# Board of Directors

**25 March 2020, 13:00 to 15:30**
**Online meeting**

## Agenda

**1**
### Chair and quorum

Information

Robert Armstrong

**2**
### Apologies for absence

Information

Robert Armstrong

**3**
### Declarations of interest

Information

Robert Armstrong

**4**
### Minutes of previous meeting

Approval

Robert Armstrong

Minutes - P1 Board - Jan 2020.pdf (10 pages)

**5**
### Ratification of decisions taken under emergency powers

Ratification

Robert Armstrong

BC1920-011a Exercise of emergency powers.pdf (1 pages)

Exercise of emergency powers -community ward.pdf (2 pages)

**6**
### Committee chairs' reports

Information

Committee chairs

**7**
### Update on COVID-19 response

Discussion

Silas Nicholls and executive team

**7.1**
### Briefing note - contingency ward

Information

Richard Mundon

Contingency Ward - briefing note.pdf (4 pages)

**7.1.1**
**COVID-19 schedule to Standing Financial Instructions**

Approval

Paul Howard

COVID-19 schedule to SFIs.pdf (3 pages)

## 8
## Approval of 2020/21 budget and confirmation of efficiency target

Approval

Rob Forster/Ged Murphy

## 9
## Future proofing of community ward - REDACTED DUE TO COMMERCIAL SENSITIVITY

Decision

Richard Mundon

Additional community ward - Trust Board paper.pdf (8 pages)

## 10
## COVID-19 risk appetite statement

Approval

Richard Mundon

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

## 11
## International recruitment update

Decision

Rob Forster

GTEC Covid-19 Escalation TB 25-3-20.pdf (6 pages)

## 12
## Consent agenda

### 12.1
### Standing Orders for the Board of Directors

Approval

Draft SOs 2020.pdf (15 pages)

Additional section to be inserted into Standing Orders.pdf (1 pages)

### 12.2
### Revised Standing Financial Instructions

Approval

Changes to SFIs.pdf (3 pages)

### 12.3
### Operational plan 2020/21

*Authority to delegate final approval to the Chief Executive and Chief Finance Officer may be requested if necessary*

Approval

draft WWL Operational Plan 2020-21v6.pdf (34 pages)

IMPORTANT AND URGENT NEXT STEPS ON NHS RESPONSE TO COVID-19 Final (005).pdf (17 pages)

### 12.4
### Gender pay gap report

Approval

Gender pay gap report.pdf (7 pages)

### 12.5
### Performance report

Information

Performance report.pdf (12 pages)

### 12.6
### Finance report and year-end position, including CHIP

Information

Private finance report.pdf (23 pages)

CHIP report.pdf (23 pages)

**12.7**

## Safe staffing report

Information

Safe staffing report.pdf (19 pages)

**12.8**

## Register of use of the common seal

Information

Use of common seal.pdf (3 pages)

**12.9**

## Appointment of temporary Executive Director

Paul Howard

Appointment of temporary Executive Director.pdf (1 pages)

**13**

## Date, time and venue of next meeting

27 May 2020, 12 noon, Royal Albert Edward Infirmary

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

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

**HELD ON 29 JANUARY 2020, 12.00 NOON**

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

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**Part 1**

**Members' attendance record:**

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

**In attendance:**

| | |
|---|---|
| Mr P Howard | Company Secretary (minutes) |
| Mr S Talwalker | Divisional Medical Director for Specialist Services |
| Dr A Twist | Divisional Medical Director for Surgery |
| Mrs A Luxon | Deputy Chief Nurse (for item 5/20 only) |

1 member of the public and 6 governors were also in attendance.

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**1/20 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.

**2/20 Apologies for absence**

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

**3/20 Declarations of interest**

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

**4/20 Minutes of the previous meeting**

The minutes of the previous meeting held on 27 November 2019 were **APPROVED** as a true and accurate record.

**5/20 Patient story**

A 20-year-old patient, supported by her parents, joined the meeting to share her experiences of the care provided by the foundation trust. The patient had been diagnosed with anorexia nervosa at the age of 16 and had presented at the Accident and Emergency Department in crisis in September 2019. The Board heard examples of excellent care that had been provided and the pivotal role that individual members of staff had played in her treatment but also heard examples of poor communication across the various departments and organisations involved in her care and examples which showed a poor understanding of the patient's underlying medical condition.

The Chair thanked the patient and her family for coming to the meeting and apologised on behalf of the foundation trust for the examples of sub-optimal care that had been described.

The Director of Workforce noted the move towards IT-based systems within the hospital and cautioned of the need to be alert to the fact that this should not negatively impact on the interaction between clinicians and patients and between departments within the hospital. The Chief Nurse supported this view and expressed her own disappointment at the lack of compassion that had been described during the patient's story. She assured the family that she would take steps to ensure that learning from the incident is shared across the organisation.

The Deputy Chief Nurse commented that the impact of the patient's experience is likely something that all can relate to and advised of the recent launch of a new training package which focuses on the mental health needs of children and young people. The We Can Talk programme, endorsed by Health Education England, was in the process of being rolled out to all clinical areas of the organisation with a view to ensuring staff feel comfortable in talking to patients about their mental health.

The Board received the report and noted the content.

*The Deputy Chief Nurse, the patient and her family left the meeting.*

**6/20 Staff story**

The Director of Workforce introduced a member of staff who had attended the meeting to share his experiences of being incorrectly identified following a patient complaint. She noted that undertaking better fact finding at the start of the process would have quickly eliminated the staff member from consideration but that, because this had not happened, he had been suspended from duty for 14 weeks before the investigation had concluded there was no case to answer. The Director of Workforce noted that this had caused significant psychological harm to the staff member concerned and commented that whilst there is an obligation for NHS bodies to comply with the duty of candour when harm is caused to patients, that obligation does not extend to instances where harm is caused to members of staff. She assured the Board that work had been undertaken following this incident to address the issues identified, including implementing the recommendations of NHS England's Fair Experience for All guidance.

The member of staff acknowledged the support he had received from the foundation trust's Freedom to Speak Up Guardian throughout the process and described the process of being advised of the allegations against him without any support being offered. He noted that there were many clues in the initial patient complaint that he was not the individual to whom the complaint related and described the impact that the allegations had had on him and his family.

The member of staff praised his line manager for the support she had provided to him throughout the process. He noted that he had requested an apology from the foundation trust once the investigation process had concluded and expressed concern that his line manager had been told that she would have to write any apology. He reminded the Board of the support he had received from her and highlighted the fact that any such apology would have been meaningless as it would not have been authentic.

The member of staff subsequently resigned and went to work as a Senior Clinical Advisor with the ambulance service. There he had received substantial support to deal with his underlying psychological injury and had returned to the foundation trust following intervention by the Director of Workforce and the Freedom to Speak Up Guardian. He concluded his comments by describing his desire for the organisation to learn from the incident and to ensure that no-one else has to have a similar experience in the future.

The Chair apologised on behalf of the foundation trust and noted the importance of ensuring that everyone involved in such processes is treated fairly and with humanity. He also thanked him for coming to the meeting to share his experiences.

*The member of staff left the meeting.*

**7/20 Chair and Chief Executive's report**

The Chief Executive referred the Board to his written report which had been circulated with the agenda to highlight a number of key issues for consideration. He drew particular attention to the fact that the draft CQC report had been received following the inspection in November 2019 and noted the inclusion of an initial feedback letter later on the agenda, which was currently subject to the usual factual accuracy checks.

The Chief Executive also briefed the Board on revised communication arrangements that had been implemented within the organisation, with a new Leaders' Forum having been introduced on a monthly basis. He noted the success of the first meeting and the intention to look to live streaming the sessions in the future to facilitate remote access. A standing invitation was issued to any Non-Executive Directors who may wish to attend the sessions.

The Chief Executive also took the opportunity to congratulate the Director of Finance on his recent appointment as Deputy Chief Executive and Chief Finance Officer at Liverpool University Hospitals NHS Foundation Trust. Whilst this meeting would not be his last, he nonetheless took the opportunity to acknowledge his work and the Chair commented on the strength of relationships that have been built across the borough.

The Board received the report and noted the content.

**8/20 Committee chairs' reports and the Board Assurance Framework**

***Patients***

Prof T Warne opened by providing a summary of business transacted at the Quality and Safety Committee meeting on 15 January 2020. He confirmed that the committee had been satisfied that the risk surrounding syringe drivers, as escalated to the Board at its last meeting, had been suitably mitigated and the risk score had reduced as a result. He also noted that the committee had sought assurances around any potential impact on patients as a result of the national reduction in availability of stock and had received positive assurances that there had not been a significant impact. The committee had also received assurances around lessons learnt following an earlier never event.

Prof T Warne noted that the committee had considered the matter of whether to continue to report data relating to the safety thermometer and confirmed that many organisations had taken the decision to stop making submissions. Confirmation was provided that an in-house alternative was available and regularly used. In response to a question from the Chief Operating Officer, the Chief Nurse noted that benchmarking data is provided through the roll out of Perfect Ward software and that this is planned to be adopted by the majority of organisations across the north. On the recommendation of the Quality and Safety Committee, the Board **APPROVED** the cessation of data submissions to the Safety Thermometer programme.

An amber delivery confidence on the board assurance framework for patients had been recommended.

***People***

Mrs L Lobley summarised the business conducted at the Workforce Committee meeting on 5 December 2019 and noted that the meeting had been themed around "learn and grow". The committee had been pleased to noted that planned recruitment of registered nurses was significantly ahead of trajectory and had asked one if its reporting groups to seek assurance around junior doctor training. An amber-red delivery confidence on the board assurance framework for people had been recommended.

***Performance***

Mr M Guymer outlined the business of the Finance and Performance Committee meeting which had met on 22 January 2020 and noted that a number of risks had been discussed. He advised that a two-part approach to the meeting had been adopted, with a separate section of the meeting dedicated to discussions around the organisation's financial position. The committee had recommended a red delivery confidence on the board assurance framework for performance.

***Partnerships***

The board assurance framework for partnerships had been circulated with the agenda and the Chair noted the recommendation of the Director of Strategy and Planning that an amber-red delivery confidence be agreed.

The Board received the verbal updates and accepted the recommendations surrounding the board assurance frameworks.

**9/20 Performance report**

The Chief Nurse opened this item by noting that two key areas of poor performance – namely hospital-acquired pressure ulcers and *C. difficile* – were subject to separate assurance reports later on the agenda. She also expressed some concern around the patient experience metric in the dashboard but confirmed that work was ongoing to improve the metric following agreement by the executive team.

The Chief Operating Officer summarised the operational metrics within the report and noted that December 2019 had been a challenging month in terms of the A&E 4-hour wait standard, although she reminded the Board that the foundation trust was still performing will in comparison with other Greater Manchester organisations. She also confirmed that 36 patients had breached the 12-hour wait from decision to admit standard in December, but noted that some of these had been the result of considered clinical decisions to prioritise other patients on the basis of need. She noted that work was ongoing across the borough to review reasons for delayed discharges and confirmed that daily system-wide teleconferences are taking place. She noted that clinical safety remains the key priority and noted the requirement for additional beds in order for the situation to substantively improve.

The Chief Executive noted the intention to construct a community unit and iterated the need for it to be operational in time for winter. He also noted that he had been

appointed as the lead Chief Executive for urgent care planning in Greater Manchester and the need to explore alternatives to A&E was acknowledged.

With regard to the coronavirus currently in other countries, the Chief Executive confirmed that there had been no confirmed cases in the United Kingdom to date and that appropriate advice on the management of symptomatic patients had been received from Public Health England. He confirmed that the organisation would be reviewing its pandemic influenza plans, as a similar approach would be taken to the management of this new virus.

The Board received the report and noted the content.

**10/20 Finance report**

The Director of Finance presented a report which had been circulated with the agenda and noted that a surplus of 1.3m had been achieved as at 31 December 2019, which was ahead of plan and allowed the organisation to achieve the quarter target which had been more challenging than originally anticipated, particularly as a result of national pensions tax changes. He noted that achievement of this quarter target had released £2.3m in provider sustainability funding. With regard to the overall year-to-date surplus, the Director of Finance advised that the reported position was significantly ahead of plan but that this included £7.9m of transferred assets from community services. As a result, the underlying position was one of a £10.3m deficit which was on target. He drew the Board's attention to the fact that the Service and Value Improvement programme was £1.7m adverse to plan and that agency expenditure remains high, with £700k having been transacted in-month. With regard to capital expenditure, the Director of Finance confirmed that it was likely that all planned expenditure would be incurred before year-end as planned.

The Chair reminded the Board that the discussions around the underlying deficit remain key to the organisation's long-term financial stability and thanked the executive team for their work to date.

The Board received the report and noted the content.

**11/20 Safe staffing report**

The Chief Nurse presented the regular safe staffing report for the Board's review and drew directors' particular attention to the executive summary which outlined the key items of note. She reminded the Board that the purpose of the report is to compare staffing levels against establishment and that the increased number of staff overall was related to the requirement to staff additional areas, such as corridors and escalation areas, and to support areas of high acuity. Notwithstanding the increased staffing, she noted that registered nurse staffing had been lower than establishment and that the care hours per patient day remained below the national average for registered staff, and above the national average for unregistered staff. She reminded the Board of the

intention to have no registered nurse vacancies by September 2020 and confirmed that performance was currently ahead of trajectory.

The Board received the report and noted the content.

**12/20 Biannual staffing review**

The Chief Nurse presented a report which had been circulated with the agenda to provide assurance of the ongoing monitoring and review of adult inpatient staffing establishments and to recommend any changes to these establishments. She noted that the recommendations formed a priority within the workforce plan which would be presented later in the agenda.

The Chief Nurse noted that the Royal College of Nurses' recommendation is a staffing model of 65%/35% registered to non-registered staff in inpatient areas, with this increasing to 70%/30% for assessment areas. She reminded the Board that it had previously agreed a minimum standard of 55% registered and 45% non-registered staff but advised that a number of ward areas had deviated from this standard; particularly in medicine and the unscheduled care directorate. She further noted that the Safer Nursing Care Tool indicated an increase in patient acuity which would also require an increased establishment in order to provide appropriate levels of care. In response to a question from Mr M Guymer, the Chief Nurse advised that it was unclear how the budgets had been allowed to deteriorate from the previously-determined levels but noted that efforts had been made to correct this after identification.

The Board received the report and noted the content.

**13/20 Workforce plan**

The Director of Workforce presented a report which had been circulated with the agenda to set out the workforce plan prioritisation process outputs and to recommend a number of changes through a phased approach. The Chief Executive confirmed that the executive team recommends the immediate approval of phase 1(a) as shown in the report.

In response to a question from Prof C Austin, the Director of Workforce confirmed that one of the key elements of the people plan would be the credentialing and accreditation of non-medical staff to fill medical role.

The Chair sought assurance, if a new standard is approved, that there would not be any further dilution and the Chief Nurse advised that analysis would be included in each safe staffing report to allow for oversight and scrutiny. Mr M Guymer commented that safeguards also need to be built into approval processes to ensure professional input as well as budgetary approvals. The Chair also noted the need for the Board to be confident that, if approved, the new posts could actually be recruited to. In response, the Chief Nurse reminded the Board of performance against the current recruitment trajectory and expressed confidence that all posts could be filled. The Director of Workforce commented that retention of staff is just as important as recruitment and confirmed that this would be addressed as part of the people plan.

In response to a question from Mr M Guymer, the Chief Executive confirmed that the Board was being asked to approve the first £3.37m of additional staffing, shown as phase 1(a) in the report.

Following discussion, the Board **APPROVED** the immediate implementation of phase 1(a) as shown in the report.

**14/20 Committee arrangements**

The Company Secretary presented a report which had been circulated with the agenda to summarise the proposed revisions to the committee structure with effect from 1 April 2020, as previously discussed with the Board at its away day.

The Board ENDORSED the content of the report.

**15/20 Update on the effectiveness of plans relating to pressure ulcers, SHMI and *C. difficile***

Assurance reports relating to the three key areas of pressure ulcers, SHMI and C. difficile had been circulated with the agenda and the Chair noted that much of the content had been covered during discussions earlier in the meeting. The Board noted the executive team's plan to facilitate a comprehensive deep clean programme through decant arrangements later in the year and endorsed the approach.

The Board received the reports and noted the content.

**16/20 Mortality**

The Medical Director presented a report which had been circulated with the agenda to summarise mortality in respect of Q2 2019/20, as recommended by national Learning from Deaths guidance.

The Board received the report and noted the content.

**17/20 CQC letter**

The Board received the initial feedback letter from the Care Quality Commission following the well-led inspection undertaken in November 2019 which had been circulated with the agenda and noted the content.

**18/20 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 proposed amendment to the Foundation Trust's constitution be **APPROVED** with effect from 1 April 2020;

2. THAT the risk appetite statement for FY2020/21 and the remainder of FY2019/20 be **APPROVED**;

3. THAT the Inclusion and Diversity Annual Report 2018/19 be received and noted;

4. THAT the 7-day service assurance report be **APPROVED**; and

5. THAT the statement of responsibilities within the foundation trust be **APPROVED**.

**19/20 Questions from the public**

No questions were received from the public.

**20/20 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.

**21/20 Date time and venue of the next meeting**

The next meeting of the Board of Directors will be held on 25 March 2020, 1.00pm at Royal Albert Edward Infirmary, Wigan Lane, Wigan, WN1 2NN.

# Action log

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

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

**("the Foundation Trust")**

# EXERCISE OF EMERGENCY POWERS

**BACKGROUND**

A. The Foundation Trust's Standing Orders for the Board of Directors provide that the Chairman and Chief Executive may, having consulted at least two Non-Executive Directors, exercise any powers that the Board has reserved to itself.

B. On 4 March 2020, the Chairman and Chief Executive consulted with Mr Ian Haythornthwaite, Mrs Lynne Lobley and Prof Tony Warne in relation to the proposed resolution shown below and all confirmed their support for the resolution.

C. The resolution relates to increased costs for groundworks associated with business case ref. 1920-011(a) which was approved by the Board of Directors on 27 November 2019 (minute reference 196/19 refers). The business case had originally been prepared on the basis of estimated costs and the additional costs became known following inspection of the site.

D. Consideration was given to deferring the decision to the next meeting of the Board of Directors. This was discounted as it would have resulted in significant delay to the project with a likelihood that the development would not be available in time to support the Foundation Trust during the accepted period of winter pressures. The possibility of convening an extraordinary meeting of the Board of Directors was similarly discounted.

**RESOLUTION**

In accordance with the powers granted to them through Standing Orders, the Chairman and Chief Executive RESOLVED THAT the approved level of expenditure in relation to business case ref. 1920-011(a) be increased by £750k to £6.094m as a result of increased costs for groundworks.

**Company Secretary**

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

**("the Foundation Trust")**

# EXERCISE OF EMERGENCY POWERS

**BACKGROUND**

A. The Foundation Trust's Standing Orders for the Board of Directors provide that the Chairman and Chief Executive may, having consulted at least two Non-Executive Directors, exercise any powers that the Board has reserved to itself.

B. On 18 March 2020, the Chairman and Chief Executive consulted with Lady Rhona Bradley, Dr Steven Elliot, Mr Mick Guymer, Mrs Lynne Lobley and Prof Tony Warne in relation to the proposed resolutions shown below and all confirmed their support for the resolution.

C. The resolutions relate to the purchase, transportation, construction and operationalisation of a contingency ward on the Royal Albert Edward Infirmary site in order to provide additional capacity to support the management of patients during the COVID-19 pandemic.

D. Under normal circumstances, planning permission would have been sought for this development. Given the urgency and the national approach to day-to-day operations, this development will proceed at risk and planning permission will be sought retrospectively if required. The risk associated with this has been partially mitigated through discussion with the Chief Executive of Wigan Borough Council.

E. Due to the urgency and the temporary nature of the facility, it is not possible to comply fully with healthcare building standards within the necessary timescales. Notwithstanding, the facility will comply with all clinical, patient care, infection control and health and safety standards.

F. Estimated capital costs of the development are expected to be in the region of £5m, to include equipment and VAT. Initially this will be funded from our own capital resources however there is a degree of confidence that this will be reimbursed at a later date. More detailed capital costs and an update on progress will be reported to the next meeting of the Board of Directors.

G. Ongoing revenue costs will be clarified in due course and will form part of the Foundation Trust's response to COVID-19.

H. Consideration was given to deferring the decision to the next meeting of the Board of Directors. This was discounted as there was an urgent requirement to secure contractor availability and to expedite construction in order to be in a position to meet the predicted surge in cases. The possibility of convening an extraordinary meeting of the Board of Directors was discounted for the same reason.

**RESOLUTIONS**

In accordance with the powers granted to them through Standing Orders, the Chairman and Chief Executive RESOLVED AS FOLLOWS:

1. THAT a temporary facility be established on the Royal Albert Edward Infirmary site to provide additional capacity to support the management of patients during the COVID-19 pandemic; and
2. THAT capital expenditure of £5m be APPROVED to fund the development, with a contingency allocation of additional £500k.

**Company Secretary**

Wrightington, Wigan and Leigh NHS Foundation Trust

**Trust Board – Briefing note**

**Additional contingency ward**

## 1.0 Introduction

This paper has been written to give an overview on the development of the new contingency ward which has been procured as part of the COVID-19 outbreak.

Members of the Trust Board are asked to note the contents of the paper.

## 2.0 Background

In accordance with the emergency powers granted to them through Standing Orders, the Chairman and Chief Executive RESOLVED AS FOLLOWS:

- THAT a temporary facility be established on the Royal Albert Edward Infirmary site to provide additional capacity to support the management of patients during the COVID-19 pandemic; and
- THAT capital expenditure of £5m be APPROVED to fund the development, with a contingency allocation of additional £500k.

## 3.0 Ward

The ward development is required to support the anticipated COVID-19 outbreak. The ward will have 52 beds in the layout of a field hospital (see appendix A) and has been commissioned on the basis of getting as much bed capacity as possible onto the site as quickly as possible. The ward will be situated in front of cancer care unit, on the car park adjacent to Wigan Lane.

## 4.0 Update

- Contractor – the planning team approached Darwins Group, the contractor for the community ward development. They have been appointed and the site will be available for them on Monday 23rd March. Car parking on the RAEI site will reduce as a result of this action.
- Design – the design has been signed off from colleagues in clinical teams, nursing, infection control, estates and facilities, fire and operational colleagues. The unit has been specifically designed to ensure that patients with COVID – 19 could be managed in this area and, as such, will have piped oxygen, suction and some medical air provision (for a min of 14 patients, though discussion are continuing about increasing this number to 28.)

- Planning permission – Wigan Borough Council have been made aware of the requirement to develop the space and, as such given the current circumstances, planning permission is not a requirement.
- Equipment – the procurement of the equipment for the unit has commenced, with a view to ensuring that there is no delay on the unit being made available to the Trust upon completion of the building.
- Timetable – we are looking to have the ward fully operational by 1st May. This is constantly being reviewed by the planning team, with a view to getting the unit operational sooner.
- Cost – the cost noted below is an estimate and will be subject to review and possible increase:

| | | |
|---|---|---|
| - | Building contract | - £3.49 million |
| - | Equipment | - £500,000 (estimated) |
| - | Risk | - £250,000 (to accommodate unforeseen changes) |
| - | Service connections | - £200,000 (estimated) |

Net cost £4,444,500
VAT £888,900
Total cost £5,333,400

It must be stressed that this development has moved from concept to commencement of construction in 72 hours, and on that basis, the costs noted above are estimates at the current time. Though to give some assurance the total cost of the ward currently equates to £4,674 per $m^2$ which represents good value for money in today's market place.

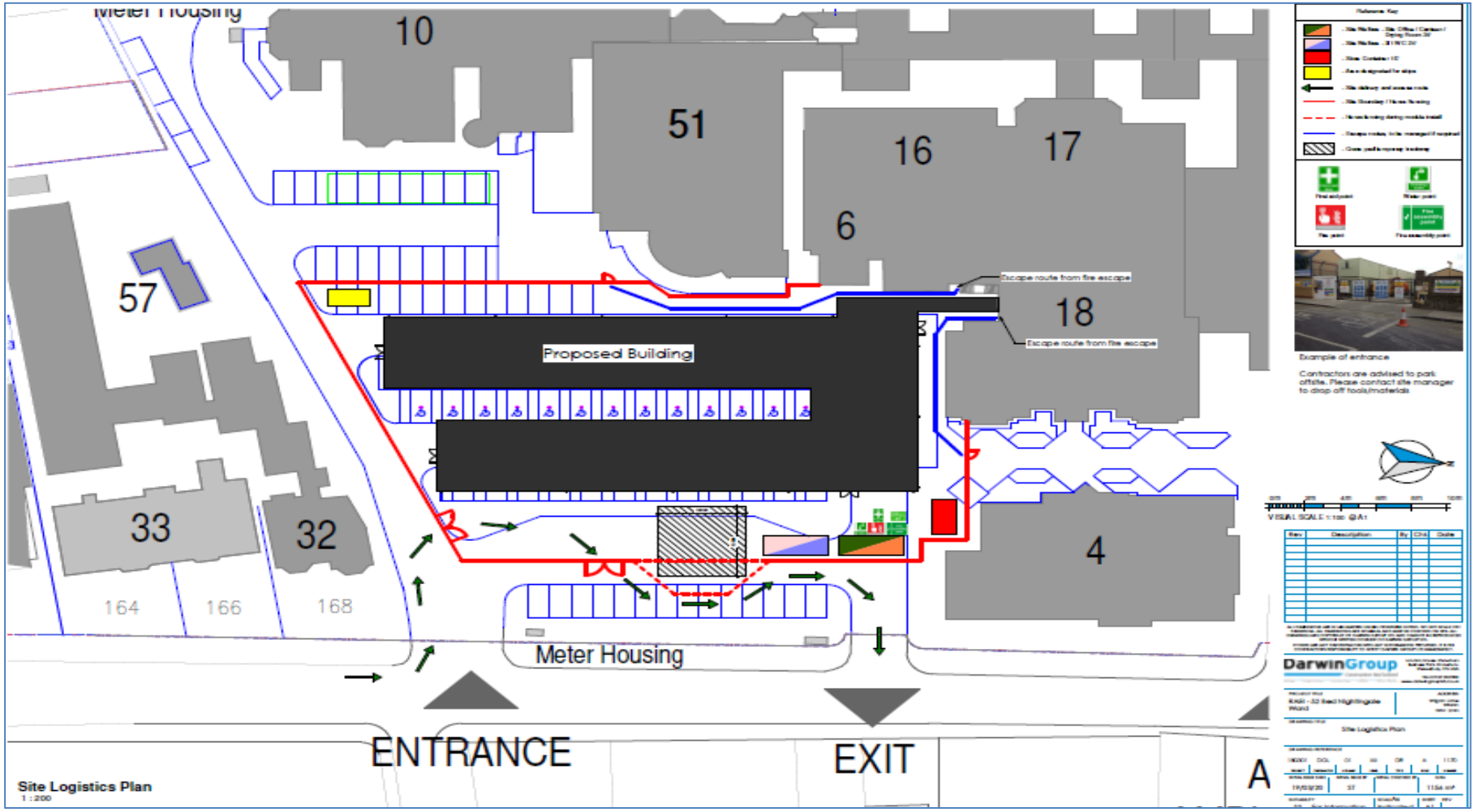
**5.0 Conclusion**

Members of the Trust Board are asked to note the progress of this development.

Chris Knights
Deputy Director of Strategy and Planning
March 2020

See appendix a – additional ward development

Appendix B – Site



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

**("the Foundation Trust")**

# COVID-19 SCHEDULE TO STANDING FINANCIAL INSTRUCTIONS

## Application of this Schedule

This Schedule was approved by the Board of Directors of Wrightington, Wigan and Leigh NHS Foundation Trust ("Board") at its meeting on 25 March 2020. [The Board has agreed that it shall have retrospective application to [ ] 2020.]

This Schedule shall remain in force until the earlier of the following:

(a) the date that the Board passes a resolution, or which is otherwise specified within such a resolution, to amend or rescind this Schedule; or

(b) the date of expiry, repeal or other bringing to an end of the Coronavirus Act 2020.

## Interpretation

As of 1 April 2020, references to "Wrightington, Wigan and Leigh NHS Foundation Trust" shall be taken to read "Wrightington, Wigan and Leigh Teaching Hospital NHS Foundation Trust".

"Standing Financial Instructions" means the Standing Financial Instructions approved by the Board as may be amended from time to time.

References to individual post holders shall be taken to include those who are formally appointed to act up into these roles as a result of the substantive post holder's incapacity or other extended unavailability. In the event of any doubt, the Chief Executive or his/her nominated deputy shall be the final arbiter on whether an individual has been so appointed.

## General statement of intent

In operating this Schedule, the Board will seek to comply wherever possible with, but shall not be bound by, extant guidance from NHS England and NHS Improvement relating to COVID-19 and guidance issued by the Cabinet Office.

The Board will seek reimbursement of any expenditure incurred as a result of dealing with COIVID-19 in line with processes put in place by the relevant national bodies, however it recognises that such reimbursement is not guaranteed.

**Effect of this Schedule**

During the period of its operation, this Schedule shall have the effect of varying Standing Financial Instructions as set out below:

1. SFI 3.7 (emergency expenditure) be amended to read:

   "In instances which are deemed as critical, an executive director can approve unbudgeted revenue up to a value of £50,000 (per instance). The Chief Executive can approve unbudgeted revenue up to a value of £100,000 (per instance) and, with the additional agreement of the Chair, up to £500,000 (per instance). Applications for such expenditure must be endorsed by the Chief Finance Officer or, in his/her absence, the Deputy Chief Finance Officer. Expenditure in excess of £500,000 must be authorised in line with the emergency powers set out in the Board's Standing Orders."

2. 7.3 (competitive quotations) be amended to read:

   "Competitive quotations are not required where the intended expenditure is directly related to COVID-19 and is less than £100,000 exclusive of VAT. Competitive quotations are required where the intended expenditure is directly related to COVID-19 and is equal to, or is reasonably expected to exceed £100,000 but does not exceed the relevant European Union threshold, exclusive of VAT. The final determination of whether the expenditure is directly related to COVID-19 shall rest with the executive director responsible for the procuring department."

3. SFI 7.6 (authorisation of waivers) be amended to read:

   "Where competitive tendering is to be waived on the grounds that the expenditure is directly related to COVID-19, the authorisation limits stipulated are as follows:

| Amount | Authorisation |
|---|---|
| Less than £100,000 excl. VAT | No waiver required |
| £100,000 to EU threshold excl. VAT | Deputy Chief Finance Officer |
| Over EU threshold excl. VAT | Chief Finance Officer |

4. SFI 7.14.3 (signing of contracts) be amended to read:

   "Contracts should be approved as follows, regardless of whether they are subject to NHS terms and conditions or not:

| Amount | Contract on NHS T&Cs |
|---|---|
| Less than £50,000 excl. VAT | Head of Procurement |
| £50,000 to EU threshold excl. VAT | Deputy Chief Finance Officer |
| Over EU threshold excl. VAT | Chief Finance Officer |

5. The table in SFI 8.2 (authorisation levels for approval of purchase orders) be amended to read:

| Approval level | Posts | Limit |
|---|---|---|
| 1. | Chief Executive/Deputy Chief Executive/Chief Finance Officer | £2,000,000 |
| 2. | Deputy Chief Finance Officer | £1,000,000 |
| 3. | Executive Director | £500,000 |
| 4. | Associate Director/Deputy Director | £250,000 |
| 5. | Head of Department or Service | £50,000 |
| 6. | Deputy Head of Department or Service | £25,000 |
| 7. | Senior Department or Service Manager | £10,000 |
| 8. | Department/Service Manager | £5,000 |
| 9. | Department/Service Approver | 2,500 |
| 10. | Requestor only | Nil |

6. SFIs 8.2.7 (calculation of revenue contract values) and 8.2.8 (calculation of capital contract values) be amended so as to be in line with amendment number 2 above.

7. SFI 11.3 (staff appointments) be amended to read:

"No Director or employee may engage, re-engage or re-grade employees in response to the COVID-19 pandemic, either on a permanent or temporary basis, or hire agency staff, or agree to changes in any aspect of remuneration, unless authorised to do so by the Trust Command and Control Group."

# REPORT

**AGENDA ITEM: 10**

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **To:** | Board of Directors | **Date:** | 25 March 2020 |
| **Subject:** | COVID-19 risk appetite statement | | |
| **Presented by:** | Company Secretary | **Purpose:** | Approval |

## Executive summary

At its last meeting, the Board approved a risk appetite statement for the remainder of the current financial year and for FY2020/21. Like many other countries around the world, the United Kingdom has now been affected by the COVID-19 pandemic and business as usual operations have effectively ceased across the sector as we strive to deal with this issue.

The Prime Minister has recently described his government as being on a "wartime footing". In a similar way, the Foundation Trust is operating on a command and control basis. Risks that would not be acceptable to the organisation under normal operating conditions are now having to be taken and decision-making is based upon well-established triage principles of doing the greatest good for the greatest number.

The Board is therefore requested to agree an updated risk appetite statement for use during the COVID-19 pandemic. Given the close proximity to the change, our new organisational name has been used in formulating this updated statement.

## Risks associated with this report

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

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

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

The WWL Way

# 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.<br>We have a **MODERATE** appetite for risks that may compromise the delivery of outcomes without compromising the quality of care.<br>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.<br>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.<br>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**<br>*"Avoidance of risk and uncertainty is a key organisational objective"* | **MINIMAL**<br>*"Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential"* | **CAUTIOUS**<br>*"Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward"* | **OPEN**<br>*"Willing to consider all potential delivery options and choose whilst also providing an acceptable level of reward and VfM"* | **SEEK**<br>*"Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)."* | **MATURE**<br>*"Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust"* |
| **Quality, innovation and outcomes** | Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision-taking authority. General avoidance of systems/technology development. | Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems/technology development to protect current operations. | Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems/technology developments limited to protection of current operations. | Innovation supported, with demonstration of commensurate improvements in management control. Systems/technology developments used routinely to enable operational delivery. Responsibility for non-critical decisions may be devolved. | Innovation pursued – desire to "break the mould" and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control. | Innovation the priority – consistently "breaking the mould" and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice. |
| **Financial/ Value for Money (VfM)** | Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern. | Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern. | Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments. | Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities. | Investing for the best possible return and accept the possibility of financial loss (with controls in place). Resources allocated without firm guarantee of return – "investment capital" type approach. | Consistently focused on the best possible return for stakeholders. Resources allocated in "social capital" with confidence that process is a return in itself. |
| **Compliance and regulatory** | Play safe, avoid anything which could be challenged, even unsuccessfully. | Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliance. | Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge. | Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences. | Chances of losing any challenge are real and consequences would be significant. A win would be a great coup. | Consistently pushing back on regulatory burden. Front foot approach informs better regulation. |
| **Reputation** | No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern. | Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention. | Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest. | Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation. | Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation. | Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks. |

*(Acknowledgement: Good Governance Institute)*

# REPORT

**AGENDA ITEM: 11**

Wrightington, Wigan and Leigh NHS Foundation Trust

| | | | |
|---|---|---|---|
| **To:** | Trust Board | **Date:** | 25th March 2020 |
| **Subject:** | Global Training and Education Centre (GTEC) Status | | |
| **Presented by:** | Ged Murphy & Rob Forster | **Purpose:** | Discussion |

## Executive summary

The Covid-19 crisis is placing a number of pressures on the GTEC programmes (MCh/MMed and Nursing Hub). In discussion at the GTEC Committee an urgent paper was requested to be delivered to Trust Board with the options, risks and mitigations associated with international staff both in and arriving into the UK, and the ability to provide training for the Dr's and nurses.

It is requested that the Trust Board have site of the issues and provide support for the GTEC staff both within WWL, and those out on training and educational placements with other Trusts.

GTEC has been requested directly by HEE and DoH to continue with the programme and to bring in as many healthcare professionals as possible until they advise us further.

41 nurses are now in Wigan and another 10 planned in April.

WWL also has 34 junior doctors working presently. These will be able to support WWL during this crisis.

GTEC will be able to, subject to government restrictions, continue with the plans to bring in about 125 doctors into England this summer.

GTEC team is satisfied that appropriate measures are in place to ensure that this programme can continue and requests the trust board to allow this important function to continue.

## Risks associated with this report

The risks are highlighted in the paper plus the Trust risks centred around staffing shortages

1. Ability to recruit and retain to required staffing levels for service delivery & service development plans. This is currently scoring 20 and therefore on the corporate risk register and has a heavy emphasis on the inability to recruit registered general nurses. This has been on the risk register since November 2017
2. Breaching the NHSI Agency Ceiling. This is scoring 16 and is on the corporate risk register. It refers directly to nursing vacancies contributing to the high agency spend. This has been on the risk register since April 2018
3. 3. Nurse staffing levels and skill mix in the Medical Division across all wards and departments are below establishment. This is scoring 20 and on the corporate risk register since October 2018.

