Board of Directors

Wed 25 November 2020, 14:00 - 16:00

By videoconference

Agenda

14:00 - 14:00
0 min

12. Declarations of interest

Information *Robert Armstrong*

14:00 - 14:02
2 min

13. Minutes of previous meeting

Approval *Robert Armstrong*

Minutes - Public board - Sep 2020.pdf (8 pages)

14:02 - 14:17
15 min

14. Staff story

Discussion *Alison Balson*

(Video)

14:17 - 14:22
5 min

15. Chair and Chief Executive's report

Information *Robert Armstrong/Silas Nicholls*

Chief Executive's report - Nov 2020.pdf (8 pages)

14:22 - 14:37
15 min

16. Situation report

Discussion *Executive Team*

(Verbal)

14:37 - 14:52
15 min

17. Committee chairs' report

Discussion *Committee chairs*

(Verbal)

14:52 - 14:57
5 min

18. Board assurance framework

Approval *Robert Armstrong*

BAF - Patients - Nov 2020.pdf (2 pages)
BAF - People - Nov 2020.pdf (4 pages)
BAF - Performance - Nov 2020.pdf (2 pages)
BAF - Partnerships - Nov 2020.pdf (2 pages)

14:57 - 15:12
15 min

19. Performance report

Discussion *M Olsen/M Fleming/S Arya*

Performance report.pdf (4 pages)

15:12 - 15:22
10 min

20. Staff health and wellbeing report

Discussion *Alison Balson*

Staff health and well-being report.pdf (8 pages)

15:22 - 15:32
10 min

21. Infection Prevention and Control board assurance framework

Discussion *Morag Olsen*

IPC BAF - Nov 2020.pdf (28 pages)

15:32 - 15:42
10 min

22. Safe staffing report

Discussion *Morag Olsen*

Safe staffing report.pdf (12 pages)

22.1.

15:42 - 15:47
5 min

23. Review of risk appetite statement

Decision *Paul Howard*

Review of COVID risk appetite statement.pdf (5 pages)

15:47 - 15:57
10 min

24. Black, Asian and Minority Ethnic (BAME) employment profile in WWL

Discussion *Alison Balson*

BAME profile report.pdf (3 pages)
BAME profile - Appendix 1 NHSEI targets.pdf (8 pages)

15:57 - 15:57
0 min

25. Consent agenda:

25.1. Quality account 2019/20

Approval

QA cover.pdf (2 pages)
QA appendix.pdf (35 pages)

25.2. Infection prevention and control annual report

Information

IPC cover.pdf (2 pages)
DIPC Annual Report 2019-20.pdf (46 pages)

25.3. Register of Clinical Ethics Group referrals

Information

Register of CEG referrals.pdf (3 pages)

25.4. Finance report

Information

Finance report.pdf (2 pages)

15:57 - **15:57**
0 min

26. Date of next meeting

Information *Robert Armstrong*

The next meeting of the Board of Directors to be held in public will be on 27 January 2021

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

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

HELD ON 30 SEPTEMBER 2020, 1.30PM

BY VIDEOCONFERENCE

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

128/20 Chair and quorum

Mr 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.

129/20 Apologies for absence

No apologies for absence were received.

130/20 Declarations of interest

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

131/20 Minutes of previous meeting

The minutes of the previous meeting held on 29 July 2020 were **APPROVED** as a true and accurate record. Confirmation was provided that all actions on the action log had been completed.

132/20 Chair and Chief Executive's update

The Chair opened by acknowledging that this would be the last Board meeting to be attended by both Ged Murphy, the Acting Chief Finance Officer, and Helen Richardson, the Chief Nurse. He thanked them both for their diligent service during their time on the Board and wished Helen well for her retirement. As Ged would be returning to his substantive position, the Chair looked forward to working with him again in the future.

The Chief Executive provided a verbal update on the current situation and commented that there were two key issues of note. The first surrounded the restarting of the elective programme and the aim of returning to more usual levels of activity on the Wrightington Hospital site, noting that all organisations had been tasked to return to 90% of pre-COVID levels of activity by the end of March 2021 with other milestones having been set out too.

The Chief Executive also advised that an increased number of general medical patients were being seen alongside an increased number of intensive care admissions with a balanced distribution across the various age ranges. He confirmed that escalation plans had been enacted and that decisions would be taken around which elements of the elective programme would be paused to accommodate the additional demand. With regard to staffing, the Chief Executive advised that levels of absence were currently 3% higher than in the previous year, with a significant proportion of these absences being the result of staff having to self-isolate or as a result of the closure of school and other childcare bubbles for dependents.

The Chair summarised his recent activities and confirmed that he had met with the Leader of Wigan Council and the Chair of Wigan Borough Clinical Commissioning Group, where the focus had been on ensuring consistent messaging across the borough and promoting place-based care wherever possible. He highlighted a recent workshop session that had been held with the Council of Governors where governors asked specific questions around quality, staffing and performance and detailed responses had been provided. He had also attended a Regional Director's meeting and a meeting of Chairs where the focus had been on phase 3 recovery whilst acknowledging that the COVID-19 situation remained fluid. Finally, the Chair took the opportunity to reiterate the national "hands, face, space" messaging.

The Board received and noted the verbal update.

133/20 Committee chairs' reports

Mr Haythornthwaite opened this item by advising that the Audit Committee had met on the previous day, where it had considered a number of reports including the internal audit progress report. He noted that this had contained one limited assurance audit report around absence management which had been undertaken at the request of management in order to fully identify the issues which needed to be addressed. He confirmed that the matter would be followed up by the committee at its next meeting in November 2020. He also noted that a number of changes to the internal audit plan had been necessary as a result of COVID-19 and that these had been approved by the committee.

Mr Haythornthwaite noted that the committee had received good assurance around the foundation trust's risk management arrangements and noted in particular the inclusion of a heat map which sets out the level of risk and the approach to management in a visual way.

Mr Guymer provided a summary of the business transacted by the Finance and Performance Committee at its meeting on 23 September 2020. The committee considered that risks were being managed well and commended the teams on the development of new reporting formats, with a balanced scorecard approach having been developed which serves to provide stronger evidence and confidence around key issues. He also noted the significant involvement of executives in regional discussions as a further source of some assurance. He noted that the committee had reviewed the board assurance framework for performance and had agreed an amber-red delivery confidence, which was predominately the result of uncertainty around the changing financial environment and the challenge of restoring activity to previous levels, with particular pressures in endoscopy and surgery. Note was also made of the fact that the schedule of committee meetings for 2021 was currently subject to review to ensure that it facilitates optimum reporting schedules.

Mrs Lobley summarised the business of the recent People Committee meeting held on 22 September 2020 and noted the continued challenges around nurse recruitment. She advised that virtual recruitment events had been put in place and that the international recruitment and "grow your own" programmes were continuing apace. She advised of the plan to form a transactional People Services Department and noted the excellent work that had been undertaken in relation to risk assessments across the organisation.

Mrs Lobley reminded the Board that a psychological support service had been established in response to the pandemic and that feedback from staff who had been redeployed during the first wave had set out a number of areas of learning for the organisation which would be applied to any future periods of redeployment. A clear message had also been received through staff feedback of the importance of visible senior leadership. Mrs Lobley confirmed that the committee had reviewed the board assurance framework for people and had agreed a red delivery confidence for the reasons described in her summary report.

Prof Warne provided an overview of the business transacted by the Quality and Safety Committee at its meetings on 12 August 2020 and 29 September 2020. He noted the introduction of new divisional reporting arrangements with high quality reports having been provided. The committee had expressed concern about the foundation trust's Summary Hospital-level Mortality Indicator (SHMI) which was an area of focus although the committee had noted that the organisation's data in respect of deaths relating to COVID-19 was comparable with other organisations in the region. Prof Warne confirmed that the committee had approved the quality priorities for the coming year and had set out a reporting schedule for each of the priorities. Particular note was made of the increase in the number of pressure ulcers reported and confirmation was provided that a 50% reduction was being sought.

An ad-hoc committee meeting had been convened the previous day to consider a number of annual reports. He noted that an increase in the number of incidents had been observed but confirmed that 97% of those incidents had resulted in no patient harm and the committee had recognised that this demonstrated a positive reporting culture. The committee had been informed of challenges in completing the deep clean programme which had been impacted by operational demands as a result of COVID-19 and the committee would be keeping the matter under review. The committee had also noted a theme within incidents around record keeping and documentation and noted that a dedicated piece of work had been commissioned to review this. Prof Warne confirmed that the committee had reviewed the board assurance framework for patients and had agreed an amber delivery confidence as a result of the issues had had previously described.

In response to a question from the Chair, the Chief Nurse noted that action plans are produced for all complaints which are intended to demonstrate the embedding of learning but recognised that these could sometimes be improved and that as a result this had been included in the quality priorities for the coming year. Prof Warne highlighted the increased number of complaints that are resolved informally rather than being escalated to a formal process.

The Board received the report and noted the content.

134/20 Performance report

The Chief Nurse opened this item by noting that the foundation trust had reported seven serious incidents in the previous period, five of which had related to healthcare-acquired pressure damage, and she echoed Prof Warne's earlier comments around this being an area of focus for the coming year. She also advised that five cases of *Clostridium difficile* had been reported in August 2020 and whilst there had been no connection between the cases, the investigations had identified learning in relation to the environment and antibiotic prescribing. She also described the additional support that had been provided to support divisions with providing timely and high-quality responses to complaints.

The Chief Operating Officer provided an update on the operational metrics within the report, with a particular focus on the elective recovery plan. She described the return to elective work in July and August 2020 and summarised the various patient pathways according to COVID-19 status. She noted the need to work differently in order to accommodate good infection prevention and control practice and confirmed that efforts were being made to identify additional capacity through the independent sector. She estimated that it would take around 12 months to completely address the backlog of long-wating patients, and that all cancer patients waiting in excess of 104 days were expected to have been treated by the end of November 2020.

Confirmation was provided that the hospital surge plan had been activated but the Chief Operating Officer iterated the fact that the limiting factor is the availability of the workforce, which would undoubtedly impact on the ability to deliver the elective programme if a second wave of the pandemic were to occur. The Chief Operating Officer also noted that the narrow definition of a COVID-19 outbreak had meant an increased number of bed closures.

The Board received the report and noted the content.

135/20 Finance report

The Acting Chief Finance Officer presented a report which had been circulated with the agenda to summarise the foundation trust's financial position as at 31 August 2020. He summarised the content and noted in particular the ending of the current COVID reimbursement approach after month six, although no further information on the revised approach had yet been received. He also noted a recent uptick in supply chain issues as a result of the pandemic which could potentially have an impact on the capital programme, although the issue was being kept under close review. Note was also made of the fact that the Greater Manchester healthcare system would be making its submission around the phase 3 plan on 5 October 2020 and the Chair commented that the Board would be looking to the Finance and Performance Committee and the finance team to help it remain abreast of developments.

Mr Guymer took the opportunity on behalf of the Finance and Performance Committee to thank Ged Murphy for his leadership during his period as Acting Chief Finance Officer.

The Board received the report and noted the content.

136/20 Workforce risk assessment update

The Director of Workforce presented a report which had been circulated with the agenda to provide an update on progress with workforce risk assessments, with a specific focus on the Black, Asian and Minority Ethnic (BAME) workforce and those who are clinically extremely vulnerable. She confirmed that the matter had previously been discussed at the Workforce Committee and that summary information was being presented to the Board to ensure that it has oversight of this important issue. She also took the opportunity to thank all involved in the process and made particular reference to the divisional teams, trade unions and the Occupational Health Department.

As the report had been circulated in advance of the meeting, the Director of Workforce provided up to date figures and confirmed that 97% of all staff had completed a risk assessment, with 91% of BAME staff and 94% of those staff with additional risk factors having been assessed. A discussion followed in relation to those who had been designated as clinically extremely vulnerable and who had been required to shield until the requirement was removed on 1 August 2020. Note was made that 174 of the 201 staff who had been shielding had now returned to work in some way, either from home or in appropriate areas of the organisation and confirmation was provided that a clear plan is in place to address the issue.

With regard to the BAME workforce, the Director of Workforce confirmed that this had been an area of focus given the disproportionately high impact of COVID-19 on this group. She noted that a virtual focus group had recently been held with over 80 participants and that the Medical Director had agreed to act as the BAME Champion.

Prof Austin acknowledged the scale of progress that had been made and enquired how the foundation trust was managing situations where staff are required to self-isolate. In

response, the Director of Workforce advised that efforts are made to adapt work to allow it to be undertaken remotely wherever possible, including the establishment of a pool of IT equipment which can be issued as needed. Confirmation was also provided that staff continue to receive their full pay when self-isolating or shielding.

In response to a question from Lady Bradley around the impact on student nurse and trainee doctors' educational programmes, the Director of Workforce confirmed that this is currently subject to review by Health Education England.

The Board received the report and noted the content.

137/20 Safe staffing report

The Chief Nurse presented the regular safe staffing report which she noted covered the period from 1 July to 31 August 2020 and which reflected the fact that many staff had been redeployed over the period. She confirmed that registered nurse vacancies remained high, particularly at Band 5 level and within the Division of Medicine but noted that the reduction in District Nurse vacancies had been sustained. In response to a question from Prof Austin around Band 5 nurse retention, the Chief Nurse commented that there is a mix of people who are going to other organisations and those who are leaving the profession completely and noted that additional analysis was being undertaken which would be reported through the People Committee.

The Board received the report and noted the content.

138/20 Review of risk appetite statement

The Director of Corporate Affairs presented a report which had been circulated with the agenda to summarise a number of changes to the risk appetite statement which had been recommended by the executive team.

The Board **APPROVED** the changes to the risk appetite statement as presented.

139/20 Board assurance framework

140/20 The Chair noted that the committee chairs had summarised much of the board assurance framework in their updates earlier in the meeting. He noted that the Quality and Safety Committee had recommended an amber delivery confidence for the board assurance framework for patients, the People Committee had recommended a red delivery confidence for the people board assurance framework and that the Finance and Performance Committee had recommended an amber-red delivery confidence for the performance board assurance framework. The Board agreed with these recommendations. With regard to partnerships, the Board agreed an amber delivery confidence and noted that partnership working across the borough was working well.

141/20 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 register of referrals received by the Clinical Ethics Group be received and noted.

2. THAT the changes to Standing Financial Instructions be **APPROVED** as presented.

3. THAT the terms of reference for the Finance and Performance Committee be **APPROVED** as presented.

4. THAT the Workforce Race Equality Standard and Workforce Disability Equality Standard reports be **APPROVED** as presented.

5. THAT the report on statutory, mandatory and recommended posts be received and noted.

142/20 Date time and venue of the next meeting

The next meeting of the Board of Directors held in public will be held on 25 November 2020, 2.00pm by videoconference.

Action log

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
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Title of report:	Chief Executive's report
Presented to:	Board of Directors
On:	25 November 2020
Presented by:	Chief Executive
Prepared by:	Paul Howard, Director of Corporate Affairs
Contact details:	T: 01942 822027 E: paul.howard@wwl.nhs.uk

Executive summary

This report is provided to summarise a number of areas of interest for the Board's attention.

Link to strategy

There are no direct links to the organisational strategy in this report.

Risks associated with this report and proposed mitigations

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

Financial implications

There are no financial implications associated with this report.

Legal implications

There are no legal implications arising from the content of this summary report.

People implications

There are no people implications arising from the content of this summary report.

Wider implications

There are no wider implications to bring to the board's attention.

Recommendation(s)

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

1. Welcome to new team members

1.1. I wanted to open this report by setting out a number of additions and changes to the membership of the executive team since the last meeting of the board.

1.2. We recently took the decision to second Sandeep Ranote into a temporary role as Medical Director for Mental Health and Integrated Care. The role, which has been established to 31 March 2021, gives us access to expert clinical knowledge and experience around mental health in support of the forthcoming changes to mental health provision across Greater Manchester. It not only allows us to influence the strategic direction of the region as a key member of the Healthier Wigan Partnership and as an anchor institution within the borough but also complements the work undertaken by the Community Services Division and helps to ensure the provision of holistic health services for the population of Wigan. I am sure you will wish to join me in welcoming Sandeep to today's meeting.

1.3. The board will also recall that we commissioned a review of our communication arrangements towards the start of the year and the review recommended that we strengthen our existing approach by appointing a Director of Communications and Stakeholder Engagement. I am delighted to advise that we have made an appointment to this post and we hope to be in a position to share more detail around the new post holder soon. I would like to thank those members of the board and the wider management team for their involvement in the selection process and I look forward to introducing the successful candidate at a future board meeting.

1.4. Both of these new roles have been established as non-voting board member posts. This means that they are an integral part of the executive team here at WWL and they will participate in all board meetings. Whilst non-voting posts, this is a technical point and all directors on the board, whether voting or non-voting, have an equal voice.

1.5. The board will be aware that Helen Richardson left WWL earlier this month and we have appointed a replacement Chief Nurse, Rabina Tindale, who we hope will be able to join us in February 2021. Rabina is currently the Deputy Chief Nurse at University College London Hospitals and is looking forward to joining us here at WWL in her first Chief Nurse post. Rabina trained in Harrogate, specialising in emergency care and spending a significant part of her career in the north of England and in Yorkshire. She developed a national profile in emergency care and has worked in leadership roles supporting the implementation of standards. She is committed to quality improvement, human factors and psychological safety through patient and staff engagement. Rabina will lead the nursing, midwifery and allied health professional workforce and will also be our Director of Infection Prevention and Control and Nominated Individual with the Care Quality Commission.

1.6. I am delighted to welcome Morag Olsen to today's meeting. Morag is our interim Chief Nurse and she has significant experience as both a Chief Nurse and a Chief Operating Officer in various organisations across the UK. We are extremely grateful to Morag for agreeing to support us in this way over the next few months and I am very much looking forward to working with her.

1.7. This will also be the first formal board meeting to be attended by our new Chief Finance Officer, Ian Boyle. Ian joined WWL on 1 October 2020 and has a significant track record of senior-level financial management in the NHS. Most recently the Chief Finance Officer at

NHS Bolton CCG, Ian is also Chair of the Healthcare Financial Management Association's North West Branch.

2. Visit from NHS England and NHS Improvement

2.1. On 29 October 2020 we received a supportive visit from NHS England and NHS Improvement to review our infection prevention and control arrangements. The visit was prompted by the number of outbreaks that had been reported and the team comprised representatives from NHS England and NHS Improvement as well as a representative from Wigan Borough Clinical Commissioning Group.

2.2. The team participated in focus groups with clinicians, divisional team members and the estates and facilities team as well as undertaking walkabouts across the Royal Albert Edward Infirmary site. During the feedback session they described WWL as an incredibly clean organisation and the team were impressed by the way that we used posters and displays around the hospital to communicate infection prevention and control messaging to our patients, staff and visitors. We have even given the national messaging a WWL face lift by introducing our own "hands – face – space" message:

2.3. The team confirmed that good use of personal protective equipment and good hand hygiene discipline had been observed throughout its visits. They recognised the challenges that we have in relation to some areas of our estate, such as a narrow main entrance and narrow corridors which makes the introduction of a "keep left" system extremely difficult, and made some suggestions as to how we could improve which we have acted upon.

2.4. The team also provided some suggestions as to how we might improve in other areas, such as the potential to use isolation pods within ward environments when necessary and ensuring the ability for the infection prevention and control team to be co-located on site. We have acted on these recommendations and we are grateful to the team for their support and feedback during the visit.

3. COVID-19 preparedness and response

3.1. On 4 November 2020 we, like all other NHS organisations, received confirmation that the NHS preparedness and response to COVID-19 would be returned to Incident Level 4 status.[1] This means that the NHS moved from being regionally managed and nationally supported as a Level 3 incident to being one that is coordinated nationally as a Level 4 incident.

3.2. Greater Manchester as a system has had robust incident management arrangements in place and indeed I chair the Greater Manchester Gold Command Hospital Cell. These arrangements have now been strengthened as the return to Level 4 facilitates inter-regional mutual aid if required.

3.3. We continue to operate under agreed protocols in respect of media and public communications. If board members would like more detail on these protocols, these can be made available on request.

