations (Follow Up)





	Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Outpatient Cancellations (F-Up Appts)	2019/20	7538	7601	7192	8415	7676	8170	8460	7738	7730	8062	8992	11495
	2020/21	10814	4197										
Outpatient Hospital Cancellations (F-Up Appts)	2019/20	2,634	2,353	2,240	2,683	2,754	2,749	2,594	2,464	2,477	2,589	3,752	5,274
	2020/21	8,815	3,227										
Outpatient Patient Cancellations (F-Up Appts)	2019/20	4,904	5,248	4,952	5,732	4,922	5,421	5,866	5,274	5,253	5,473	5,240	6,221
	2020/21	1,999	970										

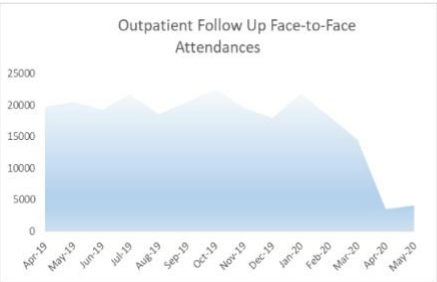
Follow Up Outpatient Waiting List – Past Due Date

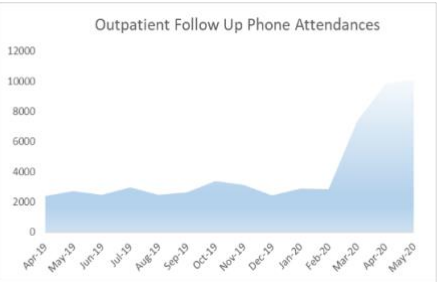


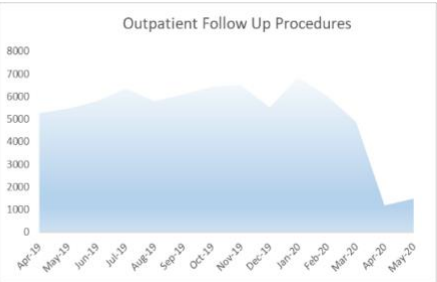
All OP FU past due date	Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2019/20	13699	13689	14067	14055	14470	14270	13122	13648	13654	12483	12806	16204
	2020/21	20373	21049										

Comment: Data includes all patients waiting for a follow-up appointment where their due date has passed

Historic Appointments (Follow-Up Attendances)





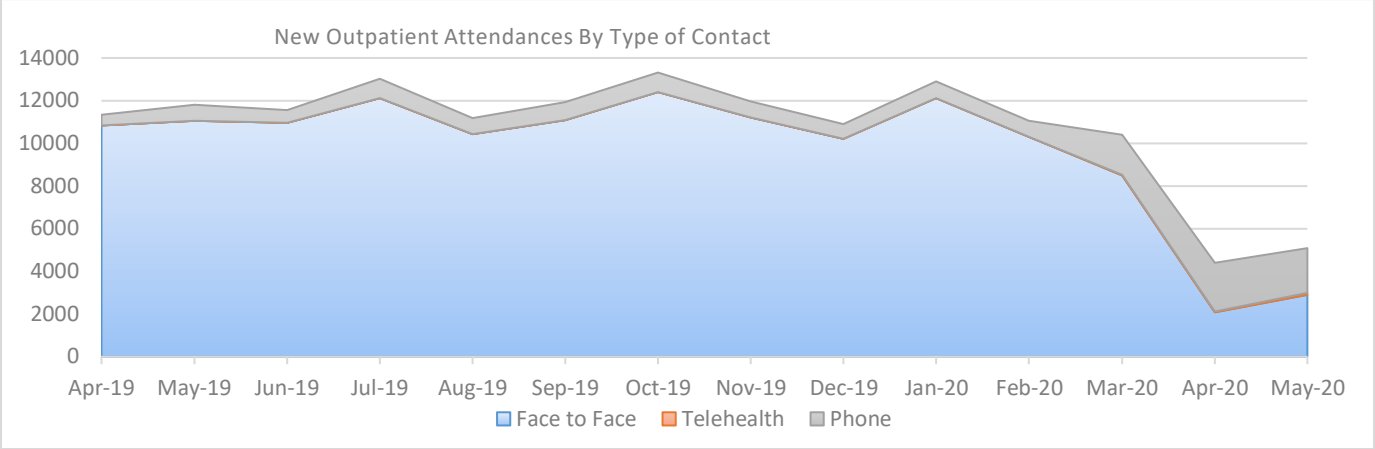


	Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Outpatient Follow Up Attendances	2019/20	27424	28691	27493	30992	26839	29226	32277	29131	25887	31507	27064	26671
	2020/21	14532	15639										
Outpatient Face-to-Face Follow Up Attendances	2019/20	19758	20502	19223	21700	18590	20496	22501	19512	17963	21804	18227	14448
	2020/21	3520	4035										
Outpatient Phone Follow Up Attendances	2019/20	2395	2733	2483	2956	2465	2644	3368	3116	2427	2869	2844	7360
	2020/21	9831	10113										
Outpatient Follow Up Procedures	2019/20	5271	5456	5787	6336	5784	6086	6408	6503	5497	6834	5993	4863
	2020/21	1181	1491										

Comment:

Outpatient Clinics

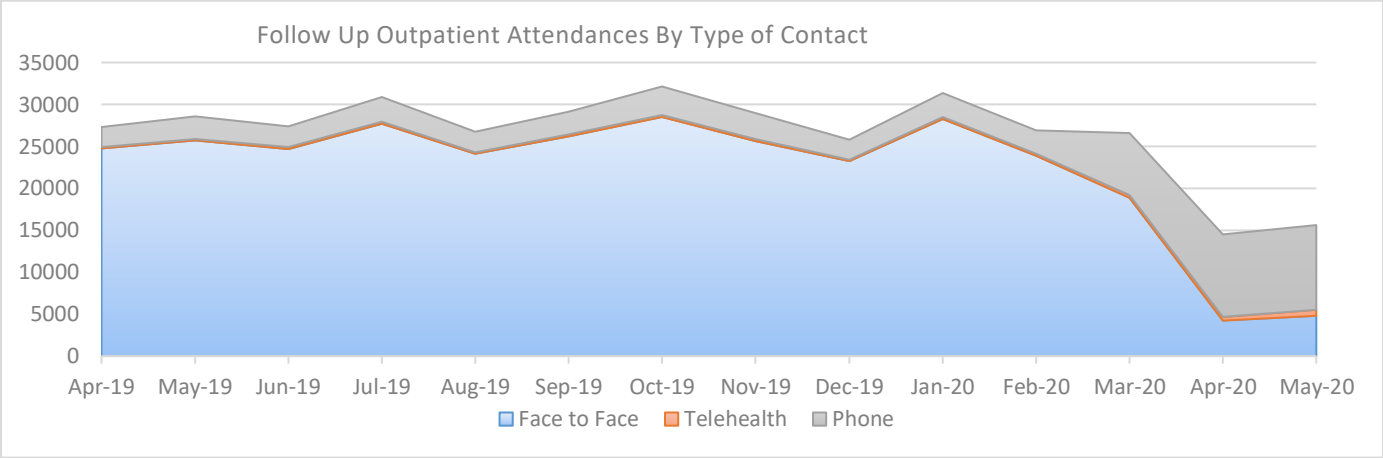
New Attendances



	Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Face to Face	2019/20	10835	11049	10959	12105	10431	11087	12404	11199	10210	12119	10308	8490
	2020/21	2071	2897										
Telehealth	2019/20	0	0	1	0	2	1	0	2	0	1	1	24
	2020/21	41	93										
Phone	2019/20	504	767	594	914	760	845	912	766	695	793	743	1899
	2020/21	2296	2095										

Comment:	New face to face attendances started reducing in March 2020. In April they were just 20% of the previous year levels but in May rose slightly to be 25% compared the same period last year. New Telehealth appointments started to take place in March 2020 but numbers remain low. New phone appointments rose from the middle of March 2020 and are now roughly three times the levels of the previous year however the rise does not match the drop in face to face attendances so less new patients are receiving appointments since the start of the pandemic. The phone appointment line include some virtual appointments.

Follow Up Attendances

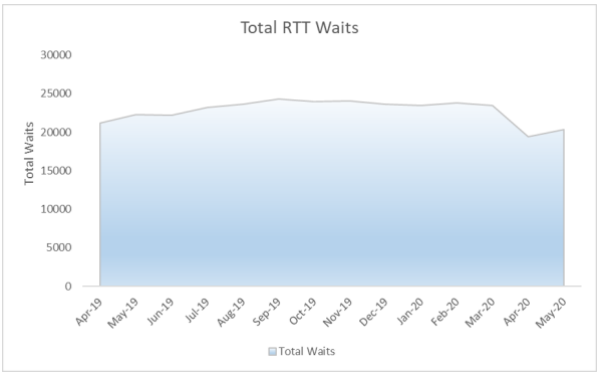


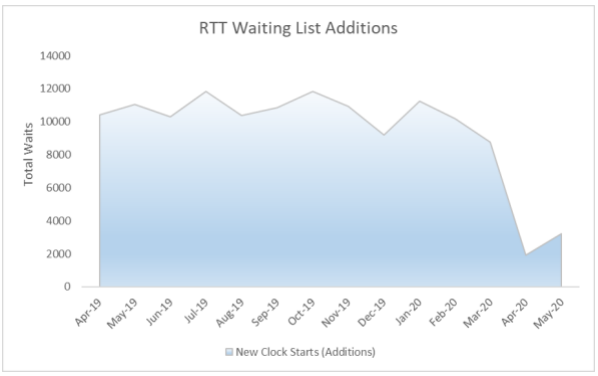
	Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Face to Face	2019/20	24743	25690	24681	27715	24124	26202	28521	25609	23228	28262	23875	18865
	2020/21	4221	4805										
Telehealth	2019/20	190	167	218	212	164	261	257	278	150	249	224	326
	2020/21	452	707										
Phone	2019/20	2394	2736	2485	2955	2458	2644	3366	3110	2422	2869	2842	7394
	2020/21	9838	10113										

Comment:	Follow up face to face attendances started reducing in March 2020. In April they were under 20% of the previous year levels. May attendances are nearly 10% higher than April. The Trust had existing Sleep Service follow up Telehealth appointments already taking place but in March 2020 numbers started to increase when clinicians started to see patients via Attend Anywhere once the pandemic started. Follow up telephone appointments rose from the middle of March 2020 and are now roughly four times the levels of the previous year however the rise does not match the drop in face to face attendances so less follow up patients are receiving appointments since the start of the pandemic. The phone appointment lines include some virtual appointments.

RTT (submitted position)

Total waiting list size

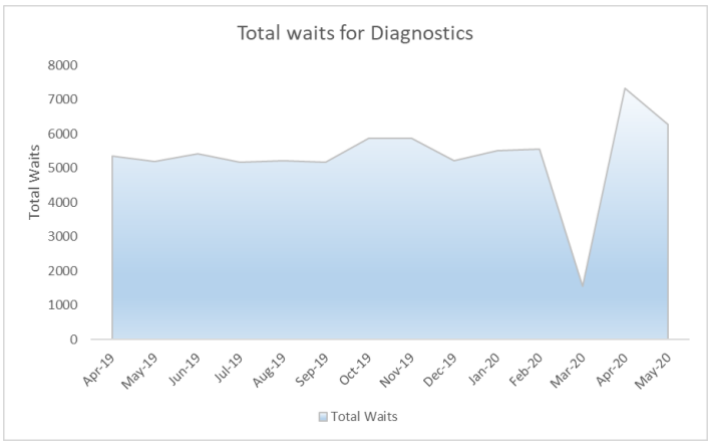




RTT	Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total WL Size	2019/20	21153	22247	22158	23221	23618	24304	23970	24026	23663	23428	23823	23459
	2020/21	19439	20361										
WL Additions	2019/20	10405	11064	10312	11831	10363	10874	11856	10922	9213	11238	10172	8753
	2020/21	1930	3237										

Comment:

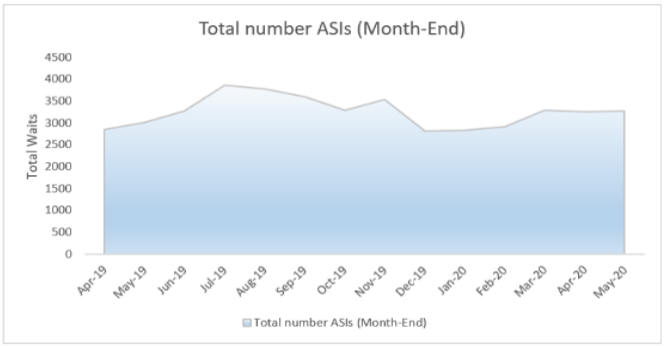
DM01- diagnostics waiting list size

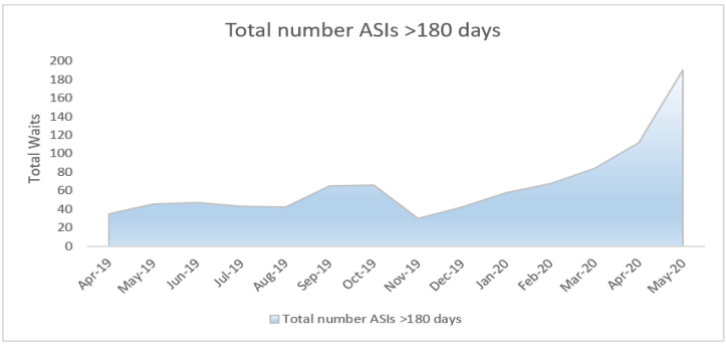


Diagnostic Test Waiting Times	Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
E.B.4	2019/20	98.17%	99.00%	99.26%	99.27%	99.14%	99.04%	99.20%	99.13%	98.45%	99.02%	99.03%	93.40%
	Breach Excess	44								29			87
	2020/21	29.29%	28.62%										
	Breach Excess	5113	4418										

E-Referrals Management

ASI – Appointment Slot Issues





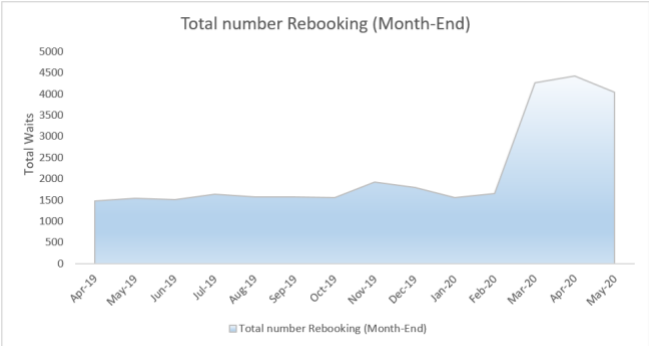
Comment: Number of patients waiting on the E-Referral ASI list (Appointment Slot Issues) at Mth End

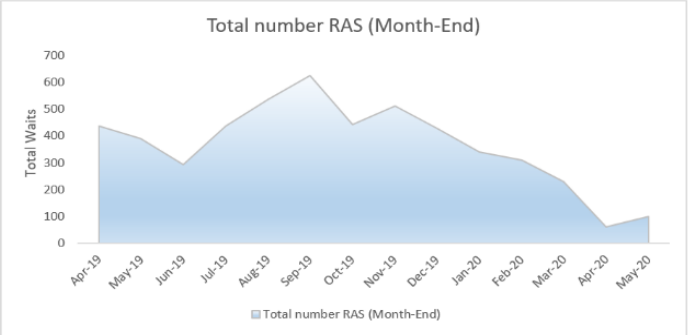
Comment: Number of patients waiting on the E-Referral ASI list (Appointment Slot Issues) for more than 180 days. Note that a patient can appear in more than one month if their wait spans different periods

Total number ASIs (Month-End)	Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2019/20	2847	3008	3273	3859	3784	3598	3287	3529	2812	2839	2914	3288
	2020/21	3262	3267										

Total number ASIs >180 days	Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2019/20	35	46	47	43	42	65	66	30	42	58	68	84
	2020/21	112	190										

Rebooking & RAS





Comment: Number of patients waiting on the E-Referral Rebooking list at Mth End

Total number Rebooking (Month-End)	Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2019/20	1473	1539	1502	1634	1572	1568	1560	1922	1799	1549	1648	4256
	2020/21	4421	4042										

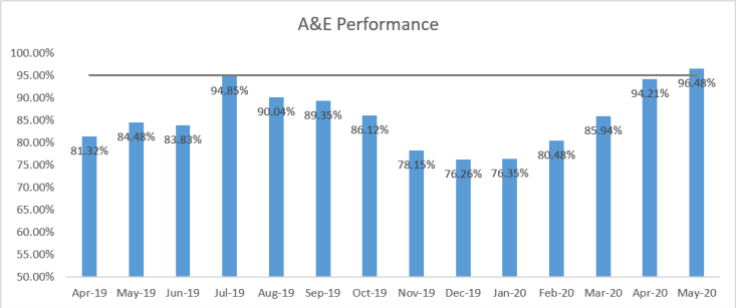
Total number Rebooking (Month-End)	Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2019/20	436	390	294	437	536	625	444	511	428	339	311	228
	2020/21	59	99										

Please note : Remaining metrics are under consideration for further comment / development.

Key Performance Indicators – National Standards (not reported above)

A. Operational Standards

A&E Performance

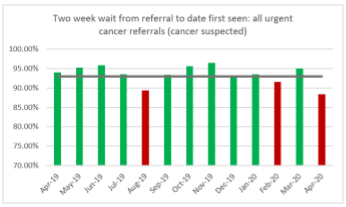


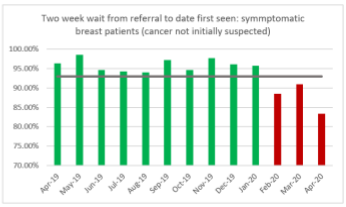
A&E Waits	Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
E.B.5	2019/20	81.32%	84.48%	83.83%	94.85%	90.04%	89.35%	86.12%	78.15%	76.26%	76.35%	80.48%	85.94%
	Breach Excess	1688	1424	1380	19	609	691	1096	2071	2283	2222	1500	787
	2020/21	94.19%	96.48%										
	Breach Excess	49											

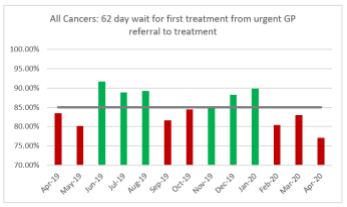
Standard - Percentage of A & E Attendances where the Service User was Admitted, Transferred or Discharged within 4 hours of their arrival at an A&E Department
Threshold - Operating standard of 95%
Consequence of breach - Where the number of Service Users in the month not admitted, transferred or discharged within 4 hours exceeds the tolerance permitted by the threshold, £120 in respect of each such Service User above that threshold. To the extent that the number of such Service Users exceeds 15% of A&E attendances in the relevant month, no further consequence will be applied in respect of the month

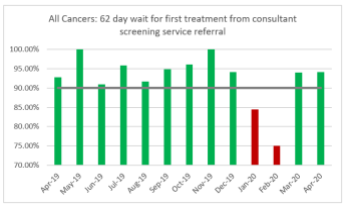
Comment:

Cancer Performance









Cancer Waits: 2 Week Target	Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
E.B.6	2019/20	93.97%	95.25%	95.90%	93.49%	89.39%	93.43%	95.59%	96.43%	93.31%	93.59%	91.53%	94.96%
	Breach Excess					41						15	
	2010/21	88.36%											
	Breach Excess	22											
E.B.7	2019/20	96.30%	98.57%	94.68%	94.21%	94.07%	97.20%	94.59%	97.69%	96.08%	95.76%	88.50%	90.91%
	Breach Excess											5	2
	2020/21	88.33%											
	Breach Excess	3											

E.B.6
Standard - Percentage of Service Users referred urgently with Suspected Cancer by a GP waiting no more than two weeks for First Outpatient Appointment
E.B.7
Standard - Percentage of Service Users referred urgently with Breast Symptoms (where cancer was not initially suspected) waiting no more than two weeks for First Outpatient Appointment
E.B.6/E.B.7
Threshold - Operating standard of 93%
Consequence of breach - Where the number of Service Users who have waited more than two weeks during the Quarter exceeds the tolerance permitted by the threshold, £200 in respect of each such Service User above that threshold

Cancer Waits: 31 Day Target	Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
E.B.8	2019/20	97.73%	100.00%	100.00%	100.00%	98.15%	98.02%	99.22%	100.00%	100.00%	98.04%	95.10%	99.21%
	Breach Excess											1	
	2020/21	100.00%											
	Breach Excess												
E.B.9	2019/20	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Breach Excess												
	2020/21	100.00%											
	Breach Excess												
E.B.10	2019/20	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Breach Excess												
	2020/21	100.00%											
	Breach Excess												

E.B.8

Standard - Percentage of Service Users waiting no more than one month (31 days) from Diagnosis to First Definitive Treatment for all Cancers

Threshold - Operating standard of 96%

E.B.9

Standard - Percentage of Service Users waiting no more than 31 days for Subsequent Treatment where that Treatment is Surgery

Threshold - Operating standard of 94%

E.B.10

Standard - Percentage of Service Users waiting no more than 31 days for Subsequent Treatment where that Treatment is an Anti-Cancer Drug Regimen

Threshold - Operating standard of 98%

E.B.8/E.B.9/E.B.10

Consequence of breach - Where the number of Service Users who have waited more than 31 days during the Quarter exceeds the tolerance permitted by the threshold, £1,000 in respect of each such Service User above that threshold

Cancer Waits: 62 Day Target	Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
E.B.12	2019/20	83.50%	80.13%	91.74%	88.89%	89.22%	81.63%	84.44%	85.34%	88.29%	89.91%	80.36%	82.96%
	Breach Excess	1	4				2	1				3	1
	2020/21	77.11%											
	Breach Excess	3											
E.B.13	2019/20	92.86%	100.00%	90.91%	95.92%	91.67%	94.87%	96.08%	100.00%	94.12%	84.44%	75.00%	94.00%
	Breach Excess										2	3	
	2020/21	94.12%											
	Breach Excess												

E.B.12

Standard - Percentage of Service Users waiting no more than two months (62 days) from Urgent GP Referral to First Definitive Treatment for Cancer

Threshold - Operating standard of 85%

E.B.13

Standard - Percentage of Service Users waiting no more than 62 days from Referral from an NHS Screening Service to First Definitive Treatment for all Cancers

Threshold - Operating standard of 90%

E.B.12/E.B.13

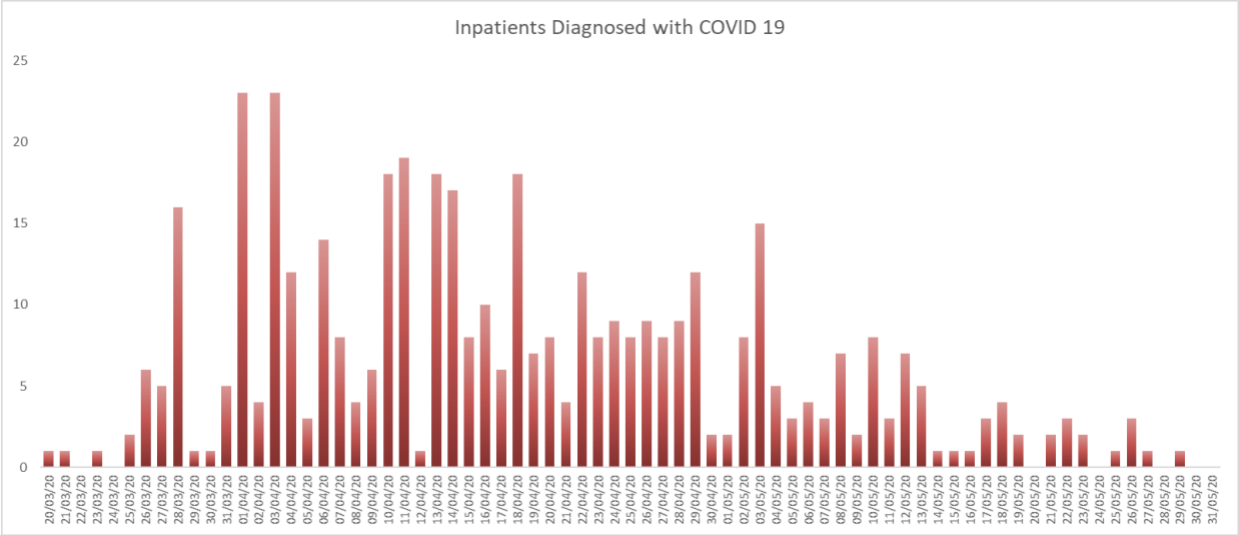
Consequence of breach - Where the number of Service Users in the Quarter who have waited more than 62 days during the Quarter exceeds the tolerance permitted by the threshold, £1,000 in respect of each such Service User above that threshold

Comment:

B. National Quality Requirements

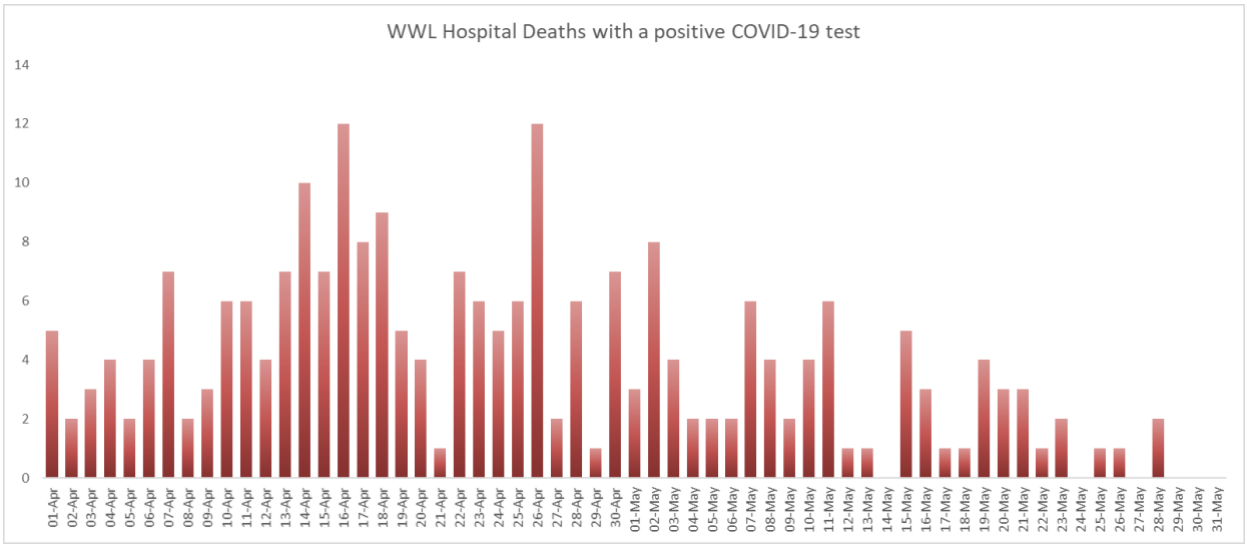
Number	Standards	Consequence of Breach	Financial Year	Threshold	Apr	May	Jun	Q1 Actual	Jul	Aug	Sep	Q2 Actual	Oct	Nov	Dec	Q3 Actual	Jan	Feb	Mar	Q4 Actual	Year End Actual
E.A.S.4	Zero tolerance methicillin-resistant Staphylococcus aureus (MRSA)	£10,000 in respect of each incidence in the relevant month	2019/20	>0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
				Breach Excess																	
			2020/21	>0	0	0		0													0
				Breach Excess																	
E.A.S.5	Minimise rates of Clostridium difficile (CDT)	As set out in Schedule 4F, in accordance with applicable Guidance	2019/20	20 **(Cumulative)**	3	7	12	12	15	17	23	23	28	30	41	41	44	46	48	48	48
				Lapses in Care Cases	1	1	1	3	1	2	0	3	0	0		0					6
				Breach Excess																	
			2020/21	20 **(Cumulative)**	3	6		6													6
				Lapses in Care Cases																	
				Breach Excess																	
	Minimise rates of gram-negative bloodstream infections (Escherichia Coli, Klebsiella & Pseudomonas Aeruginosa)	Issue of Contract Performance Notice and subsequent process in accordance with GC9	2019/20	As published by NHS England and NHS Improvement																	
				Breach Excess																	
			2020/21	As published by NHS England and NHS Improvement	2	1		3													3
				Breach Excess																	
E.B.S.4	Zero tolerance RTT waits over 52 weeks for incomplete pathways	£2,500 per Service User with an incomplete RTT pathway waiting over 52 weeks at the end of the relevant month	2019/20	>0	2	1	1		0	1	0		0	0	0		0	0	1		
				WBCCG Only	2	1	1		0	1	0		0	0	0		0	0	1		
				TFC	110 & 120	120	120			301									104		
			2020/21	>0	39			39													39
				WBCCG Only	33			33													
				TFC	Various			Various													
E.B.S.7a	All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 30 minutes	£200 per Service User waiting over 30 minutes in the relevant month	2019/20	>0	58	48	32	138	13	27	35	75	56	81	139	276	123	74	49	246	735
					3.1%	2.5%	1.8%	2.5%	0.8%	1.5%	2.0%	1.4%	3.2%	5.1%	8.6%	5.6%	7.4%	5.8%	4.0%	5.9%	3.7%
			2020/21	>0	246																246
					24.4%																24.4%
E.B.S.7b	All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes	£1,000 per Service User waiting over 60 minutes (in total, not aggregated with E.B.S.7a consequence) in the relevant month	2019/20	>0	30	15	4	49	0	2	4	6	21	59	157	237	80	26	9	115	407
					1.6%	0.8%	0.2%	0.9%	0.0%	0.1%	0.2%	0.1%	1.2%	3.7%	9.8%	4.8%	4.8%	2.0%	0.7%	2.8%	2.0%
			2020/21	>0	18																18
					1.8%																1.8%
E.B.S.5	Trolley waits in A&E not longer than 12 hours	£1,000 per incidence in the relevant month	2019/20	>0	0	0	0	0	0	0	0	0	2	6	37	45	78	30	8	116	161
				CCG																	
			2020/21	>0	0																
				CCG																	
E.B.S.6	No urgent operation should be cancelled for a second time	£5,000 per incidence in the relevant month	2019/20	>0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
				CCG																	
			2020/21	>0																	
				CCG																	
	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE, as defined in Contract Technical Guidance	Issue of Contract Performance Notice and subsequent process in accordance with GC9	2019/20	95%	95.98%	97.00%	96.28%	96.43%	97.03%	96.19%	96.65%	96.64%	97.13%	95.96%	95.98%	96.40%	96.62%	95.97%	96.37%	96.33%	96.45%
			2020/21		95.37%																
	Duty of Candour	Recovery of the cost of the episode of care, or £10,000 if the cost of the episode of care is unknown or indeterminate	2019/20	Each failure to notify the Relevant Person of a suspected or actual Notifiable Safety Incident in accordance with Regulation 20 of the 2014 Regulations	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
			2020/21		0	0		0													0
	Proportion of Service Users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	Issue of Contract Performance Notice and subsequent process in accordance with GC9	2019/20	Operating standard of 90% (based on a sample of 50 Service Users each Quarter)				68.47%				73.68%				73.33%					71.88%
			2020/21					N/A													
	Proportion of Service User inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	Issue of Contract Performance Notice and subsequent process in accordance with GC9	2019/20	Operating standard of 90% (based on a sample of 50 Service Users each Quarter)				97.26%				88.24%				95.12%					93.41%
			2020/21					N/A													