Plus the new risks associated with the Covid-19 impacts.

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

The WWL Way

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

**Global Training and Education Centre (GTEC) Status-Covid-19 as of 23rd March 2020**

**1.0 Background**

GTEC is the umbrella organisation that covers training and education placements for international clinical staff based in WWL. As such, it is reliant on the free movement of people across the globe, and being able to educate international health care professionals in the UK. Most international staff originates from India, where current cases are low. There are no restrictions on travel into the UK and the government has requested that GTEC continues to bring as many healthcare staff in as possible. As such the Covid-19 national and international guidelines and restrictions are now impacting the programmes requiring escalation to Trust Board on how GTEC is preparing to meet this challenge.

Before the status of the programmes were:

- MCh/MMed:
  - 175 Dr's currently in the UK (34 in WWL)
  - Post interviews in November 2019, 113 Dr's have passed English Language and are due into the UK for induction in July, and placement in August.
- Nursing Hub
  - 41 nurses are in the UK out of the pilot 100, total of 70 due for WWL
  - Plans are ongoing to expand the programme so that there is an ability to bring in and educate 1000 nurses per year

Detailed below are the current challenges, risks and options.

## 2.0 MCh/MMed Medical Programme

### 2.1 Dr's Currently in the UK

Below is the outline of GTEC's plans for the Medical Programme over the next few months:

2.1.1 Dr's health

This is of overriding and paramount importance and is GTEC's number one priority. GTEC advice the Dr follows the local trust procedures should they fall ill during this period, albeit due to coronavirus or otherwise. The Dr has been informed they can contact GTEC for any queries on this process and take note of the national guidelines and received e-mails from the local trust as to how to deal with this problem.

2.1.2 Teaching plans

Clinical teaching: Face to face teaching on Saturdays, is stopped but GTEC will resort to using online technology. The next scheduled class in May will be the first where we will pilot the online technology. For any practical session that was to take place between March and July (e.g. cadaveric dissection), these will be postponed to later in the year so that the Dr's benefit from this experience later in the programme. Similarly if there are important group face to face discussions that cannot be done via technology that should have taken place at this point these will be scheduled for a later date. Academic teaching: The next sessions for these are 28th March and 25th April. The academic team will be in contact with the Dr's in due course with information regarding this.

2.1.3 Work

It is likely that many trusts will be modifying their clinical activities (e.g. cancelling elective cases) which can have a direct implication on the Dr's training. This is not only for international trainees but also for British trainees. All trusts will endeavour to provide the Dr's with the best possible clinical experience. If circumstances are beyond GTEC's control a search for alternative ways to gain experience can be provided once the crisis has been resolved.

2.1.4 Submission of assignments

All online assignments will continue as normal. Cohort 11 have a poster presentation in April and the format of this will change to avoid group meetings. They also have a planned OSCE session in July. Whilst at the present time GTEC are unable to state whether this can happen in the current format as it would depend on the progression of the crisis, GTEC will put measures in place and update the Dr's as to how we propose to do this if they cannot be done in July. This could involve doing it at the earliest possible opportunity or if some of the Dr's have returned to India GTEC could organise these in November when GTEC visit the country for the next interviews.

2.1.5 Performance reviews
Some of the performance reviews will be as one to one or very small group meetings and these should go ahead as planned. For the large specialities GTEC will find ways of avoiding large group meetings and plans will be confirmed as soon as possible.
2.1.6 Thesis
The current crisis will not cause any delays in the completion of the research projects as access to online material is freely available. If the Dr's have any issue regarding this (i.e. collecting patient samples as this would have been stopped by most R&D departments) then discussions with their academic and clinical supervisor to enable the Dr to have timely help to resolve this.

2.1.7 Visitation trips abroad
Some groups were planning to visit factories where implants were being made early in the summer this year. These will be postponed to later in the year when this crisis is under control.

2.1.8 Rotation in August
GTEC are making plans to see how best to manage the rotation of doctors during this time. This not only applies to international training fellows but also to the British trainees. Some rotations have been suspended for the British trainees. This is important for the in training Dr's and GTEC will ensure that we will do our very best to fulfil their expectations. Further updates will be forwarded as the situation evolves.

**2.2 Dr's for the Next Cohort-Arrival July to September 2020**
The next cohort of Dr's has been interviewed in November. GTEC has an ethical duty of care for bringing in all health professionals into a heightened risk environment during the current crisis and communications to them will continue and they access the government websites so they can take the necessary precautions and decisions.

The next steps and mitigations are detailed below:

- Currently successful Dr's have to pass their English Language and currently over 100 have achieved this
- GTEC are finalising available vacancies in the host trusts
- At all stages the Dr's will be communicated to
- Conditional offers will go out in April to the Dr's, and reference checks will begin
- In June GTEC will decide who to bring into the UK. At this time an assessment will be made about the situation and how to progress to the next stage, so the selected Dr's can book travel arrangements and Trusts informed
- July the Dr's will have an induction week, followed by 2 weeks of shadowing prior to them starting work and embarking on the education programme. If the crisis continues then an alternative means of doing the induction will be investigated to reduce the size of the groups for the induction at Edge Hill.

## 3.0 Nursing Hub Programme

**3.1 Nurses in the UK**
3.1.1 Nurses health
As for Dr's this is of overriding and paramount importance and is GTEC's number one priority. Therefore advice for the nurse will be the same. The Nurse Educators and Pastoral Care staff has briefed every nurse on the current guidelines and are in regular contact with them.

3.1.2 WWL Requirements
The international nurse pilot indicated that 70 nurses were to be allocated to WWL. With the onset of the crisis then pressure on the wards and Professional Practise team has instigated a request to pause bringing in the nurses to ensure they receive the best quality arrival. GTEC will place the nurses from the successful interviews on hold but

there is a significant risk these nurses will be poached and this will incur costs as CoS's and Visa applications have been submitted.

3.1.3 Training Cohort Size

16 nurses are currently being trained by GTEC. The next arrivals are the 6th April where 9 are confirmed. Post this and with only GTEC Clinical Educators available then further arrivals will be delayed until the middle of May (exact date TBC but will be post the OSCE exams for 7 nurses).

If no further support other than the GTEC Clinical Educators, the numbers being educated at any time will be 25.

3.1.4 Accommodation during Training

All nurses are housed in Leigh. If a nurse becomes symptomatic then each has an individual room and can be isolated this way. In an escalation scenario then the whole flat can be locked down and the other nurses will be moved to another.

The intake on the 6th April will be accommodated in the Crewe Campus of Apollo Buckingham Health Sciences. There are reassurances and confirmations that access to 24/7 on site presence at the accommodation block to support the nurses. Again there is a process to isolate individuals and quarantine as required.

3.1.5 OSCE Intensive Training

Currently there are 22 nurses training in GTEC and OSCE preparation is continuing.

The GTEC plan can be viewed in the Appendix, which now has to be modified in light of the Edge Hill University closure and doubt over the availability of and access to their Clinical Skills and teaching areas.

3.1.5.1 Training Facilities:

The following are options for the GTEC OSCE training facilities:

- The Clinical Skills Lab in the Medical Education has been made available for the major part of the week, even if this is out of normal hours if it is busy.
- Edge Hill Clinical Skills: This has yet to be confirmed if this can be made available because of the university's closure
- Wrightington Conference Centre: The Long Drawing Room, Conference Room 2 and the Small Drawing Room, is available and will be converted to deliver OSCE training for the foreseeable future.
- Leigh Post Graduate Centre: This is a further option and has been booked up until the second week of April.
- The old mental health ward at Leigh can be investigated to act as a temporary training area for 12-16 weeks

As a result nurses can continue with their training to be prepared for the OSCE exam, minimising the risk of catching the Coronavirus by following national guidelines.

3.1.5.2 Clinical Educators

GTEC will be reliant upon the following staff to educate the nurses after Edge Hill withdrew support after being instructed to be on standby by the NMC

- GTEC has a Matron and 1 Clinical Educator, with a further Clinical Educator joining on the 29th March.
- Professor Murali and Dr Madapura Shahsidhara (Deputy Quality Lead of GTEC) will support the Clinical Educators to deliver the programme
- Agency or temporary staff can be sought if required

3.1.6 Contingency Plan

If circumstances or policy changes dictate a suspension of the training and entry process then the options are for the nurses in the UK:

- The nurses can work as front line staff in the role of extra HCA's to act as support. They have 8 months to complete the OSCE under current Visa guidelines.
- The nurses self-isolate in their accommodation and continue some self-study accessing on line materials.

If the entry process becomes impossible, then the nurse can wait in country until the situation changes.

There will be financial impacts in that CoS's may run out leading to an additional payment and it is hoped that the UKVI will view this sympathetically. This is unknown.

**3.2 Nurses Waiting to come to the UK**

The situation is fluid throughout the world, with daily changes being monitored by the GTEC team. India is where the majority of nurses originate and currently they have restrictions on incoming but not outgoing migration.

As stated above the GTEC team feel a duty of care towards the nurses and advice is available from GTEC and through the Health Education England, Global Learners programme.

3.2.1 Health Education England Supply of Nurses

HEE are sending out regular updates, and there is evidence of shutdowns of UK/Visa administration centres that may delay issuing of Visas. They also had a short postponement of issuing the cards to pay for Visas but this will be lifted w/c 30th March. However there are still nurses informing GTEC that Visas have been granted and the 6th April intake is currently standing at 11 nurses (for WWL and Stockport).

The next intake after this will be delayed until w/c 7th May to allow for in training nurses to take their OSCE and so free up training capacity for the Clinical Educators.

3.2.2 Travel

Flights are still available to come from India, but with some restrictions around transit points through the Middle East until the 28th March. The GTEC team are monitoring the situation on a daily basis and advising nurses accordingly, booking flights around the restrictions.

## 4.0 Pastoral Care

This is naturally a concerning time for any member of staff, but especially those coming into the country for the first time. Europe is now the epicentre of the virus and as such is generating a huge amount of media attention outside the UK. International Nurses and Dr's already in the UK are being briefed by their Host Trusts, and GTEC will be available to give out advice and support.

Newly arrived nurses are having a special briefing from the GTEC Matron to rapidly educate the nurse on the situation and all the Government, Trust and Local advice, knowledge, procedures and policies.

Mentoring and support is offered to the nurses regarding education of the situation, what to do if you get the symptoms, team available to have a chat to listen to fears and worries and how to access essentials such as food and medicines.

Those nurses to come in have the ability to contact GTEC and the Pastoral Care staff direct them towards the government websites for the latest information.

Doctors in the next cohort will be briefed similarly when they arrive, and GTEC will provide direct Pastoral advice at that time.

## 5.0 Risks

Current risks that have arisen during the Covid-19 crisis:

| Risk Area | Risk Description | Risk Score (L X C) | Mitigation |
|---|---|---|---|
| Quality Assurance | The programme could suffer due to lack of Clinical Educators for the Nursing Programme | 3x4=12 | • 3 GTEC Clinical Educators in post<br>• Controlling the number of nurses arriving in line with Educators available |
| Quality Assurance | The programme does not have the facilities available to maintain a good standard of training | 3x3=9 | • GTEC secured many options both of Clinical Skills space and lecture style rooms |
| Health and Welfare | In Training Dr's and Nurses fall seriously ill with Coronavirus during training | 3x4=12 | • Following Government, trust and Local guidelines<br>• GTEC constant monitoring<br>• Isolation in the accommodation is available |
| Health and Welfare | GTEC Staff have such high levels of self-isolation that the ability to support the HR process, training and pastoral care cannot be done | 3x3=9 | • Staff practise distancing<br>• Some ability to work from home<br>• Training can be delayed<br>• Pastoral Care can be done remotely<br>• Dr's programme is at an advanced stage so could withstand some delay |
| Legal | In training staff Visas run out if the crisis continues for a long period and travel becomes impossible | 2x4=8 | • Communication with the Dr or nurse<br>• UKVI applications for extensions because of exceptional circumstances |
| Reputation | Failure to deliver the quality and/or numbers will damage the | 2x4=8 | • Partners kept up to date and communicated to<br>• Full gravity of the situation is well understood<br>• Providing international staff |

| | | | |
|---|---|---|---|
| | reputation of GTEC and the Trust | | |
| Financial | Income not achieved in 2020/21 because programmes become delayed | 2x4=8 | • Safety takes priority<br>• Strong performance in 2019/20 can fund part way into 2020/21<br>• Dr's not due in until July<br>• Nurse programme is underwritten with a Business Case for the first 100 |
| Political | Government policy changes and negates the suspension of the programmes | 4x4=16 | • Programme is suspended<br>• In training nurses in the UK can work on wards<br>• Dr's are delayed entering the UK until programme resumes, gaps could appear on rotas |

**5.0 Summary**

In this unprecedented situation GTEC is mitigating each new challenge and risk, maintaining the flow of international healthcare staff into WWL and partner Trusts. Restrictions and impacts are being seen throughout the system as governments introduce further restrictions to try and stem the pandemic. GTEC will remain focussed and above all safety to patients, our community, international in training healthcare staff and the GTEC team will remain the programmes priority.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

# Standing Orders for the Board of Directors

Approved by the Board of Directors: 25 March 2020
Review date: March 2021

The WWL Way

**CONTENTS**

## INTRODUCTION

### Statutory Framework

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust ("the Foundation Trust") is a public benefit corporation. Originally named Wrightington, Wigan and Leigh NHS Foundation Trust, the organisation changed its name on 1 April 2020 to reflect the way it had developed since its establishment as part of the journey towards its ultimate aim of becoming a University Teaching Hospital.

The Foundation Trust initially came into existence on 1 December 2008 pursuant to the authorisation of Monitor under the Health and Social Care (Community Health and Standards) Act 2003 ("the 2003 Act"), now superseded by the National Health Service Act 2006 ("the 2006 Act") as amended by the Health and Social Care Act 2012 ("the 2012 Act").

The principal place of business of the Foundation Trust is:

Royal Albert Edward Infirmary
Wigan Lane
Wigan
WN1 2NN

NHS Foundation Trusts are governed by the National Health Service Act 2006, as amended by the Health and Social Care Act 2012. The functions of the Foundation Trust are conferred by this legislation and its Provider Licence.

As a statutory body, the Foundation Trust has specified powers to contract in its own name. It also has statutory powers under Chapter 5 of the 2006 Act to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

The Code of Accountability requires the Foundation Trust to adopt Standing Orders for the regulation of its proceedings and business. The Foundation Trust must also adopt Standing Financial Instructions as an integral part of Standing Orders setting out the responsibilities of individuals.

The business of the Foundation Trust is managed by the Board of Directors, who shall exercise all the powers of the Foundation Trust, subject to any exception in the 2006 Act, as amended by the 2012 Act or the Foundation Trust's Constitution. In accordance with the 2006 Act, the following are set out in detail in the Constitution:

- The composition of the Board of Directors;
- Appointment, removal and terms of office of the Chair, other Non-Executive Directors and the Chief Executive;
- Eligibility and disqualification of Directors and Governors;
- Meetings of the Board of Directors;
- Conflicts of interest of the Directors;
- Registers;
- Public documents; and
- Expenses

These Standing Orders add clarity and detail where appropriate. Nothing in these Standing Orders shall override the Foundation Trust's Constitution or the National Health Service Act 2006 (as amended).

**NHS Framework**

The NHS Foundation Trust Code of Governance requires boards to draw up a schedule of decisions reserved to the Board and to ensure that management arrangements are in place to enable responsibility to be clearly delegated appropriately. The Schedule of Matters Reserved to the Board and the Scheme of Delegation form part of Standing Orders.

The Code of Practice on Openness in the NHS sets out the requirements for public access to information on the NHS, subject for example to the Freedom of Information Act 2000.

**SO 1. INTERPRETATION**

SO 1.1. Save as otherwise permitted by law, at any meeting the Chair of the Foundation Trust shall be the final authority on the interpretation of Standing Orders (on which he/she should be advised by the Secretary).

SO 1.2. Any expression to which a meaning is given in the National Health Service Act 2006 (as amended) or in the Financial or other Regulations made under the Acts or in the Authorisation or Constitution shall have the same meaning in this document and in addition:

| | |
|---|---|
| "the 2006 Act" | means the National Health Service Act 2006 as may be amended or replaced from time to time; |
| "the 2012 Act" | means the Health and Social Care Act 2012 as may be amended or replaced from time to time; |
| "Accountable Officer" | means the Officer responsible and accountable for funds entrusted to the Trust. He/she shall be responsible for ensuring the proper stewardship of public funds and assets. In accordance with the 2006 Act, this shall be the Chief Executive. |
| "Board of Directors" or "Board" | means the Board of Directors, properly constituted as such in accordance with the Constitution; |
| "Budget" | means a resource expressed in financial terms, proposed by the Board for the purposes of carrying out, for a specified period, any or all of the functions of the Foundation Trust; |
| "Chair" | means the person appointed in accordance with the Constitution to lead the Board and the Council of Governors. The expression "the Chair" shall be deemed to include the Vice-Chair of the Foundation Trust if the Chair is absent from the meeting or is otherwise unavailable; |
| "Chef Executive" | means the person appointed in accordance with the 2006 Act to be the Chief Executive; |
| "Commissioning" | means the process for determining the need for and for obtaining the supply of healthcare and related services by the Foundation Trust within available resources; |
| "Committee" | means a committee appointed by the Board of Directors; |
| "Committee members" | means a person formally appointed by the Board of Directors to sit on or to chair specific committees; |
| "Constitution" | means the constitution of the Foundation Trust as approved from time to time by the Board of Directors and the Council of Governors in accordance with the 2006 Act as amended by the 2012 Act; |

| | |
|---|---|
| "Contracting and procuring" | means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets; |
| "Council of Governors" | means the Council of Governors as constituted in accordance with the Constitution; |
| "Chief Finance Officer" | means the executive director of finance who is the Chief Finance Officer of the Foundation Trust; |
| "Executive Director" | means a director who is an officer of the Foundation Trust appointed in accordance with the Constitution. For the purposes of this document, "director" shall not include an employee whose job title incorporates the word director but who has not been appointed in this manner; |
| "Funds held on trust" | means those funds which the Foundation Trust holds at its date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under Chapter 5 of the 2006 Act. Such funds may or may not be charitable. |
| "Provider Licence" | means the NHS Provider Licence issued by Monitor, the independent regulator of foundation trusts; |
| "Nominated Officer" | means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions; |
| "Non-Executive Director" | means a director who is not an officer of the Foundation Trust and who has been appointed in accordance with the Constitution. This includes the Chair of the Foundation Trust; |
| "Officer" | means an employee of the Foundation Trust or any other person who exercises functions for the purposes of the Foundation Trust other than solely as a Staff Governor or Non-Executive Director of the Foundation Trust; |
| "SFIs" | means Standing Financial Instructions; |
| "SOs" | means these Standing Orders; |
| "Secretary" | means a person who may be appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Foundation Trust; and |
| "Vice-Chair" | means the non-executive director appointed by the Council of Governors in accordance with the Constitution. |

## SO 2. THE BOARD OF DIRECTORS

SO 2.1. All business shall be conducted in the name of the Foundation Trust.

SO 2.2. The powers of the Foundation Trust established under statute shall be exercised by the Board of Directors except as otherwise provided for in SO 4.

SO 2.3. Directors acting on behalf of the Foundation Trust as a corporate trustee are acting as quasi-trustees.

SO 2.4. The Board of Directors has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in the Scheme of Delegation.

**Composition of the Trust**

SO 2.5. In accordance with the Foundation Trust's Constitution, the composition of the Board of Directors shall be:

- A Chair;
- not less than five (5) but not more than eight (8) other Non-Executive Directors; and
- A minimum of five (5) Executive Directors including:
  - a Chief Executive (who is the Accounting Officer);
  - a Chief Finance Officer;
  - a Medical Director who is to be a Registered Medical Practitioner or a Registered Dentist;
  - a Chief Nurse who is to be a registered nurse or midwife; and
  - at least one (1) but not more than four (4) other Executive Directors;

provided always that at least half of the Board of Directors, excluding the Chair, should comprise Non-Executive Directors determined by the Board of Directors to be independent.

**Appointment of the Chair and Non-Executive Directors**

SO 2.6. The Chair and Non-Executive Directors are appointed by the Council of Governors using the procedure set out in the Constitution.

**Terms of office of the Chair and Non-Executive Directors**

SO 2.7. The Chair and the Non-Executive Directors are to be appointed for a period of office in accordance with the Foundation Trust's Constitution and the NHS Foundation Trust Code of Governance. The terms and conditions of office are determined by the Council of Governors at a general meeting.

**Appointment of Vice-Chair of the Board of Directors**

SO 2.8. For the purpose of enabling the proceedings of the Foundation Trust to be conducted in the absence of the Chair, the Council of Governors will appoint a Non-Executive Director to be Vice-Chair for such a period, not exceeding the remainder of their terms a Non-Executive Director of the Foundation Trust, as they may specify. SO 3.10 sets out the provision if both the Chair and the Vice-Chair are absent.

SO 2.9. Any Non-Executive Director so elected may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair. The Board of Directors may thereupon appoint another Non-Executive Director to be the Vice-Chair in accordance with SO 2.8 above.

SO 2.10. The Board of Directors should appoint one of the independent Non-Executive Directors to be the Senior Independent Director, in consultation with the Council of Governors. The Senior Independent Director should be available to Directors and Governors if they have concerns which contact through the normal channels of Chair, Chief Executive or Chief Finance Officer has failed to resolve or for which such contact is inappropriate. The Senior Independent Director cannot be the Vice-Chair.

**Powers of Vice-Chair**

SO 2.11. Where the Chair of the Foundation Trust has ceased to hold office or has been unable to perform duties as Chair owing to illness, absence or any other cause, references to the Chair shall, so long as there is no Chair able to perform those duties, be taken to include reference to the Vice-Chair.

## SO 3. MEETINGS OF THE BOARD OF DIRECTORS

SO 3.1. Meetings of the Board of Directors are to be held in public. Members of the public may be excluded from a meeting for special reasons as determined by the Chair in discussion with the Secretary.

SO 3.2. The Secretary, on the instruction of the Chair, shall give such direction as seen fit in relation to arrangements for meetings to accommodate presenters of papers and information to the Board of Directors and will ensure that business is conducted without interruption and without prejudice. The Chair has the power to exclude visitors on grounds of the confidential nature of the business to be transacted. The Chair may exclude any member of the public from a meeting if they are interfering with or preventing the proper conduct of the meeting.

**Calling meetings**

SO 3.3. For ordinary meetings, the Secretary shall give to all Directors at least fourteen (14) days' written notice of the date and place of every meeting of the Board of Directors.

SO 3.4. At the request of the Chair or four (4) Directors to hold an extraordinary meeting, the Secretary shall send a written notice to all Directors as soon as possible after receipt of such request. The Secretary shall give all Directors at least fourteen (14) days' written notice of the date and place of each meeting. If the Secretary fails to call such a meeting then the Chair or the four Directors shall call such a meeting.

SO 3.5. At the request of the Chair to convene an urgent meeting, the Secretary shall send a written notice to all Directors as soon as possible after receipt of such a request. The Secretary shall give Directors as much notice as is possible in light of the urgency of the request. If the Secretary fails to call such a meeting, then the Chair or four Directors shall call such a meeting.

SO 3.6. Before each meeting of the Board of Directors, a notice of the meeting specifying the business proposed to be transacted at it shall be delivered to every Director, or sent electronically or by post to the agreed address of such Director, so as to be available at least five (5) clear days before the meeting. A postal notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

SO 3.7. Lack of service of the notice on any Director(s) shall not affect the validity of a meeting.

**Setting the agenda**

SO 3.8. The Board of Directors may determine that certain matters shall appear on every agenda for a meeting.

SO 3.9. A Director who requires an item to be included on the agenda should advise the Secretary prior to the agenda being agreed with the Chair and no less than ten (10) days before a meeting.

**Chair of meeting**

SO 3.10. At any meeting of the Board of Directors the Chair, if present, shall preside. If the Chair is absent from the meeting then the Vice-Chair shall preside. If the Chair and Vice-Chair are both absent, such Non-Executive Director as the Directors present choose shall preside.

SO 3.11. If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest, the Vice-Chair, if present, shall preside. If the Chair and Vice-Chair are absent, or are disqualified from participating, such Non-Executive Director as the Directors present choose shall preside.

**Petition**

SO 3.12. Where a petition has been received by the Foundation Trust, the Chair shall include the petition as an item for the agenda of the next Board meeting.

**Annual Members' Meeting**

SO 3.13. The Foundation Trust shall publicise and hold an Annual Members' Meeting each year.

**Voting**

SO 3.14. Every question put to a vote at a meeting shall be determined by a majority of the votes of the Chair and Directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote.

SO 3.15. All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by silence, oral expression, or by a show of hands. A paper ballot may also be used if a majority of the Directors present so require.

SO 3.16. If at least four (4) of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

SO 3.17. If a Director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

SO 3.18. Under no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

SO 3.19. An Officer who has been appointed formally by the Board of Directors to act up for an Executive Director or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Director concerned. An Officer attending to represent an Executive Director during a period of incapacity or temporary absence without formal acting-up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

**Minutes**

SO 3.20. The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting.

SO 3.21. No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be recorded at the next meeting.

SO 3.22. Minutes shall be circulated in accordance with Directors' wishes.

SO 3.23. The minutes of Board meetings shall be circulated to the Council of Governors once formally approved.

**Suspension of Standing Orders**

SO 3.24. Except where this would contravene any statutory provision or any provision of the Provider Licence or of the Constitution, any one or more of the Standing Orders may be suspended at any

meeting provided that at least two-thirds of the Board of Directors are present, including two (2) Executive Directors and two (2) Non-Executive Directors and that a majority of those present vote in favour of suspension.

SO 3.25. A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

SO 3.26. A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to Directors.

SO 3.27. The Audit Committee shall review every decision to suspend Standing Orders.

**Variation and amendment of Standing Orders**

SO 3.28. These Standing Orders shall be amended only if:

(a) Notice of the intention to vary Standing Orders has been included within the agenda for the meeting; and

(b) No fewer than half of the Foundation Trust's Non-Executive Directors in post vote in favour of the amendment; and

(c) At least two-thirds of the Directors are present; and

(d) The variation proposed does not contravene a statutory provision or provision of the Provider Licence or of the Constitution.

**Record of attendance**

SO 3.29. The names of the Chair and Directors present at the meeting shall be recorded in the minutes.

**Quorum**

SO 3.30. No business shall be transacted at a meeting of the Board of Directors unless at least six (6) Directors are present, including at least three (3) Executive Directors (one of whom must be the Chief Executive or another Executive Director nominated by the Chief Executive) and at least three (3) Non-Executive Directors, one of whom is the Chair or the Senior Independent Director. An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

SO 3.31. If the Chair or Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 7) they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at the meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next item of business.

## SO 4. ARRANGEMENT FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

SO 4.1. Subject to a provision in the Provider Licence or the Constitution, the Board of Directors may make arrangements for the exercise on its behalf of any of its functions:

(a) By a committee of Directors; or

(b) By individual Executive Directors.

**Emergency powers**

SO 4.2. The powers which the Board of Directors has retained to itself within these Standing Orders may in an emergency be exercised by the Chief Executive and the Chair after having consulted at least two (2) Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next meeting of the Board of Directors for ratification.

**Delegation to committees**

SO 4.3. The Board of Directors shall agree, as and when it deems appropriate, to the delegation of executive powers to be exercised by committees which it has formally constituted. The Constitution and terms of reference of these committees and their specific executive powers shall be approved by the Board of Directors.

**Delegation to Officers**

SO 4.4. Those functions of the Foundation Trust which have not been retained as reserved by the Board of Directors or delegated to a committee shall be exercised on its behalf by the Chief Executive. The Chief Executive shall determine which functions shall be delegated to other Officers to undertake.

SO 4.5. The Chief Executive shall prepare a Scheme of Delegation (which is set out in Standing Financial Instructions) identifying proposals which shall be considered and approved by the Board of Directors, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board of Directors as indicated above.

SO 4.6. The arrangements made by the Board of Directors as set out in the Scheme of Delegation shall have effect as if incorporated in these Standing Orders.

**Overriding Standing Orders**

SO 4.7. If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances surrounding it shall be reported to the next meeting of the Board of Directors for action or ratification.

## SO 5. COMMITTEES

**Appointment of committees**

SO 5.1. Subject to the Provider Licence and the Constitution and any direction given by NHS Improvement, the Board of Directors may, and if directed by NHS Improvement, shall, appoint committees of the Foundation Trust consisting wholly of Directors of the Foundation Trust. The Board of Directors may only delegate its powers to a committee if that committee consists entirely of Directors.

SO 5.2. A committee or joint committee appointed under this Standing Order may, subject to such directions as may be given by the regulator, and in accordance with the Constitution, appoint sub-committees consisting wholly or partly of members of the committee or wholly of persons who are not Directors.

SO 5.3. The Standing Orders of the Foundation Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committees established by the Board of Directors. In this case, the term “Chair” is to be read as a reference to the chair of the committee or sub-committee as the context permits and the term “Director” is to be read as a reference to a member of the committee, also as the context permits. There is no requirement to hold meetings of committees established by the Foundation Trust in public.

SO 5.4. Each such committee, sub-committee or group shall have such terms of reference and powers and be subject to such conditions as to reporting back to the Board of Directors as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the regulator. Such terms of reference shall have effect as if incorporated into these Standing Orders.

SO 5.5. The Board of Directors shall approve the appointments to each of the committees, sub-committees or groups that it has formally constituted. Where the Board of Directors determines, and regulations permit, that persons who are neither Directors nor Officers shall be appointed to a committee, the terms of such appointment shall be within the powers of the Board of Directors as defined by the Provider Licence and the Constitution. The Board of Directors shall define the powers of such appointees and shall agree allowances, including reimbursement for expenses where appropriate, in accordance with the Constitution.

SO 5.6. The committees established by the Board of Directors are:

(a) Audit Committee

(b) Remuneration Committee

(c) Quality and Safety Committee

(d) Finance and Performance Committee

(e) People Committee

SO 5.7. Such other committees may be established as required to discharge the Board's responsibilities.

**Confidentiality**

SO 5.8. A member of a committee, sub-committee or group shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee has reported to the Board of Directors or has otherwise concluded on that matter.

SO 5.9. A Director or a member of a committee or sub-committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee or sub-committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or committee has resolved that it is confidential.

## SO 6. DECLARATIONS OF INTEREST

SO 6.1. The Constitution requires members of the Board of Directors to declare interests which are relevant and material to the Board of Directors. All existing Directors should declare such interests. Any Directors appointed subsequently should do so on appointment.

SO 6.2. Interests which should be regarded as "relevant and material" are:

(a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of dormant companies);

(b) Ownership or part-ownership of directorships of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

(c) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS;

(d) A position of authority in a charity or voluntary organisation in the field of health and social care;

(e) Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services;

(f) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Foundation Trust including, but not limited to, lenders or banks.

SO 6.3. The register of directors' interests will include as appropriate all interests of directors and their close family members where they have control, joint control or a significant influence, regardless of whether this is in relation to healthcare.

SO 6.4. If Directors have any doubt about the relevance of an interest, advice should be sought from the Secretary who has a duty to report and discuss such matters with the Chair. Financial Reporting Standard 8 issued by the Accounting Standards Board specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

SO 6.5. A register of directors' interests will be maintained and held by the Secretary and presented to the Board annually. This will be formally recorded in the minutes. Any changes in interests should be officially declared to the Secretary where an appropriate amendment will be made.

SO 6.6. Directors' directorships of companies declared in accordance with SO 6.2 above shall also be published in the Foundation Trust's Annual Report.

SO 6.7. If a conflict of interest is established during the course of a meeting, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, this includes voting on such an issue where a conflict is established. If there is a dispute as to whether a conflict of interest does exist, a majority shall resolve the issue with the Chair having a casting vote.

## SO 7. DISABILITY OF CHAIR AND DIRECTORS IN PROCEDURES ON ACCOUNT OF PECUNIARY INTEREST

SO 7.1. Subject to the following provisions of this Standing Order, if the Chair or a Director has any pecuniary interest, either direct or indirect, in any contract, proposed contract or any other matter and is present at a meeting at which the contract or other matter is the subject of consideration, he/she shall as soon as practicable at the meeting disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

SO 7.2. The Board of Directors may exclude the Chair or a Director from a meeting while any contract, proposed contract or other matter in which he/she has a pecuniary interest, is under consideration.

SO 7.3. Any remuneration, compensation or allowances payable to the Chair or a Non-Executive Director in accordance with the Constitution shall not be treated as a pecuniary interest for the purpose of this Standing Order.

SO 7.4. For the purpose of this Standing Order, the Chair or a Director shall be treated, subject to CCC, as having an indirect pecuniary interest in a contract, proposed contract or other matter if:

(a) He/she, or a nominee, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

(b) He/she is a partner of, or is in the employment of, a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

and in the case of married persons living together, the interest of one spouse shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

SO 7.5. The Chair or a Director shall not be treated as having a pecuniary interest in any proposed contract or other matter by reason only:

(a) Of membership of a company or other body, if there is no beneficial interest in any securities of that company or body;

(b) Of an interest in any company, body or person with which he is connected as mentioned in SO 6 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on any question with regard to that contract or matter.

SO 7.6. Where the Chair or a Director:

(a) Has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body; and

(b) The total nominal value of those securities does not exceed £5,000 or on-hundredth of the total nominal value of the issued share capital of the company or body (whichever is the less); and

(c) If the share capital is of more than one class, the total nominal value of shares of any one class in which he/she has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class;

this Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his/her duty to disclose his/her interest.

SO 7.7. This Standing Order applies to a committee or sub-committee as it applies to the Board of Directors and applies to any member of any such committee or sub-committee (whether or not he/she is also a Director) as it applies to a Director.

## SO 8. STANDARDS OF BUSINESS CONDUCT

SO 8.1. Staff must comply with the national guidance contained in HSG(93)5 “Standards of Business Conduct for NHS Staff” and contained in the Foundation Trust’s Standards of Business Conduct. Reference should be made to the Standards of Business Conduct for further guidance.

## SO 9. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

### Custody of seal

SO 9.1. The common seal of the Foundation Trust shall be kept by the Secretary in a secure place.

### Sealing of documents

SO 9.2. The seal of the Foundation Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or a committee thereof, or where the Board of Directors has delegated its powers. The affixing of the seal shall be attested and signed by two (2) Directors.

**Register of sealing**

SO 9.3. An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, held by the Secretary, and shall be signed by the persons who attested the seal. A report of all sealings shall be made to the Board of Directors annually.

## SO 10. SIGNATURE OF DOCUMENTS

SO 10.1. Where the signature of any document will be a necessary step in legal proceedings involving the Foundation Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board of Directors has given the necessary authority to some other person for the purpose of such proceedings.

SO 10.2. The Chief Executive or nominated officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Foundation Trust any agreement or other document not required to be executed as a deed, the subject matter of which has been approved by the Board of Directors or committee or sub-committee to which the Board has delegated appropriate authority.

## SO 11. MISCELLANEOUS

**Standing Orders to be given to Directors and Officers**

SO 11.1. It is the duty of the Chief Executive to ensure that existing Directors and Officers and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions. Updated copies shall be issued to staff designated by the Chief Executive. For the purposes of notifying Officers of Standing Orders and Standing Financial Instructions, this may be achieved by publishing them on the Foundation Trust's intranet site.

**Documents to have the standing of Standing Orders**

SO 11.2. Standing Financial Instructions and the Reservation of Powers and the Scheme of Delegation shall have effect as if incorporated into Standing Orders.

**Review of Standing Orders**

SO 11.3. Standing Orders, and all documents having effect as if incorporated in Standing Orders, shall be reviewed annually by the Audit Committee on behalf of the Board of Directors.

**Additional section to be inserted into Standing Orders**

It is proposed that the following section be inserted at an appropriate point in the Standing Orders for the Board of Directors:

**X. Decisions in writing**

X.1 Decisions may be taken in writing by the Board of Directors.

X.2 Such decisions may only be taken in writing where the Chair (subject to X.5 below) of the relevant body agrees that the matter is urgent, cannot wait until the next meeting and does not warrant the convening of a special meeting.

X.3 Any such decision in writing must be agreed by:

X.3.1 the Chair of the Board of Directors (subject to X.5 below); and

X.3.2 at least enough directors to form a quorum, excluding any directors not eligible to vote on the matter.

X.4 Such decisions shall be as valid and effectual as if passed at a duly convened meeting of that body.

X.5 Should the Chair be unable to participate in any aspect of this process by reason of unavailability, the Vice Chair shall have the power to act as Chair.