4. COVID-19 testing for frontline staff

4.1. We have agreed to roll out regular COVID-19 testing to all our frontline staff as a way of seeking to reduce hospital-acquired infections and to provide further assurance to our patients and their families, in line with guidance from Public Health England. We expect to receive the testing kits in the coming days and once these have been received we will begin testing asymptomatic frontline staff twice a week in order to identify staff that may be carrying the COVID-19 virus.

4.2. The test is a lateral flow test, meaning that it is able to detect the presence of COVID-19 via a nasal swab with the results being available after 30 minutes. Any member of staff who receives a positive result from the lateral flow test will then undergo a confirmatory test using polymerise chain reaction (PCR) test equipment, which is the same test offered through the NHS Test and Trace Service and Pillar 1 laboratories will be used for these confirmatory tests. A staff member receiving a positive lateral flow result will be required to self-isolate immediately; if a negative PCR result is subsequently received then they will be able to resume work without completing the full self-isolation period.

4.3. All frontline staff will be provided with the testing kits which will be self-administered at home, with results being logged via an electronic form. The results of all tests will be shared with Public Health England on a weekly basis.

4.4. Testing will commence on the Wrightington Hospital site in order for us to ensure the arrangements we have put in place are effective before being rolled-out to all other sites.

4.5. Whilst undoubtedly the right thing to do for our patients and our staff, we do know that it is likely that we will see an increased level of absence as a result. It is estimated nationally that such testing will increase absence rates by c.3% and we are building this into our response plans.

[1] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/11/KW_Level_4-letter_4Nov.pdf

5. COVID-19 vaccine

5.1. Kate Bingham, Chair of the UK Vaccine Taskforce, recently said in *The Lancet* that 'no vaccine in the history of medicine has been as eagerly anticipated as that to protect against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).Vaccination is widely regarded as the only true exit strategy from the pandemic that is currently spreading globally'.

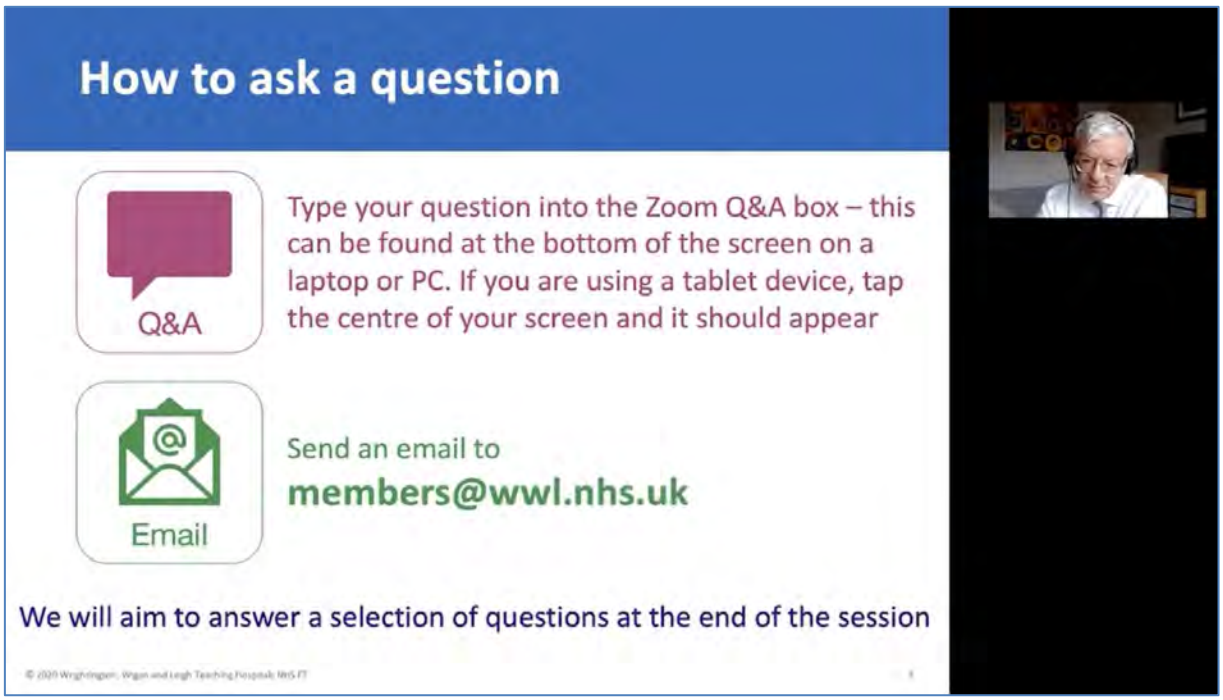
5.2. The board will be aware from the media that vaccines are in the process of being developed, and work is ongoing behind the scenes on a programme to roll-out the vaccine once it is made available for use in the UK.

5.3. Healthcare workers have been designated as a priority group to receive the vaccine and we continue to work with our partners across the borough, the region and nationally to ensure that the NHS as a whole is in a position to support this. We have established an internal team to focus on how we respond to this challenge and further information will be shared with the board once available.

6. Annual members' meeting

6.1. Due to the restrictions in place, we held our first ever virtual annual members' meeting on 22 October 2020. We were joined by 41 members of the foundation trust and the wider public.

6.2. We were determined that we would still offer the same level of transparency and information to members and the public that we would have done if we had been able to meet in person. People were able to ask any questions during the meeting or afterwards and all questions that we received have been provided with a response.



6.3. If any members of the foundation trust or members of the public were unable to attend the meeting and would like to watch the recording, it is available on our website and copies of our annual report and accounts for 2019/20 can also be downloaded.

7. Governors: Thank you and goodbye to some, welcome to others

7.1. Each year, the annual members' meeting marks the end of the term of office for a number of governors who are each appointed for three-year terms. Whilst it is possible to serve more than one term, this is not guaranteed and the maximum term of office for our governors is nine years.

7.2. This year we said goodbye and thank you to Howard Gallimore, public governor for Makerfield and Corinne Taylor-Smith, public governor for Leigh and we welcome the following new and returning governors:

8. Tackling health inequalities

8.1. In response to a request from the NHS Chief Executive and the NHS Chief Operating Officer aimed at strengthening leadership and accountability around health inequalities, the Medical Director, Sanjay Arya, has been identified as our named executive board member responsible for tackling inequalities. I am grateful to Sanjay for agreeing to lead on this important piece of work and I know that he will do so in conjunction with wider stakeholders as part of the Healthier Wigan Partnership.

9. Flu vaccination programme 2020/21

9.1. The Department of Health and Social Care and Public Health England have jointly written to all NHS organisations[2] and within their letter they outline an expectation that all frontline health and social care workers should receive a vaccination this season. Richard Mundon, our Director of Strategy and Planning, has been appointed as the board champion for the flu campaign and is responsible for its delivery. During its workshop session last month, the board confirmed its commitment to achieving the ambition of vaccinating all frontline healthcare workers.

9.2. As part of the letter we received there is a requirement for us to publish a best practice management checklist and this has been provided as an appendix to this report for information.

[2] https://www.england.nhs.uk/wp-content/uploads/2020/05/Letter_AnnualFlu_2020-21_20200805.pdf

9.3. The board will note that there is one action marked as unlikely to be delivered (action B4). This is due to the fact that face-to-face induction sessions are not currently being offered and induction is undertaken virtually. We are therefore unable to offer access to vaccination during induction, however all new starters are offered flu vaccination as part of the pre-employment process.

9.4. As at 18 November 2020 we had vaccinated 1,724 (41.07%) of our frontline healthcare workers, which places us on a similar trajectory to last year. 71% of board members had received a vaccination as at the date of writing and arrangements have been made for the remaining vaccinations to be administered on 23 November 2020. A further verbal update on both of these statistics will be provided at the meeting and I would like to thank all directors for their visible support to this important programme.

10. Safe staffing biannual review

10.1. Ordinarily we would provide the safe staffing biannual review at the November meeting. We are committed to undertaking this review, as it gives the board oversight of staffing issues and areas of any concern. The data also helps to inform discussions around our risk appetite and risk assessment approach and we recognise how important it is for our staff to know that the board receives this information on a regular basis.

10.2. Given the changes to working models as a result of the COVID-19 pandemic and potential changes that may be introduced to staffing ratios in some areas, we have taken the decision to defer the report to the next meeting of the board in January 2021, at which point it is hoped that there will be some additional clarity on staffing ratios and we will be able to provide the board with the most up to date information.

11. Recommendation

11.1. The board is recommended to receive this report and noted the content.

Appendix 1:
Healthcare worker flu vaccination best practice management checklist

		WWL self-assessment
A. Committed leadership		
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers	
A2	Trust has ordered and provided a quadrivalent (QIV) flu vaccine for all healthcare workers	
A3	Board receives an evaluation of the flu programme 2019/20, including data, successes, challenges and lessons learnt	
A4	Agree on a board champion for flu campaign	
A5	All board members receive flu vaccination and publicise this	
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	
A7	Flu team to meet regularly from September 2020	
B: Communications plan		
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades union	
B2	Drop-in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	
B3	Board and senior managers having their vaccinations to be publicised	
B4	Flu vaccination programme and access to vaccination on induction programmes	
B5	Programme to be publicised on screensavers, posters and social media	
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	
C: Flexible accessibility		
C1	Peer vaccinators, ideally one in each clinical area, to be identified, trained, released to vaccinate and empowered	
C2	Schedule for easy access drop-in clinics agreed	
C3	Schedule for 24-hour mobile vaccinations to be agreed	
D: Incentives		
D1	Board to agree on incentives and how to publicise this	
D2	Success to be celebrated weekly	

 Action complete

 Action forecast to be delivered

 Action unlikely to be delivered

Patients:
Every patient receives the best possible care

Executive lead(s):	Chief Nurse Medical Director	**Reviewing committee:**	Quality and Safety Committee	**DELIVERY CONFIDENCE** **CURRENT MONTH:**	**WEIGHTED DASHBOARD** **MONTH:** 1.86 **YTD:** 3.22
Strategic importance:	Provision of safe, effective, high-quality and evidence based care is at the heart of everything we do.				
Sources of assurance:	▪ Scrutiny by Quality and Safety Committee ▪ Scrutiny by Board of Directors ▪ Use of internal and external auditors ▪ Escalation of emerging risks ▪ Divisional performance reviews ▪ REMG			**ROLLING TREND:** Sep 2020 · Aug 2020 · Mar 2020 · Jan 2020	**ROLLING TREND:** Sep 2020: 2.35 · Aug 2020: 2.27 · Mar 2020: 2.08 · Jan 2020: 2.23

Individual risks	Original Score	Mitigations	Current score
There is a risk that patients with infectious conditions may not be able to be appropriately isolated in a timely manner due to a lack of side rooms	20	Escalated to ETM and meeting arranged to discuss the use of within Bryn Ward and other ward areas to isolate infectious patients	20
The Safeguarding Documentation pathway within HIS does not assist staff to identify safeguarding issues. Many safeguarding assessments and referrals are incomplete.	20	Risk reviewed and discussed at HIS Priority Board and agreed as a high priority.	20
Patients being discharged from hospital should have a summary of their care, medications and any follow up requirements documented and sent to their GP within 24 hours. There is a concern that letters are being created but not sent to the GP and therefore follow up activities requested from Hospital to GP may be missed.	6	Escalated to Q&S	20
Risk of insufficient quantities of the McKinley T34 syringe drivers to cope with trust demand.	16	ETM agreed T34 V3 syringe drivers to be used on risk assessment basis or Vygon Acufusers as an alternative	20
Patients not being admitted to the right ward due to bed blockages, posing a risk to patient care and a potential increase in the length of hospital stay	20	Affected by COVID-19 measures, wards are now beginning to be operationalised as before	20
There is a risk to patient safety due to a lack of medical beds resulting in patients being harmed.	20	Escalated to Trust Board	20
Radiological Diagnostic Tests: Timely review and action of radiological diagnostic tests by referrers.	15	The risk will be addressed as part of the HIS upgrade plan	20
Pressure Ulcer Prevention: There is a concern that Waterlow Scores and SSKIN Bundle risk assessments are not being completed correctly. Posing a risk to safe delivery of care plans of care and recognition of interventions required to ensure this.	15	Escalated to PAC -division to prepare plans to mitigate the contributing factors highlighted	20
Unauthorised or inappropriate access to clinical records may occur on the HIS	16	Escalated to ETM - Fair Warning privacy monitoring software is now in place	20
Trust remains an outlier with the SHMI Primary Indicator	20	The MD will provide an update on Mortality Group discussions for Q&S and ETM	20
Staff ability to correctly identify vulnerability and adequately safeguard patients under the care of the Trust.	20		20

PATIENTS: WEIGHTED DASHBOARD

Performance	Measure	Result	1 (Green)	2 (Amber-Green)	3 (Amber)	4 (Amber-Red)	5 (Red)	Weight	Month	Year	Source
Harm free care	%VTE Assessments undertaken within 24 hours of admission (indicative data)	**96.31%M 96.17%Y**	≥95%	94% - 90%	89%-85%	84%-80%	<80%	**1**	1 x 1 = 1	1 x 1 = 1	Perf. Report (Sep 2020)
Harm free care	No. Serious Falls	**0 MTD 2 YTD**	0 MTD		1 YTD	2 or 3	>3	**2**	1 x 2 = 2	4 x 2 = 8	Perf. Report (Sep 2020)
Patient Safety	% of 'red sepsis' patients receiving antibiotics within 1 hour in A&E	**85.7%**	≥95%	94% - 90%	89%-85%	84%-80%	<80%	**1**	3 x 1 = 3	---	A&E Monthly Audits
Patient Safety	No. of Never Events	**0 MTD 2 YTD**	0 MTD				1 YTD	**3**	1 x 3 = 3	5 x 3 = 15	Perf. Report (Sep 2020)
Patient Safety	100% compliance with appropriate frequency of observations	**70.7%**	100%	99-95%	94-90%	89-80%	<80%	**1**	5 x 1 = 5	---	NEWS quarterly Audits (3,6,9,12)
Infection Control	No. of MRSA	**0 MTD 0 YTD**	0				1	**3**	1 x 3 = 3	1 x 3 = 3	Perf. Report (Sep 2020)
Infection Control	No. of C. diff Lapses in Care	**1 MTD 6 YTD**	0	1 MTD	2	3	>4 YTD	**2**	2 x 2 = 4	5 x 2 = 10	Perf. Report (Jul 2019)
Patient Experience	% of patients recommending WWL for care	**92%**	≥95%	94% - 90%	89%-85%	84%-80%	<80%	**2**	---	---	Monthly FFT (2020)
Patient Experience	% of patients feeling involved with decisions about their discharge	**90.77%**	≥95%	94% - 90%	89%-85%	84%-80%	<80%	**1**	---	---	Perf. Report (2020)
Patient Experience	% of complaints responded to within the timescale agreed with the patient	**68.42%M 40.45%Y**	≥95%	94% - 90%	89%-85%	84%-80% MTD	<80% MTD/YTD	**1**	5 x 1 = 5	5 x 1 = 5	Perf. Report (Sep 2020)
Mortality	HSMR	**90.2%M 107.4% Y**	≤100 YTD	101-105	106-110 YTD	111-115	>115	**3**	1 x 3 = 3	3 x 3 = 9	Perf. Report (Jun 2020)
Mortality	SHMI	**116%**	≤100	101-105	106-110	111-115	>115	**1**	---	5 x 1 = 5	Perf. Report (April 2020)
Mortality	No. of PFDs	**0**	0	1	2	3	>4	**2**	1 x 2 = 2	1 x 2 = 2	Perf. Report (Aug 2020)
Medicines Management	% of critical medicines prescribed within 24 hours of admission or before the patient is transferred to a new area	**83.3%**	100%	99-95%	94-90%	89-80%	<80%	**1**	4 x 1 = 4	---	Pharmacy (Sep 2020)
Medicines Management	% of completed medicines reconciliation within 24 hours	**91%**	100%	99-95%	94-90%	89-80%	<80%	**2**	3 x 2 = 6	---	Pharmacy (July 2020)
Total									(41/22)	(58/18)	
Average									1.86	3.22	

Metrics highlighted in grey have been unreportable this month and will be reportable again in January 2021.

People:
Everyone has the opportunity to achieve their purpose

Executive lead(s):	Director of Workforce	**Reviewing committee:**	People Committee	**DELIVERY CONFIDENCE**	**WEIGHTED DASHBOARD**
Strategic importance:	Every member of staff has the opportunity to achieve their purpose. Safe and effective workforce to meet service needs				**MONTH:** 3.75 **YTD:** 3.75
Sources of assurance:	▪ Scrutiny by Workforce Committee ▪ Scrutiny by Board of Directors ▪ Use of internal and external auditors	▪ Escalation of emerging risks ▪ Exec-to-exec meetings ▪ REMC		**ROLLING TREND:**  Sep 2020 / Jul 2020 / Mar 2020 / Jan 2020	**ROLLING TREND:** 3.75 / 4.00 / 4.00 / 4.00 Sep 2020 / Jul 2020 / Mar 2020 / Jan 2020

Individual risks	Original Score	Mitigations	Current score
HR 84 - Ability to recruit and retain to required staffing levels for service delivery and service development plans	20	Recruitment & retention plan and trajectory International recruitment campaign – supported by NHSEI funding bid process Workforce plan Programmes of work to improve the experience of work Virtual recruitment event – January Links with Jobcentre Plus to recruit HCAs and Care Makers	20
HR104 - Failure to achieve Trust sickness absence target of 4% which impacts on staffing levels in clinical areas, agency spend and effective service provision	20	Implementation of Empactis absence management system (business case approved) – Empactis team will commence work with us in 3 months Central team collecting local absence data Psychological support programmes and 12 month proof of concept enhanced stepped approach Health & well-being staff group leads and network of champions in place	20

HR82 - Declines in safety culture and staff confidence in reporting errors, near misses and incidents	16	Psychological safety work programme commenced – diagnostic completed and action plans developed for implementation	16
HR101 - Wally' intranet provision	16	Single sign on now in place. Content review and relaunch scheduled aligned to functionality upgrade. Script issues to manage leavers being progressed between IM&T and service provider. ESR data cleanse commenced to support Active Directory automatic interface with ESR	16
HR109 - Quality of appraisals	16	My Route Plan launched. Engagement and training plan delayed due to Covid Audit and quality checks to be completed on the new paperwork	16
HR112 - Not meeting Inclusion and Diversity requirements	12	EDI strategic framework agreed. New strategy to be developed: • Improving diversity of workforce to meet population needs • Improving experience of work • Reducing inequalities Potential for Borough wide EDI objectives	16
HR115 - Organisational Staff Engagement Levels	16	New approach to the use of the Your Voice Survey. Building staff experience into the people accountability and performance framework. Leadership development, focussed on compassionate leadership ethos. Full relaunch and embedding of the WWL Behaviour Framework	16
HR127 - There is a risk that, due to the impact of Covid-19 and the requirement for social distancing, staff members will become non-compliant in modules of training that are only delivered face to face and will not be able to retake the necessary training, resulting in potential safety implications for staff, patients and the organisation.	16	Move to virtual where possible. Information to support a business case to address training shortfalls has been developed for face to face training modules with the exception of Resus There is a need for strategic ownership of Resus	16
HR126 - Inability to make critical workforce decisions around planning / availability / training to meet the needs of services due to current lack of accurate data.	15	ESR data cleanse commenced. Creation of transactional people services function, with a focus on self service where possible. Business cases approved for implementation of e-rostering throughout the Trust and Empactis absence management. Interactive workforce dashboard in development. App in development for the collection of daily sit rep data. Additional temporary resource to the eroster team to support the accuracy of shift and availability data.	15

HR128 – HCA Banding	20	Unregistered clinical workforce review Negotiation with trade unions regarding back pay, point on scale and transition arrangements Job description review and job matching process to ensure reflective of requirements	20

NARRATIVE

Employment Essentials

The clinical vacancy rate has improved in the October data, primarily due to a large cohort of our students qualifying in September and some international nurses successfully passing their OSCE. Significant vacancies remain though and active recruitment continues, including a fast track partnership with Job Centre Plus for HCA's / Care Makers and the planning of a virtual recruitment event for registered staff. A business case for a further 85 international registered nurses was approved in October and we are progressing this with the GTEC team. Further exploration is required regarding the increasing proportion of leavers have less than 12 months service.