COVID-19 update

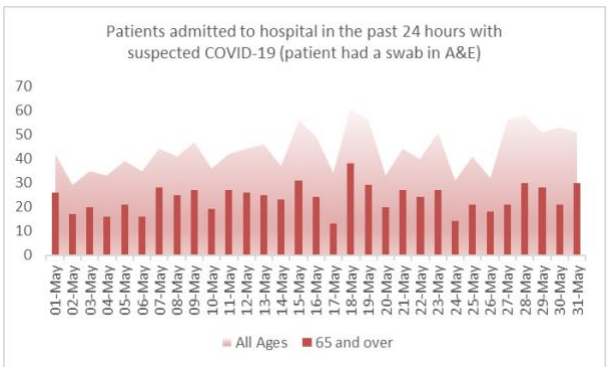


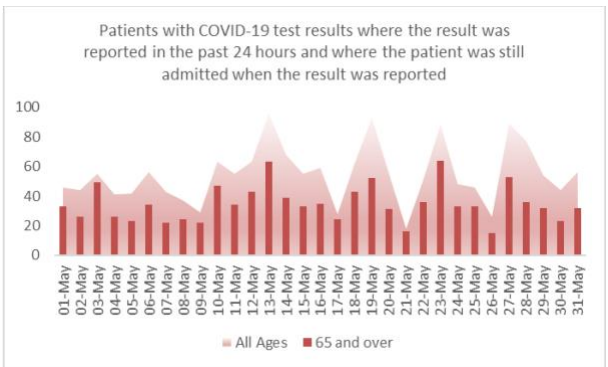
The above chart shows the trend for inpatients diagnosed with COVID-19. Please note this relates to the date that the diagnosis was made, and in line with national SITREP guidance does not include patients whose diagnosis was captured after the patient had been discharged – this has been raised as a query with NHS England definition's team.

The average number of patients diagnosed in May was 3, a significant drop compared to the April average of 10, more significantly, for the last 7 days in May the daily average has reduced further to less than one.

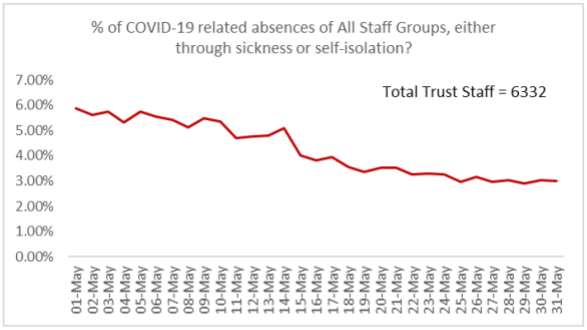


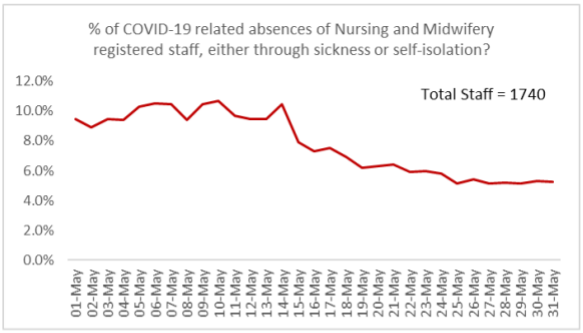
Public Health England metric:

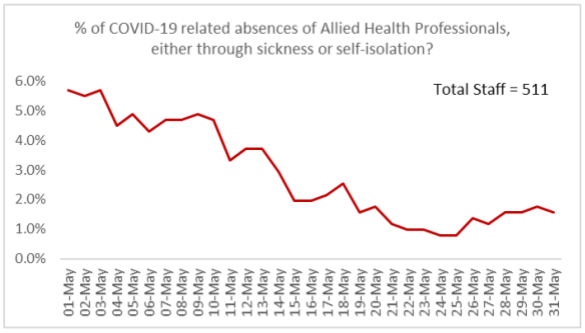


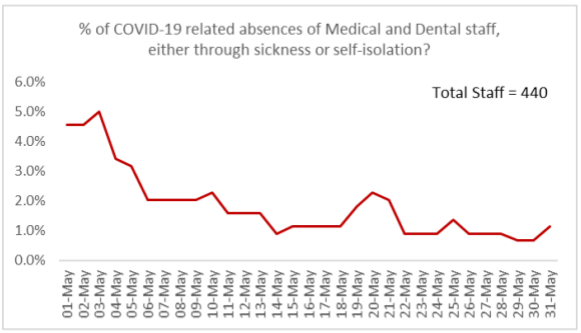


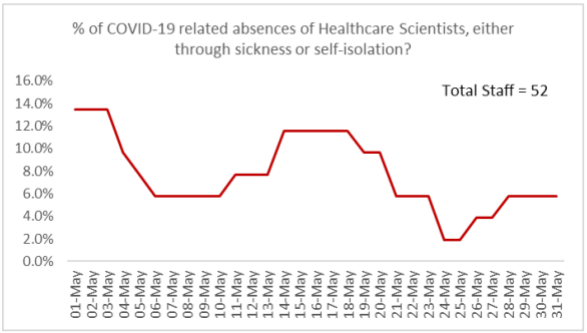
Staff Sickness Levels:

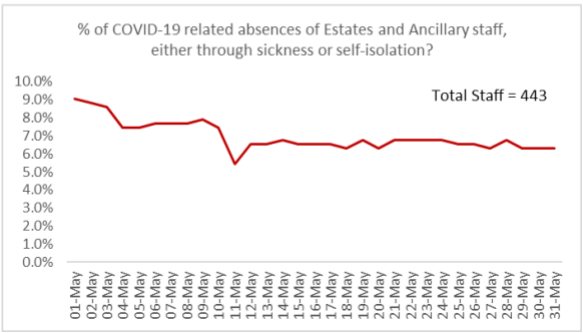












REPORT

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

AGENDA ITEM: 10

To:	Board of Directors	**Date:**	24 June 2020
Subject:	Review COVID-19 risk appetite statement		
Presented by:	Director of Corporate Affairs	**Purpose:**	Approval

Executive summary

In March 2020, the board approved a COVID-19 risk appetite statement and directed that it should be presented to each subsequent meeting to ensure its continuing appropriateness and relevant.

The statement is therefore attached for the board's review.

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.

Link(s) to The WWL Way 4wards

☒	Patients	☒	Performance
☒	People	☒	Partnerships

The WWL Way

COVID-19
Risk appetite statement

Wrightington, Wigan and Leigh Teaching Hospitals 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 Teaching Hospitals 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. We also recognise that exceptional times often call for an increased level of risk to be accepted and that the current threat posed by the global COVID-19 pandemic will require a different approach to decision making based on the balance of risk in any given circumstance. Notwithstanding, we recognise the importance of maintaining oversight of high risk incidents and we will continue to prioritise investigation and identification of areas of learning.

The Board of Directors wishes to support its directors, senior managers and other key decision makers throughout the pandemic by setting out a revised risk appetite statement. It is intended that this risk appetite statement will remain in place for as short a time as possible, and its continuing relevance will be assessed at each meeting of the Board until such a time as it is possible to return to normal operations.