*(Where "X" indicates the section number of Standing Orders)*

# REPORT

**AGENDA ITEM:**

| | | | |
|---|---|---|---|
| **To** | Board of Directors | **Date:** | 25 March 2020 |
| **Subject:** | Changes to Standing Financial Instructions | | |
| **Presented by:** | Director of Finance | **Purpose:** | Approval |

## Executive summary

This paper is presented to seek approval of changes to the Trust's Standing Financial Instructions and Budgetary Control and Delegation Arrangements. These were reviewed and endorsed by the Audit Committee at its meeting on 13 February 2020.

A summary of changes has been provided and copies of the full document are available on request.

## Risks associated with this report

None

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

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

The WWL Way

## Introduction

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

## Background

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

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

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

## Changes

The SFI's have been updated with the changes highlighted in Appendix 1.

## Recommendation

The Board is requested to approve the amendments made to the SFIs.

# APPENDIX 1

## Standing Financial Instructions - summary of amendments made

The Trust name has been amended to reflect the new name - Wrightington Wigan and Leigh Teaching Hospitals NHS Foundation Trust.[i]

Removed reference to the following polices which do not exist:

Treasury Management Policy
The Charity's Treasury Management Policy

**Security of cash, cheques and other negotiable instruments**

Amended Section 6.4.5(page 18)

**From:**

Trust credit cards should not be used to pay employee expenses, as these should be reimbursed via Payroll.

**To:**

Trust credit cards should not be used to pay for employee expenses without prior approval, as these should be reimbursed via Payroll.

**Disposal and condemnations**

Amended 14.1.2 (page 37)

**From:**

When it is decided to dispose of a Trust asset, the head of department or authorised deputy will notify the Director of Finance to determine the asset's current valuation and the impact the disposal may have on the Trust's finances. Advice will be given as to the disposal procedure and obtaining the estimated market value of the item, taking account of professional advice where appropriate

**To:**

Disposals of trust assets must be undertaken in accordance with the appropriate disposal policies.

**Business case process summary (page 50)**

Amended the capital medical equipment limit within the table from £30k to £50k.

[i] ***Trust logo on cover to be updated with new logo before circulation***

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

# WWL Operational Plan 2020/21



The WWL Way

# Contents

# 1.0 Introduction

This Operational Plan has been written within the context of the NHS Operational Planning and Contracting Guidance 2020/21, a recently refreshed Wigan Borough Locality Plan and the ongoing development of a new 10 Year Strategy for Wrightington, Wigan & Leigh NHS Foundation Trust.

The Trust's refreshed 10 Year Strategy will be published in April 2020 and will have the organization focused on the delivery of services that improve the health and well-being of the Wigan Borough. The emerging priorities of our strategy will to deliver innovation, integration and improvements in all our services, within the context of financial challenge and increasing demand; with a view to ensuring that our acute and community services deliver the best possible standard for care to all across the Wigan Borough.

This Operational Plan is the first step towards the delivery of our Five Year Strategy. Some of the key issues noted within each section of this plan are noted below:

- Finance – this section addresses the Trust activity, income and expenditure planning assumptions for 2020/21. It should be noted that discussions with NHSi and Wigan Borough Clinical Commissioning Group are still ongoing and, as such, this draft will be subject to some change before the final version is submitted in April 2020.
- Workforce – this section highlights how the Trust will look to deliver NHS interim people plan and the challenges and risks to workforce planning over the next 12 months and also provides a detailed assessment of the workforce retention strategies that the Trust will be progressing.
- Quality – this section highlights the Trust Governance arrangements for quality improvement, its quality improvement plans and provides detail on its quality improvement process in relation to how quality improvement are identified and then implemented
- Membership & Elections – this section provides an overview of all Council of Governor elections and their associated Training and Development.

The final version of the Operational Plan will be approved by the Board of Directors.

# 2.0 Financial Planning

## 2.1 Introduction

The Trust has received its revised financial improvement trajectory (FIT) set out in a letter issued by NHS England / Improvement on 31st January 2020. This letter sets the Trust's trajectory at a deficit of £2.011m with an equivalent value from the Financial Recovery Fund (FRF) leading to the expectation of a balanced budget in 2020/21.

The Trust recognises that the current financial environment dictates the need for its financial plan to be underpinned by robust modelling that ensures that forecasts forming part of the plan are understood, owned and supported by the whole organisation. WWL has a strong and proud record of delivering and exceeding its set financial targets, and considers this a key responsibility of its public responsibility. In its recent Use of Resources review published February 2020, WWL was rated Good. WWL also works in a collaborative and collective way with locality partners to ensure the Borough achieves an overall financially balanced plan.

The draft plan has been set with the engagement from both clinical and corporate stakeholders and has followed both a bottom-up and top-down process.

The draft plan has been reviewed via the Finance and Performance Committee, on behalf of the Trust Board. The committee does not believe the FRF set reflects an achievable ask of the organisation, and most importantly would require an unacceptably high risk CIP challenge of over 4.1%. WWL will as always strive to achieve (and indeed over achieve) financial plans where possible. However, on the basis of the FRF offered, and considering the inherent risks in the plan previously submitted as part of the 19/20 Recovery Plan, the committee assess that at the current time an FRF of £2.01m would result in a year end shortfall of £8m (ie a year end deficit pre FRF of £10m). It should be noted that this recommended operational plan does still include £12m of locality collaboration incentives and a further £8m of CIP schemes (equating to 2.1% of expected turnover).

WWL would request/require an additional £8m FRF allocated to ensure delivery of a balanced financial plan in 20/21. WWL will continue to advance all possible plans to achieve financial balance, including but not limited to working locally, sectorally, and regionally with commissioners and other partners.

There will be a further period of scrutiny before the submission of the final plan.

## 2.2 Impact of operational framework

The Trust has disseminated the NHS Operational Planning Guidance to all relevant staff members and the points noted within the guidance have been incorporated in to the draft plan.

The specific financial assumptions within the guidance have been adopted where appropriate, specifically:

The guidance states that provider cost improvement plans should be fully developed before the start of 2020/21, and agreed with commissioners. System leaders should ensure activity, finance, performance and workforce assumptions are mutually consistent.

Employer contributions to pensions will be handled in the same way in 2020/21 as 2019/20.

The draft plan has been set to allow the Trust to work towards achievement of:

Improve urgent and emergency care performance from the 2019/20 baseline. Reduce acute bed occupancy to 92% by expanding bed capacity and providing more community care. Elective care waiting lists should be reduced, while 52 week waits for planned care should be eliminated.

Performance against cancer standards should also improve. At least 70% of people should receive a cancer diagnosis within 28 days.

## 2.3 Contracting and planning assumptions

Discussions between the Trust and Wigan Borough CCG have been ongoing for a number of months and the locality is close to reaching a funding agreement for 2020/21. The current position between the two parties has been used as the basis for the draft plan.

2020/21 National consultation tariff has been applied to activity projections and changes in specialist commissioner funding has also been taken in to the calculation of income. Growth assumptions, previously published by Greater Manchester Health and Social Care, have been accepted in the Wigan locality and included within the plan.

Activity has been set to achieve the requirements set out in the national operational planning guidance, assuming everything else remains equal.

Pay expenditure has been uplifted in line with the last year of the national pay award and incremental drift applied as per the latest agenda for change handbook. Medical pay award has been assumed at 2%.

Expenditure has been flexed to match changes in activity and price inflation applied to non-pay and drugs expenditure.

The Trust has been notified of its CNST premium charge for 2020/21 and this has been included in the draft plan along with the technical accounting changes resulting from IFRS 16 (accounting for leases).

## 2.4 Demand Management across the system

Through the Healthier Wigan Partnership, there is an agreed approach to supporting the communities and residents of Wigan to be healthy, happy and resilient. There are numerous transformation programmes within the Wigan Locality Plan that are specifically concerned with demand management. The Community Services programme, taking a population-based approach, is underpinned by a strong emphasis on early intervention to reduce demand for services and allowing care to be delivered out of hospital. The Urgent Care Strategy for Wigan is “Home First,” which is supported by investment in support services such as a Community Rapid Response Team, again to manage demand into acute services. The extension of the Urgent Care Centre at the Royal Albert Edward Infirmary site to include Mental Health Crisis teams, Community Link Workers and Primary Care is a further key enabler to supporting admission avoidance and more appropriate access to emergency services.

There is also an extensive and system-wide collaborative transformation programme within Planned Care. Taking a multi-faceted approach, this will be delivered via an increase in the

number and type of diagnostic tests available in the community, continual improved interface between primary and secondary care clinicians to support patients being managed in primary care and review of pathways and models of care, including the use of innovation where available.

## 2.5 Financial Plan

The table below summaries the financial plan and also the 2019/20 forecast outturn as at month 10:

| Item | 2019/20 Forecast Outturn at M10 | 2020/21 Plan | Change |
|---|---|---|---|
| Income (£m) | 370.3 | 384.6 | 14.3 |
| PSF & FRF* (£m) | 8.2 | 0 | (8.2) |
| Expenditure (£m) | (373.1) | (390.4) | (17.3) |
| **Operating Surplus / (Deficit)** | **5.4** | **(5.8)** | **(11.3)** |
| Finance Costs (£m) | (3.7) | (4.2) | (0.5) |
| Gain from transfer by absorption | 7.9 | **0** | **(7.9)** |
| **Surplus / (Deficit)** | **9.4** | **(10.0)** | **(19.4)** |
| *Adjusted Financial Performance:* | | | |
| Remove transfer by absorption | (7.9) | 0 | 7.9 |
| Add back impairments | 1.4 | 0 | (1.4) |
| Remove donations | (0.1) | 0 | 0.1 |
| Remove Prior year PSF | (0.4) | 0 | 0.4 |
| **Adjusted Surplus / (Deficit)** | **2.4** | **(10.0)** | **(12.4)** |
| | | | |
| SAVI | 11.2 | 8.0 | (3.2) |
| UoR | 3 | 1 | |
| WTEs (Number) | 5,677 | 6,105 | 428 |

**Notified 2020/21 FRF of £2,011k is NOT included as it would not achieve the required year-end balance. Submission template therefore dictates zero is recorded and FIT rejected. For clarity: FRF required = £10m. Original offer £2m. Additional requested £8m.*

The table above shows a deficit of £10.0m (-£8m below the £2m FRF offer) This does not achieve the required requested Financial Improvement Target (FIT) for 2020/21 based on operational planning assumptions.

The 2020/21 plan includes a planned efficiency of £8.0m through the Trust's Service and Value Improvement (SAVI) programme, which equates to 2.1% or turnover and exceeds the NHSI recommendation of 1.6% for deficit Trusts.

The income and expenditure variance from forecast outturn to plan are explained in the sections 2.7 and 2.8.

## 2.6 Income & Activity

| Item | 2019/20 Forecast Outturn at M10 | 2020/21 Draft Plan | Change |
|---|---|---|---|
| Income (£m) | 370.3 | 384.6 | 14.3 |
| PSF & FRF (£m) | 8.2 | 0 | (8.2) |
| **Total Income (£m)** | **378.5** | **384.6** | **6.1** |

The Trust income plans reflect the NHS Standard Contract and the impact of the 2020/21 consolidation tariff for all activity.

The Trust is in the final stages of agreeing a minimum value contract with Wigan Borough CCG and the current position has formed the basis of the plan.

The 2020/21 draft final plan includes additional growth as per the agreed base line locality growth assumptions detailed below:

- Accident and Emergency - 4%
- Electives – 2%
- Non electives - 4%
- Out patients – 3%

Whilst the growth has been included in the plan it is widely acknowledged that the Trust has one of the lowest bed bases in Greater Manchester which makes it extremely difficult to meet all of the national standards set out in the constitution due to year on year increases in demand and new higher levels of surge demand.

In response to the low bed base and to maintain the integrity of the elective programme and to reduce the congestion in A&E a new community assessment unit co located on the acute site providing an additional 21 beds and 6 assessment units will be operational from October 2020. In addition to the community beds the trust is developing its same day emergency care and out of hospital pathways. This will maintain the integrity of the elective care waiting list whilst meeting the demands of emergency care.

The 2020/21 final plan also includes repatriation of elective Orthopaedic activity on the Wrightington site, which due to being on a standalone site is not compromised by the limited beds detailed above.

The draft plan does not include the £2m FRF that has been notified to the Trust as the 2020/21 FIT has not been accepted. Therefore there is a reduction in PSF/FRF funding of (£8.2m) from the 2019/20 out turn.

The draft plan includes an increase in income of £2.5m relating to the uplift for Trauma and Orthopaedics complex surgery. This is not included within tariff but was received in 2019/21 and NHSE have confirmed that this will also be received in 2020/21.

The draft plan includes £12.3m additional income relating to the underlying deficit caused by the transfer of community services plus additional funding to cover winter pressures from the local council.

The following summarises the material income changes from 2019/20 forecast to 2020/21 plan:

- 2020/21 Tariff impact - £5.3m
- Reduction in PSF/FRF - (£8.2m)
- Increase in CQUIN - £0.3m
- Specialist Commissioning changes to Cancer and Neonates funding - (£2.3m)
- Underlying demand and growth - £6.5m
- Demand management / commissioners intentions - (£2.0m)
- 2019/20 non recurrent CIP - (£1.1m)
- Community and winter funding - £12.3m
- One off non recurrent income including release of provisions - (3.8m)

## 2.7 Expenditure

Pay budgets for staff are calculated on a person by person basis. Staff who are on Agenda for Change contracts have been uplifted for the cost of the national pay award and have been funded at their current incremental level. For staff on Medical and Dental contracts a 2% pay uplift has been assumed as well as funding at current incremental levels.

Inflation on non-pay including drugs has been applied in line with national and local assumptions.

A reserves budget of £2m has been included to help mitigate any unforeseen pressures during the year. This includes £1m of corporate reserves and £1m of divisional reserves.

The following table summarises the inflation planning assumptions along with the estimated impact:

| Item | 2020/21 Inflation | Impact £m |
|---|---|---|
| Pay Awards | 3.6% | (10.3) |
| Incremental Drift | | |
| Non Pay Inflation | 1.8% | (1.4) |
| Drug Inflation | 0.6% | (0.1) |

**Pay Expenditure**

| Item | 2020/21 Forecast Outturn at M10 | 2020/21 Plan | Change |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Pay (£m) | (252.6) | (273.7) | (21.1) |
| WTE Established (Number) | 5,677 | 6,105 | 428 |

In addition to the anticipated inflationary increases, the Trust is expecting a net increase in WTE of 222 from M10 forecast WTE worked to closing 2019/20 WTE established of 5,899 WTE.

This includes an increase of 26 WTE's CIP not achieved in 2019/20 and 196 WTE for posts vacant and not temporarily backfilled (at M10). Both have been included in the 2020/21 budget.

In addition there has been an increase of approximately 214 WTE for business cases and other service developments.

The material changes from forecast outturn to plan for pay expenditure are as follows:

- 2019/20 non recurrent CIP – (£5.1m)
- Pay award & incremental drift – (£10.3m)
- Underlying demand & investments (including growth) – (£9.8m) which includes:
    - Workforce plan £3.0m
    - Global Training and Education Centre £0.9m
- Reductions for cost improvement programme – £2.7m

**Non Pay Expenditure**

| Item | 2019/20 Forecast Outturn at M10 | 2020/21 Plan | Change |
|---|---|---|---|
| Non Pay (£m) | (120.1) | (116.7) | 3.4 |

The Trust has funded 0.6% non-pay inflation for drug and 1.8% non-drug expenditure in line with both national guidance and local assumptions.

The material changes from forecast outturn to plan for pay expenditure are as follows:

- Non pay inflation – (£1.5m)
- Underlying demand & investments (including growth) – (£1.3m)
- Cost improvement programme – £5.0m
- Increase in depreciation charges based on planned capital programme – (£1.1m)
- One off release of balance sheet provisions not required in 2019/20 – £1.2m
- Impairment of Community assets in 2019/20 - £1.4m

## 2.8 Cash and Use of Resources

The closing cash balance for 2019/20 is forecast at £42.6m. Monthly closing cash balances for 2020/21 based on this opening actual balance are shown.

| Apr £m | May £m | Jun £m | Jul £m | Aug £m | Sep £m | Oct £m | Nov £m | Dec £m | Jan £m | Feb £m | Mar £m |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 38.4 | 38.3 | 38.0 | 38.2 | 38.2 | 36.8 | 35.7 | 35.6 | 34.0 | 32.1 | 26.0 | 14.8 |

Cash will be internally generated from trading profits and cash flows have been profiled to reflect movements in working balances as a result of the invoicing cycle, prepayments and release of provisions over the course of the year.

The planned closing cash balance for 2020/21 is £12.8m

The UoR Risk Ratings by month (year to date) are shown in the table below:

| Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 3 | 3 | 3 | 2 | 3 | 3 | 3 | 3 | 3 | 1 | 1 | 1 |

## 2.9 Strategic Plan v Long Term Plan Finances

Although the long term plan submitted in November 2019 showed a breakeven position for 2020/21 this included £13.0m of unidentified efficiencies and £3.0m assumed FRF, a total gap of £16.0m. This plan assumes a gap of £10.0m therefore an improvement of £6.0m.

The Trusts operational plan has also been impacted by the following items which were not included in the long term plan:

- Agenda for change pay award £3.0m above the 2.9% in the long term plan guidance
- Achievement of 92% bed occupancy - £2.2m
- Specialist commissioning tariff changes relating to Cancer and Neonates - £2.3m

## 2.10 Financial efficiencies

WWL continues with its commitment and approach to taking an integrated approach to improvement for 2020/21, aligning its internal programme of efficiency improvements alongside those that are being delivered in partnership across the locality and ensure quality and financial benefits are recognised.

The Trust has eight transformation themes and opportunities confirmed for 2020/21 and within these a number of programmes to improve the quality of services and their efficiency. All programmes, both implementation plan and benefits, are informed by analysis of information (qualitative and quantitative) to ensure plans are robust and evidenced-based. The themes for 2020/21 are: Operational Effectiveness, Workforce Transformation, Urgent

Care and Planned Care Transformation, Non-core business development, Service and Site Strategic review, placed-based working and innovation and new technology.

Financial benefits of all transformation programmes are phased in accordance with implementation plans with a focus on the benefit of programmes being delivered as early in the year as possible. Many of the programmes are a continuation of programmes of change in 2019/20, which will assist in benefits being delivery from the beginning of the financial year.

The plan includes £8m of efficiency savings which represents 2.1% of turnover and is consistent with the planning guidance.

In addition to the £8m efficiency target the Trust plan includes £12.3m relating to the locality investment initiative which demonstrates a combined required efficiency of 5.3%.

## 2.11 Agency

The Trust has and will continue to strive to reduce agency costs and the following are in place to enable this goal to be achieved:

Investment has been agreed to improve and increase recruitment in to vacant nursing roles and funds have also been approved to retain and maintain the existing nursing workforce by offering band 6 roles to registered nurses who achieve specific additional competencies.

The Trust has a close working relationship with NHS Professionals and sees the value using their expertise and flexibility to fill vacant shifts hence negating the requirement for premium rate agency workers.

In partnership with Health Education England the Trust has created a new internal team called the 'Global Training and Education Centre (GTEC)' which are developing an international nurse recruitment programme to fill vacancies at the Trust. The intention is that this programme will be utilised across the region to reduce vacant posts and the associated temporary spend.

## 2.12 Capital Planning Rules

The Trust has, as in previous years, adopted a structured approach to capital planning and management. This includes the prioritisation of risk assessed capital schemes prior to inclusion on the capital plan and monitoring of performance against the plan via a monthly Capital Committee meeting. Minutes of this meeting are provided to the Finance and Performance Committee, which is a sub-committee of the Board.

5 year rolling capital plans have previously been received from members and these plans have been used as a basis for the Trust's capital plan for 2020/21 onwards. With the exception of 2021/22 it is expected that capital expenditure will be funded from depreciation, cash reserves and where possible centrally funded capital schemes. For 2021/22 the trust will require external funding to support its capital requirements.

All schemes within the capital plan will be subject to the production of a full business case and appropriate scrutiny through the Trust governance processes.

| £m | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|---|
| Total | 38.2 | 77.4 | 48.5 | 12.0 | 12.0 |

# 3.0 Workforce Planning

## 3.1 Introduction

Workforce has been a key theme during the last quarter of 2019/2020 with the approval of our workforce plan and its key phases featuring as an area of focus and in depth discussion on Trust Board led agendas. With the energy of a newly formed group of directors under the leadership of a new Chief Executive the Trust has approved workforce plans for the next 5 years to respond to needs of our staff, our immediate community of patients and service users, plus those within the wider system across Greater Manchester.

The plans have been designed to reflect the key areas of the NHS Interim People Plan and will evolve once the final People Plan is published ensuring as a Trust we are able to remain agile to the national direction of travel. This notwithstanding, we are assured our workforce plan and WWL People Promise, mapped against the nation key priorities will deliver the Trust's objectives for 2020/2021.

## 3.2 NHS Interim People Plan

The Interim People Plan was published in June 2019 aligning to the NHS Long Term Plan which was released earlier in the year. WWL people objectives were subsequently developed and approved by the Trust's board of directors. These objectives are consistent with the themes of work identified in the NHS Interim People Plan.

The Interim People Plan sets out a new operating framework that puts **workforce planning at the centre of overall planning processes**. This recognises that the **people components of the five year local system plans will be critical to their success**.

The NHS Interim People Plan sets out 4 key priorities and themes of work:

1. Making the NHS the best place to work
2. Improving leadership culture
3. Tackling the nursing challenge
4. Delivering 21st century care

**Making the NHS the best place to work**

WWL has for many years recognised the link between staff engagement and patient experience / outcomes and productivity. The Interim People Plan reinforces this point, but highlights concerns regarding levels of bullying & harassment, the experience of BAME (Black, Asian and minority ethnic) staff and sickness absence.

The Interim People Plan recognises that the culture of the NHS is being negatively impacted by our people being over stretched. We acknowledged this within the Trust's Workforce Committee and explored those links to our quarterly 'Your Voice' staff engagement surveys and the National Staff Survey, recognising that culture is affected by much more than staffing levels alone.

The People Plan recognises the competitive employment market we operate in, the multi-generational workforce we now have and the employment flexibilities that many staff crave. Our Director of Workforce is the Exec Lead within GM HRD's leading a piece of work with 4 pilot teams across GM looking at the psychological contract of work and how we can facilitate and embed "job crafting" within our health and care teams.

The People Plan sets out the need to **prioritise the people agenda at Board** and senior leadership. The employment offer – measured through a **balanced score card that will become part of the NHS Oversight Framework**:

- Healthy, inclusive and compassionate culture
    - *Valuing and respecting all*
    - *Promoting equality, inclusion and widening participation*
    - *Tacking bullying, harassment, violence and abuse*
- Enabling development and fulfilling careers
    - *Education, training and career / professional development*
    - *Recognition of qualification and training between NHS employers ("Streamlining")*
    - *Line management and supervision*
- Staff have a voice, control and influence
    - *Whistleblowing and freedom to speak up*
    - *Physical and mental health & wellbeing to reduce sickness absence*
    - *Workload, work-life balance, clear & timely rotas, flexible working and managing unpaid caring responsibilities*
    - *Work environment*

These priorities map to our People Promise pledges and the assessment methodology we use with the Go Engage programme and diagnostic.

**Improving leadership culture**

The People Plan sets out the need to focus on developing a positive, inclusive and people centred culture that engages and inspires our people with a clear focus on improvement and advancing equality of opportunity.

Building on Developing People – Improving Care (2016), identifies four critical leadership capabilities:

- System leadership
- Established quality improvement methods
- Inclusive and compassionate leadership
- Talent management

The People Plan recognises the importance of diversity, inclusion and equality in this domain, requiring Trusts to not only champion ED&I, but to recognise our shortcomings in the area and listen to those who face exclusion and marginalisation to better understand how to advance equality and diversity. We must be an organisation that reflects the diversity of the community we serve.

It is essential that we take a more deliberate approach to talent management: identifying, assessing, developing and deploying individuals with the capacity and capability to make a difference in the most senior positions, creating a pipeline of clinical and non-clinical talent ready to take on senior leadership roles in the future. Strong clinical leadership is essential

and we need to make it easier for clinicians to pursue careers in management and leadership.

The People Plan identifies the need to develop a framework which will hold senior leaders to account. The new 'compact' being developed will set out the 'gives and gets' to shape the recruitment, development and appraisal of our NHS leaders and so our objectives are reflective of this. Our objectives are also reinforced by our Education & Leadership Strategy, underpinned by an ethos for all staff, at all levels, to have the continued opportunity to 'Learn and Grow' during their career within the Trust.

**Tackling the nursing challenge**

There is urgent need to support and retain existing nurses, significantly increase the number of newly qualified nurses joining the NHS, bring nurses in from abroad and make the most of the nurses we already have.

The Trust was invited as a high performing organisation on Cohort 5 of the NHSI Retention Direct Support Programme, and will continue to implement the learning and best practice from the programme into 2020/2021.

Undergraduate placement capacity is being expanded nationally and WWL has already agreed to significantly increase our placement allocations in support of this. Nationally, there is an aim to increase placement capacity by 25%. Nursing needs to be seen as an attractive profession and more needs to be done to strengthen the image and perception of the professions to encourage the next generation of nurses.

Our workforce plan will be implemented in a prioritised and phased approach throughout 2020/21. We continue to work at reducing our registered nurse vacancies, with an aspiration of Nil vacancies by September 2020. This will be delivered through a number of recruitment and retention strategies. These strategies focus on both aspects of a strong attraction agenda to those considering joining the Trust and also ensuring our skilled and valuable existing staff remain engaged, motivated and happy to stay with us. We also recognise that the shortage of registered nurses will continue to be a challenge for years to come. With this in mind, front and centre to maintaining patient safety and addressing these workforce challenges is to make sure that we have the right staff with the right skills to meet our population needs and to do this we will ensure our ward based registered professional staffing ratios are appropriate and evidence based to meet the needs of our services. To do this we have committed extensive investment into increasing the numbers of professionally registered staff across our inpatient wards where required.

There is recognition that it will take time to address the supply and demand gap through domestic programmes and therefore international recruitment is essential in the short to medium term.

Health Education England will continue to build global partnerships and exchanges and NHSE/I will become responsible for the coordination of local health systems' international recruitment efforts. STP's will implement 'lead recruiter' arrangements. WWL has a proven track record in ethical overseas recruitment for medical staff with the Learn, Earn & Return (MCH / MMED) programme. We will continue to build on this during 2020/21 with international nursing recruitment, in partnership with Health Education England. Having previously recruited nurses from European countries, we have a programme of nurses being recruited from India, who will be supported through a 'Learn, Earn & Return' programme.

**Delivering 21st century care**

The NHS Long Term Plan sets out a vision for 21st century care: increasing care in the community, redesigning and reducing pressure on emergency hospital services, more personalised care, digitally enabled primary and outpatient care and a focus on population health and reducing health inequalities. This will require growth and transformation of the workforce, to a workforce that is more flexible and adaptive, has a different skill mix and has more time to provide care. Our workforce will need the skills, education and training to fulfil these new roles, extend their practice and work in multi-disciplinary teams.

The Interim People Plan recognises the need to enhance the skill mix, by scaling up the development and implementation of new roles and new models of advanced clinical practice and providing clear career pathways that enable people to continue developing and achieving their maximum potential. This requires investment in developing the roles, the right professional standards and professional regulation. One of the actions identified to accelerate this richer skill mix is the development of multi-professional credentials.

## 3.3 Workforce expansion

With increasing demand, the People Plan acknowledges that we will need steady year on year growth in the clinical workforce and that **much of the additional Long Term Plan funding will go to meeting these additional pay costs**. Workforce expansion plans also need to take account of future levels of investment in education, training and workforce development, whether funded by employers or national NHS bodies.

WWL has designed a workforce plan in consideration of these requirements and through its phased approach, recognising the investment needed, has commenced a plan to build a multi-disciplinary workforce responding to the diverse needs of our patient population and accompanying the clinical workforce already established. The appointment of a Chief Allied Health Professional (AHP) and the creation of an AHP and health care scientist (HCS) strategy endeavours to give a framework and direction of travel to complement our planning and intentions.

- Medical workforce – will need to continue to grow, but we must also focus on retaining our current doctors. This may include further expansion of undergraduate medical school places. In the short term, overseas recruitment is recognised to be a vital part of the jigsaw. We will continue to utilise our successful overseas medical pipelines via our MCh programme to underpin where we have shortages in our medical workforce however we will remain agile to any success in terms of local or national recruitment or training pipelines.

  Nationally there will be a focus on the health and well-being of our junior doctors plus SAS doctors will be valued and recognised as attractive career options for doctors who may not wish to become consultants or GP's and a reformed associate specialist grade will be introduced. We have recognised this locally and in response to our engagement results of our trainee doctors our immediate priority phase of our workforce plan increases our junior doctor cohort within our wards. The Trust will remain proactive, in support of the national SAS charter and continue to work in partnership to ensure that this valuable workforce have the support, acknowledgment and autonomy they deserve in accordance with the roles they perform.

- Nursing, midwifery & AHP/HCS workforce – in addition to addressing the supply gap, registered staff should be supported to develop into advanced practice or as academics or educators for the next generation. The nursing associate role will

continue to be developed as a bridge between health care assistants and the registered nurse. We will continue to sustain our development pipelines for future nurses and AHPs via our Undergraduate Nursing and ODP Career Talent Management Pathway and AHP Strategy. We remain committed to ensuring the long term career pathways are open to our clinical staff and look to ways to ensure that advanced practitioners from all disciplines are able to work to their full clinical capabilities.

We look forward to growing our alternative workforce models, incorporating proven roles, such as physician associates who will complement and support our medical workforce.

## 3.4 Releasing time to care

Clinical teams will be supported to take increased ownership of planning and deploying the workforce. This will include consistent and effective implementation of electronic rostering and electronic job planning systems. Trusts are expected to roll these out across the entire workforce by 2021. Additional investment to be able to progress with the development of these systems is required. The Trust acknowledges what can be achieved by delivering significant service improvements and staff productivity gains through substantial reshaping of services via technology and therefore is considering this as part of its potential investment portfolio. External funding routes will be explored to take this forward should internal funding not be available.

## 3.5 Widening routes into NHS careers

The NHS must use its role as an anchor institution to create employment opportunities in local communities for school leavers, those with disabilities and those looking to switch career. Apprenticeships, at all levels, will provide a mechanism for this, alongside youth volunteering opportunities in partnership with #iwill and the Pears Foundation. STP arrangements will be put in place to optimise use of the apprenticeship levy and relationships with local education providers will be strengthened. We already have strong partnerships with local further education institutes and act as a conduit between them and higher education institutes to ensure our local population have the best opportunities to earn learn and grow, to achieve their full potential.

The Trust will remain engaged with the future workforce and the promotion of the career opportunities available to school leavers. Our recruitment and retention plan includes dedicated recruitment events, which allow apprenticeships to lead the careers conversation and showcase the positive differences that apprenticeships can make to individuals, employers and to the wider economy.

Our Talent for Care Programme also aims to inspire the future WWL workforce and to raise awareness of the variety of roles within Trust, whilst supporting young people to develop their long-term careers. Our WWL Career Ambassadors will continue to support the local community in learning about the exciting job opportunities here at WWL. It is our social responsibility to provide opportunities for local people to experience work based learning within the NHS, and the WWL Talent for Care Programme enables local people to gain valuable skills, knowledge and information about joining the WWL Family

# 4.0 Quality Planning

## 4.1 Approach to quality improvement

WWL has fully embedded the national Getting It Right First Time programme into transformation programmes of work. Monthly GIRFT and Model Hospital meetings are chaired by the Trust's Medical Director with Clinical and Operational Leads presenting updates within their speciality against opportunities identified in GIRFT programmes on a bi-annual basis. In 2019/20 the Trust created and appointed into a Clinical Director for GIRFT and Model Hospital to increase the focus and leadership around reducing unwanted variation and has already seen numerous improvements across a range of specialities as a result of improvement work.

During 2020/21 WWL is committed to ensuring that the "fundamental standards" of quality are met. The Trust considers a range of sources of assurance to understand compliance with the Fundamental Standards which is outlined in the Trust's Assurance and Escalation Framework. The Trust will continue to develop its multi-disciplinary accreditation framework in 2020/21. One of the aims of the scheme is to encourage quality improvement. Outstanding practice and innovation is captured during the accreditation visits. Clinical audits related directly to the fundamental standards are a significant element of the Trust's Corporate Clinical Audit Programme in 2020/21.

## 4.2 System delivery

The Wigan Locality Plan is now agreed and going to Wigan Health and Well Being Board in February 2020 for final sign off. Quality runs through all of the Chapters within the Locality Plan for the Integration of Health and Care Services locally.

Internal Governance Arrangements are currently being reviewed and within the draft handbook/framework received by the Governing Body this shows an Integrated Quality Group will be established to ensure quality issues are considered in the strategic decision making and governance processes of Wigan Borough CCG.

The CCG are currently at the start of drafting the new Quality Strategy based on a number of drivers one of which would be this guidance.

## 4.3 Patient Safety Strategy

In July 2019, NHS England/NHS Improvement published the NHS Patient Safety Strategy which outlines several new requirements for NHS providers, with specific actions for 2020/21. The following section highlights the actions required and how WWL will be responding to those actions during 2020/21.

- ***Adoption of the Just Culture Guide or equivalent approach endorsed by national patient and national professional organisations to ensure a fair response to incidents by provider organisations.***

  The NHS Patient Safety Strategy recognises that staff operate in complex systems with many factors influencing the likelihood of error; therefore a 'systems' approach to error should be followed. The strategy advises that NHS Trusts undertake the following:-

  - Use existing culture metrics like those in the NHS staff survey to understand their safety culture and focus on staff perceptions of the fairness and effectiveness of incident management: WWL have commenced this work to incorporate staff

engagement. Proposed focus groups will assist us to hear staff perceptions and to understand some of the solutions that may overcome them. Analysis of the latest internal staff survey data "Your voice" will assist us to understand the areas across the Trust that may require addition support.

- Focus on the development and maintenance of a just culture by adopting the NHS Just Culture Guide (referenced at the beginning of this paper) or equivalent – WWL aims to ensure that this is consistently followed and embedded. Actions taken by WWL to support this include the implementation of an employee triage panel to triage all potential conduct cases to ensure that formal processes are only initiated when absolutely appropriate. Consideration is given to whether the incident in question is an issue of misconduct, or whether there are other factors that require consideration in the first instance, for example, capability, training, process failings or human factors resulting from issues such as rostering arrangements, ill health etc. WWL is developing a personalised support system for every member of staff who is subject to formal employee relations process. This may include access to a well-being practitioner, occupational health, an independent advocate to provide support to the employee and an agreed communications framework.
- Embed the principles of a safety culture within and across local systems organisations, and align those efforts with work to ensure organisations adhere to the well-led framework and its eight key lines of enquiry – Embedding a just or patient safety culture which is open to learning, rather than punitive actions, has to be recognised at every level of the Trust and championed or role modelled by the Board of Directors and Senior Leaders.

- ***Appointing a patient safety specialist in each Trust and CCG using available guidance***

  WWL will identify a patient safety specialist, following consideration of the national role specification, and notify NHS England/NHS Improvement and Wigan Borough Clinical Commissioning Group by June 2020.

- ***Establishing medical examiner functions in acute trusts and planning for the establishment of these functions in community settings.***

  WWL is appointing 0.63WTE Medical Examiners and 1.5WTE Medical Examiner Officers to support the medical examiner function from April 2020. This reflects the national guidance and the numbers of deaths at WWL in one year. During 2020/21 WWL will ensure that this function is embedded into existing governance processes and is established as a key element of the Trust's learning from deaths agenda.

## 4.4 Local Risk Management systems

- ***Ensuring compatibility of Local Risk Management Systems with the Patient Safety Incident Management System (PSIMS), expected to launch in 2020/21.***

  WWL awaits the launch of the Patient Safety Incident Management System (PSIMS) in 2020/21 and will ensure the compatibility with Datix, the Trust's Local Risk Management System.

- ***Preparing for the inclusion of two patient safety partners on safety-related committees by the 1st April 2021***

During 2020/21 WWL will prepare for the inclusion of two patient safety partners on safety-related committee by the 1st April 2021 following the publication of a national framework for NHS Trusts.

- ***Ensure effective organisational responses to all relevant national patient safety alerts, recognising the introduction of a contractual obligation to do so. Providers to ensure appropriate internal escalation routes for actioning National Patient Safety Alerts to ensure Executive Director oversight***

  During 2020/21 WWL will continue the processes in place to review and respond to relevant national patient safety alerts, to include audits of those noted as complete by the Trust. The Trust has an internal escalation process in place to ensure Executive Director Oversight. The Trust's Chief Nurse chairs a quality group responsible for the oversight of the processes to action National Patient Safety Alerts.