Go Engage

The Q3 Your Voice data is not yet available. In response to concerns raised by staff, a series of targeted listening into action events are being scheduled to ensure staff have the opportunity to raise their concerns and for actions to be agreed and implemented. Psychological safety work programmes have commenced with the behaviour based 360 process for all 8c+ leaders and medical leaders. Feedback sessions have commenced and will be followed up with executive coaching

WWL Route Planner

Mandatory training and PDR compliance have dropped due to covid pressures. Revised My Route Plan documentation has been launched, but full training and engagement plans are temporarily paused to relieve pressure on front line leaders and teams. Both items have been removed from pay progression criteria until the end of March 2021 as a result of the Wave 2 pressures. Staff are still actively encouraged to complete PDR and mandatory training requirements and these have been prioritised based on risk

Steps 4 Wellness

It should be noted that we have seen a significant and predicted rise from October as a result of covid sickness, self isolation following test and trace contact / outbreaks and also as a result of childcare requirements when school bubbles break down. All well-being services have continued and have been re-escalated aligned to covid escalation levels. The centralised absence team and Emapctis sickness absence system are being progressed. Recruitment to the proof of concept psychological support team has also progressed and wait times for counselling have reduced significantly. We continue to experience relatively low levels of take up for the seasonal flu vaccination and have moved to offer drop in sessions rather than an appointment approach.

PEOPLE: WEIGHTED DASHBOARD

Performance	Measure	Result	1 (Green)	2 (Amber-Green)	3 (Amber)	4 (Amber-Red)	5 (Red)	Weight	Month	Year	Source
Go Engage	Friends and family test (work)	69.04%	≥95%	72-94%	68-71%	64-67%	≤63%	2	3 x 2 = 6	3 x 2 = 6	Workforce team
Employment Essentials	Turnover	8.06%		8.01-8.5%	8.51-9%	9.01-9.9%	≥10%	1	2 x 1 = 2	2 x 1 = 2	Workforce team
Employment Essentials	Leavers with less than 12 months' service	24.94%	≤10%	11-14%	15-20%	21-24%	≥25%	1	4 x 1 = 4	4 x 1 = 4	Workforce team
Route Planner	PDR completion	74.2%	≥95%	86-94%	78-85%	73-77%	≤72%	1	4 x 1 = 4	4 x 1 = 4	Workforce team
Steps 4 Wellness	Energy levels	3.47	≥4.00	3.7-3.99	3.61-3.69	3.47-3.6	≤3.46	1	4 x 1 = 4	4 x 1 = 4	Workforce team
Go Engage	Cultural enabler score	32.67	≥36	35.01-35.9	34.01-35	33.61-34	≤33.6	2	5 x 2 = 10	5 x 2 = 10	Workforce team
Total								8	30	30	
Average									3.75	3.75	

Performance:
We aim to be in the top 10%

Executive lead(s):	Chief Operating Officer Chief Finance Officer	Reviewing committee:	Finance and Performance Committee	DELIVERY CONFIDENCE	WEIGHTED DASHBOARD
Strategic importance:	Delivery of operational and finance performance underpins clinical care, facilitates the patient journey and enhances the patient experience, and affects the organisation's financial performance.				MONTH: 4.23 YTD: 4.09
Sources of assurance:	▪ Scrutiny by Finance and Performance Committee ▪ Scrutiny by Board of Directors ▪ Use of internal and external auditors ▪ Escalation of emerging risks ▪ Divisional performance reviews ▪ REMC			ROLLING TREND:  Sep 2020 / Aug 2020 / Mar 2020 / Feb 2020	ROLLING TREND: 3.30 / 3.30 / 2.35 / 2.88 Sep 2020 / Aug 2020 / Mar 2020 / Feb 2020

Individual risks scoring ≥20	Original Score	Mitigations	Current score
Risk of failure/vulnerability of back-end infrastructure resulting in no access to IT systems	20	HIS upgrade now completed	15
Potential closure of RAEI theatre 1 and 2 following annual verification report	15	Work scheduled for July 2020 - March 2021.Divisional recovery plans will be in place as mitigation	20
Potential risk of Theatre 6 failure following next revalidation, resulting in one lamina flow theatre at RAEI	15	Theatre passed its revalidation tests. Advisory repair work being considered	20
Patients with data entries under 'service lines' on SystemOne with no assurance that their pathways are being managed appropriately	15	WWL were set to take full control of the risk from Bridgewater but the dedicated team were redeployed due to COVID-19	20
Risk of incurring penalties should NHSI activity level targets fail to be met	--	Divisional plans have been set out. Not yet on risk register.	--
Reduced radiology capacity to manage the Covid-19 backlog and new patient referrals	16	Significant numbers completed. Discussions continue with GM for an overall operation plan	20
Rising SHMI rate	20	Risk escalated to Executive Team and Q&S Committee	20

*** *Risks shaded blue have been categorised as' tolerate' by the Risk Escalation Management Group*

NARRATIVE

Currently on track

PERFORMANCE: WEIGHTED DASHBOARD

Performance data as at: **31 October 2020**

Performance	Measure	Result	1 (Green)	2 (Amber-Green)	3 (Amber)	4 (Amber-Red)	5 (Red)	Weight	Month	Year	Source
4-hour standard	95% of patients should be admitted, transferred or discharged within 4 hours of arrival at A&E	74.3% M 90.4% Y	≥95%	94.9-90% YTD	89.9-80%	79.9-70% Month	≤70%	2	4 x 2 = 8	2 x 2 = 4	BI (Oct 2020)
12-hour operational standard	No patient requiring emergency admission will wait 12 hours in A&E	47 M 47 Y	0				≥1 M & YTD	2	5 x 2 = 10	5 x 2 = 10	BI (Oct 2020)
Ambulance handover standard	All handovers between ambulance and A&E must take place within 15 mins with none waiting >60m	> 60m M > 60m Y	≤ 15 mins	15-30 mins		30-59 mins MTD	>60 mins M & YTD	1			BI (2020)
Cancer treatment times	85% should wait no more than 62 days from urgent referrer to first definitive treatment	69.77% M 77.59% Y	≥85%				≤84.9% M &YTD	2	5 x 2 = 10	5 x 2 = 10	BI (Oct 2020)
18-week RTT	92% on incomplete RTT pathways (yet to start treatment) should wait no more than 18 weeks	58.20% M 56.34% Y	≥92%				≤91.9% M & YTD	1	5 x 1 = 5	5 x 1 = 5	BI (Oct 2020)
52-week RTT	Zero tolerance for patient waits over 52 weeks on an incomplete pathway	603 patients waiting 52 weeks +	0				≥1	2	5 x 2 = 10	5 x 2 = 10	BI (Oct 2020)
Diagnostic waiting times	99% of service users waiting for a diagnostic test should receive it within 6 weeks of referral	84.52% M 54.51% Y	≥99%				≤98.9%	1	5 x 1 = 5	5 x 1 = 5	BI (Oct 2020)
Paper switch off programme	By 1 Oct 2018, NHS E-referral will be used for all relevant consultant-led first OPD appointments	Complete	100%				≤99.9%	1	1 x 1 = 1	1 x 1 = 1	Complete
Control total achievement	Forecast position: Achieve finance control total before PSF	Forecast 4 quarter	Achieve 4 quarters	3 quarters	2 quarters	1 quarter	0 quarters	4	---	---	Forecast
Control total achievement	Forecast position: Achieve A&E control total trajectory	No longer applicable	Achieve 4 quarters	3 quarters	2 quarters	1 quarter	0 quarters	2	---	---	Forecast
Use of resources risk rating	Forecast position: Achieve use of resources risk rating as per plan	Forecast 4 quarter	Achieve 4 quarters	3 quarters	2 quarters	1 quarter	0 quarters	4	---	---	Forecast
Transformation	SAVI delivery against target	% M % Y	Achieved	Fail by <10%	Fail by 10-20%	Fail by 20-30% YTD	Fail by >30% MTD	3	---	---	Finance report
IT	Completion of agreed IT priorities in line with plan	85% M	100%	90-99% MTD	80-89%	70-79%	≤70%	2	3 x 2 = 6	---	IT department
Total								13	55(/13)	45(/11)	
Average									**4.23**	**4.09**	

- *Several metrics are unable to be measured due to measures put in place to address pandemic pressures. These have been lowlighted in grey and the weightings adjusted accordingly.*

Partnerships:
We work together for the best patient outcomes

Executive lead(s):	Director of Strategy and Planning	**Reviewing committee:**	Board of Directors	**DELIVERY CONFIDENCE**	**WEIGHTED DASHBOARD**
Strategic importance:	Effective partnership working underpins our strategic direction				MONTH: 2.00 YTD: 2.00
Sources of assurance:	▪ Scrutiny by committee ▪ Scrutiny by Board of Directors ▪ Use of internal and external auditors	▪ Escalation of emerging risks ▪ Exec-to-exec meetings ▪ REMC		ROLLING TREND: Sep 2020, Jul 2020, Mar 2020, Jan 2020	ROLLING TREND: 2.67 (Sep 2020), 2.75 (Jul 2020), 2.88 (Mar 2020), 2.96 (Jan 2020)

Individual risks	Original Score	Mitigations	Current score
Lack of Tier 4 CAMHS beds	16	Likely to be recalibrated as no current escalations and fed into discussions on new mental health provider. Recent discussions with GM Mental Health as part of the transition plan	16
Non-achievement of KPIs relating to cellular pathology	16	Performance issues remain, but the current focus is on testing. The Shared Services Board has been suspended, but REMG has agreed a sub-group to work through pathology risks in more detail and GM continues to pursue a pathology network through the PFB CSS sub-group and DoS	16
Unable to effectively implement Population Health within Wigan	16	Likely to be recalibrated. Reliant on GraphNet which is now approved but delayed	16

NARRATIVE

Partnership dynamics have been impacted materially by our response to COVID-19 where collaborative working and system by default are now in place. All cross-GM service change programmes have been suspended. Healthier Together and sector collaboration has been realigned to recovery and is overseen by the Executive Programme Oversight Board (EPOG), although EPOG has been suspended until April 2021. The GM Partnership is being reviewed. The Healthier Wigan Partnership has evolved to support both recovery activity in the local system and a programme focused on future population health gains and the Healthier Wigan Partnership Activation Board is regarded as successful.

With regard to the metrics overleaf: Transformation plan is aligned to recovery programme. Current research programme has delivered but current demands have increased and are hard to meet. Hospital reform is focused on short-term recovery; longer-term plan to be resurrected post-COVID.

PARTNERSHIPS: WEIGHTED DASHBOARD

Performance	Measure	Result	1 (Green)	2 (Amber-Green)	3 (Amber)	4 (Amber-Red)	5 (Red)	Weight	Month	Year	Source
Transformation	Support to BIG projects	Fully provided	Fully provided	Mostly provided	Mild problems	Moderate problems	Major problems	2	---	---	Self-assessment
Research	Numbers recruited against target	Target complete	Target complete	Ahead of target	On track	Off target	Way off target	1	1 x 1 = 1	1 x 1 = 1	R&D report
Bolton partnership	Progress on 8 key projects	Major concerns	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	3	---	---	Self-assessment
Locality partnership	Locality plan performance matrix	Mild concerns	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	2	---	---	Self-assessment
Locality partnership	Transformation of hospital care	Almost on track	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	3	2 x 3 = 6	2 x 3 = 6	Self-assessment
Locality partnership	Healthier Wigan partnership score	Almost on track	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	2	2 x 2 = 4	2 x 2 = 4	Self-assessment
Locality partnership	Community services transfer	Fully on track	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	3	1 x 3 = 3	1 x 3 = 3	Self-assessment
NW Sector p/ship	Highlight report for NWSP	Mod. concerns	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	1	---	---	Self-assessment
GM partnership	Combined theme 3 status	Mod. concerns	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	2	---	---	Self-assessment
GM partnership	Orthopaedic theme 3 status	Fully on track	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	3	---	---	Self-assessment
GM partnership	Cardiology theme 3 status	Almost on track	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	2	---	---	Self-assessment
SLAs	Compliance	55%	>95%	95-80%	80-60%	60-40%	<40%	2	4 x 2 = 8	4 x 2 = 8	SLA database
Total								24	22/11	22/11	
Average									**2.00**	**2.00**	

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Performance report
Presented to:	Board of Directors
On:	25 November 2020
Presented by:	Chief Nurse, Chief Operating Officer and Medical Director
Prepared by:	Data, Analytics and Assurance
Contact details:	BI.Performance.Report@wwl.nhs.uk

Executive summary

This paper is an interim report as Data, Analytics and Assurance continue to automate the production of a Balanced Scorecard with supporting commentary. Work is in progress to collect, process and report some of the newly defined Quality & Safety metrics.

Link to strategy

Patient
Partnership
Workforce
Site and Service

The WWL Way

Risks associated with this report and proposed mitigations

Financial implications
None currently highlighted.

Legal implications
None identified.

People implications
None identified.

Wider implications

Recommendation(s)
The committee is recommended to receive the report and note the content.

Report: M7 WWL Balanced Scorecard

QUALITY & SAFETY

	Month	ON/OFF Track	Why?
Patient Safety (Safe)			
Never Events	*M6*	*On Track*	*NE 0 in month 2 YTD*
Number of Serious Incidents	*M6*	*Off Track*	*SI - 11 Incidents in month, 40 YTD.*
Sepsis - Screening and Antibiotic Treatment (Grouped)		*Under development*	
Serious Pressure Ulcers (Lapses in Care)	*M6*	*Off Track*	*PU - 4 Incidents in month, 23 YTD.*
Serious Falls	*M6*	*On Track*	*SF 0 in month 2 YTD*
Infection Prevention and Control (Grouped)	*M6*	*Off Track*	*4 / 6 in month, 5 / 6 YTD; Metrics Off Track*
Clinical Effectiveness (Effective)			
SHMI Rolling 12 months	*M1 2021*	*Off Track*	*Latest position: 117.68*
National Patient Safety Strategy (Grouped)		*Under development*	
Patient Experience (Caring)			
Complaints Responses	*M6*	*Off Track*	*68.4% M6, 40.45% YTD; Target 90%*
Improved Discharge (Grouped)		*Under development*	
Patient Experience		*Not currently collected*	

ACTIVITY & EFFECTIVENESS

	Month	ON/OFF Track	Why?
A&E Performance (Single)	M7	Off Track	74.3% M7, 90.4% YTD; Target 95%
Cancer Performance (Grouped)	*M6*	Off Track	*3 / 8 in month, 2 / 8 YTD, Metrics Off Track*
RTT Performance (18 Weeks)	*M6*	*Off Track*	*58.20% M6; Target 92%*
RTT Performance (52 Weeks)	*M6*	*Off Track*	*603 patients waiting 52+ weeks*
Diagnostics Patients waiting under 6 weeks	M7	Off Track	84.5% M7 Target 99%
Recovery plan	M7	Off Track	Each point of delivery below proposed target level

PEOPLE

	Month	ON/OFF Track	Why?
Employment Essentials			
Clinical Vacancy Rate	M7	Off Track	9.06% M7,11.14% M6 Target 5.0%
Agency vs NHSI Ceiling	M7	Off Track	£969K M7, £863K M6, Target £502K per month
Premium Cost Spend	M7	Off Track	£2,217K M7 (9.72% over budget)
Go engage			
Your voice scores (engagment enablers, feelings & behaviours)	Q2	Off Track	3.77 Q2 Target 4, Q3 results not yet available
Your voice response rate	Q2	Off Track	19.22% Q2, Target 50%, Q3 results are not yet available
Route Planner			
Mandatory Training over rolling 12 months	M7	Off Track	89.9% M7; Target 95%
PDR`s over rolling 12 months	M7	Off Track	74.2% M7; Target 90% NB. Excludes M & D Staff
Steps for Wellness			
Sickness Absence	*M6*	*Off Track*	*5.03% M6, Target 4% M7 data is not yet available*
Time Lost due to other unplanned absence	*M6*	*On Track*	*2.49% M6, Target 4%; M7 data is not yet available*
Covid Risk Assessments	M7	Off Track	94.36% M7, Target 95%

FINANCE

Financial Position (£000s)

Balaced Scorecard Metrics	In Month Actual £000's	In Month Revised Plan £000's	In Month Var £000's	Year to Date Actual £000's	Year to Date revised Plan £000's	Year to Date Var £000's	Full Year Revised Plan £000's
Income	33,893	33,635	258	248,166	247,908	258	416,083
Expenditure	(35,904)	(36,106)	202	(243,821)	(244,023)	202	(426,991)
Surplus / Deficit	(3,135)	(3,522)	388	(3,197)	(3,584)	388	(23,638)
Cash Balance	60,675	57,075	3,600	60,675	57,075	3,600	5,523
Capital Spend	1,240	1,805	565	8,962	13,882	4,920	23,000

The plan has been updated to the NHSI/E submission made in October for the second half of the financial year.

Reported position : M7

Note: Showing October data where available. *Details in italics where latest month details have not been signed off or been presented to the relevant committee.*

Overall Trust Performance - Balanced Scorecard from 1 April to 31 October 20 : Commentary

QUALITY & SAFETY

Board are asked to note that further work is being undertaken to further strengthen the quality safety and patient experience metrics within this report. Month Reported : M6

Patient Safety (Safe)

During the month of September 2020, the Trust reported 11 incidents to StEIS (Strategic Executive Information System), which was an increase on the previous month; there were no Never Events. These incidents included 2 outbreaks of COVID, 1 unsafe discharge, 2 delay in escalation of a deteriorating patient and 3 Hospital Acquired Pressure Ulcers. Notably, this is a reduction in the number of pressure ulcers reported when compared to last month (5 were reported last month). In addition, there were 3 diagnostic incidents reported; due to the increase in diagnostic incidents, the Associate Director of Quality and Patient Safety has commissioned a review of radiology systems and processes.

4 Clostridium Difficile cases ascribed to the acute Trust. No apparent linkage between cases and a recent batch of ribotyping results indicates that recent strains are unrelated. Focus continues on improving antibiotic and antiviral prescribing for COVID cases as these continue to build. 1 MRSA bacteraemia but this was a community case with no relationship to the acute Trust. Numbers of other reportable bacteraemia cases remain low.

Clinical Effectiveness (Effective)

Patient Experience (Caring)

In the month of September, there were 19 complaint responses due, of which 13 were sent within the timescales agreed with the complainant. This equates to 68%. There were no approaches by the PHSO (Ombudsman) during the month of September. The key issues identified in the complaints received related to clinical treatment is the main subject, with Communication (6), Values and Behaviours (4), Patient Care (4), and one in respect of consent. Improving the timeliness of complaint responses is a quality priority in 2020/21.

ACTIVITY & EFFECTIVENESS

See Operational Report

PEOPLE

Employment Essentials

The clinical vacancy rate has improved in the October data, primarily due to a large cohort of our students qualifying in September and some international nurses successfully passing their OSCE. Significant vacancies remain though and active recruitment continues, including a fast track partnership with Job Centre Plus for HCA's / Care Makers and the planning of a virtual recruitment event for registered staff. A business case for a further 85 international registered nurses was approved in October and we are progressing this with the GTEC team

Go Engage

The Q3 Your Voice data is not yet available. In response to concerns raised by staff, a series of targeted listening into action events are being scheduled to ensure staff have the opportunity to raise their concerns and for actions to be agreed and implemented. Psychological safety work programmes have commenced with the behaviour based 360 process for all 8c+ leaders and medical leaders. Feedback sessions have commenced and will be followed up with executive coaching

Route Planner

Mandatory training and PDR compliance have dropped due to covid pressures. Revised My Route Plan documentation has been launched, but full training and engagement plans are temporarily paused to relieve pressure on front line leaders and teams. Both items have been removed from pay progression criteria until the end of March 2021 as a result of the Wave 2 pressures. Staff are still actively encouraged to complete PDR and mandatory training requirements and these have been prioritised based on risk

Steps 4 wellness

Absence rates are reported a month in arrears (October data refers to September absence). It should be noted that we have seen a significant and predicted rise from October as a result of covid sickness, self isolation following test and trace contact / outbreaks and also as a result of childcare requirements when school bubbles break down. All well-being services have continued and have been re-escalated aligned to covid escalation levels. Recruitment to the proof of concept psychological support team has progressed and wait times for counselling have reduced signifcantly. We continue to experience relatively low levels of take up for the seasonal flu vaccination and have moved to offer drop in sessions rather than an appointment approach.