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.

Underlying principles

We care about each and every one of our patients and we will do our utmost to preserve life, protect our patients from further harm and to promote recovery.

All healthcare providers operate with a set of finite resources and difficult decisions must be taken in times of significant challenge to determine the most appropriate allocation of those resources. We will always make these decisions on a clinical basis, weighing up factors such as potential benefits against the clinical risk and considering the likelihood of success.

Where we have to take decisions during the COVID-19 pandemic that we would not normally take under normal circumstances and these negatively impact on patients, we will do our utmost to limit the negative impact to the smallest number possible. Regrettably, it is impossible for us to say that the decisions we may need to take will never have a negative impact on patient safety. We will operate along the well-established principle of triage in seeking to do the greatest good for the greatest number.

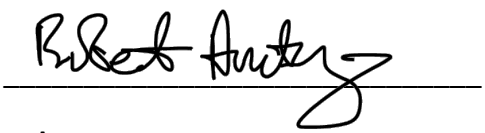
Our risk appetite

We have determined our risk appetite during the COVID-19 pandemic as follows:

Quality, innovation and outcomes	We have **a LOW** appetite for risks which materially have a negative impact on patient safety. We have a **MODERATE** 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 **SIGNIFICANT** appetite for financial risk in respect of meeting our statutory duties. We have a **HIGH** 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 **HIGH** appetite for risks which may compromise our compliance with statutory duties or regulatory requirements.
Reputation	We have a **HIGH** 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.

This risk appetite statement has immediate effect from the date of signature and its continuing appropriateness will be reviewed at each meeting until it is either amended or withdrawn.

This statement was approved by the Board of Directors at its meeting on 25 March 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

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

AGENDA ITEM: 11

To:	Board of Directors	**Date:**	24 June 2020
Subject:	Changes to committee arrangements		
Presented by:	Director of Corporate Affairs	**Purpose:**	Information

Executive summary

Earlier this year, the foundation trust changed its committee arrangements in response to the COVID-19 pandemic. The usual assurance committee arrangements were replaced with a single Pandemic Assurance Committee, which was intended to streamline governance and assurance at a time of high demand and significant national pressure.

Following a review of these arrangements, the board has concluded that the time is now right to return to the previous arrangements, albeit retaining the streamlined approach to agenda management. As a result the Quality and Safety, Finance and Performance and People Committees will be reinstated in the near future.

The board will recall that a detailed review of committee arrangements has previously been undertaken as reported to the board in January 2020. These arrangements will now be introduced, albeit the frequency of meetings will be subject to review.

The updated terms of reference for all committees will be presented to the next meeting of the board for review.

Risks associated with this report

Clear and effective reporting arrangements allow the board to obtain assurance and to have oversight of the organisation, including any associated risks. The content of this report is intended to support the organisation to mitigate risk.

Link(s) to The WWL Way 4wards

☒	Patients	☒	Performance
☒	People	☐	Partnerships

The WWL Way

REPORT

AGENDA ITEM: 11

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

To:	Board of Directors	**Date:**	24 June 2020
Subject:	Covid-19 Hot Debrief Report		
Presented by:	Chief Operating Officer	**Purpose:**	Information

Executive summary

This paper provides an overview of the process used to conduct a hot debrief from the response so far to the Covid-19 pandemic as well as the outcomes and associated actions. The process was primarily aimed at identifying actions required to improve the response to any second (or further) peaks which may occur although of course wider issues were captured. A second learning exercise has commenced which is more focused on the transformational learning and a paper will be brought on this in due course.

The Board is asked to note the contents of the report and consider the recommendations regarding the management of the actions

Risks associated with this report

Whilst there were many positives in relation to the response a number of gaps do remain which need to be resolved to improve the response. This report cross references the Infection Prevention and Control BAF and highlights a number of other broad risks. Actions are in place to respond to improve the response to a second wave or any future pandemic.

Link(s) to The WWL Way 4wards

☒	Patients	☒	Performance
☒	People	☒	Partnerships

The WWL Way

Introduction

A hot debrief takes place in response to any incident; within the NHS teams are used to utilising this method of sharing and learning on a regular basis especially in clinical areas. It should be an opportunity for team members to check in with each other, to learn from anything which didn't go well and to be open and honest. It relies on a multidisciplinary approach with all members having an equal voice which they are encouraged to use. This would often then be followed some time later by a cold debrief to formally stand down the incident in a structured way, ensuring that outstanding actions are carried forward and managed in the most appropriate way. A pandemic is obviously a different type of incident but this learning is still vital and the paper sets out the approach that has been taken and the outcomes.

Debrief Process

An initial debrief has been conducted with a wide variety of teams and individuals over the last 3 weeks. Participants have included the Executive Team, the Covid-19 operational and workforce groups, divisional teams, the senior HR team and the senior Nursing team as well as individuals who have provided feedback directly. The hot debrief has been predominantly focused on strengthening the response to further Civud-19 peaks as well as future pandemic and other major incident plans. A wider learning exercise looking at the transformational opportunities will take place over the coming weeks. The debrief was based around 6 key questions although they were used in different ways during the facilitated sessions and when individuals fed back directly. The key questions were as follows

1. What has worked well?
2. What hasn't worked well or has been the most challenging adjustment?
3. What response and recovery strategies did you invent in the heat of the moment?
4. What would make your plans more useful?
5. What are you particularly worried about in terms of a second peak in terms of response?
6. What did you learn that you want to see capture?

Outcomes

The outcomes have been themed and the table below shows these along with the positives and the things we plan to change or resolve ahead of a second peak or for a future pandemic plan.