- ***Providers should ensure continued Board-level consideration of data on the occurrence of areas that were measured by the safety thermometer.***

  WWL ceased undertaking the safety thermometer from February 2020 and will ensure that Board-level consideration of data on pressure ulcers, venous thromboembolism, catheter acquired infections and patient falls continues.

# 5.0 Membership & Elections

## 5.1 Elections to the Council of Governors

Elections to the Council of Governors were held in the summer of 2019. A total of eight public governor posts were subject to election, and there was a mixture of contested and uncontested elections.

It was not necessary to undertake elections in the Makerfield constituency as it had the necessary number of nominations to fill the seats unopposed. It is pleasing to note that, whilst there was no requirement for a contested election, there were no seats left vacant.

There were contested elections in the Leigh, Wigan and the Rest of England and Wales public constituencies. For the Leigh public constituency, 196 votes were cast out of 1,881 eligible voters, a turnout of 10.4%. In the Wigan constituency, the turnout was 12.8%, with 325 votes being cast out of a total electorate of 2,548. The Rest of England and Wales election saw a turnout of 7.7%, with 202 votes being cast from a total electorate of 2,619.

All successful candidates took up office, or continued their second term of office as appropriate, immediately following the Annual Members' Meeting on 19 September 2019. Further elections to the Council of Governors will take place in the summer of 2020, with successful candidates commencing their term of office after the Annual Members' Meeting on 17 September 2020.

## 5.2 Governor Recruitment, Training and Development

Each year we contact the membership and invite them to stand to become a member of the Council of Governors. We also offer dedicated information sessions where we outline the role of the governor and give practical examples of how to complete the various nomination forms. On appointment, governors undertake an induction and are offered the opportunity to have an informal buddy. 1:1 meetings with the Chair are organised and workshop sessions are provided throughout the year to support both new and existing governors to understand the workings of the foundation trust and the wider NHS. Additional training and development opportunities are offered throughout the year, such as sessions organised by NHS Providers and the North West Governors' Forum, organised by NHS Company Secretaries from across the region.

## 5.3 Engagement between Governors, Members and the Public

Throughout the year we run a number of information sessions which members and the public are invited to. These, along with the Annual Members' Meeting, provide an opportunity for governors to interact with members and the public and to seek their views. We also provided a number of public engagement sessions in February and March 2020 to allow governors and management the opportunity to discuss our strategy and operational plan.

## 5.4 Plans for Coming 12 Months

During 2019/20 the Council of Governors approved its Membership Engagement Strategy which sets out the engagement focus and the activities that will be undertaken, with a focus on improving the quality of our engagement including with hard-to-reach and under-represented groups.

**Appendix A - Our People objectives linked to "making the NHS the best place to work"**

| Go Engage | |
|---|---|
| **Objective** | **Measurement** |
| Improve staff engagement and organisational culture so that staff feel happy and supported in work, feeling empowered to deliver change | • National Staff Survey engagement score of 4 (5 point scale) / 7.5 (10 point scale) or above<br>• Shows continuous improvement and learning, as demonstrated through the Your Voice Surveys<br>• Has values and behaviours as a golden thread through the employment lifecycle<br>• Supports psychological safety and encourages staff to speak up<br>• Makes WWL a great place to work (Friends and Family Test – 75% recommendation as a place to work)<br>• Go Engage Your Voice survey cultural enabler score of 36 or more |
| **Steps 4 Wellness** | |
| **Objective** | **Measurement** |
| Improve the health and well-being of WWL staff | • Robust & supportive attendance management processes<br>• Improving the take up of Steps 4 Wellness programmes<br>• Responsive and pro-active occupational health provision<br>• Reduce sickness absence to 4% |

| WWL Route Planner | |
|---|---|
| **Objective** | **Measurement** |
| Expansion of the apprenticeship offer | • Improving organisational understanding of apprenticeships<br>• Increasing the demographic diversity of apprentices<br>• Providing high quality experience of work and education<br>• Providing support to learners to achieve the best possible outcomes<br>• Developing career pathways for apprentices<br>• 100% utilisation of the apprenticeship level |
| Create an environment that recognises the value of professional development | • Providing the personal and professional development opportunities to support the development of new workforce models<br>• Providing dedicated study leave allocation for clinical practitioners<br>• 100% utilisation of upskilling funding aligned to Trust and divisional priorities<br>• Development of Divisional Education & Development panels in partnership with trade union colleagues |

**Appendix B- Our People objectives linked to "improving leadership culture"**

| WWL Route Planner | |
|---|---|
| **Objective** | **Measurement** |
| Make compassionate leadership the norm | • Ensure that leaders at all levels and in all staff groups have the tools and capability to lead effectively<br>• Ensure that leadership opportunities reflect the Trust's I&D ambitions<br>• Ensure that the way results are achieved is assessed and valued equally to the delivery of results<br>• Bespoke leadership programme for all current and aspirant clinical leaders<br>• Leadership 360 to help inform self-reflection and My Route Plan discussions |
| Design and implement a robust talent management and succession planning processes | • Identifies and develops a talent pipeline for business critical positions (starting with Board roles)<br>• Is inclusive and values diversity<br>• Provides personalised development programmes<br>• Development of divisional education and development panels |
| **Go Engage** | |
| **Objective** | **Measurement** |
| I&D - WWL is an employer that values diversity and inclusion demonstrated by our workforce at all levels being representative of the community we serve | • Reducing the gender pay gap by 5%<br>• Improvement in WRES<br>• Improvement in the WDES<br>• Talent & succession plans aligned to ED&I ambitions<br>• Divisional & staff group targets regarding diversity and equality of opportunity |

**Appendix C- Our People objectives linked to "delivering 21st century care"**

| WWL essentials | |
|---|---|
| **Objective** | **Measurement** |
| Develop and implement a creative workforce plan that delivers improved and appropriate workforce models to benefit staff and patients | • Clinical vacancy rate under 5%<br>• Identified talent pool & associated succession plans<br>• 100% and prioritised use of the apprenticeship levy and CPD funding<br>• Embraces technological solutions<br>• Safely supports the delivery of planned levels of activity and patient acuity<br>• Designs workforce models aligned to integrated models of care<br>• Makes the best use of financial resources<br>• Engagement in the GM job crafting pilot to facilitate job design and employment flexibilities that are bespoke to individual needs, whilst maintaining safe & effective rostering |
| Ensure the most effective and efficient deployment of the workforce<br><br>**NB Can only be prioritised if external funding and resourcing infrastructure is available** | • Implementation of e-job planning and e-rostering (90% of the workforce by 2021) |
| Develop and implement a robust volunteer strategy<br><br>**NB Can only be prioritised if external funding and resourcing infrastructure is available** | • Trajectory to double the number of volunteers by 2023<br>• Clear alignment to the Trust's strategic vision<br>• Enables opportunities for widening participation, career development & apprenticeships<br>• Provides purpose and value to the volunteer |

| WWL essentials | |
|---|---|
| **Objective** | **Measurement** |
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| Ensure the most effective and efficient deployment of the workforce<br>**NB Can only be prioritised if external funding and resourcing infrastructure is available** | • Implementation of e-job planning and e-rostering (90% of the workforce by 2021) |
| Develop and implement a robust volunteer strategy<br>**NB Can only be prioritised if external funding and resourcing infrastructure is available** | • Trajectory to double the number of volunteers by 2023<br>• Clear alignment to the Trust's strategic vision<br>• Enables opportunities for widening participation, career development & apprenticeships<br>• Provides purpose and value to the volunteer |

Appendix D- additional tables required within planning guidance

| Table 1 | | |
|---|---|---|
| Reconfirm the total number of planned FTE staff (including both substantive and temporary staff) | Update where changes are material to strategic submission | Reason for update |
| The total number of planned staff is 6,105 in 2020/21. | Workforce plan indicates increase of 274.8 WTE for 2020/21 as @ February 2020 based on latest information. | Workforce plan is proactive however all plans must be approved via internal governance processes and therefore may not be realised.<br><br>Workforce continues to be augmented and responds to organisational need and strategic objectives. |

| Table 2 | | |
|---|---|---|
| **The best to place work actions** | **Planned outcomes**<br><br>**Y1** | **Progress and identified support needs** |
| Creating a positive, inclusive and compassionate working culture | • National Staff Survey overall engagement score of 7.5 in 2020.<br>• Your Voice overall engagement score of 4 by 20/21 Q4.<br>• Staff FFT 75% recommend as a place to work<br>• New ED&I strategy is to be developed for 2020/21, which will include workforce and service delivery performance trajectories<br>• Improvements in ED&I staff experience metrics<br>• WRES/WDES & Gender Pay Gap Action plan implementation | • Work ongoing in identifying barriers to progression, focusing on gender/ethnicity<br>• Leadership/management development offer under review and redevelopment<br>• Appraisal (My Route Plan) in redevelopment<br>• Coaching offer in redevelopment<br>• Work to embed the WWL behaviours through the development of campaigns and interventions that enhance civility, psychological safety and compassionate leadership, with a key focus on the specific needs for ED&I. |
| Giving voice, influence and value to staff | • Your Voice and NSS response rates of 30% or above<br>• Your Voice 'The organisation acts on staff feedback' score of >3.5 by 20/21 Q4 | • Review underway around methods of listening to staff, and how information gathered is acted upon and fed back |

| Table 2 ( cont'd) | | |
|---|---|---|
| **The best to place work actions** | **Planned outcomes Y1** | **Progress and identified support needs** |
| Providing an effective, safe and healthy working environment | • Dedicated FTSU Guardian and creation of cohort of Speak Up Champions<br>• Ongoing promotion of Speak Up.<br>• Completion and embedding of 'Just Culture' and 'Fair experience for all' actions<br>• Reduce employee sickness absence to <4% | • Appointment taken place of full time FTSU Guardian<br>• Ongoing progress with action plan<br>• Review of audit processes for mandatory training<br>• Steps 4 Wellness offer ongoing including wider rollout of health checks and uptake of health improvement programmes. |
| Enabling and supporting staff to develop and fulfil their potential | • NSS 2020 improvement in questions rating of quality of appraisals – to average or better than average. | • My Route Plan redesign launch in Q1 20/21<br>• Increasing utilisation of apprenticeships<br>• Planned review of development offer |
| Ensuring staff can have a predictable and flexible working pattern | • Continued exploration and adoption of staff initiatives and new ways of thinking<br>• Level 1 (level of attainment) achieved across staff groups in relation to eRostering and eJob Planning.<br>• Promotion of flexible working policy<br>• Understand staff feedback and work in partnership to develop further flexible working approaches.<br>• Action plan from engagement with staff via survey on staff childcare needs.<br>• Continuation of buying annual leave offer | • Job crafting pilot near completion and lessons learned to be integrated as appropriate |

| Table 3 | | |
|---|---|---|
| **Releasing time to care actions** | **Planned outcomes**<br><br>**Y1** | **Progress and identified support needs** |
| E-rostering: | Level 1 has already been achieved for nursing staff. | Due to financial constraints any further expansion and use of the system will require external funding or other internal funding streams to be identified. None have been identified at this time and therefore any further progress above Level 1 is not expected. |
| E-job planning: | It is expected that Level 1 will be achieved by March 2021 as a system is in place and above 90% of employees who have access to the system will be using it. | Due to financial constraints any further expansion and use of the system will require external funding or other internal funding streams to be identified. None have been identified at this time and therefore any further progress above Level 1 is not expected. |

| Table 4 | | | |
|---|---|---|---|
| **The biggest FTE challenges, please identify staff groups** | **Actions (please identify where this is in collaboration with other organisations)** | **Projected impact Y1** | **Identified support needs** |
| **Trust wide**<br>Nursing workforce – general i.e. Wards and additional areas<br>e.g.Paediatric Nursing / Theatres / Walk in Centre | • Board approved Recruitment and retention programme implemented.<br>• Phased workforce plan approved by Board, with investment to improve ward based staffing.<br>• Multi-disciplinary staffing models increased<br>• ACP development | • 50.7 wte increase in 2020/21 in reg and/or unreg staffing across wards depending on patient requirements.<br>• Ward Based AHPs & pharmacy technicians<br>• Ward based discharge coordinators | Increased funding |
| **Trust wide**<br>Medical staff - Junior doctors on wards | • Phased workforce plan approved by Board.<br>• Introduction of Physician Associate posts | • 20 junior doctors increase across inpatient wards and emergency medicine.<br>• Increase of 2 wte PAs in 2020/21 | Increased funding |
| **Specialist Services Division**<br>Medical staff - Dermatology (Consultant) – Long standing challenge. | • Locums currently<br>• North West Sector (Bolton, WWL and Salford) collaboration on joint service approach under discussion and planning phase | • Stabilised if joined up service in place. | |
| **Specialist Services Division**<br>AHP - Radiographers | • Piloting international recruitment programme via Manchester Foundation Trust.<br>• B5 to B6 development programme to underpin retention and use in marketing for roles | • Unknown<br>• Still to be scoped and taken forward. Impact currently unknown. | |

| Table 4 ( cont'd) | | | |
|---|---|---|---|
| **The biggest FTE challenges, please identify staff groups** | **Actions (please identify where this is in collaboration with other organisations)** | **Projected impact Y1** | **Identified support needs** |
| **Surgical Division**<br>Medical staff<br>- Anaesthetics (Consultant and ST3+)<br>- Paeds (Consultant)<br>- General Surgery & Colorectal (Consultant)<br>- Ophthalmology(Consultant / ST3+) | • Redesigning job plans and on-call rotas<br>• Engagement of past trainees to return<br>• Use of 'Trust' Associate Specialist posts<br>• Regional collaborative work with North West Sector on joined up service and service redesign<br>• Workforce plans inclusive of development of alternative workforce models e.g. ACPs | • Stability of workforce.<br>• Progression of new workforce models i.e. training of staff to advanced level. | • Additional temporary (supernumerary) funding with return on investment after staff qualify via conversion from medical budget |
| **Surgical Division**<br>AHP – Vascular Scientist | • Grow your own approach – developed a new training role, with a secondment supported from Radiology Dept | • Establishment/role filled | |
| **Medicine Division**<br>Medical staff<br>Emergency Medicine (ST3+; ST1/2; Consultants)<br>Acute Medicine<br>Cardiology<br>Respiratory | • Redesigning job plans and on-call rotas<br>• R&R premia<br>• MCH Programme<br>• Introductions of Physician Associate Posts<br>• Use of 'Trust' Associate Specialist posts<br>• Dedicated pharmacy support in Emergency department<br>• Workforce plans inclusive of development of alternative workforce models e.g. ACPs | • Stability of workforce.<br>• Progression of new workforce models i.e. training of staff to advanced level. | • Additional temporary (supernumerary) funding with return on investment after staff qualify via conversion from medical budget |

| Table 5 | | | |
|---|---|---|---|
| **Assumptions relating to an increase in bank from agency staffing:** | **Actions (please identify where this is in collaboration with other organisations)** | **Projected impact**<br>**Y1** | **Identified support needs** |
| Non-clinical agency | • Trust has commissioned NHSP to implement bank provision for corporate and estates roles. | • Continued reduction of agency to bank usage for those roles not excluded according the NHSI Agency rules. | • Local marketing to encourage agency workers to join the bank. |
| Internal audit on agency usage | • Outcomes from this audit may provide additional oversight and insight into identifying opportunities for transfer from agency to bank roles. | • Unknown | • Engagement from divisional medical management to identify and follow up actions. |
| Long term high cost agency workers | • Use management information to identify and open discussions with individuals (mostly medical workers) to transfer to bank from agency | • Reduction in agency costs. | • Support required from medical management and divisional operational managers. |
| Unfilled nursing shifts | • Increased bank nursing pay rates<br>• (WWL is part of the APP arrangement across Greater Manchester, which standardised agency rate cards through the NHSP vacancy management system cascade) | • Increase in bank fill rates and decrease in agency filled rates and associated spend. | • |
| Medical bank | • Promotion of medical bank via NHSP and targeted marketing campaign<br>• Doctors in training collaborative bank across lead employer commissioners<br>• Improved digital offer providing more user friendly booking process for bank workers | • Increase in medical filled shifts and decrease in agency shifts and associated spend | • |

| Table 5 ( cont'd) | | | |
|---|---|---|---|
| **Assumptions relating to an increase in bank from agency staffing:** | **Actions (please identify where this is in collaboration with other organisations)** | **Projected impact Y1** | **Identified support needs** |
| Workforce plan – increase in ward based registered/unregistered professionals | • Implementation and recruitment of 50 wte across the wards | • Outcome and improved staffing rates should also lead to increased staff on bank therefore increased fill rates, decrease in agency usage. | |
| Recruitment and retention programme | • Implementation of programme via recruitment events, financial incentives and internal retention programmes such as development programmes and dedicated study leave. | • Outcome and improved staffing rates and decreased turnover should also lead to increased staff on bank therefore increased fill rates, decrease in agency usage. | |

**To:**
Chief executives of all NHS trusts and foundation trusts
CCG Accountable Officers
GP practices and Primary Care Networks
Providers of community health services

**Copy to:**
Chairs of NHS trusts, foundation trusts and CCG governing bodies
Local authority chief executives and directors of adult social care
Chairs of Local Resilience Forums
Chairs of ICSs and STPs
NHS Regional Directors
NHS 111 providers

NHS England and NHS Improvement
80 London Road
Skipton House
London SE1 6LH
england.spoc@nhs.net

17 March 2020

Dear Colleague,

**IMPORTANT AND URGENT – NEXT STEPS ON NHS RESPONSE TO COVID-19**

Thank you for your extensive work to date to prepare for this rapidly increasing pandemic, following the NHS declaration of a Level 4 National Incident on 30 January.

Last night the Government announced additional measures to seek to reduce the spread across the country. It is essential these measures succeed. However as the outbreak intensifies over the coming days and weeks, the evidence from other countries and the advice from SAGE and the Chief Medical Officer is that at the peak of the outbreak the NHS will still come under intense pressure.

This letter therefore sets out important actions we are now asking every part of the NHS to put in place to redirect staff and resources, building on multiple actions already in train. These will:

- Free-up the maximum possible inpatient and critical care capacity.
- Prepare for, and respond to, the anticipated large numbers of COVID-19 patients who will need respiratory support.
- Support staff, and maximise their availability.

- Play our part in the wider population measures newly announced by Government.
- Stress-test operational readiness.
- Remove routine burdens, so as to facilitate the above.

Please therefore now enact the following measures:

**1. Free-up the maximum possible inpatient and critical care capacity**

The operational aim is to expand critical care capacity to the maximum; free up 30,000 (or more) of the English NHS's 100,000 general and acute beds from the actions identified in a) and b) below; and supplement them with all available additional capacity as per c) below. To that end, trusts are asked now to:

a) Assume that you will need to postpone all non-urgent elective operations from 15th April at the latest, for a period of at least three months. However you also have full local discretion to wind down elective activity over the next 30 days as you see best, so as to free up staff for refresher training, beds for COVID patients, and theatres/recovery facilities for adaptation work. Emergency admissions, cancer treatment and other clinically urgent care should continue unaffected. In the interim, providers should continue to use all available capacity for elective operations including the independent sector, before COVID constraints curtail such work. This could free up 12,000-15,000 hospital beds across England.

b) Urgently discharge all hospital inpatients who are medically fit to leave. Community health providers must take immediate full responsibility for urgent discharge of all eligible patients identified by acute providers on a discharge list. For those needing social care, emergency legislation before Parliament this week will ensure that eligibility assessments do not delay discharge. New government funding for these discharge packages and to support the supply and resilience of out-of-hospital care more broadly is being made available. (See section 6f of this letter). Trusts and CCGs will need to work with local authority partners to ensure that additional capacity is appropriately commissioned. This could potentially free up to 15,000 acute beds currently occupied by patients awaiting discharge or with lengths of stay over 21 days.

c) Nationally we are now in the process of block-buying capacity in independent hospitals. This should be completed within a fortnight. Their staff and facilities will then be flexibly available to you for urgent surgery, as well as for repurposing their beds, operating theatres and recovery facilities to provide respiratory support for COVID-19 patients. As soon as we have the detailed capacity map of what will be available in each part of the country we will share that with you via Regional Directors. NHS trusts and foundation trusts should

free up their own private pay beds where they exist. In addition, community health providers and social care providers are asked to free up community hospital and intermediate care beds that could be used flexibly within the next fortnight. These measures together could free up to 10,000 beds.

**2. Prepare for, and respond to, large numbers of inpatients requiring respiratory support**

Emerging international and UK data on COVID-19 patients suggests that a significant proportion who are hospitalised require respiratory support, particularly mechanical ventilation and to a lesser extent non-invasive ventilation.

a) Work is well in hand nationally to secure a step change in oxygen supply and distribution to hospitals. Locally, hospital estates teams have now reported on their internal oxygen piping, pumping and bedside availability. All trusts able to enhance these capabilities across their estate are asked to do so immediately, and you will be fully reimbursed accordingly. The goal is to have as many beds, critical care bays, theatre and recovery areas able to administer oxygen as possible.

b) National procurement for assisted respiratory support capacity, particularly mechanical ventilation, is also well under way in conjunction with the Department of Health and Social Care. In addition, the Government is working with the manufacturing sector to bring new manufacturers online. These devices will be made available to the NHS across England, Wales, Scotland and Northern Ireland according to need. Mark Brandreth, chief executive of Agnes Jones and Robert Hunt foundation trust is now supporting this work.

c) In respect of PPE, the DHSC procurement team reports that nationally there is currently adequate national supply in line with PHE recommended usage, and the pandemic influenza stockpile has now been released to us. However locally distribution issues are being reported. Michael Wilson, chief executive of SASH, is now helping resolve this on behalf of the NHS. In addition if you experience problems there is now a dedicated line for you: 0800 915 9964 / 0191 283 6543 / Email: supplydisruptionservice@nhsbsa.nhs.uk.

d) A far wider range of staff than usual will be involved in directly supporting patients with respiratory needs. Refresher training for all clinical and patient-facing staff must therefore be provided within the next fortnight. A cross-specialty clinical group supported by the Royal Colleges is producing guidance to ensure learning from experience here and abroad is rapidly shared across the UK. This will include: a short education package for the entire NHS workforce; a service guide, including for anaesthetics and critical care; COVID-19 clinical management guides in collaboration with NICE.

e) Segregate all patients with respiratory problems (including presumed COVID-19 patients). Segregation should initially be between those with respiratory illness and other cases. Then once test results are known, positive cases should be cohort-nursed in bays or wards.

f) Mental Health, Learning Disability and Autism providers must plan for COVID-19 patients at all inpatient settings. You need to identify areas where COVID-19 patients requiring urgent admission could be most effectively isolated and cared for (for example single rooms, ensuite, or mental health wards on acute sites). Case by case reviews will be required where any patient is unable to follow advice on containment and isolation. Staff should undergo refresher training on physical health care, vital signs and the deteriorating patient, so they are clear about triggers for transfer to acute inpatient care if indicated.

**3. Support our staff, and maximise staff availability**

a) The NHS will support staff to stay well and at work. Please ensure you have enhanced health and wellbeing support for our frontline staff at what is going to be a very difficult time.

b) As extra coronavirus testing capability comes on line we are also asking Public Health England as a matter of urgency to establish NHS targeted staff testing for symptomatic staff who would otherwise need to self-isolate for 7 days. For those staff affected by PHE's 14 day household isolation policy, staff should - on an entirely voluntary basis - be offered the alternative option of staying in NHS-reimbursed hotel accommodation while they continue to work. Sarah-Jane Marsh, chief executive of Birmingham Women's and Children's foundation trust is now supporting this work.

c) For staff members at increased risk according to PHE's guidance (including pregnant women), if necessary, NHS organisations should make adjustments to enable staff to stay well and at work wherever possible. Adjustments may include working remotely or moving to a lower risk area. Further guidance will be made available and the Royal College of Obstetrics and Gynaecology will provide further guidance about pregnant women.

d) For otherwise healthy staff who are at higher risk of severe illness from COVID-19 required by PHE's guidance to work from home, please consider how they can support the provision of telephone-based or digital / video-based consultations and advice for outpatients, 111, and primary care. For non-clinical staff, please consider how they can continue to contribute remotely. Further guidance will be made available

e) The GMC, NMC and other professional regulators are also writing to clinicians who have relinquished their licence to practice within the past three years to see whether they would be willing to return to help in some capacity.

f) Urgent work is also underway led by chief nursing officer Ruth May, NHS chief people officer Prerana Issar and Health Education England, the relevant regulators and universities to deploy medical and nursing students, and clinical academics. They are finalising this scheme in the next week.

g) All appropriate registered Nurses, Midwives and AHP's currently in non-patient facing roles will be asked to support direct clinical practice in the NHS in the next few weeks, following appropriate local induction and support. Clinically qualified staff at NHSE/I are now being redeployed to frontline clinical practice.

h) The four UK chief medical officers, the national medical director, the Academy of Medical Royal Colleges and the GMC have written to all UK doctors stressing that it will be appropriate and necessary for clinicians to work beyond their usual disciplinary boundaries and specialisms under these difficult circumstances, and they will support individuals who do so. (see https://www.aomrc.org.uk/wp-content/uploads/2020/03/0320_letter_supporting_doctors_in_COVID-19.pdf ) Equivalent considerations apply for nurses, AHPs and other registered health professionals.

**4. Support the wider population measures newly announced by Government**

Measures announced last night are detailed at:
https://www.gov.uk/government/publications/covid-19-guidance-on-social-distancing-and-for-vulnerable-people/guidance-on-social-distancing-for-everyone-in-the-uk-and-protecting-older-people-and-vulnerable-adults

a) Ministry of Housing, Communities and Local Government (MHCLG) and local authorities in conjunction with their Local Resilience Forums (LRFs) have lead responsibility for overseeing support for older and vulnerable people who are going to be 'shielded' at home over the coming months. Community health services and voluntary organisations should engage with LRFs on how best to do this.

b) A number of these individuals would be expected to have routine or urgent GP, diagnostic or outpatient appointments over the coming months. Providers should roll out remote consultations using video, telephone, email and text message services for this group as a priority and extend to cover all important routine activity as soon as possible, amongst others. David Probert, chief

executive of Moorfields foundation trust, is now leading a taskforce to support acute providers rapidly stand up these capabilities, with NHSX leading on primary care. Face-to-face appointments should only take place when absolutely necessary.

c) For patients in the highest risk groups, the NHS will be identifying and contacting them over the coming week. They are likely to need enhanced support from their general practices, with whom they are by definition already in regular contact. GP services should agree locally which sites should manage essential face-to-face assessments. Further advice on this is being developed jointly with PHE and will be available this week.

d) As part of the overall 'social distancing' strategy to protect staff and patients, the public should be asked to greatly limit visitors to patients, and to consider other ways of keeping in touch such as phone calls.

**5. Stress-test your operational readiness**

a) All providers should check their business continuity plans and review the latest guidance and standard operating procedures (SOP), which can be found at https://www.england.nhs.uk/coronavirus/.

b) Trust Incident Management Teams – which must now be in place in all organisations - should receive and cascade guidance and information, including CAS Alerts. It is critical that we have accurate response to data requests and daily sitrep data to track the spread of the virus and our collective response, so please ensure you have sufficient administrative capacity allocated to support these tasks.

c) For urgent patient safety communications, primary care providers will be contacted through the Central Alerting System (CAS). Please register to receive CAS alerts directly from the MHRA: https://www.cas.mhra.gov.uk/Register.aspx.

d) This week we are undertaking a system-wide stress-testing exercise which you are asked to participate in. It takes the form of a series of short sessions spread over four days from today. Each day will represent a consecutive week in the response to the outbreak, starting at 'week six' into the modelled epidemic. We would strongly encourage all Hospital Incident Management Teams with wider system engagement (including with primary care and local government representation) to take part.

## 6. Remove routine burdens

To free you up to devote maximum operational effort to COVID readiness and response, we are now taking the following steps nationally:

a) Cancelling all routine CQC inspections, effective immediately.

b) Working with Government to ensure that the emergency legislation being introduced in Parliament this week provides us with wide staffing and regulatory flexibility as it pertains to the health and social care sector.

c) Reviewing and where appropriate temporarily suspending certain requirements on GP practices and community pharmacists. Income will be protected if other routine contracted work has to be substituted. We will issue guidance on this, which will also cover other parts of the NHS.

d) Deferring publication of the NHS People Plan and the Clinical Review of Standards recommendations to later this year. Deferring publication of the NHS Long Term Plan Implementation Framework to the Autumn, and recommending you do the same for your local plans.

e) Moving to block contract payments 'on account' for all NHS trusts and foundation trusts for an initial period of 1 April to 31 July 2020, with suspension of the usual PBR national tariff payment architecture and associated administrative/ transactional processes.

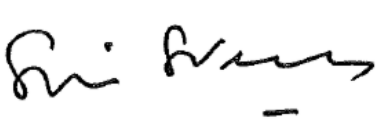
f) Additional funding to cover your extra costs of responding to the coronavirus emergency. Specific financial guidance on how to estimate, report against, and be reimbursed for these costs is being issued this week. The Chancellor of the Exchequer committed in Parliament last week that *"Whatever extra resources our NHS needs to cope with coronavirus – it will get."* So financial constraints must not and will not stand in the way of taking immediate and necessary action - whether in terms of staffing, facilities adaptation, equipment, patient discharge packages, staff training, elective care, or any other relevant category.

COVID-19 presents the NHS with arguably the greatest challenge it has faced since its creation. Our health service - through our skilled and dedicated staff - is renowned for the professional, flexible and resilient way that it responds to adversity. Please accept our sincere thanks for your leadership, and that of your staff, in what is going to be a highly challenging period.

This is a time when the entire NHS will benefit from pulling together in a nationally coordinated effort. But this is going to be a fast-moving situation requiring agile

responses. If there are things you spot that you think we all should be doing differently, please let us know personally. And within the national framework, do also use your discretion to do the right thing in your particular circumstances. You will have our backing in doing so.

With best wishes,



Sir Simon Stevens
NHS Chief Executive

Amanda Pritchard
NHS Chief Operating Officer

## ANNEX: CORONAVIRUS COST REIMBURSEMENT

This guidance sets out the amended financial arrangements for the NHS for the period between 1 April and 31 July. These changes will enable the NHS and partner organisations (including Local Authorities and the Independent Sector) to respond to COVID-19. We will continue to revise this guidance to reflect operational changes and feedback from the service as the response develops.

We will shortly be making a payment on account to all acute and ambulance providers to cover the costs of COVID-19-related work done so far this year, with final costs for the current financial year being confirmed as part of the year end processes. This initial payment will be based on information already submitted by providers. Future payments will be based on further cost submissions.

All NHS providers and commissioners must carefully record the costs incurred in responding to the outbreak and will be required to report actual costs incurred on a monthly basis. Accurate record keeping during this time is crucial - record keeping must meet the requirements of external audit, and public and Parliamentary scrutiny.

To support reimbursement and track expenditure we will in due course be asking all relevant organisations to provide best estimates of expected costs from now until the expected end of the peak outbreak. We will provide further guidance with relevant assumptions in order to support you in making these estimates.

### REVENUE COSTS

#### Contractual payments and provider reimbursement

We are suspending the operational planning process for 2020/21.

We will provide all NHS providers a guaranteed minimum level of income reflecting the current cost base on the following basis:

a) Commissioners should agree block contracts with the NHS providers with whom they have a contract (NHS Trusts, Foundation Trusts, Mental Health, Community and Ambulance trusts) to cover the period 1 April to 31 July. This should provide a guaranteed monthly payment. For CCGs the value of this payment will be calculated nationally for each CCG/provider relationship. This figure will be based on the average monthly expenditure implied by the provider figures in the M9 Agreement of Balances return plus an uplift that allows for the impact of inflation (including pay uplifts and CNST) but excluding the tariff efficiency factor. It will not include activity growth. For mental health trusts the uplift will include an additional sum consistent with

delivering the Mental Health Investment Standard. The monthly payment should include CQUIN and assume 100% delivery.

b) Trusts should suspend invoicing for non-contracted activity for the period 1 April to 31 July. A sum equivalent to the historical monthly average will be added to the block contract of the provider's coordinating commissioner. Providers should continue to record all activity including NCAs in SUS in the normal way.

c) A national top-up payment will be provided to providers to reflect the difference between the actual costs and income guaranteed by steps 1 and 2 where the expected cost base (which will be calculated as the average monthly expenditure over the period November to January uplifted for inflation) is higher. The Financial Recovery Fund and associated rules will be suspended during this period. The top-up payment will take into account individual provider CNST contributions compared to that funded in the allowance for cost inflation.

We will provide these numbers to Commissioners and Providers on Monday 23 March.

Providers should claim for additional costs where the block payments do not equal actual costs to reflect genuine and reasonable additional marginal costs due to COVID-19. These reasonable costs should include:

a) Evidenced increases in staffing costs compared to the baseline period associated with dealing with increased total activity.

b) Increases in temporary staffing to cover increased levels of sickness absence or to deal with other caring responsibilities (e.g. to look after other family members).

c) Payments for bank or sub-contractor staff to ensure all sickness absence is covered consistent with Government's announced policy and public health advice which aren't otherwise covered under normal practice; and

d) Additional costs of dealing with COVID-19 activity. For example: the costs of running NHS111 assessment pods; increases in the volumes required or prices of equipment to deal with the response to the virus which aren't offset by reductions elsewhere; extra costs of decontamination and transport for the ambulance service; higher testing volumes in acute-based laboratories; and community-based swabbing services.

Claims should be made on a monthly basis, alongside regular monthly financial reports. This should provide sufficient funds for providers to deliver a break-even

position through the period and will provide the basis against which we will monitor financial performance.

We will monitor the impact of any changes in income levels from non-NHS services, in particular from local authorities. Providers should escalate to regional teams as appropriate.

The payments made by commissioners under block contract arrangements should not be revised to reflect any short falls in normal contractual performance during this period. The majority of NHS acute providers are already exempt from the majority of contract sanctions; for the duration of the outbreak until further notice any remaining contract sanctions for all NHS provider groups are to be suspended.

It is important that providers and commissioners pay promptly during this time, so that cash flow for NHS and non-NHS suppliers of goods and services does not become a barrier to service provision.

The arrangements described above should mean there is minimal requirement for interim working capital support during this period. Providers that believe they require supplementary working capital support should follow the normal procedure to access such support.

**Funding for commissioners**

Commissioner allocations for 2020/21 have already been notified as part of operational planning and will not be changed. However, in assessing individual commissioner financial positions and affordability we will take into account:

a) The impact of the block contracting approach set out above including both the cost of removing the tariff efficiency factor and the benefit of excluding activity growth from the calculation.

b) Expected reductions in investments for service developments
    - the temporary arrangements for non-contracted activity, transferring funding to make sure that lead commissioners have adequate funds to pay providers; and
    - the costs of additional service commitments as described below for example for out of hours provision, additional NHS111 investment, purchase of step-down beds and provision of rapid discharge/ additional social care capacity.

c) We will also be reviewing planned transformation initiatives, and where we consider that these will not be able to proceed during the coronavirus emergency we will reflect this in the distribution of transformation funding.

d) In addition, a number of NHS commissioners are dependent on additional central support to fully cover their expenditure. NHSE/I will calculate a central top up payment on broadly the same basis as FRF to cover the difference between allocations as set out above and expected costs.

**Financial Governance**

The maintenance of financial control and stewardship of public funds will remain critical during the NHS response to COVID-19. Chief Executives, Accountable Officers and Boards must continue to comply with their legal responsibilities and have regard to their duties as set out in Managing Public Money and other related guidance. Any financial mismanagement during this period will be dealt with in exactly the same way as at any other time.

We recommend that NHS organisations undertake an urgent review of financial governance to ensure decisions to commit resources in response to COVID-19 are robust. Naturally, all organisations should test the resilience of their finance functions and business continuity plans to make sure that the most important elements (running payroll, paying suppliers, core reporting) can continue even with significant staff absences. We are also asking you to consider the resilience of your fraud prevention arrangements.
As normal financial arrangements have been suspended, no new revenue business investments should be entered into unless related to Covid-19 or unless approved by NHSE/I as consistent with a previously agreed plan. Where costs have already been committed or contractual commitments entered into, providers should agree an approach with NHSE/I as above.

Normal consultancy approval and agency reporting requirements must be maintained during this period.

**SPECIFIC ADDITIONAL FUNDING CONSIDERATIONS**

**Purchase of enhanced discharge support services**

CCGs will be asked to work with their local authority partners to commission additional out-of-hospital care and support capacity, in particular to facilitate step down of patients from secondary care and so free up acute beds. These are expected to be a blend of care home beds, hospices, and home-care support.

Detailed operational guidance for the procurement and management of these beds will be issued separately including more detailed finance guidance. To make sure that funding decisions do not restrict the pace of discharges, additional resources will be provided to pay for the community bed or a package of care post-discharge for any

patient that needs it. New guidance will also ensure that eligibility assessments do not delay new care packages being put in place. We will continue to review this approach and will ask CCGs and local authorities to move to standard commissioning and funding routes once the impact of Covid-19 sufficiently diminishes – you should plan therefore on the basis of an average length of care package.