FINANCE

Financial Position (Variance)

The Trust is reporting a £3.1m deficit in month and a £3.2m deficit year to date. The ICS top up & COVID allocation funding methodology for Month 7-12, which replaces the previous top up to balance approach, brings

The Trust submitted a forecast to NHSI/E showing a deficit of £23.6m for the second half of the financial year. NHSI/E are using this forecast as a plan to monitor the Trust financial performance.

The Trust deficit of £3.1m in month 7 was £0.4m favourable to the revised plan due to lower levels of elective activity than planned (and therefore lower direct expenditure), slippage on investments and higher levels of private patient income.

Cash is £60.7m at the end of Month 7 which is £3.6m better than the revised plan. The adjusted cash position in month is £32m. This is due to the block payment for November (£28.7m) being received in advance to maintain liquidity in the provider sector. This will be recovered by the end of the financial year hence the step change in available cash.

Capital spend is £8.9m year to date plus a further £5.7m incurred in respect of COVID-19 which has been reimbursed via PDC. Within the £8.9m is an additional £1.0m of COVID-19 spend which has not been reimbursed via PDC.

Please see the monthly finance report for further commentary.

Title of report:	Staff health and wellbeing report
Presented to:	Board of Directors
On:	25 November 2020
Presented by:	Director of Workforce
Prepared by:	Deputy Director of OD & Staff Engagement
Contact details:	Ext. 2949

Executive summary

Staff health and well-being has been recognised as critical organisationally and in the NHS People Promise. WWL has an established staff health & well-being programme (Steps 4 Wellness) which includes both physical and mental health. Steps of Support (SOS) has become the branding for our psychological support programmes.

SOS is a stepped programme of support, designed by clinical psychologists to meet the needs of staff during and beyond the Covid pandemic waves.

The WWL Way

The Executive Team recently approved a 12-month investment into a psychological support team and these positions have now been recruited to. This is a proof of concept arrangement, with the intention of demonstrating that stress related sickness absence remains below modelling thresholds used across Greater Manchester Trusts. Assuming this is a successful pilot, this team will become substantive, subject to formal business case.

It is essential that we break down the barriers that prevent our staff accessing psychological well-being support by encouraging everyone to recognise that "it's okay not to be okay". To support this, we have several staff group / profession well-being leads and over 90 additional well-being champions who help us with first line support and visibility. There are regular well-being walkabouts involving the well-being leads, members of the Exec Team and other senior managers.

Recent developments that will enhance the offers include a programme of Schwartz Rounds and the development of Leadership Support Circles to build on reflective support approaches.

Regular and well attended online staff briefings are taking place to ensure staff and leaders are aware of the staff well-being offers. There is also recognition, however, that not all staff will openly access the support and so it is essential that in-reach programmes of work continue and we continue to encourage staff to talk about their experiences and concerns.

It should be noted that staff feedback, both through the Covid Your Voice Survey and during staff briefings demonstrate that staff are aware of the services, they prefer to access services delivered locally by the Trust and that the services provided are beneficial for our people.

Further information about the SOS programme is included in Appendix 1.

Link to strategy

The well-being of staff is a key component of WWL's People Promise, the NHS People Plan and NHS People Promise. Supporting staff to remain well in work is essential for us to be able to safely and effectively deliver services for our patients.

Risks associated with this report and proposed mitigations

There is a risk that the psychological impact of Covid on our staff will remain a live and real issue not only in the peak of the pandemic, but for many years to come. It is essential that we continue with our commitment and capacity to support psychological well-being to ensure we mitigate against the longer-term risks associated with the trauma staff have experienced.

Financial implications

The Trust has invested in the 12 month proof of concept psychological support service enhancement and long term sustainability of the service will be subject to business case in Q3 2021/22

Legal implications

The Health & Safety at Work Act (1974) places expectation on employers to secure the health, safety and welfare of employees. Additionally, the Health and Safety Executive management standards set out expectations on employers to support good health at work.

People implications

Psychological support is an essential component of the WWL and NHS People Promise. Providing our stepped approach aims to help keep our people well in work and also aims to helps expedite safe and successful return from sickness absence.

Wider implications

N/A

Recommendation(s)

The Trust Board is asked to note and take assurance from the psychological support services that are available and continue to be enhanced for our people.

Appendix 1

WWL's Covid-19 Response Plan

Psychological Support for Staff: Pandemic Phase 2

Nicole Williams,
Chartered Occupational Psychologist
Deputy Director of Organisational Development

Tony Clayson,
Consultant Staff Wellbeing Lead
Consultant Orthopaedic Surgeon

Common Concerns and Feelings

- Fear of exposure to Covid-19
  - PPE, bringing it home, becoming unwell
- Psychological work-related distress
  - Fears around redeployment
  - Moral distress
  - Changes in work role and practices
  - Loss of control over work routine, location, etc
  - Childcare and caring responsibilities
  - Fear of speaking up
- Financial / Resource Pressures
  - Staffing shortages
  - Resources needed to do job (IT, training, etc)
  - Family finances (redundancy, furlough, debts, etc)
- Other emotional reactions
  - Resentment, perceptions of unfairness
  - Different perceptions/interpretation of risk
  - Grief, bereavement
  - Emotional exhaustion – numb, lacking enthusiasm
  - Feeling disempowered and out of control

Dealing with Uncertainty and Change

- Each person will have their own concerns regarding work or personal experience
- Feeling worried, concerned or anxious is understandable in a changing situation.
- How we each deal with these feelings can affect our transition to new roles (redeployment) as well as our wellbeing and performance in the immediate and long term

Understanding your current level of wellbeing

- Screening tool
- Simple way to understand your current level of wellbeing and psychological need.
- Are you ok, or just bearing up?
- Is it time to focus on your wellbeing?
- What might help you to build your wellbeing at this time?
- Contact S4W team for more information

Building our own psychological wellbeing & resilience

Level 3: OH and staff counselling, trauma-focused treatment, mental health pathways.

Level 2: CISM Services, OOO support, psychological assessments, GM resilience hub

Level 1: EAP, SOS Rooms, Chaplaincy and spiritual care, Schwartz Rounds, local screening, wellbeing champions, In Reach

Level 0: Health promotion and prevention: staff training, wellbeing leads, walkabouts, coaching, communication and information, apps

Building our own psychological wellbeing & resilience

Communication
- Steps 4 Wellness Resource Pack
- Staff Briefings

Staff Training
- Three Step Process
- Psychological First Aid
- Mindfulness Workshops
- Coaching

Wellbeing Leads

Apps
- Headspace

Building our own psychological wellbeing & resilience

Employee Assistance Programme (EAP)

- Provided by Health Assured
- 0800 028 0199
- Up to 6 telephone counselling sessions

Steps of Support (SOS) rooms

- Safe space, cross site locations
- Trained psychological support practitioners

In Reach Support

Building our own psychological wellbeing & resilience

Chaplaincy & Spiritual Care

- Available to all staff of all faiths/beliefs/none
- Ext 2324, 2314 or email chaplaincy.spiritualcare@wwl.nhs.uk
- Mulifaith prayer rooms – safe space for respite
- Remote support for relatives of patients

Chaplaincy & Spiritual Care

Reflective Groups

- **Schwartz Rounds** – sign up via joanne.briscoe@wwl.nhs.uk
- **Leadership Support Circles**

Dates and Topics

Thursday 17th December - 1PM - Zoom	The Day I Nearly Walked Out
Wednesday 27th January - 1PM - Zoom	When I Felt Like a Fraud
Thursday 25th February - 1PM - Zoom	A Person I'll Never Forget
Thursday 25th March - 1PM - Zoom	Thrown in at the Deep End
Wednesday 28th April - 1PM - Zoom	When My Best Doesn't Seem Good Enough
Tuesday 25th May - 1PM - Zoom	The Power of Apology

Wellbeing Champions

Building our own psychological wellbeing & resilience

Critical Incident Stress Management Service

- **Defusing**
- **Crisis Management Briefings**
- **Debriefing**

CISM
CRITICAL INCIDENT STRESS MANAGEMENT

Power to Respond App

- App specifically designed to support trauma responses
- For staff and managers
- Contact staff.engagement@wwl.nhs.uk

KRTS POWER TO RESPOND®

Psychological Assessments

Occupational Health & Counselling

Contacts

- **Steps 4 Wellness Team:** staff.engagement@wwl.nhs.uk, 07511 270 011
  - Senior Clinical Psychologist, Dr Alison Booth
  - Wellbeing Manager, Zoe Garnett
- **Your Wellbeing Leads:** Tony Clayson, Ann Carey, Michelle Bradshaw, Anne Edwards, ...
- **90+ wellbeing champions**
- **Chaplaincy and Spiritual Care** - Ext 2324, 2314, chaplaincy.spiritualcare@wwl.nhs.uk
- **Occupational Health** – Ohnurses@wwl.nhs.uk, 01942 77 3613

Title of report:	Infection Prevention and Control (IPC) Board Assurance Framework
Presented to:	Board of Directors
On:	25 November 2020
Presented by:	Chief Nurse / DIPC
Prepared by:	DD IPC
Contact details:	T: 07798741695 E: 3115

Executive summary

This report contains the latest IPC Board Assurance Framework (new template published 15 October 2020).

Key issues to highlight include:

- A review of the IPC audit programmes is taking place to identify priorities.
- IPC Safety champions are to be established to support compliance.
- One system for test and trace risk assessments of staff is being developed by HR linked to IPC.
- IPC mandatory training is being updated to include the latest national guidance.
- A process is being established for the CEO/DIPC/Exec on call to sign off all data submissions to NHSE.
- The process for reporting COVID outbreaks to the Board is being reviewed.
- Cleaning schedules for non-clinical areas require review and audit.
- Due to the number of patients with COVID-19 we are currently not able to separate patient pathways in all cases.
- IPC are to review and amend the CPE SOP based on new national guidance.
- Admission screens are not currently differentiated and patient tests routinely take more than 24 hours.
- Not all staff are face fit tested to current FFP3 models.
- Action is being taken to emphasise key IPC measures including mask use and social distancing.
- A business case is being developed to support absence management.

In addition to this, new national IPC guidance has been issued by NHSE on 17/11/20 that will require significant changes to a number of areas including:

- Cleaning schedules
- Patient testing regimes
- Staff testing regimes
- Patient flow

Risks associated with this report and proposed mitigations
Risks associated with this report are being managed through Trust governance processes.
COVID guidance continues to change on a regular basis and the demands on infection prevention and control teams remains very high and the team are working long hours and at weekends.

Financial implications
Business cases have been drawn up to:

- recruit additional Facilities staff to maintain the new cleaning standards
- implement Empactis and cloud based e-rostering to all staff groups to provide real time staff data.
- improve IPC resource and IT surveillance

Legal implications
This framework links to the 10 criteria in the Code of Practice on the prevention and control of infection, which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People implications
Additional staff are likely to be required long-term as outlined in financial implications above.

Wider implications
IPC have led on developing and collating the evidence for this framework but ongoing support is required from across the trust to maintain and build on the standards required.

Recommendation(s)
The Board to note the contents of the report.
IPC continue to update the Framework as actions are completed.

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes	• All patients attending A/E are screened for COVID-19 on registration with a risk assessment completed. Symptomatic and asymptomatic patients are segregated at this point. • Flow chart is in place Ward allocation of symptomatic, asymptomatic, positive and negative patients. • All patients within the community are contacted to ensure a face to face visit is clinically required ensuring that staff do not mix visits for both symptomatic and asymptomatic patients. • Telephone advise lines are in place where visits are not required.	No gaps	N/A
• Patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	• Microbiology results are obtained and documented in HIS before patients are moved to designated COVID-19 negative or positive ward. • If symptomatic but negative, patients are reassessed by medics. If COVID-19 still suspected patients stay on the ward and are retested which is all documented on HIS. • There is a Flowchart on Screening of admissions for COVID-19 infection' and in the Standard Operating Procedure on swabbing. • This is supported by frequent updates within the COVID-19 Newsletters. • Quarterly audits commenced from August	No gaps	N/A

• compliance with the national guidance around discharge or transfer of COVID-19 positive patients	• National guidance is in use and documented on WWL intranet and in SOPs. • There is a flow chart on stepping patients down based on national guidance and this is included in the COVID-19 SOP. • Information, flowcharts and the rationale on swabbing practice has been provided to the council to share with the care homes.	None	N/A
• Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice	• Monitoring of IPC practices against key policies (including COVID-19) is included within IPC audit programme and includes environmental checklists, hand hygiene and PPE. • Monitoring of IPC practice is also included within matrons mini audits.	COVID-19 audits currently taking a level of priority	Reviewing the current audit program is taking place
• Monitoring of compliance with PPE, consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	• PPE audit tool revised to incorporate new guidance	Limited audits undertaken to date	The establishment of IPC/ Safety champions in each ward is being undertaken
• Staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase	• Trust SOP established. • Mass testing inline with guidance rolling out. • Test & Trace risk assessments in place	Multiple systems are currently in place that may be causing delays in communication transfer.	Development of one system for all staff through HR linked to IPC First mass asymptomatic staff testing programme implemented within the Trust Oct/November 2020
• Training in IPC standard infection control and transmission-based precautions are provided to all staff	• Mandatory training covers - IPC level 1 and 2 - standard and transmission precautions. - PPE All are undertaken via e-learning modules	None	N/A

• IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training	• COVID -19 slides to form part of the above	Training slides being developed	All national guidance to be incorporated within the mandatory training
• All staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work	• Multi- modal communications strategy has been implemented which includes poster, roller banner and newsletter campaign. • Defined SOP developed and implemented	RCA review recommendations have changed the communication routes to reiterate importance	All managers use the 'just culture' framework for escalation of workforce incidents.
• all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	• PHE national guidance in place across the Trust • There is a PPE Store at each main site: PPE is delivered daily to wards and additional stock is available 24/7 if required. • A PowerPoint Presentation on PPE (along with a quiz to test learning) went live on e-learning for all staff and is now mandatory	None	N/A
• National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	• All new guidance is acted upon in a timely manner • Where necessary SOP's are updated • Changes are communicated through the IPC team, newsletters and Divisional leads	None	N/A
• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	• BAF for IPC • DIPC or Deputy present to the Board through the performance report or specific agenda items • Quality and Safety committee review quarterly	None	N/A
• risks are reflected in risk registers and the board assurance framework where appropriate	• Risk register • BAF IPC	None	N/A

• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• Q&S sign off for IPC audit programme annually • IPC Committee monitors progress and establishes mitigating actions to be taken	None	N/A
• That Trust CEOs or the executive responsible for IPC approve and personally signs off, all data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner.	• Establishing a rota for CEO, DIPC or Exec on call to sign off all information.	Process to achieve this is being established	Process to be in place by mid November
• ensure Trust Board has oversight of ongoing outbreaks and action plans.	• Reported through Quality and Safety Committee • Reported through Performance report to Board	Reviewing timely updates to the Board	Assessing a mechanism to achieve this
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	• Staff self-declaration for extremely vulnerable or high risk categories as defined by Public Health England. • Line manager risk assessment of the above individuals • All redeployed staff to undertake additional training to meet their needs • Where staff have been redeployed additional training has been provided. • PPE training is mandatory	None	N/A
• designated cleaning teams with appropriate training in required techniques and	• Domestic Response team and designated Domestics in place. • All Domestics are trained in the correct use of	None	N/A

use of PPE, are assigned to COVID-19 isolation or cohort areas	PPE and have been masked fit tested and issued with personal Corpro half mask		
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	• Domestic provision for the cleaning of isolation rooms and cohort areas follow PHE and National Guidance in place . • SOP in place in conjunction with IPC • Rapid Response Domestic team cover terminal cleans and work out of hours.	None	N/A
• increased frequency at least twice daily of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	• A second tier clean is carried out in all isolation rooms and cohort areas to assist with the removal of bioburden as set out in national guidance	None	N/A
• cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	• SoChlor used at 1,000ppm is used for cleaning	None	N/A
• Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning /disinfectant solutions/products as per national guidance	• Manufacturers guidance followed and available on the intranet and included in decontamination SOP	None	N/A
• 'frequently touched' surfaces e.g. door/toilet	• IPC review Ward Housekeeping schedules • Compliance is audited via Matron and IPC Spot	None	N/A

handles, patient call bells, over bed tables and bed rails should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions or body fluids	audits and reported to IPC Committee. • Disinfectant wipes are recommended for non-clinical area PCs and phones. Wipes also available on 'cleaning stations' at ward entrances/exits for re-usable half masks. • SOP's in place for all Facilities staff • Environmental cleaning audits in place and reported to the IPCC		
• electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards should be cleaned a minimum of twice daily	• Decontamination SOP in place	Audit process to be defined	Establish a mechanism to undertake an audit and monitor
• rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	• Limited designated PPE doffing areas. • All clinical areas undergo decontamination of the environment at least twice daily • Outbreak reviews monitored	None	N/A
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	• Linen system managed in line with PHE and National guidance • SOP available on the Intranet • External contractor performance against the contractual requirements	None	N/A
• single use items are used where possible and according to single use policy	• Single Use SOP in place • Single Use is included in mandatory level 2 IPC training. • Patient Safety Alerts communicated through internal Newsletters, Governance Team and changes to individual policies	None	N/A
• reusable equipment is appropriately	• Strategic and Operational Decontamination Groups in place	Timely meeting of the Decontamination Group	

decontaminated in line with local and PHE and other national guidance	• Decontamination SOP both WWL wide and at departments levels in place • All reusable equipment is decontaminated in line with national guidance • Audit programme in place • Risk assessment process in place to minimise risk		
• ensure cleaning standards and frequencies are monitored in non- clinical areas with actions in place to resolve issues in maintaining a clean environment	• Cleaning schedules in place	Lack of an audit tool to assess compliance with standards	
• ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air	• Mechanical ventilation available in some admission and waiting areas. • Where mechanical ventilation is not available, managers have been advised to encourage the dilution of air by opening windows. • Window restrictors are in place for all windows	None	N/A
• there is evidence organisations have reviewed the low risk COVID-19 pathway, before choosing and decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants	• SoChlor is used for the routine cleaning of the environment across all risk pathways and will continue.	None	N/A
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial	• Regular remote antimicrobial ward rounds are performed by the Consultant Microbiologist. • Daily Antimicrobial ward rounds undertaken within Critical Care by Consultant Microbiologist	None	N/A

stewardship is maintained	• Data collected on each intervention and feedback given. • Antimicrobial Pharmacist continues to review prescribing and new guidance as appropriate. • Antimicrobial audit in place		
• mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Mandatory reporting through the Board performance report • Mandatory reporting through the quarterly IPC paper to Quality and Safety Committee • Monthly reporting through Divisional Quality Assurance Groups	None	N/A
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
• **Key lines of enquiry**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting	• National guidance reviewed frequently with discussion at Board and Exec Team on restrictions • Changes communicated through Divisional Teams and via COVID Newsletter. • Visitor disclaimer in use.	None	N/A
• areas in which suspected or confirmed COVID-19 patients are being treated in areas clearly marked with appropriate signage and have restricted access	• Blue, yellow, green system in place across as GM with supporting SOP. • Entry to wards is via swipe which restricts unauthorised access. • Colour coded signs for all wards in place. • Signs include key instructions e.g. PPE required and who can enter. Also clear signage in ECC indicating symptomatic and asymptomatic patient areas.	Pace of changing environments means that some wards may have multiple different designated areas	Reviewing guidance from 17/11 on patient flow
• information and guidance on COVID-19 is available on all trust websites with easy read versions	• Dedicated COVID tab on landing page of Trust Intranet with divided sections including PPE and IPC.	None	N/A