Theme	Worked Well	Issues and Gaps to be Resolved	Actions	Assigned To
Communications	• Use of wider range of channels (WhatsApp for example) • Staff briefings	• Inconsistent communications across the organisation • Lack of clarity leading to miscommunication	• Staff briefings • Review of Wally	• Head of Communications and PR
Staff (Re)deployment	• Many temporary changes at speed • Willingness to be flexible by broad range of staff	• Clear communications around future redeployment personalised to individuals • Recognising skills of broad range of staff to support a second peak or future pandemic	• Staff briefings • Improved use of E-roster • Implementation of Absence Manager • Expansion of virtual training offer	• Head of Communications and PR • Director of Workforce
Technology	• Rapid roll out of MS Teams • Expansion of VPN capacity • Rapid expansion of virtual clinics • Additional hardware distribution • Rapid evolution of reporting solutions • Availability of communication tools for patients and families	• Different platforms used by different organisations hampered multidisciplinary working • Unintended consequences e.g. Attend Anywhere resulting in additional admin processes	• Maintain use of MS Teams • Support home working • Review transformational change as part of learning exercise	• Chief Information Office • Director of Workforce • Director of Transformation
Decision Making	• Clear leadership • Increased autonomy • Streamlining processes	• Lack of clarity around the meaning of “command and control” • Reasonable use of command and control	• Development of decision making flowchart and feedback process	• Chief Operating Officer • Director of Strategy and Planning

		• Mechanism for decisions to be challenged and reversed • The need for clear escalation triggers • Finding the balance of autonomy • Making new processes business as usual	• Development of Escalation Triggers Dashboard • Review changes to processes (e.g. streamlining recruitment checks)	• Director of Workforce
Culture	• The WWL family • Support to work together • Psychological support	• Link with decision making and the inappropriate use of “command and control” • Lack of civility in staff interaction • Listening to experts and taking their advice	• Maintain psychological support • Commence civility and psychological Safety project	• Director of Workforce
Equipment	• Mutual support across GM	• Wider understanding of logistical and equipment capabilities • Lack of up to date local asset registers	• Understand fundamental constraints to critical services • Establishment of local up to date asset register • Include learning in major incident plan	• Director of Strategy and Planning • Chief Operating Officer
Infection Prevention and Control	• PPE central store and direct procurement • Mutual support across GM	• Hospital associated Covid • PPE • Asymptomatic Testing • Rapidly changing guidance making communication difficult	• Complete actions in IPC BAF	• Chief Nurse (DIPC)
Patient Experience		• More information needed for patients • Impact of additional moves as a result of ward classification	• Increase material available to patients • Include escalation plan in major incident plan	• Chief Nurse (DIPC) • Chief Operating Officer

Data	• Rapid evolution of reporting by BI	• Absence of accurate workforce data hampered management and reporting • No central data reporting area for information	• Improved use of E-roster • Development of BI dashboard	• Director of Workforce • Chief Information Officer
Resilience		• Impact of second peak on workforce • Solutions for staff who are high risk or shielding • Maintain and step up services according to latest guidance	• Continued psychological support to staff • Shielded staff skills audit •	• Director of Workforce • Chief Operating Officer • Director of Strategy and planning
Testing	• Testing team at Leigh for staff and elective patients	• Testing for inpatients at 7 days • Impact of asymptomatic staff testing	• Finalise plan for all patient and staff testing	• Chief Operating Officer • Director of Workforce

Conclusions and Recommendations

It is clear that the organisation responded rapidly and, in many regards, successfully to the Covid-19 pandemic with swift action taken to respond to a rapidly evolving rising tide incident. The business continuity and incident plans in place provided a solid base to work from but did not go far enough in practical terms nor could they have predicted the raft of ever changing guidance, constraints and direction of an NHS England declared Level 4 incident. There are many opportunities to learn and improve plans as well as maintain many of the transformational changes made and it is vital that this opportunity is not lost.

It is recognised that many of the actions above are already in train but it is important that they are captured and monitored in one place so that the learning opportunities are not lost. It is recommended that the overall action plan is managed through the Management Board with a regular update to the Board. There is a substantial amount of learning to be incorporated into both the pandemic plan and the major incident plan and these will be updated and signed off through the normal processes.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

REPORT

AGENDA ITEM: 11

To	Board of Directors	**Date:**	24 June 2020
Subject:	Month 2 Finance Report		
Presented by:	Acting Chief Finance Officer	**Purpose:**	For Approval

Executive summary

It is recommended that the Board notes the month 2 financial position, as reported to NHSI, and approves the change to Standing Financial Instructions in respect of the approval process for capital business cases as outlined within the report.

Risks associated with this report

None

Link(s) to The WWL Way 4wards

☐	Patients	☒	Performance
☐	People	☐	Partnerships

The WWL Way

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Finance Report

Month 2 ending 31st May 2020

The WWL Way

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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	35,790			70,798		
Expenditure	(34,721)			(68,725)		
Financial Performance	0			0		
Cash Balance	64,738			64,738		
Capital Spend	2,109			9,145		

Key Messages:

- NHSI/E have been very clear to NHS organisations that financial governance must remain during the Covid pandemic. Informing the Public of the Trust's financial position is part of our governance and assurance process and as such the Financial Board Report will continue to be produced and issued.

- National operational planning was suspended mid-March therefore the Trust does not have a budget approved by NHSI.

- The Trust is reporting a break even position in Month 2 and year to date. This is as per the instruction from NHSI due to the block funding and financial arrangements in place during the Covid pandemic.

- Cash is £64.7m at the end of Month 2.

- Capital spend is £9.1m year to date. This includes £5.9m on COVID-19 associated projects which will be fully reimbursed via non-interest bearing PDC.

- The Board is asked to approve a change to the Standing Financial Instructions, the Chair of Audit Committee is aware of these changes and is in support. The change relates to business cases. As per NHSI guidance revenue only non-COVID business cases are temporarily suspended (exceptional circumstances may be considered). Business cases are still required before the Trust commits to capital expenditure.

    - Business as usual capital spend e.g. minor Estates works pre-approved via the capital setting process
    - Strategic and capital schemes with revenue implications, approval route:
        - Up to £500k Executive Team Meeting
        - £500k to £1,000k Finance & Performance
        - Over £1,000k Trust Board

REPORT

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

AGENDA ITEM: 11

To:	Board of Directors	**Date:**	24 June 2020
Subject:	Register of referrals received by the Clinical Ethics Group		
Presented by:	Director of Corporate Affairs	**Purpose:**	Information

Executive summary

It was agreed at the Pandemic Assurance Committee on 13 May 2020 that a high-level summary of cases referred to the Clinical Ethics Group would be reported to the board each month. The attached table summarises the referrals that have been received from the group since the last board meeting.

The board will also wish to note that the membership of the group has been extended to include a representative of the foundation trust's Chaplaincy and Spiritual Care service, Revd Canon Anne Edwards, to ensure the holistic consideration of matters under the group's purview.

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

Register of referrals made to the Clinical Ethics Group
20 May to 19 June 2020

Ref.	Date of referral	Time of referral	Urgent or routine referral	Date CEG convened	Time CEG convened	Summary of case	CEG recommendation	Issues escalated to management
CEG-003	3 Jun 2020	N/A	Retrospective for assurance	4 Jun 2020	0800hrs	Request to consider the use of best interests around antibody testing for patients without the capacity to consent	Matter referred to Executive Scrutiny Group with feedback from the Clinical Ethics Group	To be considered by Executive Scrutiny Group