Additional funding will be provided based on monthly cost returns from CCGs.

**Specialised services**

As described above, Specialised Services contracts will follow the same principles as CCG commissioned activity, and block values will be based on the average 2019/20 expenditure up to month 9, with an uplift to recognise the impact of pay uplifts and other cost increases.
Arrangements for pass through Drugs and Devices costs will continue to operate as currently on a cost and volume basis, to ensure that providers do not face any financial consequences of any increases in activity or cost.

Specialised providers will be required to respond to the most serious cases of COVID-19 through the provision of High Consequence Infectious Disease units, Extracorporeal Membrane Oxygenation services and other specialised care functions. Any specific investments and costs incurred by these units are being coordinated through the National Highly Specialised team.

**NHS 111**

NHS 111 has been commissioned nationally to provide a dedicated Covid-19 response service. This service will continue to be contracted for and funded nationally. In addition, having reviewed the pressures on the wider NHS 111 service additional funding will be released from NHSE/I via lead commissioners, who will then make necessary arrangements for payment to NHS 111 providers.

**General Practice**

The key principle is that from 1 April we free up practices to prioritise workload according to what is necessary to prepare for and manage the outbreak, and therefore guarantee that income will be protected if other routine contracted work has to be substituted. This does not prevent us from continuing to measure activities (for example those undertaken with QOF) but it ceases to put 2020/21 income at risk for performance.

We will make sure that funding does not influence clinical decision making by ensuring that all GP practices in 2020/21 continue to be paid at rates that assume they would

have continued to perform at the same levels from the beginning of the outbreak as they had done previously, including for the purposes of QoF, DES and LES payments.

CCGs should plan to make payments on this basis. NHSE/I will reimburse any additional costs as part of our wider finance agreement on Covid-19.

**Out of Hours Provision**

CCGs have been asked to procure additional GP out of hours provision in order to provide home-based care for any patients that have tested positive for coronavirus in the community. CCGs will be reimbursed for the additional costs incurred in delivering this service through the allocations process. CCGs will be required to submit a monthly return of additional cost incurred which will provide the basis of additional payments. To keep the administrative burden to a minimum, where a CCG has contracted for this service on behalf of itself and others, reimbursement will be directed through the lead CCG.

**Community Pharmacy**

Where required, CCGs will be reimbursed for the following:

a) An NHS Urgent Medicines Supply Service for patients whose General Practice is closed.

b) A Medicines Delivery Service to support Covid-19 positive and vulnerable patients self-isolating at home.

c) Payments to contractors who are required to close due to Covid-19 related reasons.

**Optometry and dental**

For the time being we expect that funding for dentistry and optometry will continue in line with existing contractual arrangements using assumptions rolled over from 2019/20 where required. We will keep this under review and address any issues as they arise.

**Third and Independent Sector Providers**

Details of reimbursement for any additional services to be procured from the third sector or from independent sector organisations will be issued in due course.

## CAPITAL COSTS

NHSE/I will shortly issue indicative capital allocations for 2020/21. Additional capital expenditure will be required to support our response to the virus in a number of areas, including purchase of pods, capital modifications to existing estate, purchasing of ventilators and other medical equipment, and IT assets to enable smarter working including remote consultations. In a number of cases NHSE/I may bulk-purchase assets to secure the necessary resource as quickly as possible. However, this will not always be practical or desirable, so below are the arrangements for providers and commissioners to access capital in relation to the COVID-19 response. The key criteria against which we will assess claims are:

a) The proposed expenditure must be clearly linked to delivery of our COVID-19 response;
   NHS
b) In the case of asset purchases, the asset must be capable of being delivered within the expected duration of the outbreak; and

c) In the case of modifications to estate, the works must be capable of being completed within the expected duration of the outbreak.

### Commissioner capital

We anticipate that individual claims for capital expenditure by commissioners will fall within the delegated budgetary limits for NHSE/I of £10m. Any requests for capital expenditure by commissioners including any assets being purchased on behalf of general practice should be relayed to NHSE/I regional teams for assessment with the national team, following which the required capital allocation will be issued.

### Provider capital

We anticipate that individual claims for capital expenditure by providers will fall within the delegated budgetary limits for trusts of £15m. Any requests for capital expenditure by providers should be relayed to NHSE/I regional team for rapid assessment with the national team to enable swift decision making and disbursement of cash where appropriate. PDC charges will not be levied on any funding supplied in connection with COVID-19.

**Summary**

| Group | Service line | Funding method |
|---|---|---|
| **Revenue costs** | | |
| All NHS organisations | Contracting basis | All providers to move to block contract, |
| | Self-isolation of workers | To be directly reimbursed as required |
| | Increased staff costs in the event of sick or carer's leave | To be directly reimbursed as required |
| | Other additional operating costs | Reasonable costs to be reimbursed |
| Acute providers | Pod provision | Initial on-account payment based on submissions received so far<br>Final 19/20 payment based on updated cost template<br>Ongoing 20/21 costs to be reimbursed monthly based on cost submissions |
| | Laboratory costs | To be directly reimbursed as required |
| CCGs | Purchase of step-down beds | Final 19/20 payment based on cost submissions<br>Ongoing 20/21 costs to be reimbursed monthly based on cost submissions |
| | Out of Hours (primary care) capacity increase | Additional allocations to be paid to CCGs to pass on to providers |
| Specialised services | Patient admissions | To be funded through block contractual payments |
| | Drugs costs | Payments for drugs not included in tariff will continue in the normal way |
| Ambulance providers | Additional PPE and cleaning | Initial on-account payment based on submissions received so far<br>Final 19/20 payment based on updated cost template<br>Ongoing 20/21 costs to be reimbursed monthly based on cost submissions |
| Community | Swabbing services | Final 19/20 payment based on updated cost template<br>Ongoing 20/21 costs to be reimbursed monthly based on cost submissions |

| Group | Service line | Funding method |
|---|---|---|
| NHS 111 | National CRS function | Costs to be reimbursed nationally |
| | Additional local 111 funding | Additional allocations to be paid via CCGs where agreed |
| **Capital costs** | | |
| Acute providers | Equipment and estate modification as required | PDC allocation from DHSC to provider trust |
| CCGs (including primary care) | Equipment as required | NHS England allocation to CCGs funded via DHSC mandate adjustment |

# REPORT

**AGENDA ITEM: 12**

Wrightington, Wigan and Leigh NHS Foundation Trust

| | | | |
|---|---|---|---|
| **To:** | Board of Directors | **Date:** | 25 March 2020 |
| **Subject:** | Gender Pay Gap Report | | |
| **Presented by:** | Director of Workforce | **Purpose:** | Approval |

## Executive summary


This report provides an analysis of the Trust`s Gender Pay Gap information as at 31 March 2019 and is the third round of annual mandatory reporting the Trust has undertaken. It was considered by the People Committee at its meeting on 24 March 2020.

The data highlights as at 31 March 2019 the Trust has a 35.53% mean average gender pay gap with females earning **£7.92 an hour less** than males. As at March 2019 the Trust has a 19.98% median hourly rate gender pay gap with females earning **£3.09 an hour less** than males. This position has slightly improved in comparison with 2018 data.

As at 31st March 2018 male staff proportionately continue to be heavily constituted within the highest earning quartile (quartile 4) with **35.62%** of all male staff being situated within quartile 4 when they represent **21%** of the overall Trust workforce. A key factor is due to the Medical & Dental workforce being predominantly male at 74% and this staff group are predominantly constituted within the highest earning quartile.

As at 31st March 2019 female staff proportionately continue to have lower representation in the highest earning quartile at 64.38% compared with female staff representing 79% of the overall workforce.

The 2019 bonus gender pay gap highlights an improving position over a 3 year timeframe at an mean gender pay gap of **55%** in 2019 compared with **75%** in 2017. The bonus pay is primarily related to clinical excellence awards that are awarded to recognise and reward Consultants who perform `over and above` the standard expected in their role

A key factor underpinning the Trust`s gender pay gap is due to gender pay differentials within the Medical & Dental staff group and Admin & Management staff groups. Within these staff groups female staff are significantly constituted within the lower pay quartiles and this is a key contributing factor underpinning the Trusts overall gender pay gap.

Gender Pay Gap actions including improvement trajectories are included within the Inclusion & Diversity Strategy.


The WWL Way

| Risks associated with this report |
|---|
| It is noted there are possible risks of adverse publicity being generated due to the Trust`s gender pay gap and in addition this could negatively impact upon the engagement of female staff who may feel unfairly treated and disengaged. Whilst it is recognised these risks exist it is noted there has been no adverse publicity generated to date in response to the publishing of the Trust`s previous Gender Pay Gap information. In addition there is not yet any qualitative data that suggests engagement levels have been adversely impacted linked specifically to the Trust`s gender pay gap.<br><br>There are possible risks of employment tribunal claims relating to discrimination arising from the gender pay gap; however, to date no claims of this nature have arisen within the Trust.<br><br>The existing gender pay gap risk assessment will be reviewed in response to these potential risks and follow up actions will be undertaken as appropriate. |

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

## 1 Background

On the 31 March 2017, it became mandatory for public sector organisations with more than 250 employees to report annually on their gender pay gap.

The gender pay gap differs from equal pay and the two terms are not interchangeable. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman.

The gender pay gap shows the differences in the **average pay** between men and women. If a workplace has a particularly high gender pay gap, this can indicate there may a number of issues to deal with, and the individual calculations may help to identify what those issues are.

The Trust is obliged to publish the following information on our public-facing website and report to government by the 31st March 2020:

- The difference between the mean hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees ( 'the mean gender pay gap');
- The difference between the median hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees ('the median gender pay gap');
- The difference between the mean bonus pay paid to male relevant employees and that of female relevant employees ('the mean gender bonus gap');
- The difference between the median bonus pay paid to male relevant employees and that of female relevant employees ('the median gender bonus gap')
- The proportions of male and female relevant employees paid bonus pay ('the proportions of men and women getting a bonus'); and
- The proportions of male and female relevant employees in the lower, lower middle, upper middle and upper quartile pay band ('the proportion of men and women in each of four pay quartiles').

## 2 Gender Pay Gap Reporting Key points

Appendix 1 includes a full copy of the Trust`s Gender Pay Gap information which has been obtained from the Electronic Staff Record (ESR) standard reports. The ESR standard reports are nationally produced to ensure the NHS meet their gender pay gap reporting requirements and the reporting period for the gender pay gap data is as at 31 March 2019.

2.1 Key Points to note are:

- The Trust workforce is 79% female and 21**%** male
- The Trust Medical & Dental workforce is 74% male and 26% female with 31% of the Trust`s overall male workforce being constituted within the Medical & Dental staff group
- As at March 2019 the Trust has a 35.53% mean average gender pay gap with females earning **£7.92 an hour less** than males. The mean average gender pay gap in 2019 has improved marginally in comparison with 2018 data when as at 31st March 2018 females earned **£7.93 an hour** less than males with a 36.52% mean average gender pay gap
- As at March 2019 the Trust has a 19.98% median hourly rate gender pay gap with females earning **£3.09 an hour less** than males. The median gender pay gap in 2019 has improved and as at 31 March 2018 females earned **£3.29 an hour less** than males with a 21.67% median gender pay gap.
- As at 31st March 2018 **35.62%** of male staff are situated within the highest earning quartile (quartile 4) compared with male staff representing 21% of the overall workforce. A key factor is due to the Medical & Dental workforce being predominantly male at 74% and this staff group are predominantly constituted within the highest earning quartile.
- As at 31st March 2019 female staff proportionately continue to have lower representation in the highest earning quartile at 64.38% compared with female staff representing 79% of the

overall workforce. This position has improved slightly compared with March 2018 data when 63.98% of female staff were constituted within quartile 4.

- The 2019 bonus pay highlights an improving position over a 3 year timeframe with an average bonus gender pay gap of **65%** in 2017, **60%** in 2018 and **55%** in 2019. The median gender pay gap of **75%** in 2017, **71.05%** in 2018 and **55.56%** in 2019. The bonus pay is primarily related to clinical excellence awards that are awarded to recognise and reward Consultants who perform `over and above` the standard expected in their role. It should be noted the Consultant workforce is predominantly male at 82%.

### 2.2 Gender Pay Gap Granular reporting

In response to the gender pay gap reporting the Trust has undertaken a granular analysis of the gender pay gap data by staff group to identify any hot spot areas. Medical & Dental and Administrative & Management staff groups have been identified as areas where gender pay is a particular concern.

The medical & dental staff group has a 25.34% mean gender pay gap with female medical & dental staff earning **£9.83 per hour less** than male medical & dental staff. This is due to female medical & dental staff being primarily constituted within this staff group`s lower pay quartiles with only 11% of female medical & dental staff being constituted within the medical & dental highest pay quartile (quartile 4).

If we exclude Medical & Dental staff from the Trust wide gender pay gap figures the Trust`s mean gender pay gap is **5.01%** which equates to females earning **0.74 pence** less than male staff per hour. This compares with the Trust`s overall gender pay gap (inclusive of Medical & Dental staff) of 35.53% which equates to females earning **£7.92 an hour less than male staff.**

An analysis of the gender pay gap for the Administrative & Management staff group highlights this staff group has a 31.54% average pay gap with female administrative & management staff earning **£5.70 an hour less** than male administrative & management staff. Males within this staff group are significantly constituted within the highest pay quartile at 27% male in quartile 4 compared with 16% male in quartile 1, 8% male in quartile 2 and 10% male in quartile 4.

## 3 Financial Impact

The potential financial impact resulting from gender pay gap is the risk of any employment claim awards relating to discrimination and unlike other tribunal claims such as unfair dismissal there is no limit on the compensation that can be awarded in discrimination claims. To date there have been no employment tribunal claims linked to gender pay gap levied against the Trust.

## 4 People Impact

Gender Pay Gap is a complex issue and there are many contributing factors including external societal factors and internal workforce factors. The people issues which arise from the gender pay gap are wide ranging and at the heart of this issue is fairness and equality of opportunity for female staff within the organisation. Actions which respond to the gender pay gap are included within the Inclusion & Diversity Strategy which has been submitted as a separate paper for consideration and approval by the Committee.

## 5 Recommendations

Please see the Inclusion & Diversity Strategy for recommendations in response to the gender pay gap.

## 6 Conclusion

The Board is requested to approve the gender pay gap report for publication.

**Appendix 1**

**Gender Pay Gap Report summary data**
**As at 31st March 2019**

### 2.1 Table 1- Average & Median Hourly rate

| Gender | Avg. Hourly Rate | Median Hourly Rate |
|---|---|---|
| Male | £22.30 | £15.47 |
| Female | £14.38 | £12.38 |
| Difference | £7.92 | £3.09 |
| Pay Gap % | 35.53% | 19.98% |

### 2.1.1 Average Hourly rate

As at 31st March 2019 the Trust has a 35.53% mean average gender pay gap with females earning **£7.92 an hour less** than males. In comparison with March 2018 data the mean average pay gap has marginally improved and as at 31 March 2018 females earned **£7.93 an hour less** than males with a 36.52% mean average gender pay gap.

### 2.1.2 Median Hourly rate

As at 31st March 2019 the Trust has a 19.98% median hourly rate gender pay gap with females earning **£3.09 an hour less** than males. In comparison with March 2018 data the median gender pay gap in 2019 has improved and as at 31 March 2018 females earned **£3.29 an hour less** than males with a 21.68% median gender pay gap.

### 2.2 Table 2- % male and female employees in each pay quartile

| Quartile | Female | Male | Female % | Male % |
|---|---|---|---|---|
| 1 | 1051 | 197 | 84.21% | 15.79% |
| 2 | 1043 | 206 | 83.51% | 16.49% |
| 3 | 1050 | 192 | 84.54% | 15.46% |
| 4 | 808 | 447 | 64.38% | 35.62% |

This calculation requires an employer to show the proportions of male and female full-pay relevant employees in four quartile pay bands. All employees are placed into the cumulative order according to their pay which is undertaken by dividing the workforce into 4 equal parts.

Compared with quartiles 1-3 males are most highly constituted within quarter 4 at 35.62% compared with an average of between 15.79%- 16.49% within the other quartiles. Comparatively the reverse is true for females and they constitute 64.38% of quartile 4 compared with an average of between 83.51%- 84.52% within the other quartiles.

The information compares % within the individual quartiles. However, if we review the broader picture comparing the overall workforce constitution there are 1042 male employees and of these 447 are within quartile 4 which represents 42.9% of all male employees. Comparatively of 3952

female employees only 808 females are constituted within quartile 4 which represents only 20.4% of all female employees.

In comparison with 2018 reporting there have been some improvements in the composition of females within the pay quartiles, namely slight increases of female staff within quartiles 2- 4 in the 2019 reporting data.

**2.3 Bonus information**

**Table 3**

| Gender | Avg. Pay | Median Pay |
|---|---|---|
| Male | £15,196.36 | £9,048.02 |
| Female | £6,839.05 | £4,021.33 |
| Difference | £8,357.31 | £5,026.69 |
| **Pay Gap %** | **55.00%** | **55.56%** |

**Table 4**

| Gender | Employees Paid Bonus | Total Relevant Employees | % |
|---|---|---|---|
| **Female** | 9.00 | 4086.00 | 0.22% |
| **Male** | 82.00 | 1087.00 | 7.54% |

The data in tables 3 & 4 relates to clinical excellence awards for medical staff as this is the only payment identified within the ESR standard report which falls within the set definition of `bonus pay`. Clinical Excellence Awards recognise and reward Consultants who perform `over and above` the standard expected in their role. The payments within the Trust`s bonus information contains both local and national Clinical Excellence Awards. The Local CEA`s are administered within the Trust on an annual basis and the national CEAs are determined externally and administered by the Department of Health.

The data highlights that the average bonus pay gap for females as at March 2019 is 55.00% and the median pay gap is 55.56%. In comparison with March 2018 the position has improved and as at 31st March 2018 there was 60.78% average bonus pay gap and 71.05% median pay gap. As at 31st March 2019 0.22% of female staff received a bonus payment in comparison with 7.54% of male staff. When reviewing these figures consideration should be given to the overall consultant workforce profile which is predominately male at 82%.

NHS
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NHS Foundation Trust

# Board Performance Report

February 2020

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

# Executive Summary (February 2020)

## Key Messages

Highlights:

There is an early sign of a reduction in Pressure Ulcers with Lapses in Care and the number of reported Clostridium Difficile in comparison to the previous two months.

Lowlights:

A Never Event related to Wrong Site Surgery occurred in February 2020. The key learning relates to not undertaking 'stop before you block'.
There was a patient Fall with Harm in February 2020 which resulted in a Fractured Neck of Femur. This is subject to investigation.

Community Metrics:

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

Please Note:

Due to timing conflicts between finalising this report and Mandatory National Reporting Deadlines, some metrics can only be reported 1 month retrospectively, e.g. 18 Week RTT Targets, Cancer Waiting Times and Diagnostic Waiting Time.

Please also see Scheduled Care Report and Unscheduled Care Report.

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## Top 10 Performance

| Group | ID | Metric Name | Period Covered | Date Last Updated | National Top 10% | Performance | Percentile | Rank / Trusts |
|---|---|---|---|---|---|---|---|---|
| Safe | 2 | Summary Hospital-level Mortality Indicator (SHMI) | SEP-18 - AUG-19 | 18/02/20 | Yes | 115.42 | 3.2% | 5/126 |
| Safe | 3 | Safety Thermometer / Harm Free Performance | JAN-20 | 18/02/20 | No | 94.70% | 39.8% | 40/99 |
| Safe | 4 | Cancer 2 Week Wait Performance | DEC-19 | 18/02/20 | No | 93.59% | 55.12% | 71/128 |
| Safe | 5 | 18 Week Incomplete Referral To Treatment (RTT) Performance | DEC-19 | 18/02/20 | No | 89.02% | 24.8% | 32/126 |
| Safe | 6 | Patient-led assessments of the care environment (PLACE) | JAN-18 - DEC-18 | 26/09/18 | Yes | 0.98% | 0.74% | 2/136 |
| Effective | 7 | Accident & Emergency 4 Hour Wait Performance | JAN-20 | 18/02/20 | No | 76.35% | 59.09% | 66/111 |
| Effective | 8 | Diagnostic 6 Week Wait Performance | DEC-19 | 18/02/20 | No | 1.55% | 44.88% | 58/128 |
| Caring | 10 | Friends & Family Assessment Result | DEC-19 | 18/02/20 | No | 93.00% | 64.06% | 83/129 |
| Caring | 11 | National Patient Survey Result | JAN-18 - DEC-18 | 15/10/19 | No | 0.81 | 48.85% | 65/132 |

| Top 10% | Top 25% | Top 50% |
|---|---|---|
| 2 | 1 | 3 |

| Bottom 50% | Bottom 25% | Bottom 10% |
|---|---|---|
| 3 | 0 | 0 |

## Top 5 Performing Metrics

| # | Metric Name | Rank |
|---|---|---|
| 1 | Patient-led assessments of the care environment (PLACE) | 2 |
| 2 | Summary Hospital-level Mortality Indicator (SHMI) | 5 |
| 3 | 18 Week Incomplete Referral To Treatment (RTT) Performance | 32 |
| 4 | Safety Thermometer / Harm Free Performance | 40 |
| 5 | Diagnostic 6 Week Wait Performance | 58 |

## Bottom 5 Performing Metrics

| # | Metric Name | Rank |
|---|---|---|
| 1 | Friends & Family Assessment Result | 83 |
| 2 | Accident & Emergency 4 Hour Wait Performance | 66 |
| 3 | Cancer 2 Week Wait Performance | 71 |
| 4 | National Patient Survey Result | 65 |

## Local Trust Positions

| Provider Name | GM Rank | North Rank | National Rank |
|---|---|---|---|
| WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST | 1/7 | 7/44 | 14/136 |
| BOLTON NHS FOUNDATION TRUST | 2/7 | 13/44 | 24/136 |
| TAMESIDE HOSPITAL NHS FOUNDATION TRUST | 3/7 | 14/44 | 25/136 |
| MANCHESTER UNIVERSITY NHS FOUNDATION TRUST | 4/7 | 20/44 | 43/136 |
| SALFORD ROYAL NHS FOUNDATION TRUST | 5/7 | 27/44 | 66/136 |
| PENNINE ACUTE HOSPITALS NHS TRUST | 6/7 | 33/44 | 92/136 |
| STOCKPORT NHS FOUNDATION TRUST | 7/7 | 35/44 | 98/136 |

## In Month

### 18 Weeks: Incomplete


Target: 92.0%

### Cancer 62 Day: GP Referral


Target: 85.0%

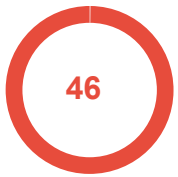
### Diagnostics: 6 Weeks


Target: 99.0%

### **A&E: 4 Hour Target


Target: 95.0%

### C. Difficile Infections




YTD Target: 18

## Year To Date

### Serious Falls


FY Target: 0

### Never Events


FY Target: 0

### MRSA


FY Target: 0

# 1.1 : Harm Free

| | Latest | | | | | Previous | | YTD | | Sparkline - Latest 13 Months | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Metric Title | Target | Actual | Period | RAG | Trend | Actual | Period | Actual | RAG | Chart | Min. Value | Max. Value | Period |
| Serious Harms: Community Acquired Grade 3-4 Pressure Ulcers | ** | 2 | Feb-20 | | → | 2 | Jan-20 | 19 | | | 0 | 4 | Apr-19 to Feb-20 |
| Harms: Total | ** | 74 | Feb-20 | | ↓ | 77 | Jan-20 | 894 | | | 62 | 94 | Feb-19 to Feb-20 |
| Serious Harms: Total | ** | 5 | Feb-20 | | ↓ | 9 | Jan-20 | 112 | | | 5 | 20 | Feb-19 to Feb-20 |
| Serious Harms: Number of Never Events | <= 0 | 2 | Feb-20 | | ↑ | 0 | Jan-20 | 5 | | | 0 | 2 | Feb-19 to Feb-20 |
| Serious Harms: Number of Serious Falls | <= 0 | 0 | Feb-20 | | ↓ | 1 | Jan-20 | 4 | | | 0 | 2 | Feb-19 to Feb-20 |
| Serious Harms: Hospital Acquired Grade 3-4 Pressure Ulcers | ** | 1 | Feb-20 | | ↑ | 0 | Jan-20 | 25 | | | 0 | 6 | Feb-19 to Feb-20 |
| Number of Serious Incidents | <= 0 | 9 | Feb-20 | | ↑ | 7 | Jan-20 | 91 | | | 1 | 16 | Feb-19 to Feb-20 |
| Mod/Low Harms: Hospital Acquired Pressure Ulcer Grade 2 | ** | 0 | Feb-20 | | → | 0 | Jan-20 | 33 | | | 0 | 9 | Feb-19 to Feb-20 |
| Mod/Low Harms: Number of Moderate Falls | <= 0 | 1 | Feb-20 | | ↑ | 0 | Jan-20 | 11 | | | 0 | 3 | Feb-19 to Feb-20 |
| Mod/Low Harms: Safety Thermometer | >= 95.0% | 99.53% | Jan-20 | | ↑ | 98.24% | Dec-19 | 98.59% | | | 97.38% | 99.54% | Feb-19 to Jan-20 |
| Mod/Low Harms: Settled Clinical Litigation Cases | ** | 5 | Feb-20 | | ↑ | 3 | Jan-20 | 37 | | | 1 | 7 | Feb-19 to Feb-20 |
| Mod/Low Harms: VTE Assessments (% of Admissions) | >= 95.0% | 95.93% | Feb-20 | | ↓ | 96.63% | Jan-20 | 96.46% | | | 95.67% | 97.13% | Feb-19 to Feb-20 |

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

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

During the month of February 2020, the Trust has submitted 9 incidents to StEIS. These incidents related to the internal Major Incident linked to our IT Systems, an unexpected death, an unstageable Community Acquired Pressure Ulcer and Hospital Acquired Pressure Ulcer, a category 4 Community Acquired Pressure Ulcer, missed treatment for arterial fibrillation, a delay in VTE treatment, delayed surgical diagnosis and a stillbirth. The Never Event relating to Wrong Site Surgery occurred on the 29th February 2020; however reported to STEIS in early March 2020. Initial investigation has identified that 'stop before you block' had not been undertaken. Immediate actions include the implementation of second site marking of injection site by the injector prior to the start of the procedure. Quality and Safety Committee will receive a deep dive into this Never Event following completion of the investigation. The Trust is starting to see some signs of improvement regarding Pressure Ulcer prevention, however this remains a key focus. Trajectories for improvement will be set from April 2020 and trends monitored by the Board of Directors. A review of the reporting of safeguarding incidents and how the Board are sighted on these is being undertaken.

# 1.2 : Harm Free - Infections

| | Latest | | | | | Previous | | YTD | | Sparkline - Latest 13 Months | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Metric Title | Target | Actual | Period | RAG | Trend | Actual | Period | Actual | RAG | Chart | Min. Value | Max. Value | Period |
| Infections/Bacteraemias: Total | ** | 2 | Feb-20 | | ↓ | 8 | Jan-20 | 99 | | | 2 | 17 | Feb-19 to Feb-20 |
| Serious Harms: Infections: Clostridium Difficile | <= 1 | 2 | Feb-20 | 🔴 | ↓ | 4 | Jan-20 | 46 | 🔴 | | 1 | 10 | Feb-19 to Feb-20 |
| Serious Harms: Infections: Clostridium Difficile Lapses in Care | <= 0 | 0 | Nov-19 | 🟢 | → | 0 | Oct-19 | 6 | | | 0 | 2 | Feb-19 to Nov-19 |
| Infections: Catheter Associated Urinary Tract | <= 0 | 0 | Jan-20 | 🟢 | ↓ | 1 | Dec-19 | 9 | | | 0 | 2 | Feb-19 to Jan-20 |
| Serious Harms: Bacteraemias: MRSA | <= 0 | 0 | Feb-20 | 🟢 | → | 0 | Jan-20 | 0 | 🟢 | | 0 | 0 | Feb-19 to Feb-20 |
| Serious Harms: Bacteraemias: MRSA - Avoidable Cases | ** | 0 | Feb-20 | 🟢 | → | 0 | Jan-20 | 0 | 🟢 | | 0 | 0 | Feb-19 to Feb-20 |
| Serious Harms: Bacteraemias: MSSA | ** | 0 | Feb-20 | 🟢 | ↓ | 1 | Jan-20 | 8 | | | 0 | 4 | Feb-19 to Feb-20 |
| Serious Harms: Bacteraemias: E-coli | ** | 0 | Feb-20 | 🟢 | ↓ | 3 | Jan-20 | 24 | | | 0 | 7 | Feb-19 to Feb-20 |
| Bacteraemias: Klebsiella | ** | 0 | Feb-20 | 🟢 | → | 0 | Jan-20 | 9 | | | 0 | 2 | Feb-19 to Feb-20 |
| Bacteraemias: Pseudomonas | ** | 0 | Feb-20 | 🟢 | → | 0 | Jan-20 | 3 | | | 0 | 1 | Feb-19 to Feb-20 |

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

**Threshold not confirmed ~ based on assumption

Trajectories for improvement for Clostridium Difficile will be set from April 2020 and trends monitored by the Board of Directors.

# 2 : Mortality

| | Latest | | | | | Previous | | YTD | | Sparkline - Latest 13 Months | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Metric Title | Target | Actual | Period | RAG | Trend | Actual | Period | Actual | RAG | Chart | Min. Value | Max. Value | Period |
| Number of Hospital Deaths | ** | 98 | Feb-20 | | ↓ | 105 | Jan-20 | 1,117 | | | 88 | 114 | Feb-19 to Feb-20 |
| Hospital Crude Death Rate | ** | 1.55% | Feb-20 | | ↑ | 1.49% | Jan-20 | 1.46% | | | 1.25% | 1.78% | Feb-19 to Feb-20 |
| PFD Coroner Notifications | ** | 0 | Feb-20 | ● | → | 0 | Jan-20 | 0 | ● | | 0 | 0 | Feb-19 to Feb-20 |
| Deaths after Readmission | ** | 16 | Feb-20 | | ↓ | 32 | Jan-20 | 329 | | | 16 | 39 | Feb-19 to Feb-20 |
| HSMR (Latest Month) | <= 90 | 101.1 | Nov-19 | ● | ↑ | 96.2 | Oct-19 | N/A | | | 80.9 | 130.6 | Apr-18 to Nov-19 |
| HSMR (Latest YTD) | * | 107.4 | Nov-19 | | ↑ | 106.9 | Oct-19 | N/A | | | 95.2 | 109.9 | Dec-18 to Nov-19 |
| HSMR Weekday | <= 90 | 95.5 | Nov-19 | ● | ↓ | 99.0 | Oct-19 | N/A | | | 73.1 | 131.1 | Apr-18 to Nov-19 |
| HSMR Weekend | <= 90 | 116.0 | Nov-19 | ● | ↑ | 90.1 | Oct-19 | N/A | | | 73.6 | 162.1 | Apr-18 to Nov-19 |
| SHMI (Rolling 12 Months) | <= 90.0 | 116.5 | Sep-19 | ● | ↑ | 115.7 | Aug-19 | N/A | | | 109.1 | 116.5 | Jun-18 to Sep-19 |

## Commentary (Page Owner : Medical Director)

**Threshold not confirmed ~ based on assumption

NJanuary 2020 brought a surprisingly low total number of deaths. At 98 it is below the average of 100. Despite the low number of deaths the death rate has gone up (Death Rate = Deaths / Admissions). The number of admissions during winter is often lower because of the severity of illness. Mortality Rates are given for HSMR (data to November) and SHMI (data for the year to September). HSMR is at expected levels around the normal of 100. SHMI remains much unchanged at 116. It has slowly risen over the preceding months after a change in the calculation methodology. Further actions related to SHMI are outlined in the Q3 2019-20 Mortality Report to the Board of Directors.

# 3.1 : Midwifery - Part 1

| | Latest | | | | | Previous | | YTD | | Sparkline - Latest 13 Months | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Metric Title | Target | Actual | Period | RAG | Trend | Actual | Period | Actual | RAG | Chart | Min. Value | Max. Value | Period |
| Maternity: Midwife / Birth Ratio | <= 1.30 | 1.24 | Feb-20 | | | 1.24 | Jan-20 | N/A | | | 1.23 | 1.26 | Feb-19 to Feb-20 |
| Maternity: Skills drills/2 day Mandatory Training Attendance | >= | 16.43% | Feb-20 | | | 3.57% | Jan-20 | N/A | | | 3.57% | 95.34% | Feb-19 to Feb-20 |
| Maternity: Total monthly bookings | >= 240 | 209 | Feb-20 | | | 239 | Jan-20 | 2,390 | | | 182 | 240 | Feb-19 to Feb-20 |
| Maternity: Booked by 12+6 Weeks | >= 90.0% | 89.05% | Feb-20 | | | 91.85% | Jan-20 | N/A | | | 85.78% | 94.84% | Feb-19 to Feb-20 |
| Maternity: Induction of Labour | <= 30.0% | 47.03% | Feb-20 | | | 41.62% | Jan-20 | N/A | | | 32.12% | 47.03% | Feb-19 to Feb-20 |
| Maternity: Normal Deliveries | >= 60.0% | 61.83% | Feb-20 | | | 62.00% | Jan-20 | N/A | | | 49.10% | 62.00% | Feb-19 to Feb-20 |
| Maternity: Water Births | >= 8 | 11 | Feb-20 | | | 3 | Jan-20 | 115 | | | 3 | 15 | Feb-19 to Feb-20 |
| Maternity: Instrumental Deliveries | <= 10.0% | 12.90% | Feb-20 | | | 6.50% | Jan-20 | N/A | | | 6.50% | 17.22% | Feb-19 to Feb-20 |
| Maternity: Elective Caesarean Sections | <= 15.0% | 7.53% | Feb-20 | | | 13.50% | Jan-20 | N/A | | | 7.53% | 17.34% | Feb-19 to Feb-20 |
| Maternity: Emergency / Non Elective Caesarean Sections | <= 17.0% | 17.74% | Feb-20 | | | 18.00% | Jan-20 | N/A | | | 14.41% | 22.84% | Feb-19 to Feb-20 |
| Maternity: Total Caesarean Sections | <= 27.0% | 25.27% | Feb-20 | | | 31.50% | Jan-20 | N/A | | | 25.27% | 37.07% | Feb-19 to Feb-20 |

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

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

The Midwife to Birth ratio remains unchanged at 1:24, as bookings have dipped again this month, and the birth rate remains below target. Multi-disciplinary mandatory training is presently on target and is being redesigned to ensure it meets all of the requirements for CNST maternity Incentive scheme year 3. A robust plan is in place to achieve the 90% compliance by year end. Induction of labour remains high due to the acuity of women and the impact of Saving Babies Lives 2 (SBL2) focussing on reduced fetal movements and suspected or actual small for gestational age in accordance with National recommendations. However this has not impacted on the normal delivery rate as the overall Caesarean section rate has decreased again this month and is lower than the National average at just over 25%; and the instrumental delivery rate also remains within the national rate. The Episiotomy rate with normal birth is a little higher this month; however the normal birth rate remains above target at just under 62%.

# 3.2 : Midwifery - Part 2

| | Latest | | | | | Previous | | YTD | | Sparkline - Latest 13 Months | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Metric Title | Target | Actual | Period | RAG | Trend | Actual | Period | Actual | RAG | Chart | Min. Value | Max. Value | Period |
| Maternity: Total Births | >= 240 | 186 | Feb-20 | | | 200 | Jan-20 | 2,268 | | | 167 | 232 | Feb-19 to Feb-20 |
| Maternity: Episiotomy with normal birth | <= 6.0% | 7.83% | Feb-20 | | | 4.84% | Jan-20 | N/A | | | 2.22% | 10.07% | Feb-19 to Feb-20 |
| Maternity: 3rd/4th degree tears | <= 3.0% | 2.70% | Feb-20 | | | 1.52% | Jan-20 | N/A | | | 0.47% | 3.03% | Feb-19 to Feb-20 |
| Maternity: Initiation of breastfeeding | >= 55.0% | 50.54% | Feb-20 | | | 51.50% | Jan-20 | N/A | | | 44.95% | 54.15% | Feb-19 to Feb-20 |
| Maternity: Average post-natal length of stay | <= 1.8 | 1.5 | Feb-20 | | | 1.6 | Jan-20 | N/A | | | 1.3 | 1.9 | Feb-19 to Feb-20 |
| Maternity: Still Births (>24 weeks) | <= 1 | 2 | Feb-20 | | | 3 | Jan-20 | 12 | | | 0 | 3 | Feb-19 to Feb-20 |
| Maternal Readmissions within 30 Days | <= 5 | 2 | Feb-20 | | | 0 | Jan-20 | 21 | | | 0 | 4 | Feb-19 to Feb-20 |
| Maternal admissions to ICU | <= 2 | 0 | Feb-20 | | | 1 | Jan-20 | 2 | | | 0 | 1 | Feb-19 to Feb-20 |
| Maternity Complaints | <= 2 | 2 | Feb-20 | | | 0 | Jan-20 | 16 | | | 0 | 5 | Feb-19 to Feb-20 |
| Maternity: New Claims | * | 0 | Feb-20 | | | 0 | Jan-20 | 1 | | | 0 | 1 | Feb-19 to Feb-20 |

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

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

The Infant feeding team continue work to promote and support mothers to initiate breastfeeding. WWL has full Baby Friendly accreditation and Gold status which identifies that those who choose to Breast feed sustain this: this month the number of mothers who have opted to breastfeed remains below the national average but has shown a sustained increase within the last 5 months and the midwifery team continue to promote the benefits of breastfeeding to all mothers and families. Unfortunately there have been 2 stillbirths this month and these will undergo full multidisciplinary review and follow National guidance for investigation and feedback to parents. The overall number of complaints received remains low in number however 2 have been received this month.