	• External website has clear information and advice on https://www.wwl.nhs.uk/		
• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	• Infection status is communicated verbally before the patient is transferred and then in writing via a transfer form when the patient is moved. • Discharge to assess process works to rapidly discharge patients to the most appropriate setting with a philosophy of home wherever possible reducing contact with others. • All patients swabbed every 7 days in line with GM guidance and if no recent swab again 48hours before discharge to nursing or care home	None	N/A
• there is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice.	• Roller banners are displayed at each entrance to prompt patients, visitors and staff to comply with hands face, space. • Alcohol hand gel/ mask stations are available at hospital and department entrances. • Patient leaflets on in patient swabbing and use of face masks.	None	N/A
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases	• Patients are assessed on admission and admitted to the most appropriate bed • All patients attending A/E are screened for COVID-19 symptoms on registration • Patients are further assessed at triage and segregated appropriately • telephone screening is in place for all elective patients. • SOPs are in place to support NICE Guidance	None	N/A

• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from Non COVID- 19 cases to minimise the risk of cross-infection as per national guidance	• As above	None	N/A
• staff are aware of agreed template for triage questions to ask	• COVID-19 risk assessment questions included within COVID SOP. • HIS core assessments questions included the COVID-19 checklist	None	N/A
• triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	• Staff within AED have received specific training in relation to COVID-19 clinical case definition. • Pathways of care are defined within the Trust COVID-19 SOP. • Triage questions and COVID-19 checklist assessment within HIS further supports staff in clinical care definition and patient allocation	None	N/A
• face coverings are used by all outpatients and visitors	• FRSMs are available in all clinical areas and at all entrances • A SOP on masks wearing completed.		
• face masks are available for patients with respiratory symptoms	• FRSMs are available in all clinical areas and at all entrances; all visitors are asked to wear masks as they enter hospital. • There is an SOP on mask wearing. • Patients are asked to wear a mask where possible and where it is not interfering with their care e.g. oxygen masks. • There is an information leaflet for patients on masks approved at IPC Committee.	Many patients either refuse to or can't wear masks	Staff asked to ensure patients are sat/lay at least 2m apart and pull curtains if safe to do so.
• provide clear advice to patients on	• FRSMs are available in all clinical areas and at all entrances; staff and visitors are requested to wear masks as they enter hospital.	Many patients either refuse to or can't wear masks	Staff asked to ensure patients are sat/lay at least 2m apart and pull

use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care	• There is an SOP on mask wearing. • Patients are asked to wear a mask where possible and where it is not interfering with their care e.g. oxygen masks. • There is an information leaflet for patients on masks approved at IPC Committee.		curtains if safe to do so.
• ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff	• Seating rearranged or areas blocked off to ensure segregation. • Floor markings where required. • Hot clinic areas in the community have reduced and have clear signage. • Staff are not utilising patient entrances in order to reduce footfall • Perspex screens were present in AED reception. • Perspex screens required across the organisation reviewed and implemented.	None	N/A
• for patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative	• COVID SOP in place.	Process required to monitor patient moves.	November – Daily tracker in place to monitor patient moves. SOP reinforced at times of significant pressure
• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re- tested and contacts traced promptly	• COVID SOP in place. • Patient Incident forms completed for those patients with hospital onset COVID-19 that links with T&T requirements	Patient flow and bed allocation needs to be reviewed	Compliance with new guidance will address the gaps in assurance
• patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	• In line with departmental SOPs should patients attend who are symptomatic a risk assessment is undertaken • All COVID departmental SOPs are sign off by the IPC	None	N/A

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	• Patient pathways have been risk-stratification and included within the Trust COVID-19 SOP. • Display posters and updates on the Trust intranet also available. • Environmental risk assessments have been completed at ward and departments levels.	Due to the number of patients with COVID 19, currently we are not able to separate pathways.	Tracking patients through the Bed management team, the number of transfers and outbreak occurrences to minimise risk. This is monitored and supported by IPC
• all staff (clinical and non-clinical) have appropriate training, in line with latest national guidance to ensure their personal safety and working environment is safe	• Daily Trust Newsletter updating staff on the current position • IPC team accessibility • Divisional senior leaders, Exec team visible to staff • Where concerns are raised additional bespoke training is undertaken by the relevant individual to ensure staff comply. • A detailed IPC Checklist is being used to assess areas for the safe return of staff from isolating etc	None	N/A
• all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to Don and Doff it safely	• Don and doff posters are displayed in all wards and departments. • IPC check posters are present on ward visits. IPC advice is available 24/7. • The Professional Practice Team have supported IPC to carry out classroom training on donning & doffing. • Internal Patient Safety Notice was circulated Trust Wide via the Divisional Governance Leads in	None	N/A

	relation to the appropriate use and decontamination of reusable FFP3 masks. • Assurance was sought that this alert was circulated to all Ward and Departments has been received from all Divisions. • Don and doff guidance is included in the PPE e-learning module. • H&S and IPC advise and support was given Procurement for the purchase of PPE		
• a record of staff training is maintained	• All mandatory training is recorded through personal passports and electronically through the Trust mandatory training system. • FFP3 mask fit training is organised by H&S and records are held centrally.	None	N/A
• appropriate arrangements are in place that any reuse of PPE in line with the MHRA CAS Alert is properly monitored and managed	• The alert was received and distributed • WWL has not experienced severe shortages of PPE and not had to instigate this guidance.	None	N/A
• any incidents relating to the re-use of PPE are monitored and appropriate action taken	• The Procurement Group (includes medical representation, IPC and H&S) monitor PPE stock. • All incidents investigated and documented in Datix	None	N/A
• adherence to PHE national guidance on the use of PPE is regularly audited	• IPC visit wards regularly. • IPC developed and piloted a new PPE audit tool in June. Results are fed back to clinical teams and included in IPC reports. • All key wards PPE compliance is audited monthly and fed into IPCC and the quarterly report to Board	None	N/A
• hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to	• A communication strategy has been developed to promote key principles to minimise COVID-19 transmission, including availability of hand hygiene products, face masks and promotion of social distancing	None	N/A

minimise COVID-19 transmission such as:			
• hand hygiene facilities including instructional posters	• Instructional posters available at all alcohol hand gel stations throughout the hospital and ward/ department entrances. • Guidance is given to all elective patients within the patient information booklet	None	N/A
• good respiratory hygiene measures	• Facemasks are available at all hospital and ward/ department entrances. • Roller banners and posters are used to promote mask use and good respiratory hygiene	None	N/A
• maintaining physical distancing of 2 metres wherever possible unless wearing PPE as part of direct care	• Roller banners and posters used to promote social distancing. • Trust SOPs clearly define the need to maintain 2 metres distance unless wearing PPE as part of patient care. • There are signs on doors to indicate the maximum number of people who should be in the room at any one point. • Floor marking are present in many out patient areas and keep left signs in corridors	None	N/A
• frequent decontamination of equipment and environment in both clinical and non-clinical areas	• Decontamination of the environment within clinical areas included within the Trust COVID-19 SOP • Facilities audit compliance in clinical areas monthly that are reviewed by IPCC	Potential gap as auditing of non-clinical areas hasn't taken place	Discussion is taking place within the team to rectify the position
• clear advice on use of face coverings and facemasks by patients/ individuals, visitors and by staff in non-patient facing areas	• Facemasks are available at all hospital and ward/ department entrances. • Roller banners and posters are used to promote mask use and good respiratory hygiene	None	N/A
• staff regularly undertake hand hygiene training and observe standard infection control	• Hand hygiene training is mandatory • Hand hygiene audits take place monthly in all clinical areas and the results are monitored by IPCC and the Board	Due to clinical pressures some wards have not submitted their audit reports.	Explore how additional support to Ward Managers will ensure improvement in this position

precautions			
• the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance	• There are no hand dryers in any clinical areas at WWL. • Where hand dryers were available for the public these have been deactivated and replaced with paper towels.	None	N/A
• guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas	• Hand hygiene posters are available from IPC and on intranet. • Laminated posters displayed in all areas	None	N/A
• staff understand the requirements for uniform laundering where this is not provided for on site	• National guidance has been followed with information for staff on laundering their uniforms • Staff have been updated through the COVID Newsletters	None	N/A
• all staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE national guidance and other if they or a member of their household display any of the symptoms	• National guidance is being followed and available on the intranet. • Updates are included in the COVID Newsletters. • A drive through facility for staff testing at Leigh and at Wrightington and the phlebotomists can also swab staff as required at RAEI. • IPC liaise closely with H&S and Occupational Health as required. • Mass staff testing took place in October prior to the National scheme	None	N/A
• a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population	• An electronic laboratory reporting process (Queue) provides the IPCT with timely COVID-19 positive results. • An in-house COVID-19 App has been developed	None	N/A

and for hospital/organisation onset cases (staff and patients/individuals)	by the Trust BI Team that supports the collation, evaluation and summary of cases of COVID-19. • HOCI are reported via the daily nosocomial sitrep and summary directly to the Board bimonthly • Local PHE information on population transmission is circulated to EXEC's and IPC		
• positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	• Patient investigation templates are completed for patients who test positive for COVID-19 eight or more days after admission. • If the criteria for outbreak is met this is report to DIPC and NHSE/I • SOP in place that is monitored through IPCC		
• robust policies and procedures are in place for the identification of and management of outbreaks of infection	• SOP for the identification and management of COVID-19 outbreaks that incorporates national guidance. • This has been approved by the IPCC. • Daily outbreak meetings are held when necessary.	None	N/A
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff	• Patient pathways according to risk stratification have been defined and included within the Trust COVID-19 SOP which has been disseminated to all clinical teams. • Environmental risk assessments have been completed by wards and departments to establish safe flow of patients and staff	Due to the number of patients with COVID 19, currently we are not able to separate pathways.	Tracking patients through the Bed management team, the number of transfers and outbreak occurrences to minimise risk. This is monitored and supported by IPC
• areas/wards are clearly signposted, using physical	• 'Zone' display posters developed and updates on the Trust intranet provided.		

barriers as appropriate to patients/individuals and staff understand the different risk areas	• Entry to wards is via swipe which restricts unauthorised access.		
• patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	• Patients are currently cohorted on admission into symptomatic or non-symptomatic areas then wards. • Where a designated side room is available this would be used • Once the COVID result is known they are moved to either +ve or –ve ward. • There is an Operational flowchart and COVID SOP. • Reminder in Newsletters and in COVID SOP	A risk assessment has been undertaken to explore the number of side rooms required by the Trust	A business case for the converting of a ward has been undertaken
• areas used to cohort patients with suspected or confirmed COVID- 19 are compliant with the environmental requirements set out in the current PHE national guidance	• All bed spaces have been reviewed • Ward staff are requested to use privacy curtains between beds to minimise close contact where safe to do so; reminder in Newsletters and in COVID SOP. • IPC guidance on blue, green and yellow wards has been implemented and circulated to all wards • Reinforced through Newsletter • SOP covering all actions required • IPC environmental checklists are reviewed every time an outbreak is declared.	None	N/A
• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	• All previous IPC policies and SOPs are in place and up to date to identify and appropriately place patients. • Side rooms on non-COVID wards are used for patients requiring isolation for other reasons e.g. MRSA. • C.diff patients are managed on Pemberton ward. Bryn Ward (unusual layout) and Winstanley ward (COVID +ve ward) have separate SOPs. • Mandatory surveillance data is reported to IPCC and Trust Board.	New national CPE guidance published October	IPC to review and amend CPE SOP

8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • ensure screens taken on admission given priority and reported within 24hrs	• There is a prioritisation system in place at Oldham virology lab which prioritises clinical specimens over staff screening samples but does not differentiate admission screens.	Admission screens are not differentiated	Discuss with Salfrod Lab how this might be implemented.
• regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	• Regular monitoring is undertaken by a Consultant Microbiologist. • Reporting times for results are highly variable and currently averages 39.5 hours	Audit suggests that samples routinely take greater than 24 hours from sampling to reporting. Report presented to IPCC in Nov.	Recommendations made to reduce transit time added to COVID Reduction plan. PAWS Pathology plan Introduction of lab testing at Salford rather than Oldham to reduce transit time. Introduction also planned of on-site lateral flow testing as an initial rapid screen. NHSE made aware of this issue when visited on 29/10 and said they would also escalate it and support WWL being an early implementer of near patient testing. Point of care testing bid is awaited
• testing is undertaken by competent and trained individuals	• The Laboratories used are UKAS accredited	None	N/A
• patient and staff COVID-19 testing is undertaken	• Testing is performed in line with national guidance • Trust guidance is in line with NICE	None	N/A

promptly and in line with PHE and other national guidance	recommendations on testing for suspected COVID cases and for other infections. • The HIS tracking board highlights if swabs take longer than 48 hours and highlights when patients need re-swabbing. • System established for antibody testing • The swabbing team can be mobile and help to swab staff during outbreaks. • Testing is provided by Northern Care Alliance, monitoring of compliance is through contractual discussions		
• regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	• NCA Virology lab as part of their accreditation system. • Errors reported to WWL Microbiologist should these occur.	None	N/A
• screening for other potential infections takes place	• National policy is followed for the screening of patients for MRSA and CPE.	New national CPE guidance been published in October we are currently reviewing this	IPC to review and update CPE SOP.
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms	• IPC Policies and SOPs are approved at IPCC and are on the Intranet and kept up to date. • IPC and microbiology advice is available 24/7. • IPC level 1 and 2 e-learning is mandatory in line with national guidance	None	N/A
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	• All new guidance is acted upon in a timely manner • Where necessary SOP's are updated • Changes are communicated through the IPC team, newsletters and Divisional leads	None	N/A
• all clinical waste and	• Trust adheres to national guidance and Waste	None	N/A

linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	Legislation. This is evidenced within the Trust's Waste Management Policy and Procedures under Category waste. Community staff also follow the Trust's Policies including the national guidance regarding the disposal of COVID-19 PPE within a patient's home environment. • The Clinical Waste Management Module is now mandatory for all staff		
• PPE stock is appropriately stored and accessible to staff who require it	• PPE is distributed to the wards on a daily basis. The main PPE store is on the RAEI site and is accessible 24/7. Opening times are highlighted in COVID Newsletters. • PPE store also at Leigh and Wrightington. • In Community, PPE store well stocked and accessible to all teams	None	N/A
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported	• All staff requested to complete a self-declaration form confirming if they fall within the extremely vulnerable or high risk categories as defined by PHE. Where staff have been determined to fall within these groups, personal risk assessments have been completed by line managers with the support of Occupational Health. Records of the outcomes from the self-declarations forms logged and maintained within HR. • A comprehensive programme of support has been developed for all staff, including: Access to rest spaces with trained volunteers to provide a listening ear; in-reach support for teams when requested (e.g. at times of higher stress), training for managers in supporting staff; a 24/7 telephone helpline; staff counselling (including remotely); development of roles as clinical wellbeing leads and wellbeing champions; communications and information about self-care and sources of support. This is accessible by all staff, including those who	None	N/A

	are at-risk. Regarding those staff that are shielding, developing tailored support in addition to the above, in terms of accessing support remotely, and having access to information about supporting positive mental health when shielding. • Regular communications have been sent via senior managers; the HR team continue to be proactive and engaged with managers and individuals to obtain this information. • Home working supported for all staff where possible.		
• that risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff	• Personal risk assessments have been completed by line managers with the support of Occupational Health. • Records of the outcomes from the self-declarations forms logged and maintained within HR.	None	N/A
• staff required to wear FFP3 reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally	• Face fit testing is available across all acute sites and at one location in the community and is run by the H&S team. • All mask fit testers have been trained in line with national legislation. • A SOP has been developed and shared with all Testers. • Mask fit training records are held centrally. • Some staff cannot wear a close fitting FFP3 mask e.g. due to facial hair. There were 9 air powered hoods on site at RAEI and a further 11 were purchased and distributed to key areas. Face fit testing sessions are continuing on a regular basis to ensure staff are fit tested to the FFP3 masks currently available	None	N/A
• staff who carry out fit test training are trained and competent to do so	• Fit test training is overseen by the Trust H&S team and conducted by staff who have been trained in line with national legislation and	None	N/A

	competent to do so		
• all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	• Face fit testing sessions are continuing on a regular basis to ensure staff can receive fit test training in the FFP3 masks currently available	Face fit testing continues but the Central Register of staff tested indicates that not all staff are tested to a model that is currently in stock.	The Central Register has been shared with Divisions along with a request to prioritise staff who require retesting, initially those working in positive, symptomatic and asymptomatic, and where aerosol generating procedures are undertaken.
• a record of the fit test and result is given to and kept by the trainee and centrally within the organisation	• Record of the fit test and result is given to the staff member and mask fit training records are held centrally by the H&S team.	None	N/A
• for those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods	• Individuals that fail a fit test are tested on an alternative model until options are exhausted. If a secure fit cannot be achieved staff are advised to use a mechanical respirators and hood. Records are kept by the individual and held centrally by the H&S team	None	N/A
• for members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	• Included within the Respiratory Protective Equipment- Training Guidance SOP • Individuals that continue to fail fit tests and are unable to be provided with alternative respirators and hoods are provided with the opportunity for redeployment in line with Occupational Health and HR policies. • The Trust has a designated Redeployment team who oversee staff skill mix, knowledge and experience	None	N/A
• a documented record of this discussion should be available for the staff	• Documented records of staff redeployment are kept in line with Occupational Health and HR policies	None	N/A

member and held centrally within the organisation, as part of employment record including Occupational health			
• following consideration of reasonable adjustments e.g. respiratory hoods, personal re- usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record	• Documented records of staff redeployment are kept in line with Occupational Health and HR policies	None	N/A
• Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	• A centrally held mask fit register is maintained and is available.	A member of the Board had weekly oversight of a summary of the register during the first wave.	Advice from the Director of Corporate affairs will be sought on the best mechanism for this regular review.
• consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent / emergency care pathways as per national guidance	• Healthroster system used for nurses. • Medical rotas for medical staff. • DDNs reviewed nursing staff rotas and all staff risk assessments now completed. Where safe and practicable staff are only moved between similar colour coded areas in response to acuity and dependency of patients. There has also been a reduction in the volume of temporary staff working across the Trust. Staff risk status is clearly recorded on e-roster. Head of E&F reviewed non-clinical staff	Some staff do have to move between different areas on a daily basis. This includes circulating staff such as porters and phlebotomists. October – significant staff absent due to Covid/Mass testing necessities significant staff redeployment	Staff are trained in the use of PPE and carry hand gel. Guidance for circulating staff is included in colour coded ward guidance on ward entrances

	allocation but it was not possible to achieve everywhere		
• all staff should adhere to national guidance on social distancing (2 metres) if not wearing a facemask and in non-clinical areas	• National guidance has been adopted and promoted. Staff reminded regularly via Newsletters and Posters. Also in COVID SOP. • Mask usage made compulsory for all visitors and staff inside hospital buildings as per national guidance 15/6/20. • Office space has been redesigned to ensure social distancing e.g. in the Life Centre. • All community premises have been reviewed for social distancing and a number of work areas have been designated as no longer in use. Environmental checklists completed and risk assessments drawn up to support the return of shielding staff. Wards asked to include minimum numbers at staff handovers	Learning from recent outbreaks identifies areas at risk are break and staff rooms	Action being taken to review all areas again and guidance reiterated to all staff via variety of communications. Gold command agreed on 27/10 that all staff would now be expected to wear masks on trust sites inside and outside action being taken to enact this.
• health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone	• Space planning exercise undertaken at the start of the pandemic. • Maximum staff allowance per room assessments completed and supportive guidance provided to Departmental managers • Environmental risk assessments completed	Lessons learnt form outbreaks have identified that improvements are still required in social distancing within non-clinical areas, e.g. offices, break rooms	Social distancing, care sharing rules re-emphasised through Trust Newsletter Mask wearing guidance updated to include all areas of the Trust including outdoor spaces and shared offices in line with new guidance
• staff are aware of the need to wear facemask when moving through COVID-19 secure areas	• Trust SOP for Masks in place and circulated to all departments. Regular reminders provided within Trust Newsletters and by the use of posters and roller banners	None	None
• staff absence and well-being are monitored and staff who are self- isolating are supported and able to	• Staff absence is recorded for payroll purposes through e-roster and through e-SVLs. This means that data taken from ESR can be 4/6 weeks in arrears. In order to comply with the daily SITREP	Workforce data flows and the lack of accurate real time workforce data is on the corporate risk register	Business case is being developed re Empactis absence management system

access testing	requirements, absence data is recorded either in spreadsheets submitted by Divisional representatives or from the e-roster. • E-roster is currently rolled out to the majority of nurses and some AHPs. Whilst there are still data quality issues, this is a more accurate reflection of absences. We do not have a shift by shift live record of staff absences. However, a small absence/ e-roster resource is now actively contacting wards and departments to ensure that absences are recorded on the e-roster for those within the scope of current provision. This covers most nurses and some AHPs. • Key actions are being progressed to mitigate this risk and to improve the availability of such data, including real time absence. • Well-being offers are widely available to staff members, with pro-active holistic well-being provision through our Steps 4 Wellness and occupational health services. Psychological support programmes are in place including access to well-being apps, EAP, SOS rooms with trained facilitators, critical incident debriefing and departmental support programmes. There are nursing, AHP and medical well-being leads identified along with over 70 well-being champions within wards and departments. • The Trust continues to actively manage and support staff through attendance management procedures. The Strategic HR lead completes a monthly review of all longterm sickness absence cases with HR Business Partners. Staff have access to COVID-19 swab tests via a Trust drive through facility at Leigh along with tests through regional centres and home testing. All staff who require swab tests can be accommodated and this has been communicated through internal	(HR126), scoring 15.	

	mechanisms		
• staff who test positive have adequate information and support to aid their recovery and return to work	• Flow charts based on national guidance outline the processes and time periods to follow and are on intranet. Staff are supported via managers during absence in accordance with all sickness absence. • HR advisors are available to staff and managers to seek advice and support where any individuals are concerned or have questions around returning to work or being absent due to COVID.		