# 4.1 : Patient Experience

| | Latest | | | | | Previous | | YTD | | Sparkline - Latest 13 Months | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Metric Title | Target | Actual | Period | RAG | Trend | Actual | Period | Actual | RAG | Chart | Min. Value | Max. Value | Period |
| Number of Complaints Upheld by Ombudsman | ** | 0 | Feb-20 | | | 0 | Jan-20 | 0 | | | 0 | 0 | Feb-19 to Feb-20 |
| Number of Complaints Partially Upheld by Ombudsman | ** | 0 | Feb-20 | | | 0 | Jan-20 | 1 | | | 0 | 1 | Apr-19 to Feb-20 |
| Percentage of Complaints Responded to on Time | ** | 10.53% | Feb-20 | | | 28.21% | Jan-20 | 56.50% | | | 10.53% | 76.60% | Feb-19 to Feb-20 |
| Friends & Family: Decisions about Discharge Home? | >= 90.0% | 88.95% | Jan-20 | | | 92.12% | Dec-19 | N/A | | | 83.95% | 92.12% | Feb-19 to Jan-20 |
| Delivering Same Sex Accommodation: Mixed Sex Accommodation Breaches | * | 0 | Feb-20 | | | 0 | Jan-20 | 9 | | | 0 | 5 | Apr-19 to Feb-20 |

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

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

During February 2020, 4 out of 38 responses were sent within the timescales agreed with the complainant (11%). From January 2020 the Chief Nurse reviews every response prior to Chief Executive sign-off. The Chief Nurse explained to Board that this process to improve the quality of responses may result in a decline in response rates for a period of time. Key principles to ensuring a quality complaint response have been developed and examples of good complaints responses are being shared with case managers. The Trust has sought external training support for those involved in complaints handling and investigation. In February 2020, themes continue related to clinical treatment, however there were 5 in respect of discharges (which will be fed into the Discharge Improvement Committee), 4 relating to waiting times, and 3 related to communication. 1 complaint has been reviewed by the PHSO and was not upheld. The PHSO requested one set of records to review in the month.

# 4.2 : Patient Experience Survey

| | Latest | | | | | Previous | | YTD | | Sparkline - Latest 13 Months | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Metric Title | Target | Actual | Period | RAG | Trend | Actual | Period | Actual | RAG | Chart | Min. Value | Max. Value | Period |
| Patient Survey Q1: Staff Introduction | >= 90.0% | 92.35% | Feb-20 | | ↓ | 93.71% | Jan-20 | 92.26% | | | 88.51% | 96.53% | Feb-19 to Feb-20 |
| Patient Survey Q2: Worries and Fears | >= 90.0% | 93.53% | Feb-20 | | ↑ | 87.41% | Jan-20 | 89.98% | | | 85.71% | 93.89% | Feb-19 to Feb-20 |
| Patient Survey Q3: Pain Control | >= 90.0% | 96.47% | Feb-20 | | ↑ | 90.21% | Jan-20 | 94.08% | | | 89.61% | 96.47% | Feb-19 to Feb-20 |
| Patient Survey Q4: Family and Doctor | >= 90.0% | 97.06% | Feb-20 | | ↑ | 91.61% | Jan-20 | 92.31% | | | 88.32% | 97.14% | Feb-19 to Feb-20 |
| Patient Survey Q5: Decisions about Care and Treatment | >= 90.0% | 92.94% | Feb-20 | | ↑ | 81.12% | Jan-20 | 86.05% | | | 78.38% | 92.94% | Feb-19 to Feb-20 |
| Patient Survey Q6: Food Choice | >= 90.0% | 98.82% | Feb-20 | | ↓ | 100.00% | Jan-20 | 97.55% | | | 94.74% | 100.00% | Feb-19 to Feb-20 |
| Patient Survey Q7: Healthy Food | >= 90.0% | 96.47% | Feb-20 | | ↑ | 92.31% | Jan-20 | 92.08% | | | 86.96% | 97.22% | Feb-19 to Feb-20 |
| Patient Survey Q9: Know Consultant | >= 90.0% | 69.41% | Feb-20 | | ↓ | 76.92% | Jan-20 | 80.41% | | | 69.41% | 90.28% | Feb-19 to Feb-20 |
| Patient Survey Q10: Enough Privacy | >= 90.0% | 99.41% | Feb-20 | | ↓ | 100.00% | Jan-20 | 98.92% | | | 94.81% | 100.00% | Feb-19 to Feb-20 |
| Patient Survey Q11: Call Bell | >= 90.0% | 97.06% | Feb-20 | | ↑ | 93.01% | Jan-20 | 96.13% | | | 93.01% | 98.08% | Feb-19 to Feb-20 |
| Patient Survey Q12: Compassion | >= 90.0% | 98.82% | Feb-20 | | ↑ | 97.90% | Jan-20 | 98.01% | | | 96.62% | 100.00% | Feb-19 to Feb-20 |
| Patient Survey Q13: Given Required Care | >= 90.0% | 98.82% | Feb-20 | | ↑ | 95.80% | Jan-20 | 97.32% | | | 95.80% | 98.82% | Feb-19 to Feb-20 |

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

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

In relation to the Real Time Patient Experience Survey:
It is fantastic to see all but one question achieving over 90%. The questions in the Real Time Patient Experience Survey are being aligned to NHS National Patient Survey questions. This will mean that the question “Do you know which Consultant is currently treating you?” is proposed to change to “Did you have confidence and trust in the doctors treating you?".

# 5 : Workforce

| | | Latest | | | | Previous | | YTD | | Sparkline - Latest 13 Months | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Metric Title | Target | Actual | Period | RAG | Trend | Actual | Period | Actual | RAG | Chart | Min. Value | Max. Value | Period |
| Total Pay vs Budget | <=£ 0 k | £ 1,248 k | Feb-20 | | ↓ | £ 1,457 k | Jan-20 | £ 5,011 k | | | £ -233 k | £ 1,457 k | Feb-19 to Feb-20 |
| Friends & Family Test - Recommendation as place to work | >= 75.0% | 78.13% | Feb-20 | | ↑ | 66.49% | Oct-19 | N/A | | | 61.94% | 78.13% | Apr-19 to Feb-20 |
| Clinical & Non Clinical Overall Vacancy Rate | <= 3.5% | 7.55% | Feb-20 | | ↓ | 8.62% | Jan-20 | 9.67% | | | 7.05% | 10.87% | Feb-19 to Feb-20 |
| Sickness absence - Total | <= | 5.59% | Jan-20 | | ↑ | 5.52% | Dec-19 | 4.82% | | | 4.19% | 5.59% | Feb-19 to Jan-20 |
| Quarterly Engagement Score | >= 4.00 | 3.91 | Feb-20 | | ↓ | 3.95 | Oct-19 | N/A | | | 3.90 | 3.95 | Apr-19 to Feb-20 |
| Appraisals over rolling 12 months | >= 90.0% | 87.51% | Feb-20 | | ↑ | 84.66% | Jan-20 | N/A | | | 83.79% | 88.13% | Mar-19 to Feb-20 |
| Friends & Family Test - Recommendation as place for treatment | >= 80.0% | 66.57% | Feb-20 | | ↓ | 78.43% | Oct-19 | N/A | | | 66.57% | 78.56% | Apr-19 to Feb-20 |
| Mandatory Training over rolling 12 months | >= 95.0% | 88.86% | Feb-20 | | ↓ | 95.68% | Jan-20 | N/A | | | 88.86% | 95.68% | Mar-19 to Feb-20 |
| Agency vs NHSI Ceiling | <=£ 0 k | £ 959 k | Feb-20 | | ↓ | £ 1,084 k | Jan-20 | £ 8,163 k | | | £ 101 k | £ 1,084 k | Feb-19 to Feb-20 |

## Commentary (Page Owner : Director of Workforce)

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

Rolling 12-month sickness from Feb 19 - Jan 20 increased to 4.77% (compared to 4.71% last reported). The in-month sickness also increased to 5.59% (compared to 5.52% in Jan 20). Temporary spend increased in Month 11 in respect of Locum, Bank NHSP, Cost per Case, Additional Sessions, Zero Hours Contracts, Overtime and Bank Internal (increased by £113k, £112k, £81k, £58k, £24k, £24k and £7k). There was also a marginal increase in Bank. These increases were offset by a reduction of £125k in respect of Agency. Overall, the results of the Feb 20 Staff Engagement Quarterly Pulse Check highlight a moderate level of engagement within the Trust. The overall engagement score for Feb 20 is 3.91, a slight decrease compared to Oct 19 (3.95). Trustwide there are 208 job plans at the following stages: 12 (Discussion), 23 (1st sign off), 5 (2nd sign off), 168 (signed off). Please note that these figures relate only to Consultant job plans.

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# NHSI Metrics

| | Latest | | | | | Previous | | YTD | | Sparkline - Latest 13 Months | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Metric Title | Target | Actual | Period | RAG | Trend | Actual | Period | Actual | RAG | Chart | Min. Value | Max. Value | Period |
| 4 Hour A&E Breach Performance % (All Types) | 95.0% | 80.47% | Feb-20 | | | 76.38% | Jan-20 | 83.74% | | | 76.24% | 94.76% | Feb-19 to Feb-20 |
| Access: 18 Weeks Referral To Treatment Incomplete Pathway | 92.0% | 88.77% | Jan-20 | | | 89.03% | Dec-19 | 91.23% | | | 88.77% | 93.06% | Feb-19 to Jan-20 |
| Diagnostics: Patients waiting over 6 weeks | 99.0% | 99.02% | Jan-20 | | | 98.45% | Dec-19 | 98.97% | | | 98.17% | 99.42% | Feb-19 to Jan-20 |
| Two week wait from referral to date first seen: all urgent cancer referrals (cancer suspected) | 93.0% | 93.55% | Jan-20 | | | 93.31% | Dec-19 | 94.05% | | | 89.39% | 96.60% | Feb-19 to Jan-20 |
| Two week wait from referral to date first seen: symptomatic breast patients (cancer not initally suspected) | 93.0% | 95.97% | Jan-20 | | | 96.08% | Dec-19 | 95.85% | | | 93.15% | 98.57% | Feb-19 to Jan-20 |
| All Cancers: 62 day wait for first treatment from urgent GP referral to treatment | 85.0% | 89.91% | Jan-20 | | | 88.29% | Dec-19 | 86.10% | | | 80.13% | 91.74% | Feb-19 to Jan-20 |
| All Cancers: 62 day wait for first treatment from consultant screening service referral | 90.0% | 84.44% | Jan-20 | | | 94.12% | Dec-19 | 94.32% | | | 84.44% | 100.00% | Feb-19 to Jan-20 |
| Serious Harms: Infections: Clostridium Difficile | 1 | 2 | Feb-20 | | | 4 | Jan-20 | 46 | | | 1 | 10 | Feb-19 to Feb-20 |
| Serious Harms: Infections: Clostridium Difficile Lapses in Care | 0 | 0 | Nov-19 | | | 0 | Oct-19 | 6 | | | 0 | 2 | Feb-19 to Nov-19 |
| Community: % IAPT Patients beginning treatment within 6 weeks | 75.0% | 100.00% | Feb-20 | | | 100.00% | Jan-20 | 97.79% | | | 95.57% | 100.00% | Apr-19 to Feb-20 |
| Community: % IAPT Patients beginning treatment within 18 weeks | 95.0% | 100.00% | Feb-20 | | | 100.00% | Jan-20 | 99.94% | | | 99.15% | 100.00% | Apr-19 to Feb-20 |

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

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# Finance Report

## Month 11 ending 29th February 2020

The WWL Way

Contents

## Performance on a Page

| | In Month | | | Year to Date | | | Full Year |
|---|---|---|---|---|---|---|---|
| | Actual £000's | Plan £000's | Var £000's | Actual £000's | Plan £000's | Var £000's | Plan £000's |
| **Financial Performance** | | | | | | | |
| Income | 36,588 | 31,640 | 4,949 | 347,459 | 340,020 | 7,439 | 373,839 |
| Expenditure | (31,956) | (29,535) | (2,421) | (337,427) | (329,830) | (7,598) | (359,369) |
| Financing / Technical * | (1,004) | (995) | (9) | 0 | (4,755) | 4,755 | (11,939) |
| Surplus / Deficit * | 3,628 | 1,110 | 2,518 | 5,277 | (754) | 6,031 | 2,531 |
| Control Total ** | 2,724 | 183 | 2,541 | (8,489) | (7,817) | (673) | (5,458) |
| **Other** | | | | | | | |
| SAVI | 950 | 1,687 | (737) | 9,337 | 12,483 | (3,146) | 14,500 |
| Agency Spend | 959 | 41 | (918) | 10,062 | 453 | (9,610) | 494 |
| Cash Balance | 54,264 | 17,233 | 37,031 | 54,264 | 17,233 | 37,031 | 18,322 |
| PSF Earned | 549 | 549 | 0 | 4,155 | 4,155 | 0 | 4,703 |
| FRF Earned | 368 | 368 | 0 | 2,784 | 2,784 | 0 | 3,150 |
| Capital Spend | 1,722 | 1,126 | (596) | 7,029 | 10,874 | 3,845 | 14,000 |
| UOR | 3 | 1 | 2 | 3 | 3 | 0 | 2 |

**Key Messages:**

- The Trust is reporting a £3.6m surplus in month which is above plan by £2.5m. Year to date, the Trust is reporting a £5.3m surplus which is £6.0m ahead of plan however this includes £7.9m technical benefit for the transfer of assets from community services, which is excluded for control total purposes.

- The performance against the control total is £2.5m above plan in month and £0.7m below plan year to date.

- Income of £6.9m is included in month 11 following the conclusion of locality agreement support from WMBC towards the transformation ongoing in developing integrated community services which generated a significant financial challenge for the Trust. Support in in recognition that WWL is committed to transforming at pace and working with the Council and commissioners to achieve an overall financially balanced service.

- Ongoing locality agreements are reaching a positive conclusion and will further benefit month 12 performance with the ongoing objective of reaching WWL's year-end financial control total.

- The 2019/20 contract has been agreed with Wigan Borough CCG at a value equalling plan without challenge deductions.

- Cash is £54.2m at the end of month 11 which is £37.0m better than plan principally due to the bonus payments relating to last year's performance and capital underspend in year.

- PSF for Q4 will be paid in advance in month 12 and will benefit the Trust by £2.7m on the anticipation of reaching year end plan.

- Capital spend is £7.0m year to date which is behind plan by £3.9m, this is predicted to reach plan by year end.

- SAVI is below plan by £0.7m in month and £3.1m behind plan in the year to date.

- WWL has received clearance from our external auditors to proceed with the Community Health Investment Plan (CHIP) which is an investment fund for Assets outside of the hospital to help stem demand into the hospital and improve the overall health and wellbeing of the locality. This is a joint arrangement with the Council and is fully supported by NHSI, reflecting the ambition and aim of the NHS Long Term Plan and Wigan Borough Locality Plan.

## Trust Summary

| | In Month - £000 | | | Year to Date - £000 | | | Full Year - £000 |
|---|---|---|---|---|---|---|---|
| | Actual | Plan | Variance | Actual | Plan | Variance | Plan |
| Trading Surplus / (Deficit) | 3,628 | 1,110 | **2,518** | 5,277 | (754) | **6,031** | 2,531 |
| Exclude: Capital Donations / Grants | 13 | (10) | **23** | 64 | (124) | **188** | (136) |
| Exclude: I&E Impariments | 0 | 0 | **0** | 1,392 | 0 | **1,392** | 2 |
| Exclude: Prior Year Bonus Payment | 0 | 0 | **0** | (370) | 0 | **(370)** | 0 |
| Exclude: Community Asset Transfer | 0 | 0 | **0** | (7,913) | 0 | **(7,913)** | 0 |
| **Position vs. Control Total** | **3,641** | **1,100** | **2,541** | **(1,550)** | **(878)** | **(672)** | **2,397** |
| Exclude: PSF | (549) | (549) | **0** | (4,155) | (4,155) | **(0)** | (4,703) |
| Exclude: FRF | (368) | (368) | **0** | (2,784) | (2,784) | **0** | (3,150) |
| **Position vs Control Total exc PSF and FRF** | **2,724** | **183** | **2,541** | **(8,489)** | **(7,817)** | **(673)** | **(5,456)** |

- The Trust is £0.7m behind its control total year to date.
- The challenges for the Trust remain:
  - A reduction in additional activity carried out by clinical staff due to the impact of national pension changes although the contract agreement with WBCCG means this only impacts non-WBCCG activity albeit mitigated in part by the capacity and flexibility solution.
  - Recurrent delivery of SAVI– see page 10.
  - Continued premium rates paid to agency workers and to employed staff via LPVs and increased fill rates.
  - Budget pressures associated with the transfer of community services.
- A total of £10.1m has now been spent on agency staff YTD, in the main to cover clinical roles and rotas.
- The performance of the Community Services Division is shown on page 8. The internal "fully staffed" plan for the Division equated to a £6.9m deficit, however on transfer NHSI set a control total using a £3.15m deficit. The front line element of the Community Services Division is £0.7m overspent year to date and this includes £3.5m of vacant posts.
- The Trust has been set a future control total by NHSI which expects the Trust to return to financial balance without FRF by 2021/22, highlighting the requirement for substantial and sustained transformation in service delivery and significant cost adjustments from the current underlying position.
- The Trust has submitted a draft operational plan to NHSI which indicates it will not meet the financial improvement trajectory set by NHSI by £8m (including £2m FRF). This mirrors other providers and commissioners in GMHSCP and recovery meetings are ongoing at a Trust and Regional level. There is a seprate update on the agenda.
- COVID-19 impact on 20/21 plans cannot yet be determined.

## Divisional Summary

- The following table shows contribution (income less expenditure) by Division:

| Division | In Month - £000 | | | Year to Date - £000 | | |
|---|---|---|---|---|---|---|
| | Actual | Plan | Variance | Actual | Plan | Variance |
| Medicine | 1,265 | 1,566 | **(301)** | 18,601 | 22,317 | **(3,716)** |
| Surgery | (451) | 336 | **(786)** | 2,287 | 6,374 | **(4,087)** |
| Specialist Services | 1,630 | 1,891 | **(261)** | 20,192 | 23,776 | **(3,584)** |
| Community Services | 678 | 696 | **(17)** | 7,100 | 7,807 | **(706)** |
| Finance | (291) | (302) | **11** | (3,156) | (3,337) | **181** |
| IM & T | (989) | (948) | **(41)** | (10,078) | (10,447) | **369** |
| Director of Strategy & Planning | (128) | 70 | **(198)** | (1,152) | (354) | **(797)** |
| Dir of Operations | (51) | (48) | **(3)** | (493) | (522) | **29** |
| Human Resources | (276) | (192) | **(84)** | (2,518) | (2,119) | **(399)** |
| Medical Director | (142) | (141) | **(1)** | (1,326) | (1,474) | **148** |
| Estates & Facilities | (2,581) | (2,645) | **64** | (28,788) | (29,546) | **759** |
| Nurse Director | (570) | (546) | **(24)** | (4,968) | (5,618) | **650** |
| Trust Executive | (80) | (60) | **(20)** | (707) | (731) | **24** |
| GTEC | (37) | 0 | **(37)** | (56) | 0 | **(56)** |
| **Total** | **(2,023)** | **(324)** | **(1,699)** | **(5,062)** | **6,125** | **(11,187)** |

- The Medicine Division has a £0.3m adverse variance in month. Income was £0.7m favourable in month whilst there was an adverse variance of £1.0m on expenditure, including an adverse variance on nursing (£0.3m), medical staff (£0.3m) and 1:1 specialised care (£0.1m).

- The Surgery Division is reporting an adverse variance of £0.8m in month. Income has an adverse variance of £0.3m in month and expenditure is also £0.5m adverse to plan. This includes a provision of £0.2m for consultant job plan changes.

- The Specialist Services Division is reporting an adverse variance of £0.3m in month. T&O day case and elective activity is £0.1m favourable with an increase in throughput and complexity resulting in the highest income per day average ever achieved. This includes an increase in activity through the LLP capacity and flexibility solution.

- The Community Services Division is approximately on plan in month (this is only front line services and does not include the additional resource in corporate functions brought in to support Community). The position includes £0.3m from vacant posts in month, offset by a £0.2m adverse variance on GP out of hours.

- The Estates & Facilities division is £0.1m favourable to plan in month.

- Strategy and Planning is £0.2m adverse to plan due to the SAVI target for the POD 4 legal claim which is delayed until next financial year (and is not a certainty).

## Highlights and Risks

| Highlights: |
| --- |
| The Trust's cash balance remains strong at £54.3m. |

| Risks: | Mitigations: |
| --- | --- |
| The internal financial analysis for Community services shows a potential £6.9m deficit versus the E&Y due diligence report which showed a deficit of £3.9m. This is now further exacerbated as the GP out of hours service is expected to cost more than originally expected. | Agreement with WMBC for community transformation support, including ongoing review of approved vacancies and integration of transformed service within the Trust. |
| Spend on agency workers is now £10.1m which exceeds agency spend for the whole of last year which was £7.1m. In particular, agency expenditure on nursing staff has risen over the last four months. | Three business cases have been approved to employ medical staff in the Medicine division which will help to reduce agency spend.. |
| Medical staff unwilling to provide additional sessions due to tax implications. This is impacting activity and income across a wide number of specialties, most noticeably Trauma & Orthopaedics. | The trust began contracting with an LLP in orthopaedics from the start of October, to create operational capacity and flexibility. This is being extended to include Anaesthetics and General Surgery. National policy changed in March budget increasing earnings threshold – the impact is unclear at the time of drafting. |
| The overall trading position of the Trust continues to be challenged by rising costs and lower activity in key areas. | Transformation team review of services, improvement opportunities and recurrent improvement via a Trust internal improvement plan. |
| COVID-19 possible impact on capacity, demand and ability to treat. Large emerging national challenge. | COVID task force and plan set up and led by CEO. Impact unclear at the time of drafting. All associated costs being captured and coded. |

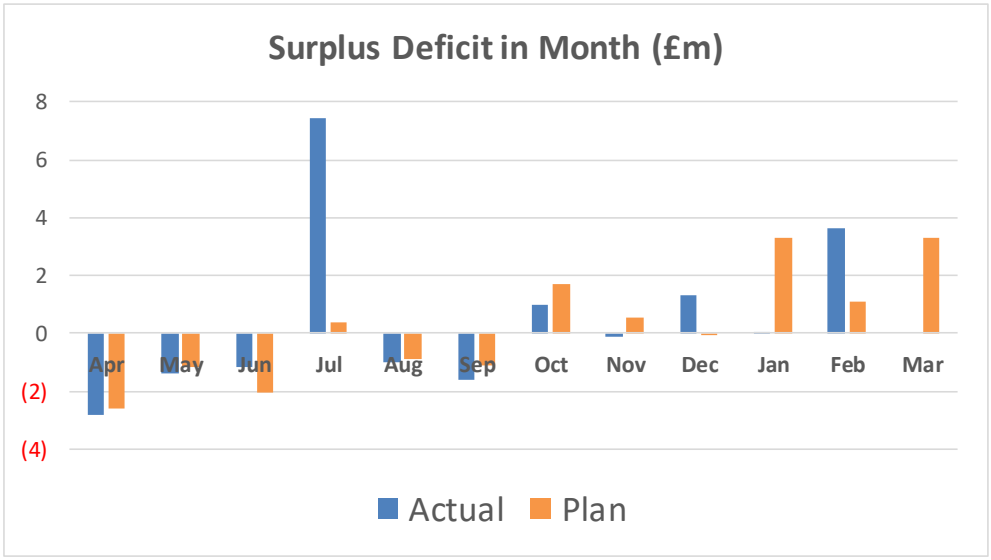
## Community Services

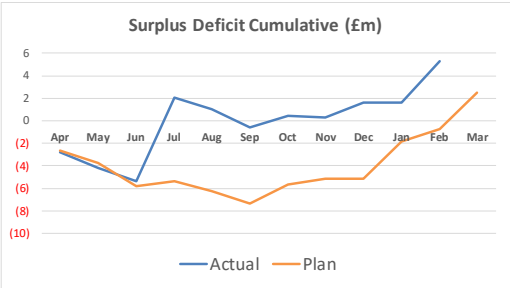
| £000s | Month | | | YTD | | |
|---|---|---|---|---|---|---|
| | Actual | Plan | Var | Actual | Plan | Var |
| Income | 3,979 | 3,832 | 147 | 42,383 | 42,107 | 275 |
| Pay | (2,464) | (2,767) | 303 | (27,150) | (30,616) | 3,465 |
| Pay Reduction | | 182 | (182) | | 2,331 | (2,331) |
| Non-Pay | (836) | (636) | (200) | (8,132) | (6,912) | (1,220) |
| Non-Pay Reduction | | 85 | (85) | | 896 | (896) |
| Divisional Contribution | 678 | 696 | (17) | 7,100 | 7,807 | (706) |
| Corporate Overheads* | | | | | | |
| Estates | (418) | (461) | 42 | (5,632) | (5,880) | 249 |
| IM&T | (218) | (248) | 29 | (2,171) | (2,723) | 552 |
| Chief Operating Officer | (2) | (2) | (0) | (15) | (26) | 11 |
| Director of Strategy | (5) | (7) | 3 | (69) | (78) | 9 |
| Finance | (37) | (40) | 3 | (391) | (445) | 55 |
| HR | (34) | (40) | 6 | (319) | (440) | 121 |
| Nurse Director | (73) | (72) | (1) | (633) | (795) | 162 |
| Pharmacy | (20) | (22) | 2 | (142) | (223) | 80 |
| Legal Costs | | | | | | |
| Other | | | | | | |
| Total | (808) | (892) | 84 | (9,372) | (10,611) | 1,240 |
| **Surplus / (Deficit)** | **(130)** | **(197)** | **67** | **(2,271)** | **(2,805)** | **533** |

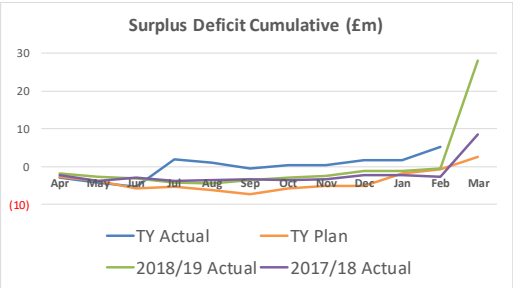
* The specific expenditure and budget associated for each corporate division in relation to the community services. This is included within the overall performance of the corporate divisions noted within the divisional summary.

- Front line pay underspent by £3.5m in the year to date, however this is reduced by a £2.3m efficiency target to a net underspend of £1.1m.
- GP out of hours overspent by £1.2m year to date (reflected in non-pay) with contract discussions not yet resolved.
- Contribution from the Community Services division is £0.7m below plan year to date.
- Overhead support costs for the Community Services division are £1.2m better than plan year to date due to delays in recruiting to posts and new staff progressing through the appointments process. The variance is reducing as vacancies are filled.
- There is a favourable variance of £0.6m year to date within IM&T which includes the benefit of the revised value of the IT SLA with Bridgewater.

## Surplus Deficit



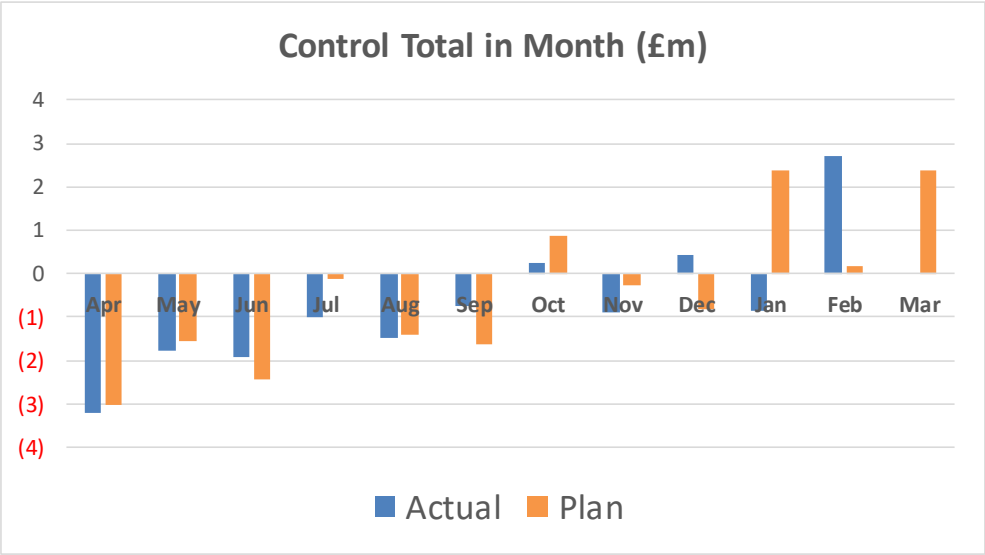

- The Trust is reporting an actual surplus of £3.6m against the planned surplus of £1.1m in month 11. Year to date, the Trust is reporting an actual surplus of £5.3m against the planned deficit of £0.8m.

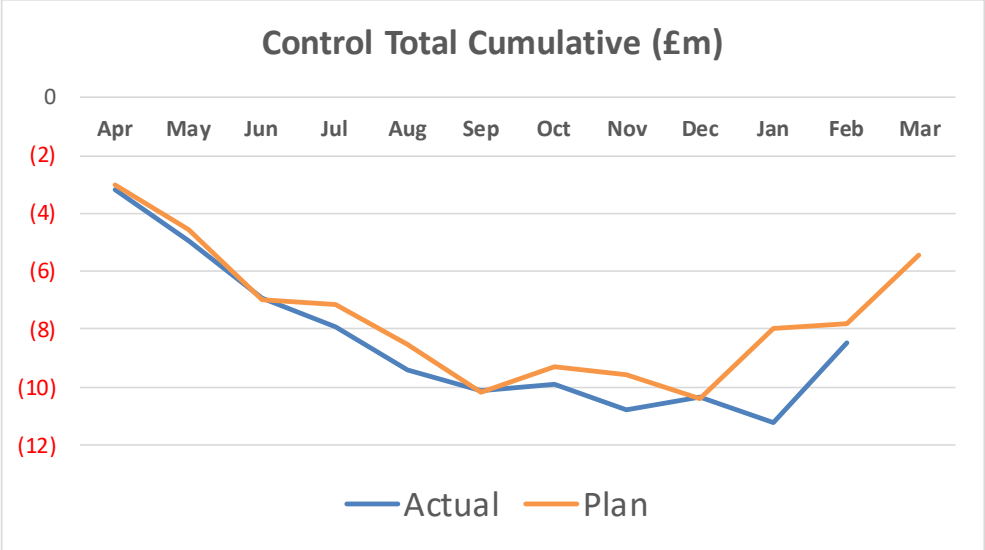
- In month 11, income is £4.9m favourable to plan and expenditure is £2.4m adverse to plan. Year to date, income is £7.4m favourable to plan and expenditure is £7.6m adverse to plan.

- The second graph shows the cumulative position. The plan included an improvement from October when SAVIs were forecast to generate an improvement. The improvement in SAVI has not materialised with the programme behind plan by £3.1m year to date.

- This has been mitigated through the Community Health Investment Plan (CHIP) at a value of £6.9m in month 11.

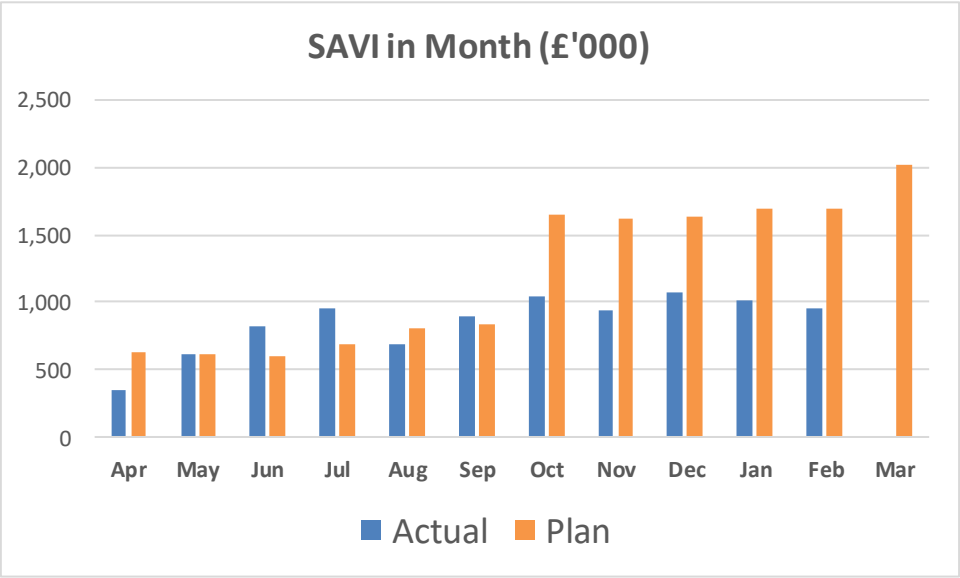
## Control Total (Pre PSF & FRF)

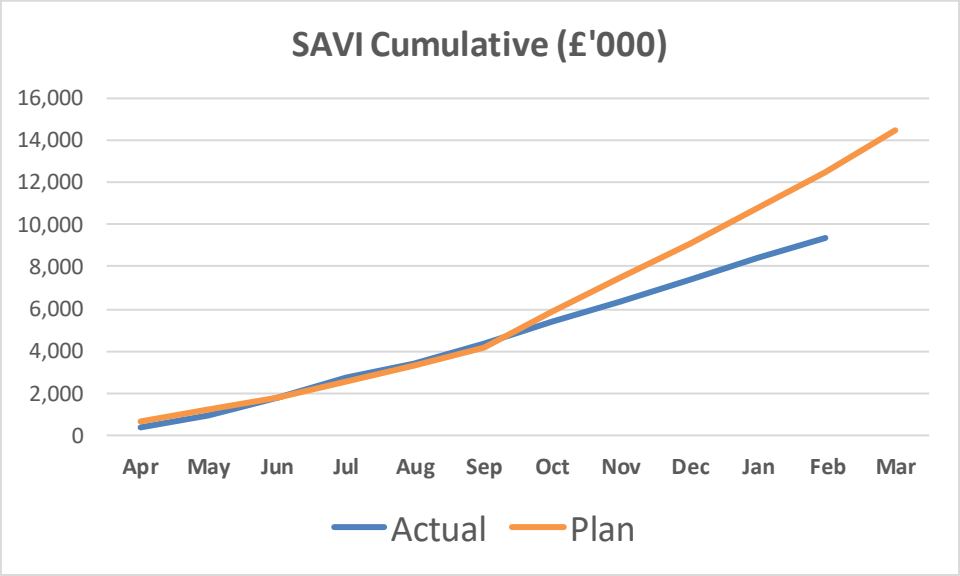



- The Trust is £2.5m favourable to the control total in month 11 and £0.7m adverse year to date.
- The control total is the target set by NHSI which has to be achieved at the end of each quarter to trigger the payment of Provider Sustainability Funding (PSF) and Financial Recovery Fund (FRF).
- £1.1m of PSF and £0.7m of FRF has been included in the month 11 position for quarter 4 at risk assuming the Trust does achieve the quarter 4 control total.
- There is £1.6m of PSF and £1.1m of FRF available for achievement of the control total in quarter 4.
- No year-end bonus payments have been notified for 2019-20.

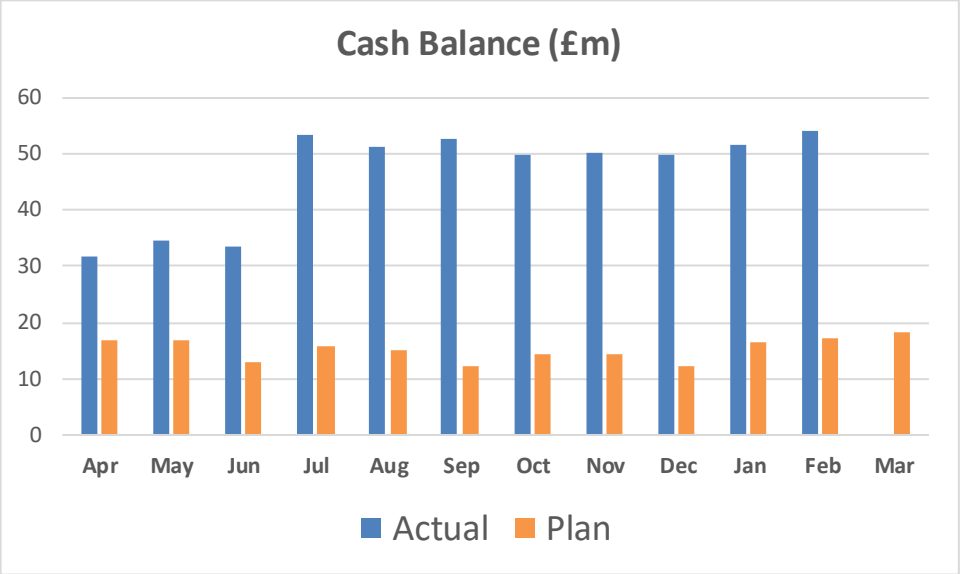
## SAVI Performance




- The CIP/SAVI transacted in month 11 is £1.0m which £0.7m below plan. Year to date, SAVI is £3.1m below plan.
- The plan increased from month 7 in anticipation of the delivery of savings from the big schemes and the pipeline.
- Year to date, a total of £2.2m has been transacted recurrently which is £11.1m behind the recurrent plan.

## Cash Balance

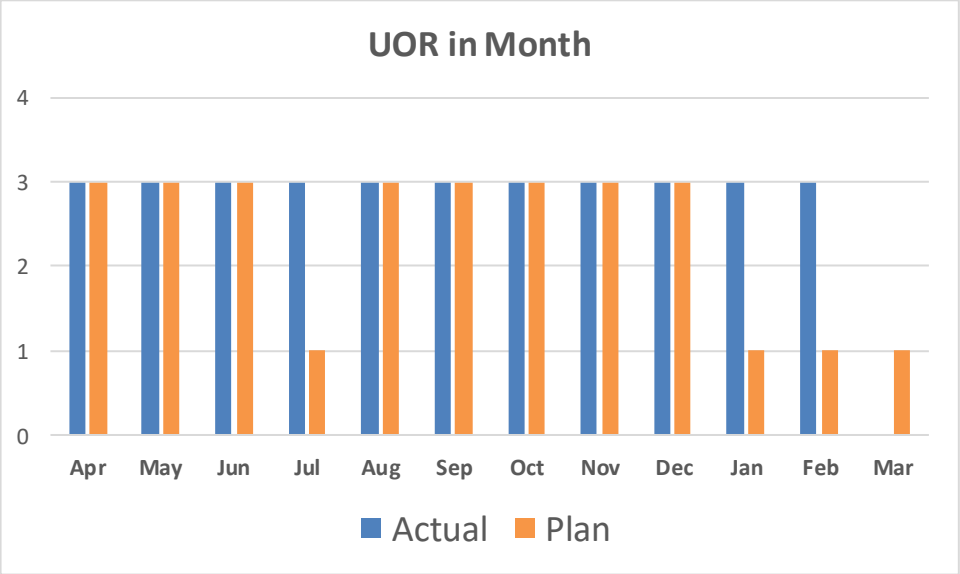


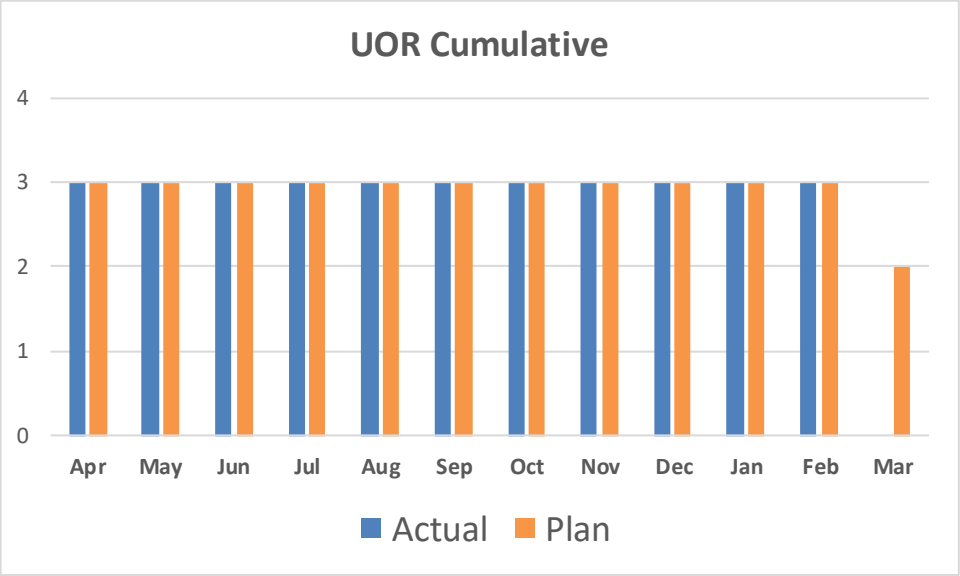

- Opening cash balances at the beginning of April were higher than plan as a result of receipts against land sales and contract income invoices being settled at the end of March. These receipts continue to support the Trust's higher than planned cash balance.

- Cash has increased in the month by £2.7m as a result of an increase in trade and other payables.

- Closing cash at the end of the financial year is expected to be circa £38m providing income and expenditure (including capital) meets plan and SAVI targets are achieved.

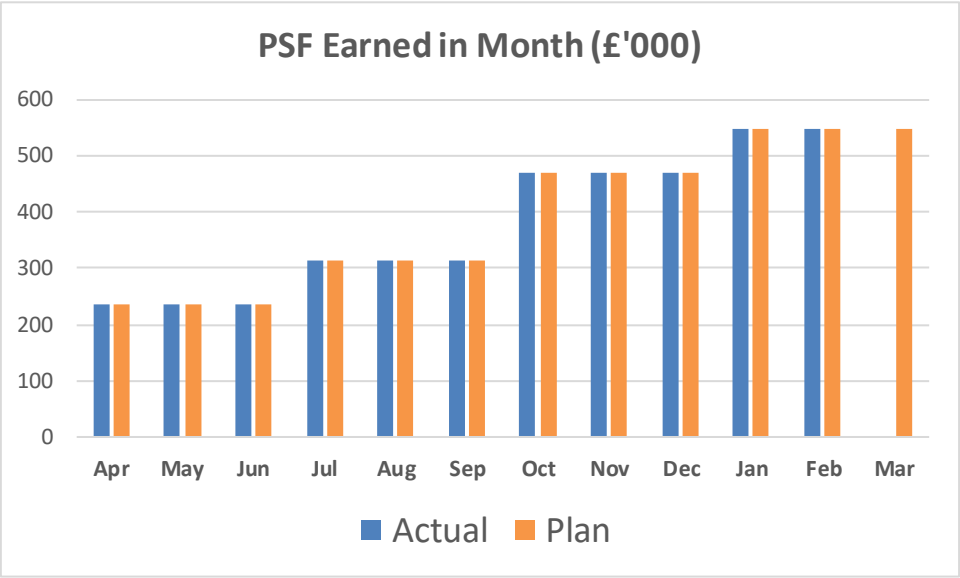
## Use of Resources (UoR)

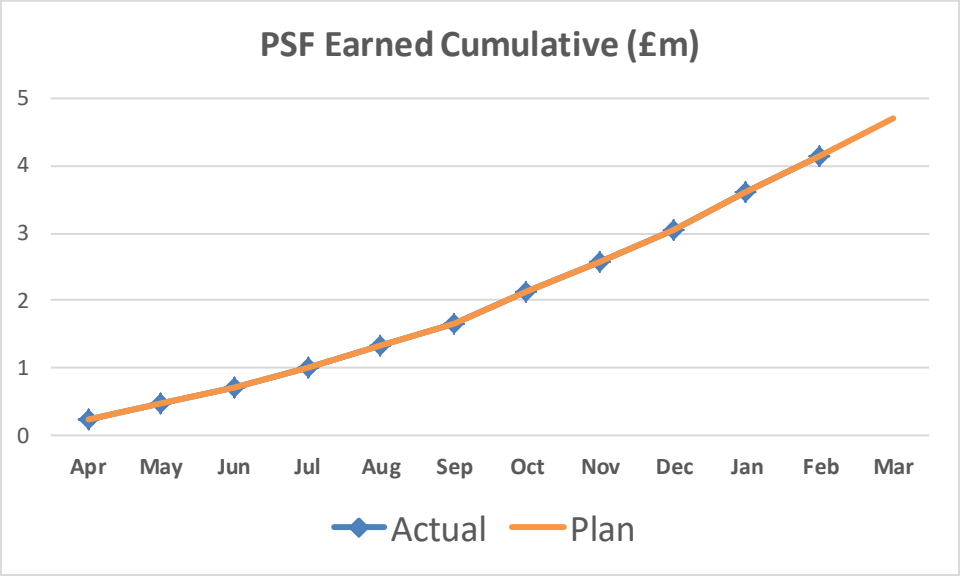



- The Use of Resources (UOR) score is rated 1 to 4 with 1 denoting the strongest financial position.
- The Trust score in month and year to date is 3 which is on plan.
- Year to date the Trust is scoring a 3 against capital service capacity and income and expenditure margin; 4 against agency spend; 2 against distance from financial plan and 1 against liquidity.

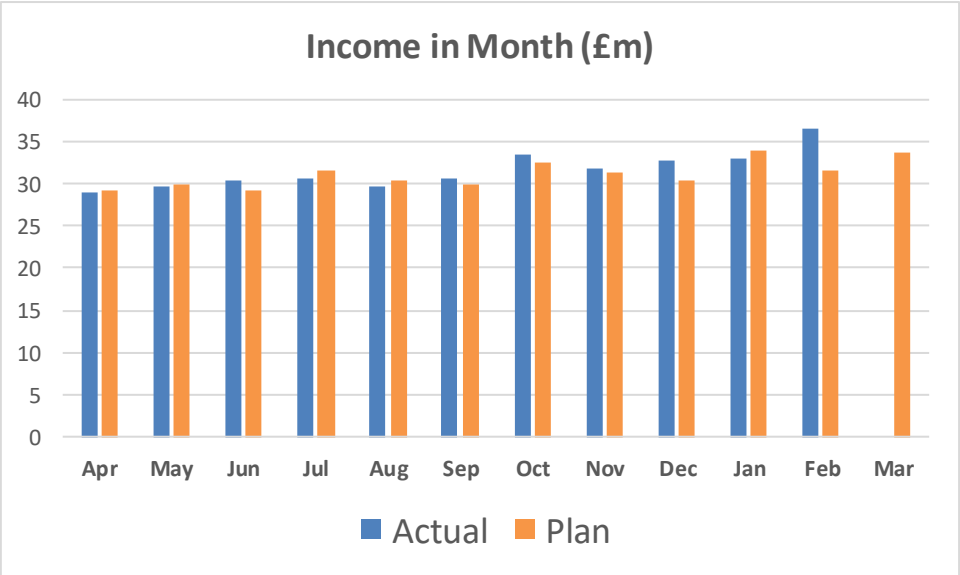
## Provider Sustainability Funding (PSF)

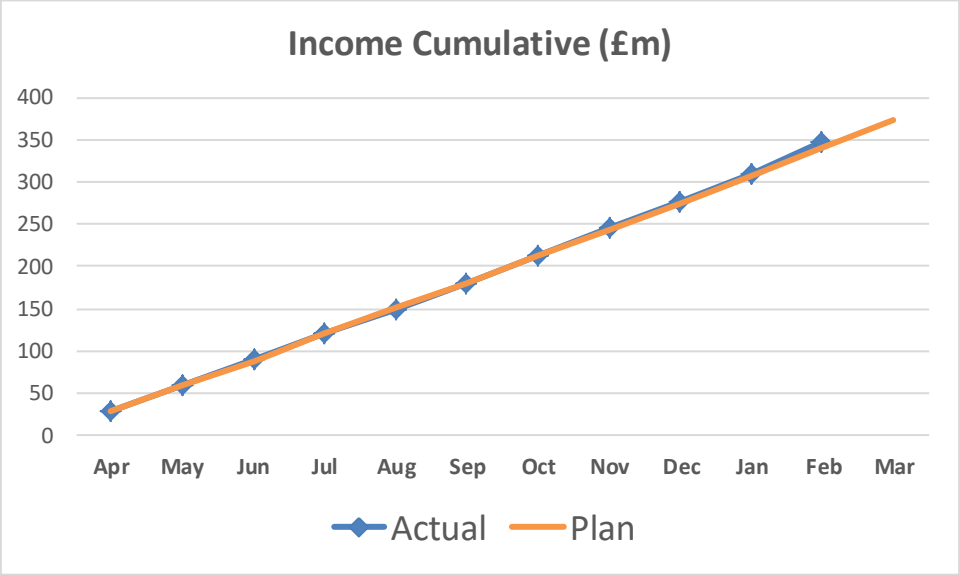



- The Provider Sustainability Funding (PSF) for month 11 is £0.5m.
- The PSF funding relates solely to financial performance in 2019/20.
- The Trust achieved the control total for Q1, Q2 and Q3 and therefore the full value of PSF has been included for that period.
- The PSF for month 10 and 11 of £1.1m is included at risk based on achieving the Q4 control total.

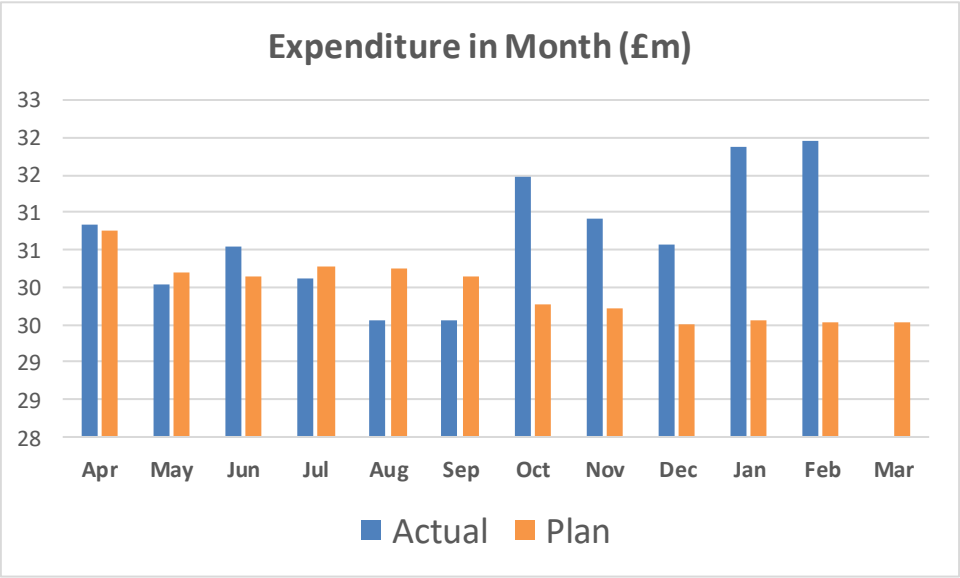
## Income

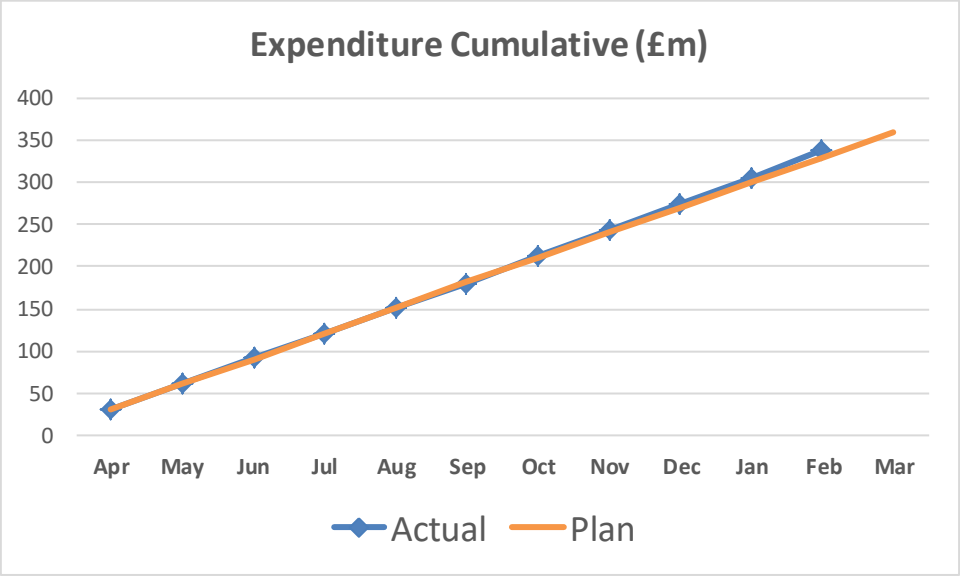



- Income is ahead of plan by £4.9m in month and £7.4m year to date.
- The clinical divisions are £5.8m behind plan predominantly due to elective activity under performance.
- The 2019/20 contract has been agreed with Wigan Borough CCG with a deficit of £0.1m in month and a benefit of £2.2m year to date associated with activity and settlement of challenges.
- A review of year end provisions has improved the income position by £4.5m year to date.
- The in month and year to date position also includes a £6.9m benefit relating to support from the local authority for Community Services.

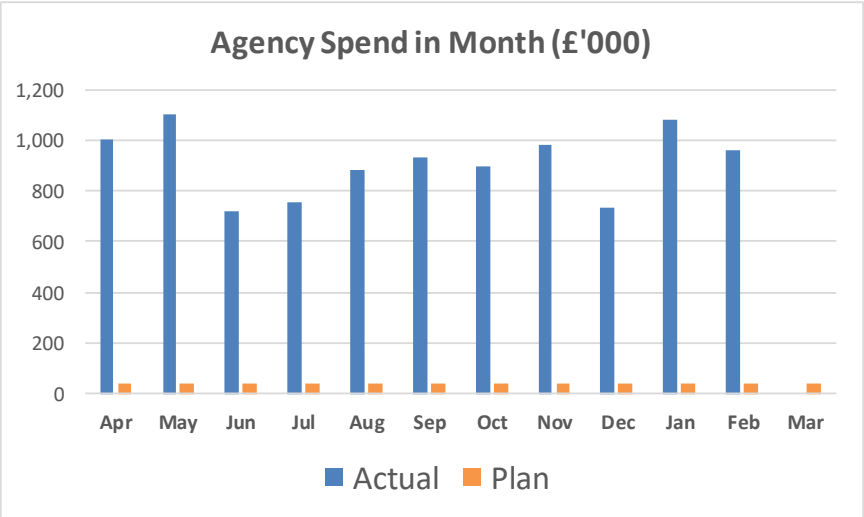
## Expenditure

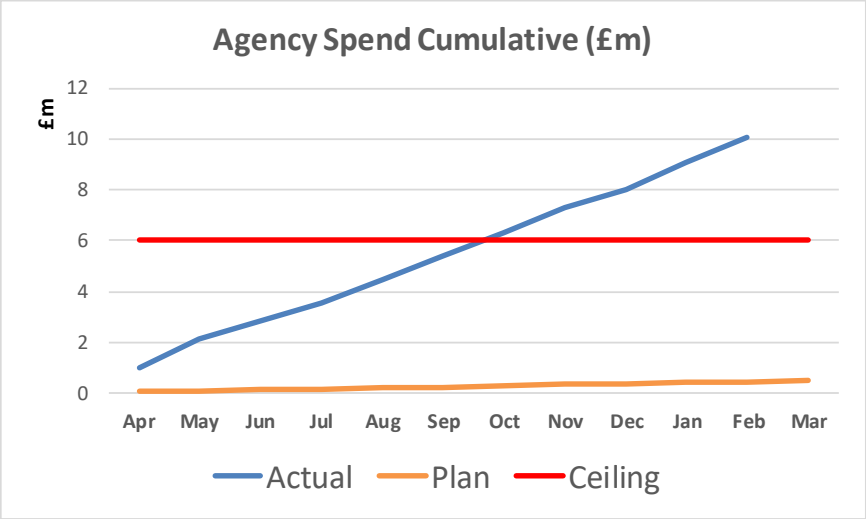



- Expenditure is above plan by £2.4m in month 11 and £7.6m above plan year to date.
- Pay expenditure is £1.2m adverse to plan in month 11 and £4.8m adverse to plan year to date. Pay expenditure includes actual agency expenditure of £1.0m in month which remains high compared to the 2018/19 monthly average of £0.6m.
- Non pay expenditure is £1.2m adverse to plan in month and £4.8m adverse to plan year to date. The adverse variance in month includes £0.3m Community (including GP out of hours); £0.2m SAVI; £0.2m Estates and Facilities and £0.2m Surgery.
- Trust reserves of £1.1m have been released to support the position year to date and have been utilised to fund the cost pressure from the medical pay award.

## Agency Spend



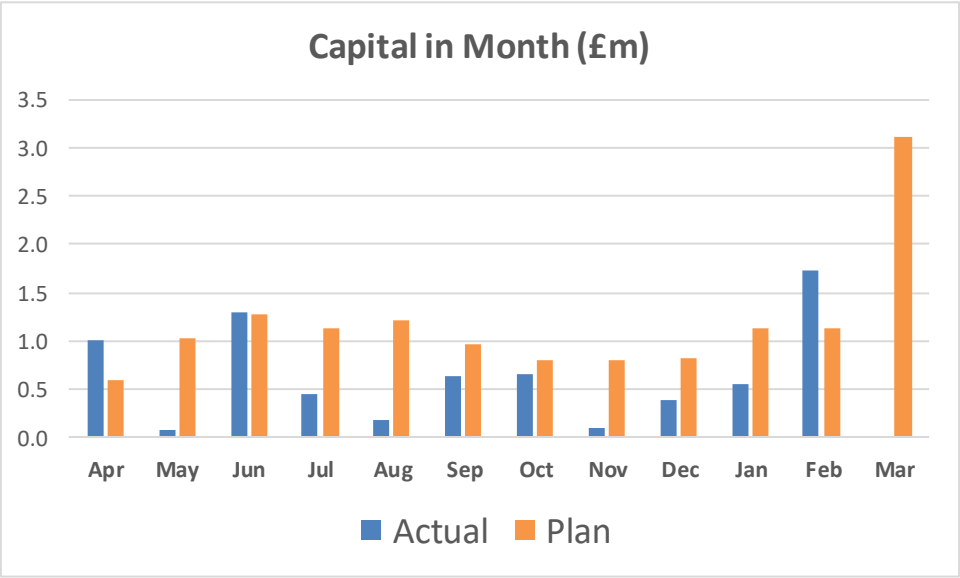

- Agency spend in month 11 is £0.9m above plan, £9.6m above plan year to date.

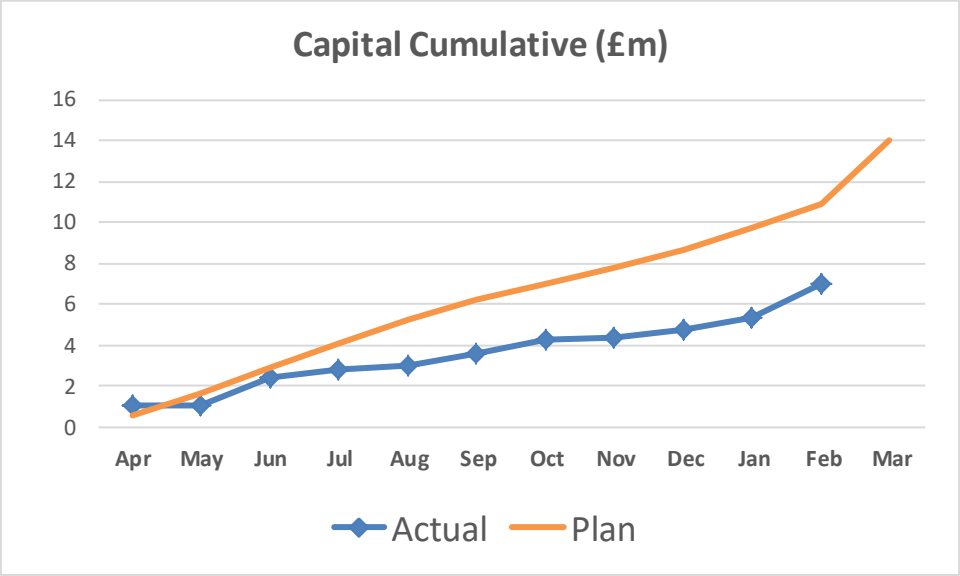
- There was £0.4m of agency expenditure in month 11 within the Medicine division across scheduled and unscheduled care. Agency expenditure on £0.3m in nursing staff and £0.1m on medical staff. The higher level of nursing agency seen in month 10 has continued into month 11.

- There was £0.3m of agency expenditure within the Surgery division in month 11 which was across a range of specialties, including Child Health and Theatres.

- As discussed and agreed during the budget setting process for 19/20, the Trust only sets a minimal budget for agency spend as the contra for agency spend will be vacant positions (including a budget for agency plus full establishment would be a double count). Remedial action including recruitment drives, switching medical staff to the bank are all being progressed but the process of filling vacancies means that agency run rates are still higher than expected driven by pension issues and operational demands.

## Capital Spend




- The capital programme is overspent in month by £0.6m and underspent year to date by £3.9m
- The original capital programme of £8m originally notified to NHSI has increased to £14m and schemes have been re-profiled to reflect this change.
- The Trust is expecting to spend its capital allocation for the year based on scheduled deliveries and notified scheme completion dates.

# Memorandum - Trading Activity

**Profitabilty Tables of Commerical Ventures - Memorandum Report**

| £000s | Annual | Month | | | YTD | | |
|---|---|---|---|---|---|---|---|
| | Plan | Actual | Plan | Var | Actual | Plan | Var |
| **McH/MMed Programme** | | | | | | | |
| Income | 1,873 | 254 | 156 | 98 | 2,391 | 1,717 | 674 |
| Pay | (261) | (28) | (22) | (6) | (295) | (239) | (56) |
| Non-Pay | (1,007) | (196) | (84) | (112) | (1,251) | (923) | (328) |
| **Contribution to the Trust bottom line** | **605** | **51** | **50** | **0** | **540** | **555** | **(15)** |
| **Contribution held in reserves** | **0** | **(20)** | **0** | **(20)** | **306** | **0** | **306** |
| **Total Contribution** | **605** | **30** | **50** | **(20)** | **845** | **555** | **291** |
| **Occupational Health [1] [2]** | | | | | | | |
| Income | 297 | 35 | 23 | 12 | 394 | 271 | 123 |
| Pay | (674) | (45) | (56) | 11 | (550) | (619) | 69 |
| Non-Pay | (260) | (40) | (17) | (23) | (200) | (243) | 43 |
| **Contribution** | **(637)** | **(49)** | **(49)** | **(0)** | **(356)** | **(591)** | **235** |
| **Go Engage** | | | | | | | |
| Income | 801 | 12 | 67 | (55) | 164 | 734 | (570) |
| Pay | (202) | (11) | (16) | 5 | (141) | (186) | 45 |
| Non-Pay | (91) | 4 | (7) | 11 | (73) | (82) | 9 |
| **Contribution** | **508** | **4** | **43** | **(39)** | **(50)** | **466** | **(516)** |
| **Private Patients [2]** | | | | | | | |
| Income | 2,748 | 299 | 207 | 92 | 3,564 | 2,469 | 1,095 |
| **Catering [1]** | | | | | | | |
| Income | 3,066 | 329 | 242 | 87 | 3,000 | 2,801 | 198 |
| Pay | (3,456) | (330) | (286) | (43) | (3,295) | (3,170) | (125) |
| Non-Pay | (2,552) | (197) | (213) | 15 | (2,233) | (2,339) | 106 |
| **Contribution** | **(2,941)** | **(198)** | **(257)** | **59** | **(2,528)** | **(2,708)** | **180** |

[1] Includes the cost of delivering internal service as well as supporting external income
[2] This is the financial position before SAVI transactions.

# Memorandum – Trust Forecast and Agency Spend

## A. Divisional Performance

- The following table shows the year to date performance by Division as at month 11.

| Division | Year to Date Variance £'000 | | | | |
|---|---|---|---|---|---|
| | Income | Pay | Non Pay | Other | Total |
| Medicine | 2,475 | (5,179) | (1,011) | | (3,716) |
| Surgery | (1,992) | (1,161) | (934) | | (4,087) |
| Specialist Services | (6,597) | 1,334 | 1,679 | | (3,584) |
| Community Services | 275 | 1,134 | (2,115) | | (706) |
| Corporate Divisions | 62 | 2,452 | (1,608) | | 907 |
| Corporate Items | | | | 10,514 | 10,514 |
| **Total** | **(5,777)** | **(1,421)** | **(3,989)** | **10,514** | **(673)** |

- The Medicine Division has a £3.7m adverse variance year to date. Income is above plan by £2.5m offset by an adverse variance of £5.2m on pay and £1.0m on non-pay. There is £4.4m actual agency expenditure year to date.

- The Surgery Division is reporting an adverse variance of £4.1m year to date across a range of specialties. Income is £2.0m adverse to plan; pay is £1.2m adverse to plan and non-pay is £0.9m adverse to plan.

- The Specialist Services Division is £3.6m adverse to plan year to date. Income is £6.6m adverse to plan. T&O income is £2.8m adverse to plan year to date due to day case, elective and non-elective activity. There is a £2,0m adverse variance on income due to chemotherapy pass through drugs which is offset by a favourable variance on non-pay expenditure. McH income is £0.8m adverse to plan year to date which is offset by a favourable variance on pay.

- The Community Services Division is £0.7m adverse to plan year to date (this is only front line services and does not include the additional resource in corporate functions brought in to support Community). Non pay is adverse to plan by £2.1m which includes the GP out of hours cost pressure. Pay is £1.1m favourable to plan due to vacant posts.

- The Corporate Divisions are £1.0m favourable to plan year to date. Pay is £2.5m favourable to plan which includes vacant posts to support the Community Division. Non pay is £1.6m adverse to plan which includes IM&T (£0.6m); Estates and Facilities (£0.3m) and Nurse Director (£0.3m) which relates to HEE funding is offset by income.

- Within the Corporate items there are several significant items causing the favourable variance of £10.5m year to date;

    - £7.7m favourable variance due to a review of prior year provisions

- £1.1m favourable variance for reserves
- (£3.7m) adverse variance year to date for the unachieved pipeline SAVI
- £2.2m favourable variance for agreement of the 2019-20 contract with Wigan Borough CCG
- (£2.0m) adverse variance from the planned income associated with the NHSI tariff challenge which was rejected
- £6.9m favourable variance for CHIP

## B. Divisional Forecast

The following table shows the month 11 forecast by Division and the planned mitigation.

| Division | Full Year Forecast Variance £'000 | | | | |
|---|---|---|---|---|---|
| | Income | Pay | Non Pay | Other | Total |
| Medicine | 3,067 | (5,835) | (1,106) | | (3,874) |
| Surgery | (2,501) | (1,180) | (1,024) | | (4,705) |
| Specialist Services | (6,908) | 1,324 | 1,738 | | (3,845) |
| Community Services | 338 | 1,021 | (2,344) | | (985) |
| Corporate Divisions | 22 | 2,235 | (2,151) | | 106 |
| Corporate Items [1] | | | | 8,264 | 8,264 |
| **Unmitigated Total** | **(5,982)** | **(2,435)** | **(4,887)** | **8,264** | **(5,040)** |
| | | | | | |
| **Mitigations:** | | | | | |
| Community Health Investment Plan | | | | | 5,100 |
| **Total Mitigations** | | | | | **5,100** |
| | | | | | |
| **Forecast Including Mitigations and PSF/FRF** | | | | | **60** |

- The unmitigated forecast full year variance to the control total is £5.0m.
- The forecast for the Divisions of Medicine, Surgery and Specialist are predominantly an extrapolation of current run rates, albeit there is a forecast improvement in orthopaedic activity in the final month versus the average year to date.
- The forecast for Community Services and the Corporate Divisions deteriorate compared to the current run rate due to recruitment into vacant posts.
- Within the forecast for Corporate Items, there is an adverse variance of £4.4m for unachieved pipeline SAVI and £3.0m NHSI tariff shortfall plan in quarter 4 (income not agreed), which offset the favourable year to date position detailed on the previous page.
- The planned mitigation for the forecast variance is a further £5.1m through the Community Health Investment Plan (CHIP), taking the total value of CHIP in year to £12.0m. Without this, the Trust will not achieve the Q4 control total and unlock the Q4 PSF and FRF payments of £2.7m.

## C. Agency Expenditure Breakdown

### Table 1: Pay and Agency Expenditure at Month 11

| Year to Date £'000 | Total Pay | | | Agency | | | Other | | |
|---|---|---|---|---|---|---|---|---|---|
| **Division** | **Budget** | **Actual** | **Variance** | **Budget** | **Actual** | **Variance** | **Budget** | **Actual** | **Variance** |
| Medicine | 57,852 | 63,031 | **(5,179)** | 269 | 4,387 | **(4,117)** | 57,582 | 58,644 | **(1,062)** |
| Surgery | 62,568 | 63,729 | **(1,161)** | 0 | 3,006 | **(3,006)** | 62,568 | 60,723 | **1,845** |
| Specialist Services | 45,655 | 44,321 | **1,334** | 183 | 827 | **(643)** | 45,472 | 43,495 | **1,977** |
| Community Services | 28,284 | 27,150 | **1,134** | 0 | 793 | **(793)** | 28,284 | 26,357 | **1,927** |
| Corporate Divisions | 33,918 | 34,866 | **(948)** | 0 | 1,050 | **(1,050)** | 33,918 | 33,816 | **102** |
| **Total** | **228,277** | **233,097** | **(4,820)** | **453** | **10,062** | **(9,610)** | **227,825** | **223,035** | **4,789** |

### Table 2: Agency Expenditure by Type at Month 11

| **Division** | **Year to Date Actual £'000** | | | | |
|---|---|---|---|---|---|
| | **Medical** | **Nursing** | **Admin & Clerical** | **Other** | **Total** |
| Medicine | 2,386 | 1,620 | 1 | 379 | 4,387 |
| Surgery | 1,733 | 733 | 309 | 230 | 3,006 |
| Specialist Services | 247 | 359 | 0 | 221 | 827 |
| Community Services | 271 | 104 | 10 | 408 | 793 |
| Corporate Divisions | (19) | 0 | 1,069 | 0 | 1,050 |
| **Total** | **4,618** | **2,816** | **1,389** | **1,239** | **10,062** |

- The year to date agency expenditure is £10.1m.
- The Medicine Division has spent £4.4m year to date with £2.4m on medical agency to cover gaps in rotas and pressures across the Division. This is for consultant and middle grade posts, predominantly in acute medicine and geriatric medicine as well as a number of other specialties. Three business cases have recently been approved to convert agency expenditure into established posts. Nursing agency expenditure is £1.6m year to date and has seen an increase over the last two months.
- The Surgery Division has agency expenditure of £3.0m year to date with £1.7m on medical agency to cover gaps in rotas. This spans a range of specialties within the division. The agency is predominantly covering vacancies within the establishment.
- The Specialist Services Division has spent £0.8m year to date due to a consultant post in Dermatology, nursing and radiology agency which is offsetting vacant posts.
- The Community Division has incurred agency expenditure of £0.8m year to date for nursing and AHP staff which is covering vacant posts.
- The Corporate Divisions have spent £1.1m year to date for agency expenditure, predominantly on administrative and clerical staff. This is offsetting vacancies and is reducing now permanent recruitment into posts to support the Community Division has taken place.