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Safe Staffing Report
Presented to:	Board of Directors
On:	25 November 2020
Presented by:	Chief Nurse
Prepared by:	Assistant Chief Nurse
Contact details:	T: 01942 778570 fiona.bryant@wwl.nhs.uk

Executive summary

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

For completeness this report also includes adult and children's community services.

This report covers the time period September to October2020. Inpatient areas have returned to COVID staffing levels and fill rates reported within the report are against the Trust agreed staffing requirements. The agreed nurse to patient ratio is 1:12 Covid staffing levels, this is the agreed minimum of nurses required, however as staffing levels allow the nurse to patient ratio would be amended

The Board are asked to note;

- Registered nurse vacancies remain high, most significantly at B5 level. The greatest risk with respect to B5 vacancy factor remains within the division of Medicine. In part this can be attributed to the investment in nursing establishments agreed by the Board in the financial year 19/20.
- There has been a sustained reduction in District Nursing vacancies remain 14% as in the previous report.
- The recent restrictions on international recruitment remains in place and this does continue to delay the plan to minimise band 5 vacancies by September 2020. The trajectory for recruitment is therefore being recast taking into account the current labour B5 turnover rates with the intention of minimising vacancies by the end of the financial year. This trajectory remains dependent on the lifting of constraints to international travel.
- Many services have stepped down which has allowed staff to be redeployed to areas of increased activity and pressure such as Critical care areas and covid positive areas. However the impact of residual qualified and none qualified nursing staff vacancies and sickness absence

levels and these are reflected in fill rates in October. Fill rates are only one indicator of quality; skills and competencies and staff feedback need to be also considered. There has been an increase in the use of temporary staffing to back fill vacancies and sickness absence. With both NHSP and where required agency staff to cover staffing short falls. It is important to note that as the organisation over the past two months has gone back in to a covid surge this is will impact on availability of staff and has the potential to again impact upon staff psychological well-being especially with the need for further redeployment. A number of staff have require a further period of shielding this also impacts on staff availability. Staff that had previously been redeployed during the first serge had just settled back in to their original teams, but have now been required to redeployed for a second time

- Within the Community Division District Nursing vacancies have remained high but static around 14%.

- There has been a slight increase in the reporting of red flags within nursing which reflects the drop in the fill rates. Additional shifts have been advertised and there is a good up by substantive, bank and agency staff and those on the temporary register. However due to the current pandemic sickness and staff needing to isolate due to other family members has added an additional pressure. An NHSP incentive has been agreed for part time staff. One red flag has been raised with respect to Maternity Services within the reporting period. This was delay in recognition of abnormal vital sign, not linked to staffing ratios.

- There are only a small number of Registered Midwifery vacancies and the division continues to proactively recruit to support continuity of carer models.

- Community have had an improving trend in pressures ulcers in Q4 19/20 and Q1 20/21. The bedded areas of the Trust saw an improvement in Q4 19/20, however these improvement have not been sustained and further work is required to embed the pressure ulcer improvement plan across all areas.

Link to strategy

Delivery of safe care

Risks associated with this report and proposed mitigations

- Registered nurse vacancies remains particularly high specifically at B5 level within the division of Medicine, this continues to result in a high use of temporary staff. The plan to reduce B5 vacancies by the end of the financial year has been refreshed to reflect current B5 turnover rates. We are proactively recruiting our 3rd year student nurses, along with a commitment to the international recruitment program through GTEC, along with recruitment through NHSP. We have committed to the recommencement of virtual recruitment events which are planned. There remain residual risks with respect to international recruitment which is dependent on the lifting of international travel constraints. However we have a cohort of 18 international nurses who will join the nursing workforce on 21st December 2020, initially undertaking an orientation and shadowing shifts. 7 of the international nurses have critical care experience; the additional nurses will be shared across the Divisions. From the 25th January we will also have access to 27 more international nurses who will work to achieve there OSKE and will then commence a period of orientation to the trust and then will join the nursing workforce. Ongoing reviews of staffing continue to ensure there is an appropriate balance of substantive and temporary staffing to provide safe care, and there is increased focus on local induction of temporary staff.

- Community have had an improving trend in pressures ulcers in Q4 19/20 and Q1 20/21. The bedded areas of the Trust saw an improvement in Q4 19/20, however these improvement have

not been sustained and further work is required to embed the pressure ulcer improvement plan across all areas.

Financial implications

Temporary staffing costs related to high vacancy levels and increased absence

Legal implications

- Potential for an increase in litigation associated with the development of pressure ulcers.

People implications

- Potential impact on staff wellbeing associated with vacancy rates, escalation of areas with no established staffing models
- Impact on staff due to redeployment to alternative work area due to need to maintain patient safety during Covid pandemic.
- Brilliant Basics campaign to assist in addressing the cultural issues identified within the report with respect to accountability, delegation of duties and professional responsibilities of registered staff.

Wider implications

- Increased scrutiny from Commissioners and Regulators

Recommendation(s)

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

Safe Staffing Report – September to October 2020.

1.0 INTRODUCTION

The purpose of this report is to provide the Board to provide assurance of the ongoing monitoring of nurse staffing levels across inpatient areas in line with national requirements.
For completeness this report also includes adult and children's community services.
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 and SafeCare submissions with respect to 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 – September to October 2020

The current reporting period reflects the staffing position during the second wave of the covid 19 pandemic

Fill rates within inpatient areas have declined in some ward areas, with some variation for both registered and unregistered staff throughout September and October. This reflects some of the areas that were required to escalate due to increased activity across medicine. The escalated areas did not have the appropriate establishment to staff these areas, which resulted in staff redeployment to provide nursing care to this group of patients. In October Standish Wards fill rate still reflected against a roster requirement for 10 beds rather than the 28 actually open, and therefore is artificially inflated (Appendix 2). This error has been escalated and will therefore be corrected for the next report.

During this reporting period E roster staffing levels were placed at the Covid agreed ratio of 1:12 registered nurses within bedded areas of the Trust, in accordance with the COVID escalation Plan.

In April 2020 inpatient ward establishments were increased in accordance with the investment agreed by Board in 2019. This has resulted in an increase in the percentage of registered nurse vacancies which is reflected within the appendices of this report.

At the end of October 2020 the current nursing vacancy for both qualified and unqualified shows 347 WTE deficits across the organisation. Of these, 70 WTE have been appointed to and 31 WTE are due to be filled via the pipeline of either student nurses or international nurses, which have been allocated to specific wards or departments. Therefore, the total number of nursing vacancies as of this report not recruited to is currently showing as 183 WTE qualified and 63 WTE unqualified.

Specifically looking at band 2, there remains a vacancy of 34.36 WTE vacancies across all divisions. This figure excludes care makers. There are currently 22 WTE Care makers employed from the first surge. The aim will be to offer the Care Makers a substantive role as HCSW; this is currently being worked through with staff side and HR, to support a seamless transition. Additional Care Makers have also been recruited

To address this a proactive recruitment day is scheduled of both qualified and unqualified staff. Internally we have agreed to run a Band 2 to 3 workforce development, this is to retain our existing band 2 to upskill them to extend their role skilling them to take greater responsibility. This will support a releasing time to care approach.

In relation to the NHSP recruitment drive along with the 15 nurses placed over the last reporting period a further 3 staff have in the pipeline which will offset the number of qualified vacancies. These are the nurses on the alternative rate card offering the enhanced rate of £30 per hour.

At the end of October 2020 the Trust had 246 WTE nurse vacancies; 183 WTE are registered nurse vacancies (Appendix 2 Table 2).

Of these 120 WTE are at B5 level with the greatest number of vacancies (83.68 WTE) being within the Division of Medicine (Appendix 2 Table 3); this represents a reduction of 12.23 WTE B5 vacancies since the last report. 63.97 WTE posts are associated with the uplift in staffing as approved by Trust Board in response to the nursing establishment review.

There is a plan in place to reduce Band 5 vacancies to zero by the end of the current financial year which involves international recruitment, proactive recruitment of final year students and a targeted and generic recruitment events. The Turnover at Band 5 level has on average is around 4-5 staff/month. As a consequence the trajectory for recruitment is has been reviewed and refreshed by the Deputy Chief Nurse and Deputy Director of HR.

The Director of Workforce and Chief Nurse are working in partnership with NHS Professionals (NHSP) in an agreed approach to recruit an additional 30 WTE registered staff to assist in augmenting clinical teams where there are high vacancy rates within the Division of Medicine. To date 10.32 WTE registered staff have been recruited.

This plan will be overseen by the Divisional Directors of Nursing as part of the workforce plan.

The staffing within the community has improved greatly, there is still a vacancy of 25.5 WTE qualified nurse vacancy and 8.84 WTE DN vacancies

Staffing gaps are being mitigated by utilising other professional groups to augment the service, and the block booking of bank and agency staff. No patient safety issues have been identified with this report period

The daily review of skill mix across the District Nursing Teams has continued with consideration taken of activity, complex and active, staffing numbers and the redeployment of staff. The division has continued the practice of a daily RAG rated report which supports risk based decision making with the movement of staff to support the delivery of safe care.

There was no patient safety or staffing concerns in the Community Division with regards to Children's Services. There is 1 WTE vacancies within Children's Services which are split between Children's Community Nursing Team (0.4 WTE) and the School Nursing Service (0.6 WTE).

Rainbow ward had previously been red for nurse staffing, however for the reporting period this has improved and is demonstrated in the fill rates for qualified and unqualified staff. This can be attributed to staff returning from other areas due to the covid pandemic. Currently the area does not have any vacancy either. Despite this the area does carry a 9% sickness rate which for a specialised area does at times place a pressure on the area. It should be noted that the bed base on Rainbow Ward 19 beds in total throughout this period of time and a ratio of 1:6 (RN to patient) was maintained throughout September and October

CHPPD data from the Model Hospital is provided in Appendix 2 Table 6; this data was refreshed in March 2020. The Trust continues to compare favourably for CHPPD for overall staffing against peers and national benchmarking data and this continues to be reflected in the improved fill rates for registered staff in March 2020. However the up to date data is not available for this report, so will be reported next time

The number of nursing red flags reported had increased for the month of October and this is reflected in the fill rates especially in medicines specifically unscheduled care areas. . The fill rates across unscheduled care have deteriorated in October, this area is carrying a high vacancy and sickness absence rate which will impact on the ability to cover the off duty, these were predominately during daytime hours when additional senior staff would be available (Appendix 2 Table 4).

1 red flag was raised on the Acute Stoke Unit during October 2020 indicating that there were less than 2 registered nurses on duty; there were no reported patient harms at this time.

Previous reports have highlighted nursing red flags being raised with regards to delays in the administration of pain relief. This has not been escalated as an issue in the current financial year however this information cannot be triangulated with patient experience as the patient satisfaction survey was suspended during the pandemic. It is anticipated that this survey will be reinstated in November 2020.

There have been no red flags raised within the current reporting period in Maternity services. There are currently no Registered Midwife vacancies within the team, and no midwifery red flags have been raised.

The quality metrics provided within Appendix 1 demonstrate a decrease in the number of harms across the Trust from pressure ulcers. 3 Pressure ulcers were escalated to StEIS in October 2020; 2 unstageable, ASU, Winstanley, and 1 cat 3 Aspull. These have been reviewed and there are some common themes. These are around skin assessment documentation not reflecting patient skin integrity, risks not identified on admission, lack of registered nurse oversight and accountability, body maps not completed on transfer or discharge of patients to another care setting. TVN have been

undertaking drop in on all wards to undertake bites sizes retraining. The Improvement plan has been completed and a themed Siri review on progress.

There have been 163% increases in StEIS reportable incidents from the previous safe staffing report and is an increasing trend. In October there were 29 notifications to StEIS 1 was deescalated of these 9 were related to covid ward out breaks

Community have had an improving trend in pressures ulcers in Q4 19/20 and Q1 20/21. The bedded areas of the Trust saw an improvement in Q4 19/20. There have be no reported pressure ulcers for the month of October. However sustained improvement has not been achieved so ongoing focus and work is required to embed the pressure ulcer improvement plan across all areas.

All pressure ulcers regardless of grade are subject to concise investigation and scrutinised for lapses in care by the Pressure Ulcer Improvement Panel. A refreshed Trust Wide Pressure Ulcer Improvement Plan has been developed which incorporates all the themes identified from the investigation reports received which has been approved by the Chief Nurse. This improvement plan has been developed with all the clinical divisions and progress against the actions will be monitored by the Patient Safety Quality Improvement Group. There is assurance that patients are being nursed correctly on profiling beds/mattresses both within the hospital and in the community, however further work is required to embed the proactive use of devices to assist in the off-loading of heels which is included within the pressure ulcer improvement plan.

A 50% reduction target in avoidable Category 3 and 4 Pressure Ulcers has been agreed by Quality and Safety Committee as an objective within the Trust Quality Accounts. Whilst there has been some improvement in the level of Registered Nurse oversight of pressure ulcers, there remains inconsistency in practice across the Trust which suggests this practice change is not yet fully embedded. Safety huddles have been introduced across the bedded areas of the Trust augmented by Matron spot checks of documentation and coaching conversations with staff.

The Chief AHP has been tasked with overseeing the Brilliant Basics project to improve the fundamental basic care delivery. A launch date is yet to be agreed with the Chief Nurse.

2 CDT's have been reported in October 2020, which is reduced form previously bringing the Trust total to 21 against an annual trajectory of 20; 3 of these have been subject to internal review, From the reviews completed there have been no identified lapses in care. A Trust Wide CDT Reduction Plan is being developed to address the increasing number of cases being reported. The plan focuses on the areas of learning identified from the lapses in care i.e. delays in sampling and isolation of the patient, and use of Personal Protective Equipment (PPE).

In addition the Trust recommenced the deep clean programme in July 2020; however due to the 2nd covid pandemic serge this has been suspended.

There was 1 fall reported where moderate or severe harm occurred within the reporting period. This was on the AS, however from review of this case it was downgrade as the patient did not experience any actual harm .

4.0 ACTIONS BEING TAKEN

The B5 vacancy reduction plan is being reviewed and refreshed to reflect current labour turnover rates. The retention of our band 5 workforce is also being reviewed with the band 5 to 6 uplift programme; some staff are currently on the programme with an aim to refresh this

Partnerships working with NHS Professionals (NHSP) to recruit an additional 30 WTE registered staff to assist in augmenting clinical teams where there are high vacancy rates within the Division of Medicine, of these 10.32WTE have been recruited to.

Bi-weekly monitoring of the progress to reduce B5 vacancies within the Trust

Brilliant Basics campaign to address basic care standards and culture is being overseen by the Chief AHP. The pressure ulcer improvement plan is being overseen by the Deputy Chief Nurse.

A CDT reduction plan has been developed by the Deputy Director of Infection Prevention and Control which incorporates lessons learnt where lapses in care have been identified.

5.0 RECOMMENDATIONS

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

Appendices

Appendix 1 Safe Staffing Exception Reports October 2020

Appendix 1

SAFE STAFFING EXCEPTION REPORT – October 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	84.2%	144.8%	3.5	169.0%	139.1%	7.3	15.58%	4.40%	14.35%			1/5	0/1	0/1		
Astley	87.6%	146.5%	3.1	111.7%	148.3%	5.5	10.67%	8.89%	20.37%		1			0/1		
Bryn North												0/2				
Bryn South	89.1%	116.7%	4.1	123.6%	145.1%	7.2	25.64%	Unable to report vacancies as there is no budget recorded for this department				0/6	1/0			
Coronary Care Unit	99.3%	88.0%	7.7	367.5%	0.0%	3.0	8.56%	31.17%	32.01%				1/0			
Highfield																
Ince	91.3%	90.5%	3.0	98.9%	140.4%	4.6	10.76%	28.87%	44.46%			0/1				
Pemberton	75.2%	106.5%	4.6	109.2%	137.8%	5.1	9.83%	9.50%	8.72%			0/2		0/1		
Shevington	89.6%	91.9%	4.1	96.0%	124.9%	6.3	17.70%	14.29%	26.47%			0/4				
Standish	206.5%	158.5%	3.4	227.6%	252.0%	4.7	10.92%	15.25%	35.86%			0/4		0/1		
Winstanley	163.7%	93.0%	5.3	107.0%	85.2%	5.1	7.29%	9.20%	26.59%			0/2		0/5		

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	94.8%	118.5%		132.4%	212.5%		6.84%	23.60%	31.44%			0/3		0/2		
A&E Paeds	119.9%	101.7%					3.44%	2.48%	2.48%							
A&E NP's	53.4%	0.0%		24.2%												
CDW	70.7%	98.0%		106.5%	103.4%		1.63%	14.83%	25.33%							
Lowton	59.7%	92.1%		105.3%	131.6%		10.06%	5.82%	22.69%			0/6		1/3		
Medical Assessment Unit	78.7%	113.4%		89.3%	109.1%		17.06%	13.09%	28.50%			0/8		0/3		

Division of Surgery

Ward	Average Fill Rates (%) & CHPPD						Staff Availability			Staff Experience	Nurse Sensitive Indicators				Patient Experience % (Number surveyed)	
	RN / RM			CSW												
	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	110.4%	103.8%	26.9	104.6%	0.0%	4.7	3.23%	0.00%	0.00%				4/1			
Langtree	79.0%	106.1%	2.9	156.4%	229.1%	4.3	13.82%	7.63%	17.89%			0/3		0/4		
Orrell	83.7%	82.0%	3.4	106.4%	107.8%	5.7	8.67%	3.98%	2.46%		1	0/6				
Swinley	97.2%	94.0%	3.3	133.8%	209.6%	4.4	8.03%	4.10%	11.84%			0/5				
Maternity Unit	102.8%	91.8%	12.7	108.2%	93.1%	3.7	8.73%	0.00%	0.00%					0/2		
Neonatal Unit	104.4%	109.2%	9.2	110.6%	0.0%	1.4	4.17%	0.00%	0.00%					0/1		
Rainbow	95.0%	94.3%	9.9	123.0%	93.5%	3.8	9.09%	0.00%	0.00%			0/1		0/2		