# REPORT

**AGENDA ITEM: 12**

Wrightington, Wigan and Leigh NHS Foundation Trust

| | | | |
|---|---|---|---|
| **To:** | Board of Directors | **Date:** | 25 March 2020 |
| **Subject:** | Safe Staffing Report | | |
| **Presented by:** | Chief Nurse | **Purpose:** | Information and assurance |

## Executive summary


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

The Board are asked to note;

- There has been a reduction in staffing pressures on the acute site for nurse staffing and an associated reduction in avoidable harms from the development of category 1-4 pressure ulcers, however DTI's on heels continue to be reported within the Trust and education and equipment has been provided to mitigate this risk.
- Registered nurse CHPPD is now above peer and national average as a consequence of the increase in registered staffing numbers associated with recruitment to substantive posts, the nursing incentive scheme and the use of agency nurses.
- There has been a reduction in the reporting of red flags within nursing which reflects the improved fill rates and the ongoing uptake of additional shifts by substantive, bank and agency staff. No red flags have been raised in February with respect to any inpatient area having less than 1 registered nurse.
- Overall vacancy rates have reduced within the reporting period and there was a second successful recruitment event held in February 2020.
- There has been a review and renegotiation of bank rates of pay for registered and unregistered staff which will assist in the withdrawal of LPV for nursing staff.
- Trust Board accepted the recommendations contained within the Bi-annual staffing review and the associated increase in ward establishments will be reflected in new budgets agreed for 2020/21.
- The falls improvement group is undertaking a deep dive reviewing patients who have had multiple falls whilst in our care in order to mitigate this risk.
- The plans to reinvigorate the PJ Paralysis campaign to assist in the reduction of deconditioning of patients and associated risk of falls.


The WWL Way

| Risks associated with this report |
| --- |
| Skill mix remains a concern across clinical divisions with individual wards being noted on the Corporate Risk Register.<br><br>Nurse Staffing remains the biggest risk on the risk register.<br><br>Risks reported with respect to vacancies within District Nursing Services<br><br>The increase in the number of patients who have had multiple falls whilst in our care |

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

Wrightington, Wigan and Leigh NHS
NHS Foundation Trust

**Safe Staffing Report – January and February 2020.**

## 1.0 INTRODUCTION

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

## 2.0 SAFER STAFFING EXCEPTION REPORT

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

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

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

**3.0 CURRENT POSITION – January and February 2020**

The overall nursing fill rate for the Trust was 111.2% in January 2020 and 111.8% in February 2020; the overall fill rate for registered nurses was 102.34% and 101.3% respectively. Divisional fill rates for registered nurses were 106.1% Division of Medicine, 98.5% Specialist Services Division and 105.9% Division of Surgery in January; February's fill rates were 105.2% Division of Medicine, 96% Specialist Services and 104% Division of Surgery. For overall fill rates the Trust would be rated as green.

Throughout January and February 2020 the Trust has continued to see a reduction in the number of areas flagging red for registered nurse fill rate (Appendix 2, Table 1). The Board should note, however, that the fill rates provided are based on the current funded establishment levels and do not reflect the staffing required or the skill mix shortfall, particularly within Scheduled Care, that has been highlighted to the Board in previous reports. The overall position is enhanced as a consequence of the internal registered nurse incentive scheme and the increase in registered nurse shifts being undertaken by agency staff.

Orrell Ward was re-designated temporarily as a medical ward towards the end of December 2019. Prior to this change the staffing model associated with the clinical area was reviewed and staffing requirements were adjusted to reflect the acuity and dependency needs of the patients who would be receiving care on the ward. Appendix 1, therefore, reflects an increase in fill rates for both registered and unregistered nurses against the budgeted establishment and planned hours in order to safely deliver care within the clinical area.

To assist in the reduction of agency use in the nursing workforce, review and renegotiation of NHSP pay for registered and unregistered staff has been undertaken by the Divisional Director of Nursing for Surgery supported by the finance team. Approval was given to increase the rates of pay in accordance with the review undertaken. To offset this increase it is intended to remove the local pay variations agreed for staff to work at short notice from April 2020.

Appendix 2, Table 2 provides details of the vacancies across the inpatient wards and community services for January and February 2020. The overall number of registered vacancies reported within the Trust has reduced within the reporting period. There continues to be an increase in the number of unregistered nurse vacancies reported. The number of registered nurse vacancies within District Nursing Services has reduced from 14.5 WTE in December 2019 TO 10.6 wte in February 2020. District Nursing Services are being migrated over to the e roster system and staff are also now able to pick up shifts via NHSP to fill the gaps in service and mitigate any risk.

The number of red flags reported by inpatient areas in response to patient quality and safety issues has fallen further within this reporting period. This is to be expected given the increasing fill rates reflected in earlier within the report. Of particular note no red flags have been raised where there has been less than 1 registered nurse on duty in February 2020; where these red flags were raised in January there is no triangulation with harms reported in the clinical areas (Highfield, Winstanley and Orrell) and staff were redeployed to these areas to mitigate the risk. (Appendix 2 Table 4). The majority of the red flags raised continue to be related to a shortfall in registered nursing time; this is linked to short notice sickness, vacancies within specific areas and the number of escalated areas in the Trust. Delays in the administration of pain relief

also feature within the red flags raised; this information can be triangulated with the deterioration in patient experience in the management of pain control.

There have been no red flags raised in January/February 2020 in Maternity services.

In January 2020 Trust Board received the second Bi-annual staffing review which recommended that the previously identified skill mix deficits were corrected and that there was an increase in the ward establishments from the start of the new financial year; this recommendation was supported by the Board. In addition the Board supported the need to increase establishments in response to acuity and dependency, and in response national staffing level recommendations to deliver the Non-Invasive Ventilation (NIV) service. The funding to support these changes will be included in Divisional budgets on commencement of the new financial year. The Board should note that some of these positions may be filled by other Health Professionals to meet the needs of the patients being cared for within specific clinical areas.

A second recruitment event was held in February 2020. 17 registered nurses were offered positions and a further 15 posts were offered to future qualifiers. A vacancy mapping exercise is to be held in March 2020 to consider all posts currently on offer, including international recruitment and those posts identified for alternative workforce models, and the residual vacancies and a decision will be made whether to defer the next quarterly recruitment event

4 community acquired pressure ulcers were reported to StEIS across January and February 2020. Initial review of these cases identified some staffing concerns with respect to skill mix and process not being followed. 1 hospital acquired pressure ulcer was reported to StEIS in February 2020. This harm occurred on Orrell Ward which, as previously mentioned, was repurposed from a surgical assessment ward to a medical inpatient area. Initial review of this case identified a lack of assessment and documentation in part associated with the change in purpose from short stay to long stay care provision and associated review and education of staff with respect to systems and processes when patients have an extended stay, and lack of equipment to assist in the prevention of harm.

The quality metrics provided in Appendix 1 indicate that there has been a decrease in the number of category 1-4 pressure ulcers reported as being acquired whilst in hospital care, however there continues to be reporting of deep tissue injuries (DTI's) particularly to patients heels. Since December 2019, all hospital acquired pressure ulcers are subject to a panel review chaired by the Deputy Chief Nurse to determine whether there have been any omissions in care that have resulted in harm to the patient. These reviews have resulted in practice change within some clinical areas, the purchase of additional equipment to assist in the management of the patient and increased education for staff. There have been 2 serious falls within the reporting period (MAU and Winstanley) which are currently subject to internal investigation; there were no associated staffing concerns at the time the falls took place. There continues to be an increase in the number of no and low harm reported falls despite the improvements to fill rates. On review this increase appears to be associated with an increase in the number of patients having multiple falls whilst in our care. The Falls Improvement Group is currently reviewing incidents for root causes and the clustering of incidents to determine appropriate interventions to mitigate this risk. In addition the Chief AHP is planning to relaunch the PJ Paralysis Campaign in April 2020 which should assist with the reduction of deconditioning of patients and improve compliance with good footwear.

CHPPD data from the Model Hospital is provided in Appendix 2 Table 6; this data was refreshed in December 2019. Whilst the Trust continues to compare favourably for CHPPD for overall staffing against peers and national benchmarking data. The improved fill rates reported in December 2019 have improved the registered nurse CHPPD from 4.4 to 4.8 against a peer average of 4.5 and the national average of 4.7. Unregistered CHPPD continues to compare favourably with peers and the national average but this is indicative of the reduction of skill mix previously mentioned within the report.

**4.0 ACTIONS BEING TAKEN**

Review of overall vacancies, employment offers and divisional plans for alternative workforce is being undertaken in March 2020.

The Falls Improvement Group are undertaking a programme of work to review and mitigate the risk of patients having multiple falls whilst in our care.

The PJ Paralysis campaign is being relaunched by the Chief AHP to assist in the reduction of deconditioning of patients and associated risk of falls.

Plans to phase out LPV rates for nurses and midwifery are being progressed.

**5.0 SUMMARY**

The overall nursing fill rates in inpatient areas across the trust for January and February 2020 are 111.2% and 111.8% respectively. Fill rates for registered staff across the Trust throughout both reporting periods were over 100%.

This reduction in registered nurse staffing pressures on the acute site has seen an associated reduction in avoidable harms from the development of category 1-4 pressure ulcers, however DTI's on heels continue to be reported within the Trust and education and equipment has been provided to mitigate this risk.

Registered nurse CHPPD is now above peer and national average as a consequence of the increase in registered staffing numbers associated with recruitment to substantive posts, the nursing incentive scheme and the use of agency nurses.

There has been a reduction in the reporting of red flags within nursing which reflects the improved fill rates and the ongoing uptake of additional shifts by substantive, bank and agency staff. No red flags have been raised in February with respect to any inpatient area having less than 1 registered nurse.

Overall vacancy rates have reduced within the reporting period and there was a second successful recruitment event held in February 2020.

There has been a review and renegotiation of bank rates of pay for registered and unregistered staff which will assist in the withdrawal of LPV for nursing staff.

Trust Board accepted the recommendations contained within the Bi-annual staffing review and the associated increase in ward establishments will be reflected in new budgets agreed for 2020/21.

The falls improvement group is undertaking a deep dive reviewing patients who have had multiple falls whilst in our care in order to mitigate this risk.

The plans to relaunch the PJ Paralysis campaign to assist in the reduction of deconditioning of patients and associated risk of falls.

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

**Allison Luxon: Deputy Chief Nurse**

## Appendix 1
## SAFE STAFFING EXCEPTION REPORT – January 2020

### Division of Medicine – Scheduled Care

| | Average Fill Rates (%) & CHPPD | | | | | | Staff Availability | | | Staff Experience | Nurse Sensitive Indicators | | | | Patient Experience % (Number surveyed) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | RN / RM | | | CSW | | | | | | | | | | | | |
| Ward | Day shift (%) | Night shift (%) | CHPPD | Day shift (%) | Night shift (%) | CHPPD | Sickness (%) | Vacancies (%) | Vacancies (%) - Registered Nursing Band 5-8 | Datix Incidents - related to staffing/Red Flags | CDT | Falls (Harm / No Harm) | PU (Grade 1&2 / Grade 3 & 4) | Drug Admin Errors (Harm / No Harm) | Do you think the hospital staff did everything they could do to control your pain? | Have you been given the care you felt you required when you needed it most? |
| Acute Stroke Unit | 90.3% | 100.0% | 3.0 | 152.3% | 116.6% | 5.7 | 6.22% | 2.15% | 3.79% | 0 | | 0/3 | | 0/4 | 100.00% | 100.00% |
| Astley | 107.8% | 118.7% | 3.0 | 131.6% | 159.0% | 5.8 | 6.33% | 5.49% | 1.17% | 0 | | 0/1 | | | 80.00% | 100.00% |
| Coronary Care Unit | 118.6% | 101.1% | 7.5 | 91.9% | 0.0% | 2.1 | 6.92% | 1.11% | 0.94% | 0 | | | | | 100.00% | 100.00% |
| Highfield | 119.2% | 100.2% | 5.4 | 130.0% | 85.6% | 5.3 | | | | 2 | | 0/1 | | 0/1 | | |
| Ince | 103.0% | 115.8% | 3.4 | 109.2% | 131.4% | 4.1 | 4.41% | 9.52% | 16.88% | 0 | | | | 0/3 | 100.00% | 100.00% |
| Pemberton | 110.5% | 101.6% | 5.5 | 139.4% | 148.6% | 5.9 | 1.06% | 9.05% | 14.10% | 0 | | | | 0/1 | | |
| Shevington | 109.9% | 103.3% | 3.3 | 127.9% | 183.4% | 5.2 | 6.53% | 19.83% | 37.23% | 0 | | 0/4 | | 0/1 | 100.00% | 100.00% |
| Standish | 107.0% | 100.7% | 2.5 | 144.3% | 162.9% | 5.9 | 5.00% | 8.93% | 20.05% | 0 | | 0/6 | | | 100.00% | 100.00% |
| Winstanley | 105.2% | 97.1% | 3.1 | 118.4% | 115.1% | 4.7 | 5.08% | 5.32% | 30.23% | 4 | 2 | 0/4 | | 0/1 | 85.70% | 100.00% |

## Division of Medicine – Unscheduled Care

| | Average Fill Rates (%) & CHPPD | | | | | | Staff Availability | | | Staff Experience | Nurse Sensitive Indicators | | | | Patient Experience % (Number surveyed) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | RN / RM | | | CSW | | | | | | | | | | | | |
| Ward | Day shift (%) | Night shift (%) | CHPPD | Day shift (%) | Night shift (%) | CHPPD | Sickness (%) | Vacancies (%) | Vacancies (%) - Registered Nursing Band 5-8 | Datix Incidents - related to staffing/Red Flags | CDT | Falls (Harm / No Harm) | PU (Grade 1&2 / Grade 3 & 4) | Drug Admin Errors (Harm / No Harm) | Do you think the hospital staff did everything they could do to control your pain? | Have you been given the care you felt you required when you needed it most? |
| A&E Emg Care | 93.9% | 111.8% | | 102.2% | 148.1% | | 5.11% | 19.12% | 20.63% | 0 | | 0/3 | | 0/2 | | |
| A&E Paeds | 81.4% | 69.7% | | | | | 0.00% | 19.82% | 19.82% | 0 | | | | | | |
| A&E NP's | 182.2% | 4.5% | | | | | | | | | | | | | | |
| CDW | 96.8% | 111.1% | | 95.4% | 87.0% | | 8.31% | 0.78% | 0.00% | 0 | | 0/1 | | | 100.00% | 100.00% |
| Lowton | 110.8% | 101.3% | | 106.8% | 107.8% | | 13.49% | 5.54% | 16.07% | 1 | | 0/4 | | 1/2 | 90.00% | 100.00% |
| Medical Assessment Unit | 91.7% | 105.5% | | 98.4% | 94.0% | | 7.93% | 7.81% | 23.33% | 6 | | 1/3 | | 0/1 | 75.00% | 75.00% |

## Division of Surgery

| | Average Fill Rates (%) & CHPPD | | | | | | Staff Availability | | | Staff Experience | Nurse Sensitive Indicators | | | | Patient Experience % (Number surveyed) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | RN / RM | | | CSW | | | | | | | | | | | | |
| Ward | Day shift (%) | Night shift (%) | CHPPD | Day shift (%) | Night shift (%) | CHPPD | Sickness (%) | Vacancies (%) | Vacancies (%) - Registered Nursing Band 5-8 | Datix Incidents - related to staffing/Red Flags | CDT | Falls (Harm / No Harm) | PU (Grade 1&2 / Grade 3 & 4) | Drug Admin Errors (Harm / No Harm) | Do you think the hospital staff did everything they could do to control your pain? | Have you been given the care you felt you required when you needed it most? |
| ICU/HDU | 89.8% | 84.9% | 32.1 | 82.3% | 0.0% | 3.4 | 10.40% | 1.07% | 1.46% | 9 | | | | | | |
| Langtree | 97.8% | 101.5% | 2.6 | 116.6% | 155.9% | 2.8 | 5.55% | 2.42% | 10.40% | 3 | | 0/4 | | 0/1 | 75.00% | 100.00% |
| Orrell | 125.8% | 142.4% | 5.0 | 155.7% | 231.5% | 6.4 | 10.18% | 0.00% | 0.00% | 18 | | 0/3 | | 0/1 | 100.00% | 100.00% |
| Swinley | 105.1% | 108.7% | 2.6 | 103.1% | 121.5% | 2.5 | 3.90% | 0.00% | 4.66% | 7 | 1 | 0/2 | | 0/2 | 50.00% | 66.70% |
| Maternity Unit | 102.4% | 96.7% | 14.5 | 77.2% | 93.0% | 4.0 | 12.10% | 0.00% | 0.00% | 0 | | | | 0/1 | 100.00% | 100.00% |
| Neonatal Unit | 103.0% | 116.1% | 11.6 | 99.5% | 0.0% | 1.4 | 5.44% | 0.03% | 0.00% | 0 | | | | | 100.00% | 100.00% |
| Rainbow | 114.1% | 95.7% | 9.1 | 135.3% | 83.9% | 3.4 | 5.86% | 4.24% | 6.73% | 0 | | | | 0/4 | 100.00% | 100.00% |

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

## Division of Specialist Services

| | Average Fill Rates (%) & CHPPD | | | | | | Staff Availability | | | Staff Experience | Nurse Sensitive Indicators | | | | Patient Experience % (Number surveyed) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | RN / RM | | | CSW | | | | | | | | | | | | |
| Ward | Day shift (%) | Night shift (%) | CHPPD | Day shift (%) | Night shift (%) | CHPPD | Sickness (%) | Vacancies (%) | Vacancies (%) - Registered Nursing Band 5-8 | Datix Incidents - related to staffing/Red Flags | CDT | Falls (Harm / No Harm) | PU (Grade 1&2 / Grade 3 & 4) | Drug Admin Errors (Harm / No Harm) | Do you think the hospital staff did everything they could do to control your pain? | Have you been given the care you felt you required when you needed it most? |
| Aspull | 101.4% | 99.5% | 3.4 | 145.6% | 177.8% | 4.95 | 12.82% | 14.61% | 30.03% | 34 | | 0/7 | | 0/4 | 66.70% | 66.70% |
| Ward A | 100.8% | 90.1% | 3.4 | 89.6% | 80.2% | 3.21 | 6.34% | 12.12% | 17.63% | 1 | | | | 0/1 | 100.00% | 100.00% |
| Ward B | 106.9% | 112.0% | 3.5 | 89.5% | 91.9% | 3.11 | 9.30% | 4.76% | 2.80% | 0 | | | | 0/1 | 100.00% | 100.00% |
| JCW | 91.7% | 85.7% | 6.4 | 58.7% | 74.2% | 2.76 | 13.04% | 11.37% | 19.20% | 0 | | 0/1 | | | | |

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

# SAFE STAFFING EXCEPTION REPORT – February 2020

## Division of Medicine – Scheduled Care

| | Average Fill Rates (%) & CHPPD | | | | | | Staff Availability | | | Staff Experience | Nurse Sensitive Indicators | | | | Patient Experience % (Number surveyed) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | RN / RM | | | CSW | | | | | | | | | | | | |
| Ward | Day shift (%) | Night shift (%) | CHPPD | Day shift (%) | Night shift (%) | CHPPD | Sickness (%) | Vacancies (%) | Vacancies (%) - Registered Nursing Band 5-8 | Datix Incidents - related to staffing/Red Flags | CDT | Falls (Harm / No Harm) | PU (Grade 1&2 / Grade 3 & 4) | Drug Admin Errors (Harm / No Harm) | Do you think the hospital staff did everything they could do to control your pain? | Have you been given the care you felt you required when you needed it most? |
| Acute Stroke Unit | 99.6% | 101.2% | 3.2 | 150.6% | 148.3% | 6.6 | 7.52% | 0.00% | 0.00% | 0 | | 0/2 | | | 100.00% | 100.00% |
| Astley | 105.1% | 103.4% | 2.7 | 141.2% | 160.2% | 6.1 | 7.99% | 5.31% | 0.70% | 0 | 1 | | | | 87.71% | 100.00% |
| Coronary Care Unit | 112.2% | 100.0% | 7.5 | 125.3% | | 2.5 | 4.92% | 1.11% | 0.94% | 1 | | 0/1 | | | 100.00% | 100.00% |
| Highfield | 103.9% | 93.8% | 5.1 | 134.8% | 90.4% | 5.8 | | | | 0 | | 0/2 | | | | |
| Ince | 102.6% | 108.6% | 3.2 | 115.0% | 134.2% | 4.3 | 4.37% | 8.22% | 14.03% | 0 | | 0/4 | | | 100.00% | 85.71% |
| Pemberton | 96.3% | 103.4% | 5.4 | 123.7% | 102.3% | 4.9 | 7.14% | 5.32% | 14.10% | 0 | | | | 0/2 | | |
| Shevington | 103.0% | 105.4% | 3.2 | 134.2% | 176.1% | 5.2 | 9.72% | 16.94% | 32.26% | 2 | 1 | 0/2 | | 0/1 | 100.00% | 100.00% |
| Standish | 106.1% | 113.7% | 2.5 | 156.4% | 157.8% | 6.0 | 5.45% | 6.63% | 14.13% | 0 | | 0/7 | | 0/2 | 100.00% | 100.00% |
| Winstanley | 98.0% | 98.5% | 2.9 | 107.0% | 115.6% | 4.5 | 3.74% | 4.44% | 24.84% | 1 | | 1/0 | | 0/1 | 87.50% | 100.00% |

## Division of Medicine – Unscheduled Care

| | Average Fill Rates (%) & CHPPD | | | | | | Staff Availability | | | Staff Experience | Nurse Sensitive Indicators | | | | Patient Experience % (Number surveyed) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | RN / RM | | | CSW | | | | | | | | | | | | |
| Ward | Day shift (%) | Night shift (%) | CHPPD | Day shift (%) | Night shift (%) | CHPPD | Sickness (%) | Vacancies (%) | Vacancies (%) - Registered Nursing Band 5-8 | Datix Incidents - related to staffing/Red Flags | CDT | Falls (Harm / No Harm) | PU (Grade 1&2 / Grade 3 & 4) | Drug Admin Errors (Harm / No Harm) | Do you think the hospital staff did everything they could do to control your pain? | Have you been given the care you felt you required when you needed it most? |
| A&E Emg Care | 94.5% | 104.7% | | 101.4% | 153.0% | | 3.14% | 20.45% | 21.48% | 0 | | 0/4 | | 0/5 | | |
| A&E Paeds | 108.5% | 95.4% | | | | | 0.34% | 25.76% | 25.76% | 0 | | | | | | |
| A&E NP's | 171.6% | 0.0% | | | | | | | | | | | | | | |
| CDW | 99.7% | 96.6% | | 99.8% | 106.8% | | 4.41% | 9.83% | 8.81% | 0 | | | | 0/1 | 100.00% | 100.00% |
| Lowton | 100.2% | 113.4% | | 134.0% | 136.7% | | 8.22% | 6.41% | 14.20% | 4 | | 0/4 | | 0/5 | 90.00% | 100.00% |
| Medical Assessment Unit | 97.2% | 110.6% | | 108.3% | 110.2% | | 7.14% | 6.01% | 18.74% | 2 | | 0/4 | | 0/3 | 100.00% | 100.00% |

## Division of Surgery

| | Average Fill Rates (%) & CHPPD | | | | | | Staff Availability | | | Staff Experience | Nurse Sensitive Indicators | | | | Patient Experience % (Number surveyed) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | RN / RM | | | CSW | | | | | | | | | | | | |
| Ward | Day shift (%) | Night shift (%) | CHPPD | Day shift (%) | Night shift (%) | CHPPD | Sickness (%) | Vacancies (%) | Vacancies (%) - Registered Nursing Band 5-8 | Datix Incidents - related to staffing/Red Flags | CDT | Falls (Harm / No Harm) | PU (Grade 1&2 / Grade 3 & 4) | Drug Admin Errors (Harm / No Harm) | Do you think the hospital staff did everything they could do to control your pain? | Have you been given the care you felt you required when you needed it most? |
| ICU/HDU | 91.8% | 86.9% | 29.1 | 89.4% | | 3.2 | 8.14% | 0.57% | 0.88% | 10 | | | | 0/1 | | |
| Langtree | 98.1% | 100.0% | 2.7 | 123.8% | 154.3% | 2.9 | 10.40% | 5.03% | 13.17% | 10 | | 0/4 | | 0/1 | 100.00% | 100.00% |
| Orrell | 118.3% | 141.8% | 4.9 | 173.1% | 260.5% | 7.4 | 11.05% | 0.08% | 0.00% | 15 | | 0/6 | | 1/1 | 100.00% | 100.00% |
| Swinley | 104.1% | 109.3% | 2.4 | 120.6% | 132.1% | 2.7 | 1.5% | 1.9% | 9.3% | 6 | | 0/4 | | 0/5 | 100.00% | 100.00% |
| Maternity Unit | 102.1% | 98.1% | 16.0 | 80.1% | 98.9% | 4.6 | 8.56% | 0.00% | 0.00% | | | | | | 100.00% | 100.00% |
| Neonatal Unit | 97.8% | 108.7% | 14.3 | 93.5% | | 1.6 | 1.06% | 0.00% | 0.00% | 0 | | | | | 100.00% | 100.00% |
| Rainbow | 108.8% | 93.0% | 8.2 | 130.9% | 91.5% | 3.2 | 8.42% | 0.00% | 1.42% | 1 | | 0/1 | | 0/2 | 90.00% | 100.00% |

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

## Division of Specialist Services

| | Average Fill Rates (%) & CHPPD | | | | | | Staff Availability | | | Staff Experience | Nurse Sensitive Indicators | | | | Patient Experience % (Number surveyed) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | RN / RM | | | CSW | | | | | | | | | | | | |
| Ward | Day shift (%) | Night shift (%) | CHPPD | Day shift (%) | Night shift (%) | CHPPD | Sickness (%) | Vacancies (%) | Vacancies (%) - Registered Nursing Band 5-8 | Datix Incidents - related to staffing/Red Flags | CDT | Falls (Harm / No Harm) | PU (Grade 1&2 / Grade 3 & 4) | Drug Admin Errors (Harm / No Harm) | Do you think the hospital staff did everything they could do to control your pain? | Have you been given the care you felt you required when you needed it most? |
| Aspull | 98.5% | 100.7% | 3.6 | 153.1% | 171.8% | 5.40 | 10.00% | 15.30% | 31.86% | 12 | | 0/4 | | 0/1 | 100.00% | 88.89% |
| Ward A | 101.7% | 90.8% | 4.0 | 93.9% | 92.8% | 3.78 | 6.92% | 4.72% | 7.99% | 0 | | | | 1/1 | 87.50% | 100.00% |
| Ward B | 101.7% | 103.4% | 4.0 | 91.3% | 94.0% | 3.85 | 7.86% | 4.76% | 2.80% | 0 | | | | | 87.50% | 100.00% |
| JCW | 78.2% | 91.7% | 6.7 | 72.1% | 86.4% | 3.71 | 8.67% | 17.56% | 23.01% | 0 | | | | | | |

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

**Appendix 2**

| | **November 19** | | **November 19** | | January 2020 | | February 2020 | |
|---|---|---|---|---|---|---|---|---|
| No of areas | Red Metrics Registered Staff Days | Red Metrics Registered Staff Nights | Red Metrics Registered Staff Days | Red Metrics Registered Staff Nights | Red Metrics Registered Staff Days | Red Metrics Registered Staff Nights | Red Metrics Registered Staff Days | Red Metrics Registered Staff Nights |
| 24 | **4** | **5** | 4 | 4 | 1 | 2 | 1 | 0 |

*Table 1. Red Metrics October to December 2019*

| | **November 2019** | | December 2019 | | January 2020 | | February 2020 | |
|---|---|---|---|---|---|---|---|---|
| Specialty | Registered | Unregistered | Registered | Unregistered | Registered | Unregistered | Registered | Unregistered |
| Medicine | 37.98 | 2.89 | 37.98 | 2.89 | 27.44 | 6.15 | 22.2 | 10.37 |
| Surgery | 31.27 | 12.58 | 25.2 | 10.95 | 23.25 | 10.03 | 22.91 | 4.2 |
| Specialist Services | 12.89 | 8.6 | 10.6 | 11.38 | 13.99 | 0.2 | 13.99 | 0.2 |
| Community Services Adult | 48.49 | 14.0 | 64.77 | 22.15 | 32.29 | 10.84 | 37.61 | 12.24 |
| Community Services Children | | | | | | | | |
| **Total** | **130.63** | **38.07** | **138.55** | **47.37** | **96.97** | **27.22** | **96.71** | **27.01** |

*Table 2. Nurse Vacancies November 2019 to February 2020 by Division (Community figures exclude therapy staff January and February 2020)*

| Month | Registered WTE | Unregistered WTE |
|---|---|---|
| December 2018 | 64.71 | 15.47 |
| January 2019 | 70.36 | 7.3 |
| February 2019 | 62.49 | 7.3 |
| March 2019 | 87.17 | 16.68 |
| April 2019 | 160.11 | 23.32 |
| May 2019 | 149.41 | 22.86 |
| June 2019 | 97.81* | |
| August 2019 | 186.37 | 34.96 |
| September 2019 | 159.13 | 35.81 |
| October 2019 | 132.9 | 32.58 |
| November 2019 | 130.63 | 38.07 |
| December 2019 | 138.55 | 47.37 |

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

| **Red Flag Category** | **No. of Incidents November 2019** | **No. of Incidents December 2019** | **No of Incidents January 2020** | **No of Incidents February 2020** |
|---|---|---|---|---|
| Shortfall of more than 8 hours or 25% of registered nurses in a shift | 110 | 85 | 43 | 40 |
| Delay of 30 minutes or more for the administration of pain relief | 118 | 100 | 34 | 20 |
| Delay or omission of intentional rounding | 0 | 6 | 1 | 0 |
| Less than 2 registered nurses on shift | 16 | 13 | 7 | 0 |
| Vital signs not assessed or recorded as planned | 0 | 1 | 0 | 3 |
| Unplanned omission of medication | 1 | 0 | 0 | 1 |
| **Total** | **245** | **205** | **85** | **64** |

*Table 4. Nursing Red Flags November 2019 to February 202*

| Red Flag Category | No. of Incidents November 2019 | No. of Incidents December 2019 | No. of Incidents January 2020 | No. of Incidents February 2020 |
|---|---|---|---|---|
| Unit on Divert | 1 | 0 | 0 | 0 |
| Co-Ordinator Unable to Remain Super-numerary | 0 | 0 | 0 | 0 |
| Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing) | 0 | 0 | 0 | 0 |
| Delay of 30 or more between presentation and triage | 0 | 0 | 0 | 0 |
| Delay of 2 hours or more between admission for induction and beginning of process | 0 | 0 | 0 | 0 |
| Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour | 0 | 0 | 0 | 0 |
| **Total** | **1** | **0** | **0** | **0** |

*Table 5. Maternity Red Flags November 2019 to February 2020.*

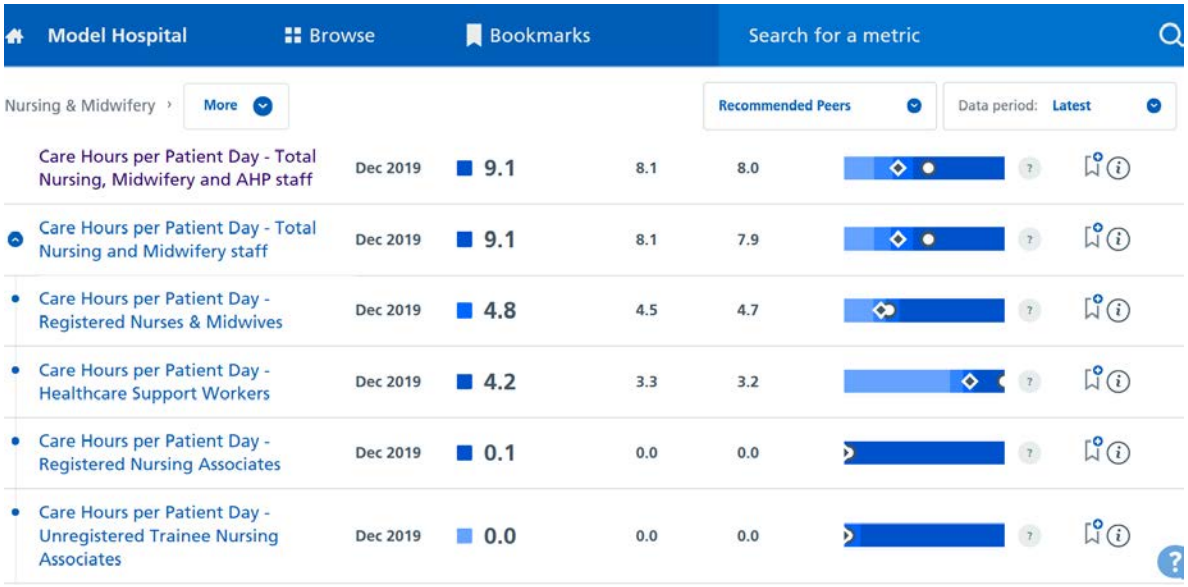



*Table 6.Use of Resources December 2019 (Source Model Hospital)*

# REPORT

**AGENDA ITEM: 12**

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **To:** | Board of Directors | **Date:** | 25 March 2020 |
| **Subject:** | Use of the foundation trust's common seal during FY2019/20 | | |
| **Presented by:** | Company Secretary | **Purpose:** | Information |

## Executive summary

This report outlines the occasions on which the foundation trust's common seal has been applied during financial year 2019-20.

## Risks associated with this report

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

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

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

The WWL Way

## 1. BACKGROUND

1.1. All foundation trusts are required to have a common seal.[1] The constitution of Wrightington, Wigan and Leigh NHS FT provides that the seal shall only be affixed under the authority of the Board of Directors.[2] The Board has previously resolved that attestation by any two directors shall be deemed to be affixing the seal under the board's authority.

1.2. A seal must be applied in order for the foundation trust to execute documents as a deed. Certain types of document are not legally binding unless they are executed by deed; the most common being those that deal with transfers of land, some leases or tenancies, mortgages, powers of attorney and certain business agreements. It can also sometimes be beneficial to execute other documents as a deed rather than as a simple contract because the time limit for bringing a claim under a deed is double the time limit for a simple contract (12 years as opposed to 6 years).

1.3. The board has reserved to itself responsibility for reviewing the use of the common seal, and this report is presented in order to satisfy that requirement.

## 2. USE OF THE COMMON SEAL

2.1. Since the last report to the board, the common seal of Wrightington, Wigan and Leigh NHS Foundation Trust has been applied on 12 occasions, as shown in the table below:

| Seal № | Date seal applied | Description of document | Use attested by: |
|---|---|---|---|
| 104 | 4 Jun 2019 | JCT Minor Works Building Contract in relation to minor building works to form a new café/shop area at Leigh Infirmary | 1. R Armstrong<br>2. A Foster |
| 105 | 27 Jun 2019 | Lease of land adjacent to the Christopher Home building at Royal Albert Edward Infirmary. | 1. R Forster<br>2. M Fleming |
| 106 | 11 Jul 2019 | Transfer of whole of registered titles relating to Pemberton Health Centre. | 1. A Balson<br>2. R Armstrong |
| 107 | 10 Oct 2019 | Licence to assign underlease relating to The Pharmacy at Leigh Infirmary. | 1. M Fleming<br>2. H Richardson |
| 108 | 10 Oct 2019 | Underlease for part of Claire House Health Centre. | 1. M Fleming<br>2. H Richardson |
| 109 | 10 Oct 2019 | Underlease for part of Chandler House Health Centre. | 1. M Fleming<br>2. H Richardson |
| 110 | 10 Oct 2019 | Underlease for part of Boston House Health Centre | 1. M Fleming<br>2. H Richardson |
| 111 | 29 Oct 2019 | Underlease Plus Agreement Plan relating to the second floor of Boston House Health Centre | 1. R Forster<br>2. R Mundon |

[1] Sch.7, para.29(1) National Health Service Act 2006

[2] At Paragraph 20.2

| Seal № | Date seal applied | Description of document | Use attested by: |
|---|---|---|---|
| 112 | --- | Entry voided | --- |
| 113 | 13 Nov 2019 | Deed of Covenant relating to 6 Dobson Close, Appleby Bridge, Wigan | 1. S Nicholls<br>2. R Mundon |
| 114 | 13 Nov 2019 | Underlease Plus Agreement relating to Platt Bridge Health Centre | 1. S Nicholls<br>2. R Mundon |
| 115 | 30 Jan 2020 | Underlease of offices on the ground and second floor of the Investment Centre, Waterside Drive, Swan Meadow Road, Wigan | 1. M Fleming<br>2. A Balson |
| 116 | 30 Jan 2020 | JCT Design and Build Contract 2016 in relation to the pre-installation building works to allow the installation of Siemens' MRI scanner | 1. M Fleming<br>2. A Balson |

2.2. All occasions on which the common seal is applied are recorded in a register which is held by the Company Secretary. This is available for inspection by directors on request.

## 3. RECOMMENDATIONS

3.1. The board is recommended to note the occasions on which the common seal has been applied during financial year 2019-20.

**Appointment of temporary Executive Director**

The Board is requested to pass the following resolution:

1. THAT Ged Murphy be formally appointed as Acting Chief Finance Officer with effect from 1 April 2020 until such a time as a substantive appointment is made, with the associated entitlement to exercise the voting rights of the Executive Director concerned.