Division of Specialist Services

Ward	Average Fill Rates (%) & CHPPD						Staff Availability			Staff Experience	Nurse Sensitive Indicators				Patient Experience % (Number surveyed)	
	RN / RM			CSW												
	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	93.4%	90.6%	3.2	116.7%	165.0%	6.05	11.73%	18.79%	34.40%			0/4		0/3		
Ward A	93.6%	81.1%	4.1	73.7%	96.5%	3.99	2.00%	23.15%	22.65%			0/1				
Ward B	95.2%	107.3%	3.8	100.5%	107.8%	4.30	14.50%	22.52%	21.85%			0/7		0/1		
JCW							14.60%	18.47%	24.44%							

Other – Community Covid

Ward	Average Fill Rates (%) & CHPPD						Staff Availability			Staff Experience	Nurse Sensitive Indicators				Patient Experience % (Number surveyed)	
	RN / RM			CSW												
	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?
Leigh Covid Recovery Unit							6.4%	Unable to report vacancies as there is no budget recorded for this department								

October 2020

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

Appendix 2

	August		October	
No of areas	Red Metrics Registered Staff Days	Red Metrics Registered Staff Nights	Red Metrics Registered Staff Days	Red Metrics Registered Staff Nights
24	**6**	**4**	**8**	**3**

Table 1 *Red Metrics in Inpatient Areas October 2020*

Month	Registered WTE	Unregistered WTE
August	272.1	78.48
October	182	56

Table 2 *Nurse Vacancies October 2020 Trust Wide)*

	August 2020	October 2020
Specialty		
Medicine	98.61	90.62
Surgery	28.36	26.93
Specialist Services	35.14	35.32
Community Services	17.2	25.55
Corporate	0.69	0.52
Total	**180**	**178**

Table 3 *Band 5 Nurse Vacancies August to October 2020 by Division*

Red Flag Category	Number of of Incidents August 2020	Number of Incidents September 2020	No of Incidents October 2020
Shortfall of more than 8 hours or 25% of registered nurses in a shift	12	13	20
Delay of 30 minutes or more for the administration of pain relief	0	0	0
Delay or omission of intentional rounding	0	0	0
Less than 2 registered nurses on shift	0	0	1
Vital signs not assessed or recorded as planned	0	0	0
Unplanned omission of medication	0	0	0
Total	**12**	**13**	**21**

Table 4 *Nursing Red Flags August and October 2020*

Red Flag Category	No. of Incidents August 2020	Number of incidents October 2020
Unit on Divert	0	0
Co-Ordinator Unable to Remain Super-numerary	0	0
Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0
Delay of 30 or more between presentation and triage	0	0
Delay of 2 hours or more between admission for induction and beginning of process	0	0
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0
Total	**0**	**0**

Table 5 *Maternity Red Flags June to August 2020.*

CHPPD	Data period	Trust value	Peer median	National median	Chart	Actions
Care Hours per Patient Day - Total Nursing, Midwifery and AHP staff	Mar 2020	11.6	9.4	9.1		
Care Hours per Patient Day - Total Nursing and Midwifery staff	Mar 2020	11.6	9.4	9.1		
Care Hours per Patient Day - Total AHPs staff	Mar 2020	0.0	0.0	0.0		
Cost per Care Hour - Total Nursing and Midwifery staff	Q4 2018/19	£20.6	£23.6	£23.7		
Cost per Patient Day - Total Nursing and Midwifery staff	Q4 2018/19	£174.4	£195.3	£189.6		

Table 6.Use of Resources March 2020 (Source Model Hospital)

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Review of COVID-19 risk appetite statement
Presented to:	Board of Directors
On:	25 November 2020
Presented by:	Director of Corporate Affairs
Prepared by:	Paul Howard, Director of Corporate Affairs
Contact details:	T: 01942 822027 | E: paul.howard@wwl.nhs.uk

Executive summary

In March 2020, the Board approved a COVID-19 risk appetite statement and directed that it should be presented to each subsequent meeting to ensure its continuing appropriateness and relevance. The risk appetite statement was subsequently amended by the Board at its last meeting in September 2020.

The statement is attached to this report and the proposed amendments are highlighted in yellow for ease of reference.

Link to strategy

The establishment of a clear risk appetite statement informs decision making within the organisation.

Risks associated with this report and proposed mitigations

The content of this report is intended to support organisational risk management by articulating the foundation trust's risk appetite in a dedicated statement.

Financial implications

There are no financial implications arising out of this report.

Legal implications

There are no legal implications arising out of the content of this report.

People implications

There are no people implications in this report.

Wider implications

There are no wider implications to bring to the committee's attention.

Recommendation(s)

The Board is recommended to approve the revised COVID-19 risk appetite statement as appended to this report.

COVID-19
Risk appetite statement

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Introduction

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

At Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust we recognise that complete risk control and avoidance is impossible but that risks can be minimised by making sound judgments and having a common understanding of the organisation's risk appetite and value set. We also recognise that exceptional times often call for an increased level of risk to be accepted and that the current threat posed by the global COVID-19 pandemic will require a different approach to decision making based on the balance of risk in any given circumstance. Notwithstanding, we recognise the importance of maintaining oversight of high risk incidents and we will continue to prioritise investigation and identification of areas of learning.

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

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

Underlying principles

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

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

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

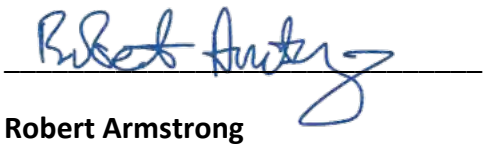
Our risk appetite

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

Quality, innovation and outcomes	We have **a LOW** appetite for risks which materially have a negative impact on patient safety. We have a **MODERATE** appetite for risks that may compromise the delivery of outcomes without compromising the quality of care. We have a **SIGNIFICANT** appetite for innovation that does not compromise the quality of care.
Financial and Value for Money (VfM)	We have a **HIGH** appetite for financial risk in respect of meeting our statutory duties. We have a **HIGH** appetite for risk in supporting investments for return and to minimise the possibility of financial loss by managing associated risks to a tolerable level. We have a **HIGH** appetite for risk in making investments which may grow the size of the organisation.
Compliance/ regulatory	We have a **MODERATE** appetite for risks which may compromise our compliance with statutory duties or regulatory requirements.
Reputation	We have a **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 30 September 2020.



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

Appendix: Risk appetite matrix

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

Title of report:	BAME employment profile in WWL
Presented to:	Board of Directors
On:	25 November 2020
Presented by:	N/A – Consent agenda
Prepared by:	Director of Workforce
Contact details:	2949

Executive summary

It is nationally recognised that BAME employees are often underrepresented in decision making roles within the NHS. Furthermore, the national and Trust submitted Workforce Race Equality Standard demonstrates that BAME employees experience inequalities in their employment, whether that be access to development and career progression opportunities, their likelihood of being recruited to a position from being shortlisted and their likelihood to be subject to formal disciplinary processes.

To support Trusts to take positive action to improve the diversity of their workforce from an ethnicity perspective, NHSEI have set an improvement trajectory for each Trust in relation to BAME representation across the pay bands (Appendix 1). We have been unable to confirm the methodology for this. WWL's ambition should be to increase diversity at all levels, including senior leaders (Band 8a and above) and at Board level. Strict adherence to the set trajectory could result in potential further detriment to WWL BAME employees, due to the small numbers included in the trajectory. For example, the target for equality at band 9 suggest the requirement for no BAME staff in that particular pay band.

96% of the Wigan Borough population is White British / White Irish. WWL's workforce demographic demonstrates that 90% of our employees are of the same ethnic background.

When looking at BAME groups, WWL's workforce demographic, compared to the Wigan Borough is detailed in the table below:

	Wigan Borough	WWL
Mixed	0.9%	0.8%
Asian	1.1%	5.2%
Black	0.5%	0.8%
Other	0.2%	1.2%
Not stated		0.7%
Total	2.7%	8.7%

60% of WWL's medical and dental employees are BAME and this equates to 52% of the overall BAME employees in WWL. It is important that we do allow the proportion of BAME medical staff to shape an artificial position of diversity across the rest of the workforce.

When looking at our BAME representation in non-Medical positions, we have 283 positions at band 8a and above and currently 10 of these employees are BAME. Rather than focus on the specific trajectory targets, it is important that we look to increase the level of diversity in these key decision-making roles. Whilst there is significant national focus on the BAME group, it is important that WWL aims for increased diversity at senior levels in the Trust from all protected groups, as we already know from reported data that we have issues of inequality to address in relation to a significant gender pay gap and for staff living with disabilities.

Our current BAME workforce profile is detailed below:

Pay Scale	White	BME	Not Stated	Grand Total
Band 8a	176	7	2	185
Band 8b	45			45
Band 8c	14	1		15
Band 8d	14	1		15
Band 9	7			7
Very Senior Managers (including NEDs)	15	1		16
Grand Total	**271**	**10**	**2**	**283**

There have been recent additional appointments at Board level that are not reflected in the above table that increases the ethnic diversity of the Board, with the appointment of Dr Sandeep Ranote, on secondment until the 31st March 2021, to the position of Medical Director for Mental Health and Integration and Rabina Tindale, our new Chief Nurse who will commence employment at WWL in the coming months.

Taking things forward

We are currently developing a new Equality, Diversity and Inclusion Strategy that will focus on three key themes:

- Ensure our workforce is diverse, representing the needs of our local population
- Improve the experience of work for people in protected groups
- Eliminate inequality in employment

Specifically, in relation to ethnic diversity our key actions will include:

- Targeted leadership and professional development programmes
- Targeted BAME talent mapping, including the use of behaviour-based psychometrics and 360 feedback
- Reverse mentoring
- Positive action in recruitment, targeted at specific areas of the community and workforce
- A fresh approach to the way adverts and job descriptions are framed to promote diversity
- A review of recruitment and selection processes to ensure that staff from protected groups are not disadvantaged
- Showcasing case studies of career progression for BAME employees
- Development of self-directed staff networks with access to members of the Trust Board

In delivering these actions, there are limitations that will have to be taken into consideration and potentially considered through business case processes, notably the lack of dedicated specialist workforce EDI resource and limited education, training and development budgets. There are possibilities that we could consider developing shared locality or regional resource to support this agenda and we will be looking to address the provision of training and development funding through a strategic training needs analysis approach to inform considerations at budget setting.

Link to strategy

Workforce equality, diversity and inclusion forms a key component of the WWL and national People Promise. There is a clear evidence base that having increased diversity in an organisation, especially in roles where key decisions are made improves the effectiveness of an organisation.

Risks associated with this report and proposed mitigations

The lack of dedicated workforce EDI specialist resource and access to education, training and development funding could restrict the progress we are able to make and the scale of transformation. There needs to be full Trust Board support for this agenda in acknowledging that there is significant work for the Trust to do and to fully embrace the benefits of diversity throughout the organisation.

Financial implications

Linked to the identified risks, additional Workforce EDI specialist resource would be required, with potential for developing a shared resource with locality or regional partners to fully deliver against our aspirations.

Available training, education and development funding is extremely limited. We will look to consider this at budget setting with a strategic learning analysis.

Legal implications

There is a statutory responsibility under the Equality Act (2010) protect people from discrimination in the workplace. There is a further responsibility on the Trust through the public sector equality duty to:

1. Eliminate discrimination
2. Advance equality of opportunity
3. Foster good relations between different people when carrying out their activities

People implications

Addressing inequalities in work for employees in protected groups will see improvement in engagement across the organisation, as increased diversity improves experience at work, decision making and organisational performance.

Delivering these ambitions will require input throughout the employment life cycle, from recruitment to career development, engagement activities and employee relations processes.

Wider implications

Whilst this paper focusses in the main on the profile of our BAME workforce, we must also consider the experience of work and diversity across all protected groups within the Trust.

Recommendation(s)

The Board is asked to:

- Approve the ambition to increase diversity across the Trust and notably in senior leadership roles
- Avoid setting specific and restrictive targets, but instead to focus on improving diversity in senior roles and monitoring progress with this
- Support the development of talent programmes for underrepresented groups
- Recognise the potential limitations to progress as highlighted in the report

NHS Improvement

NHS England

A Model Employer:

Increasing black and minority ethnic representation at senior levels across Wrightington, Wigan and Leigh NHS Foundation Trust

Implementing the NHS Workforce Race Equality Standard (WRES) leadership strategy

Background

There exists a huge reservoir of talent which is not being tapped into by the barriers that are often placed in the way of staff development and opportunities. Greater diversity and inclusion improves opportunities to tap into that diverse talent pool. The NHS is at its best when it reflects the diversity of the country and where the leadership of organisations reflects its workforce.

Research shows that organisations that have diverse leadership are more successful and innovative than those that do not. Employees who feel valued are more likely to be engaged with their work, and diversity at senior levels increases productivity and efficiency in the workplace. Such organisations are better placed to reduce health inequalities of our diverse communities and leads to better patient care, satisfaction and outcomes.

This document sets out the ambitious challenge of ensuring black and minority ethnic (BME) representation at all levels of the workforce. This includes leadership being representative of the overall BME workforce by 2028. The document outlines both the aspirational goals for your organisations as well as a comprehensive and holistic set of objectives to support the NHS, as part of the existing Workforce Race Equality Standard (WRES) programme of work.

This content of this document presents an example of a commitment to meet the aspirations on improving BME representation across the workforce and at leadership positions in the NHS, as set-out in the in both the NHS Long Term Plan[1] and within the WRES 'Model Employer' leadership representation strategy[2].

NHS trusts are encouraged to work with the national WRES Implementation team to agree and finalise the detail of the aspirational goals and action plans.

1. The need for accelerated improvement

Since its introduction in 2015, NHS England's WRES programme has been providing direction and tailored support to the NHS, enabling organisations to continuously improve their performance in this area.

The WRES has required NHS trusts to annually self-assess against nine indicators of workplace experience and opportunity, and to develop and implement robust action planning for improvement.

WRES data for the last three years shows year-on-year improvement for BME staff on a range of indicators. Increasing the representation of BME staff at senior and leadership levels across the NHS is an area that requires further accelerated support.

The overall BME workforce in the NHS is increasing, however this is not reflected at senior positions where there is an acute under-representation of BME staff. Aspirational goals to increase BME representation at leadership levels, and across the pipeline, will reinforce the existing WRES programme of work.

[1] https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/
[2] https://www.england.nhs.uk/wp-content/uploads/2019/01/wres-leadership-strategy.pdf

2. The 10-year ambition modelling

Table 1. Wrightington, Wigan and Leigh NHS Foundation Trust workforce by ethnicity: March 2018

	Total headcount	Overall %	% known ethnicity
BME workforce	420	8.3%	8.4%
White workforce	4582	90.4%	91.6%
Unknown workforce	66	1.3%	
Total	5068		

The table above shows organisation staff breakdown by ethnicity for Wrightington, Wigan and Leigh NHS Foundation Trust as at 31 March 2018. The staff are split into three broad ethnic categories: 'BME' (Black and Minority Ethnic), 'white' and 'unknown'. The ethnic categorisation follows the national reporting requirements of Ethnic Category as outlined in the NHS Data Model and Dictionary, and as used in NHS Digital data.

Table 2. Goal setting for bands 8a-VSM BME recruitment for Wrightington, Wigan and Leigh NHS Foundation Trust

	Proportion of BME workforce (n)	Additional BME recruitment over the next 10 years to reach equity[1]	Total BME staff in AfC band by 2028 to reach equity[1]
Band 8a	4.6% (6)	**5**	11
Band 8b	0.0% (0)	**3**	3
Band 8c	0.0% (0)	**1**	1
Band 8d	0.0% (0)	**1**	1
Band 9	0.0% (0)	**0**	0
VSM	6.7% (1)	**0**	1

[1] Reaching the value in column "Proportion of BME workforce" (note: by 2028 this may have changed)

The table above shows the additional recruitment of BME staff required, in Agenda for Change (AfC) bands 8a to VSM, to achieve equity of representation at Wrightington, Wigan and Leigh NHS Foundation Trust by 2028.

Table 3. Goal setting trajectory for bands 8a-VSM BME recruitment for Wrightington, Wigan and Leigh NHS Foundation Trust

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Band 8a	6	6	7	7	8	8	9	9	10	10	11
Band 8b	0	0	1	1	1	1	2	2	2	3	3
Band 8c	0	0	0	0	0	1	1	1	1	1	1
Band 8d	0	0	0	0	0	0	1	1	1	1	1
Band 9	0	0	0	0	0	0	0	0	0	0	0
VSM	1	1	1	1	1	1	1	1	1	1	1

The table above shows the 10-year trajectory to reach equality by 2028 for AfC bands 8a to VSM. The numbers show the required staff in post for each year.

Progress against the data in the above table will be looked at by the WRES team and national regulators, and therefore should also be focussed upon by the respective organisation, on an annual basis.

3. Current performance: 2019 update

Table 4. 2019 staff in post compared to 2019 trajectory ambition for Wrightington, Wigan and Leigh NHS Foundation Trust

	2018 actual	2019 actual	2019 ambition	Gap
Band 8a	6	6	6	0
Band 8b	0	1	0	1
Band 8c	0	0	0	0
Band 8d	0	1	0	1
Band 9	0	0	0	0
VSM	1	0	1	-1

There has been an increase in the number of BME staff in AfC bands 8b and 8d. The trust is on track to deliver equity by 2028 for all AfC bands except for VSM band.

As the proportion of BME staff in the trust changes, the 10-year trajectory will change as well. It is strongly recommended that the trust regularly monitors its progress against its respective aspirational targets. The WRES team will work with the trust to review the aspirational targets and trajectories every three years.

4. Key points of consideration

- The data source for the above modelling is the trust workforce data 2018 WRES submission.

- Modelling assumptions:
    - Assumes no change in the number of staff in the organisation over the next ten years.
    - Assumes constant number of employees and leavers per year based on data between March 2017 and March 2018.
    - The model considers the number of BME recruits to replace leavers and increase representation up to equality by 2028.
    - BME proportions are recorded as a total of known ethnicities.

- The above model presents the aspirational goals relating to managerial staff on the agenda for change pay scale. The trust will need to replicate this approach for its **medical** workforce.

- Staff and staff-side within the trust, and other key stakeholders, should be engaged in a meaningful way regarding the strategic direction of travel.

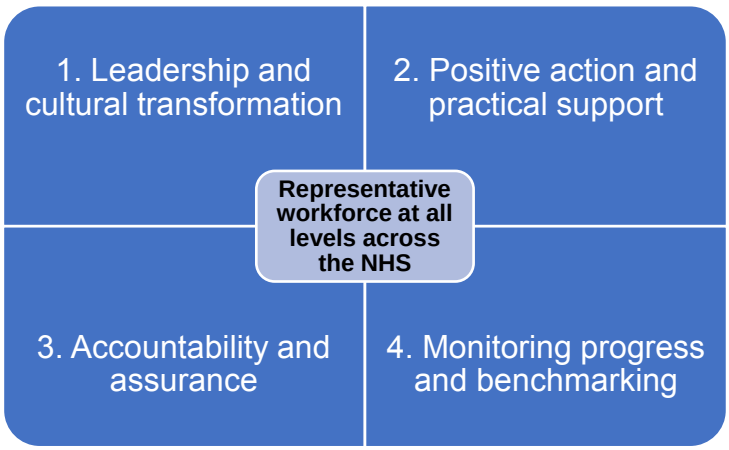
- Commitment and accountability regarding the aspirational goals and supporting plans should lay with the trust board.

5. Supporting delivery of the ambition

The WRES team will support the wider system to focus on driving improvements in BME representation at senior levels across the NHS – building a sustainable talent pipeline for the future. A clear focus will be upon both growing and supporting existing BME talent from within the NHS, as well as attracting talent from outside of the NHS.

To help meet the aspirations set-out above, dedicated support to individual organisations, and parts of the NHS, will be provide by the WRES Implementation team. This support is presented under four broad headings, as outlined below.

Figure: WRES model of support for improving BME representation across the NHS workforce



5.1 Leadership and cultural transformation

- Demonstrate commitment to becoming an inclusive and representative employer - role modelling on race equality – **work will be carried out to transform deep-rooted cultures of workforce inequality via organisational leadership strategies** – a focus here will be upon NHS Improvement's Culture and Leadership Programme; engage supporters and including stakeholders in the planning process and in helping to share messaging, rationale and process.

- Require VSMs and board members to mentor/reverse mentor and sponsor at least one talented ethnic minority staff at AfC band 8d or below – coaching skills and structured support will be made available to senior staff to carry this out. **Mentoring, reverse mentoring and sponsoring will be part of the senior leader's performance objectives** that will be monitored and appraised against.

- Recruitment drive on BME non-executive directors (NEDs) – as a starting point, **a drive to appoint BME NEDs will be encouraged**. Existing NEDs will be encouraged to play an active role in mentoring and sponsoring BME staff that have the potential to get to an executive role within three years.

5.2 Positive action and practical support

- Talent management – to meet set aspiration, concrete measures to remove barriers to our most talented ethnic minority staff succeeding, will be put in place. To enable this to happen, there needs to be a consistent narrative within organisations, based on a **fit-for-purpose national approach to effective talent management across the NHS**.

- Diverse shortlisting and interviewing panels – **recruiting managers will be held accountable for institutionalising diverse shortlisting and interview panels**. There would seldom, if ever, be acceptable exceptions for not having a BME member on shortlisting and interview panels; this is firmly within the organisation's control. Where BME interviewees are not appointed, justification should be sent to the organisation's chair setting out, clearly, the process followed and the reasons for not appointing the BME candidate.

- Batch interviews should be considered where appropriate – panel interviews of single applicants may not always provide the optimum assessment of a candidate's skills and capabilities, and can contribute towards creating conditions for bias. **Organisations will be encouraged to examine the merits of interviewing a batch of candidates** for a number of different roles/positions.

- Technical WRES expertise at regional levels – the WRES Experts Programme aims to develop cohorts of race equality experts from across the NHS to support the implementation of the WRES within their organisation. Participants become part of **a network of professionals across the NHS that advocate, oversee and champion the implementation of the WRES** at regional and local level. The work on meeting leadership aspirations at local level will be built into the existing WRES Experts Programme.

- Promote success and share replicable good practice – **identification and dissemination of models of good practice, evidence based interventions** and processes from across the NHS – from the wider public, private, voluntary and charitable sectors – will help support NHS organisations to achieve the required outcomes.

5.3 Accountability and assurance

- Build assurance and accountability for progress – NHS organisations across the country will be supported to **develop workforce race equality strategies and robust action plans that are reflective of their WRES data**. These action plans provide an ideal vehicle to continuously improve on the issues that, the data show, are of key concern for the organisation. Progress against the aspirations will form part of an organisation's action planning for the WRES. This work will be included in the Single Oversight Framework; Care Quality Commission (CQC) inspection; and the CCG Assurance and Improvement Framework.

- Senior leaders and board members will have performance objectives on workforce race equality built into their appraisal process – senior leaders should be held accountable for the level of progress on this agenda. Working with national healthcare bodies, **progress on workforce race equality will be embedded within performance reviews of chairs and chief executives** – including emphasis on WRES implementation and on progress in meeting the set goals for their respective organisation.

- Building the capability and capacity of BME staff networks across the NHS – to play a key part of the accountability and transparency approach will play a key role. There will be a concerted effort towards **supporting leaders of BME staff networks and trade union representatives, across the NHS to raise the visibility of their work**, and to provide a source of meaningful and sustained engagement with the WRES programme of work.

5.4 Monitoring progress and benchmarking

- Benchmarking progress – **benchmarking and progress will be established and published as part of NHS Improvement's Model Hospital hub and WRES annual data reporting**, through which the monitoring of progress against set aspirations over time will be undertaken, and good practice shared.

- Periodic update – due to the changing nature of BME workforce composition across the NHS, the right approach will be to **periodically update the assessment of the overall progress that has been made on meeting the aspirations** – starting at the end of 2020, and local organisations will be supported via the national WRES team to do the same.

- Oversight – the lack of BME leadership is a system-wide issue that requires a system-wide response. CEOs within a regional healthcare footprint are encouraged to come together on this agenda regularly. **Collaborative working between healthcare organisations at local level, and with key partners, will be essential.** This will require all relevant organisations to focus resource on workforce race equality in a more intentional manner.

6. Further information

Further information and support will be available from the NHS England WRES Implementation team.

Email: england.wres@nhs.net

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Quality account 2019/20
Presented to:	Board of Directors
On:	25 November 2020
Presented by:	N/A – Consent agenda
Prepared by:	Associate Director of Quality Governance and Patient Safety
Contact details:	Nichola.Halpin@wwl.nhs.uk

Executive summary

The attached annual safeguarding report was considered by the Quality and Safety Committee (as the assurance committee on behalf of the board) at its meeting on 29 September 2020, and the committee recommended approval by the Board.

This annual report is therefore presented for formal approval.

Link to strategy

N/A

Risks associated with this report and proposed mitigations

There are no risks associated with this report.

Financial implications

There are no financial implications to bring to the board's attention.

Legal implications

There are no legal implications arising from this report.

People implications

There are no people implications to highlight.

The WWL Way

Wider implications

There are no wider implications to highlight.

Recommendation(s)

The Board is asked to receive and note the report.

Wrightington, Wigan and Leigh Teaching Hospitals

NHS Foundation Trust

Quality Report **2019/20**





WELCOME TO OUR
2019/20 QUALITY REPORT

WHAT IS A **QUALITY REPORT**

All providers of NHS Services in England are required to produce an Annual Quality Report. The purpose of a Quality Report is to inform the public about the quality of services delivered by us. Quality Reports enable NHS Trusts to demonstrate commitment to continuous, evidence based quality improvement and to explain progress to the public.
This is our twelfth Quality Report.

PART 1:
STATEMENT FROM THE CHIEF EXECUTIVE

I am pleased to present the 2019/20 Quality Report for Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (WWL).

We are immensely proud to provide healthcare services to both the people of Wigan and those from further afield and we set high standards in relation to the care we provide and the services we offer. Quality underpins everything that we do at WWL and informs our most strategic decision-making. By way of example, in April 2020 we became a teaching hospital which is the first step in our longer-term ambition to become a university teaching hospital. For us, the move to become a teaching hospital and ultimately obtaining university hospital status is synonymous with the delivery of the highest standards of patient care and in our soon-to-be-released ten-year strategy we will set ourselves the aim of being outstanding in everything we do. In October and November 2019 we were rated as 'Good' overall by the Care Quality Commission, as well as being rated 'Good' across each of the five key domains – safe, effective, caring, responsive and well led. Our use of resources was similarly determined to be 'Good' by NHS Improvement. All of our acute sites have individually been rated as 'Good' with the Thomas Linacre Centre being rated as 'Outstanding'.

In its inspection report, the CQC highlighted a number of areas of outstanding practice, including:

- The establishment of an independent domestic violence advocacy service for patients and staff;
- Our dedicated innovation investment fund and our dragon's den style approach to allocation of the funding;
- The use of Holmium laser equipment to provide day case treatment for patients with prostate cancer which limits the need for admission and for more invasive surgery;
- The piloting of hip replacement surgery as a day case procedure which significantly reduces the time spent in hospital for patients undergoing hip surgery;
- The development of a critical care patient acuity and staffing risk assessment tool within critical care to ensure that nurse staffing is safe and appropriate to the needs of the patients and the unit; and
- The approach to management of emergencies within our maternity department.

During the year we have continued to follow our Quality Strategy 2017-21 and our quality priorities for the coming year have been set out later in this report as part of our aim to move towards zero avoidable harm by 2021. Over the next twelve months we will be developing the next iteration of our Quality Strategy which will be linked to our overall organisational strategy.

"I would like to take this opportunity to place on record my thanks to all staff, both clinical and non-clinical, who work tirelessly to provide excellent care to our patients.

It does not go unnoticed."

We recognise that delivery of quality is dependent on a number of factors, the most significant of which is our workforce. We believe in the importance of fostering and maintaining a positive culture and we aim to be the employer of choice in the borough and beyond. We know that when staff feel happy and comfortable at work they go on to deliver better quality services, and we are committed to doing what we can to make WWL an outstanding place to work. I would like to take this opportunity to place on record my thanks to all staff, both clinical and non-clinical, who work tirelessly to provide excellent care to our patients. It does not go unnoticed.

We also recognise the importance of learning lessons when things do not go as planned and during the year we have focused on improving the quality of responses to any complaints we receive. This not only serves to improve the experience of those who make contact with us to share their concerns but also allows us to undertake a more systematic review of lessons so that these can be shared across the organisation.

The Board of Directors is committed to quality and WWL continues to actively participate in a number of initiatives, such as NHS QUEST which is a network of foundation trust that work together collaboratively with the triple aim of improving quality and safety, leading the way in technology-enabled innovation and striving to be the best employers in the NHS. We firmly believe that working with other organisations who are as committed to the quality agenda as we are, can only be beneficial for all concerned and we work hard to make sure that organisational boundaries do not prevent the improvement of services for the benefit of our patients.

This report sets out our performance in detail and I am pleased to confirm that, to the best of my knowledge, the information it contains is an accurate and fair reflection of our performance.

Silas Nicholls
Chief Executive and Accounting Officer

PART 2:
PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCES FROM THE BOARD

PART 2.1:
PRIORITIES FOR IMPROVEMENT IN 2020/21

This is the 'look forward' section of our Quality Report. In April 2017 we were delighted to publish our Quality Strategy 2017/21 outlining the framework to improve quality over the next four years. This section outlines the improvements we plan to take over the next year. Over the next twelve months we will be developing the next iteration of our Quality Strategy which will be linked to our overall organisational strategy.

Quality Strategy 2017/21

Our Quality Strategy 2017/21, published in April 2017, set the direction of travel for the next four years. The aim of the strategy is:

"To move towards zero avoidable harm by 2021 through continual reduction"

The Quality Strategy maintains our values to provide safe, effective and compassionate care. The strategy focuses on five primary drivers:

Quality Priorities for 2020/21

We have agreed our annual priorities for 2020/21 which support our Quality Strategy 2017/21 and consider some of our challenges. The annual priorities were agreed following consultation with staff and stakeholders including Governors, Wigan Borough Clinical Commissioners Group and Healthwatch Wigan and Leigh. The quality priorities, the rationale for their selection and how we plan to monitor and report progress are outlined opposite.

All quality priorities have a timescale for achievement by the 31st March 2021 and progress to achieve them is monitored by our Quality and Safety Committee.

The Trust is committed to driving forward these quality priorities and the improvements required. It should be noted that the management of the COVID-19 pandemic and associated actions remains one of the Trusts greatest priorities.

Patient Safety (Safe)

Priority 1:	**95% of patients with Red Flag sepsis will receive antibiotic treatment within 1 hour in both Accident and Emergency (A&E) and on wards**
Rationale:	Red Flag sepsis requires treatment within an hour of diagnosis, and patients should receive antibiotics during within an hour. If sepsis is not treated early, it can become life threatening.
Monitoring:	Quarterly monitoring Reported within Divisional Quality and Safety reports as outlined by the metrics below: • % of patients who received antibiotics within 1 hour in A&E; • % of patients who received antibiotics within 1 hour on wards.
Reporting:	Divisional Governance meetings (DQEG) Quality and Safety Committee

Priority 2:	**95% of patients with an elevated NEWS2 score (5 in total or 3 in one domain) will be screened for Sepsis in A&E and on the wards**
Rationale:	Sepsis screening is associated with a decreased mortality rate. The surviving sepsis campaign (SSC) guidelines emphasise routine screening of potentially infected patients who are likely to be septic to improve the early identification and treatment of sepsis
Monitoring:	Quarterly monitoring Reported within Divisional Quality and Safety reports as outlined by the metrics below: • % of patients who received a sepsis screen within 1 hour in A&E; • % of patients who received a sepsis screen within 1 hour on wards.
Reporting:	Divisional Governance meetings (DQEG) Quality and Safety Committee

Priority 3:	**To reduce grade 3, grade 4 and unstageable pressure ulcers contributed to by lapses in care by 50%**
Rationale:	WWL wants to continue the work that has been already undertaken to reduce grade 3, grade 4, and unstageable pressure ulcers occurring both within the acute setting and within the community due to lapses in care.
Monitoring:	Monthly monitoring Reported within Divisional Quality and Safety reports as outlined by the metrics below: • Number of pressure ulcers as described that have developed due to lapses in care
Reporting:	Divisional Governance meetings (DQEG) Quality and Safety Committee

Priority 4:	**To reduce the number of CDT infections by 20% where there have been lapses in care**
Rationale:	Infection with Clostridium difficile - (CDT) is the most common cause of hospital-acquired diarrhoea in the developed world. Prudent prescribing of antibiotics, correct hand hygiene, the use of personal protective equipment, environmental decontamination and isolation can prevent infection.
Monitoring:	Monthly monitoring Reported within Divisional Quality and Safety reports as outlined by the metrics below: • Number of CDT infections that have developed due to lapses in care
Reporting:	Divisional Governance meetings (DQEG) Quality and Safety Committee

Clinical Effectiveness (Effective)

Priority 1:	**To achieve a Summary Hospital Level Mortality Indicator (SHMI) within the expected range**
Rationale:	WWL's SHMI has increased in recent months following a period of improvement. The Trust is currently in Band 1 (worse than expected) with a SHMI of 1.17 for the rolling 12 month period March 2019 – February 2020. Further work is required to improve WWL's position to move into Band 2 (as expected).
Monitoring:	Monthly SHMI reviews Monitoring of Divisional Pathway SHMI including Trauma and Orthopaedics, to be included in Divisional reporting to the Quality and Safety Committee.
Reporting:	Monthly mortality meetings Quality and Safety Committee

Priority 2:	**Compliance with the National Patient Safety Strategy (NPSS)**
Rationale:	To deliver improvements in patient care and experience in line with NPSS requirements. The following improvements are required within the organisation: • 87% of patients to benefit from the use of the emergency laparotomy care bundle; • Increase the use of the COPD discharge bundle by 50% over baseline; • Increase the use of the ED Checklist by 50% over baseline.
Monitoring:	Quarterly monitoring Reported in Divisional Quality and Safety reports as the metrics below: • % of patients who receive the emergency laparotomy care bundle; • % of patients who receive the COPD discharge bundle; • % of patients who have the ED checklist completed.
Reporting:	Divisional Governance meetings (DQEG) Quality and Safety Committee

Patient Experience (Caring)

Priority 1:	**To ensure all complaint responses are timely and have learning identified and demonstrable action is taken**
Rationale:	To improve our patients experience of care and ensure learning from patient feedback is embedded into practice
Monitoring:	Quarterly monitoring Reported in Divisional Quality and Safety reports as the metrics below: • 90% of complaints responded to on time; • 100% of complaints with an improvement plan to address learning where it is identified (i.e. for all fully and partially upheld complaints).
Reporting:	Divisional Governance meetings (DQEG) Quality and Safety Committee

Priority 2:	**To improve patients experience of discharge**
Rationale:	Improving discharge from hospital is one of the Trust's key patient experience priorities.
Monitoring:	Monthly monitoring Reported in Divisional Quality and Safety reports the metrics below: • 100% of discharge checklists completed; • 100 % of discharge summaries provided to the patient (and GP); • 50% reduction of upheld complaints and incidents relating to discharge.
Reporting:	Divisional Governance meetings (DQEG) Quality and Safety Committee

Priority 3:	**To embed an organisational culture of psychological safety, civility and respect**
Rationale:	It is essential that staff are provided with civility, respect and psychological safety as it is recognised that this is a key enabler to safe and effective care.
Monitoring:	Quarterly monitoring • Your Voice Survey: score above 3.6 or an improvement of >0.1 on each of the areas (Working Relationships, Psychological Safety, Influence, Clarity); • National Staff Survey: score of 7, or an improvement >0.2 on each of the identified areas (Immediate Managers, Team Working, Health and Wellbeing at Work, Staff Engagement and Morale); • Psychological Safety: scores above 3.6, or an improvement >0.1 for the three areas (Conditions, Beliefs and Behaviours).
Reporting:	People Committee Quality and Safety Committee

PART 2.2
STATEMENTS OF ASSURANCES FROM THE BOARD

We are required to include formal statements of assurances from the Board of Directors which are nationally requested to give information to the public. These statements are common across all NHS Quality Reports.

2.2.1 Review of Services

During 2019/20 Wrightington Wigan and Leigh NHS Foundation Trust ("WWL") provided and/or sub-contracted 68 relevant health services detailed in the Trust's mandated services including the Wigan Community Adults and Children's services which transferred from Bridgewater Community NHS Trust in April 2019.

WWL has reviewed all the data available to them on the quality of care in these relevant health services.

The income generated by the relevant health services reviewed in 2019/20 represents 93% of the total income generated from the provision of health services by WWL for 2019/20.

NHS Trusts are required to include this statement in their Quality Account to demonstrate that they have considered the quality of care across all the services delivered across WWL for inclusion in this Quality Account, rather than focusing on just one or two areas.

2.2.2 Participation in Clinical Audits

During 2019/20, WWL participated in 27 National Clinical Audits and 6 National Confidential Enquiries covering relevant health services that WWL provides. In addition WWL participated in a further 16 National Audits (Non-NCAPOP) recommended by HQIP.

The National Clinical Audits and National Confidential Enquiries that WWL participated in and for which data collection was completed during 2019/20 is listed in Appendix A alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry.

The reports of National Clinical Audits were reviewed by the provider in 2019/20 and WWL intends to take the following actions to improve the quality of healthcare provided. Other national reports will be presented once published.

Audit	Trust Actions
Sentinel Stroke National Audit programme (SSNAP)	The SSNAP audit data is reviewed regularly and discussed at all Operational Delivery Network (ODN) Meetings. It is used to highlight areas that need improvement both locally and within Greater Manchester, and ideas identified on how the ODN can support WWL to improve areas when needed.
National Paediatric Diabetes Audit (NPDA)	The national audit showed case-mix adjusted mean HbA1c (mmol/mol) was 76.2 which is a negative outlier compared to national aggregate of 67.5. Quality Improvement (QI) sessions were held monthly with implementation of a pathway which continues to show improvements.
National Emergency Laparotomy Audit (NELA)	The Trust now has a NELA Nurse Practitioner who drives forward quality improvement initiatives from yearly reports, sharing best practice and benchmarking care delivery against national standards which aims to improve mortality and morbidity in emergency laparotomy patients.
National Joint Registry (NJR)	Regular updates are provided at audit meetings and areas for improvement highlighted. **The Information from the 2017/18 Audit is as follows:** **Wrightington site:** Total number of Hip/Knee replacements was 3098. There were 3078 operations (99.4%) that matched the NJR and 20 unmatched operations (0.6%) of which 12 had not been submitted to the NJR, 4 had an incorrect operation date and 4 had an incorrect operation surgeon. There were a further 13 operations that had been correctly submitted to the NJR that did not match with what had been coded. **Wigan site:** Total number of Hip/Knee replacements was 111. There were 93 operations (83.8%) that matched the NJR and 18 unmatched operations (16.2%) of which 10 had not been submitted to the NJR, 4 coded as operation being performed at Wrightington and 3 had an incorrect operating surgeon There were a further 16 operations that had been correctly submitted but did not match with what had been coded.

The reports of 155 (to the end of Q3) Local Clinical Audits were reviewed by the provider in 2019/20. A selection of these audits is outlined below and WWL has taken or intends to take the following actions to improve the quality of healthcare provided:

Audit	Trust Actions
Termination of Pregnancy (TOP)	Improvement in documentation and since provided following the introduction of a pathway and check list. Documentation is now almost 100% in all areas.
Outcome Form Audit in Ophthalmology	Improvement of outcome forms in outpatients to 97% completion compared to previous outcome of 47% as a result of a training session to educate staff on how to complete forms.
Pre-operative Airway Assessment	Improvement in documented airway assessment in 80% of patients (previously 73% in 2017 and 48% in 2015) and improvement in airway assessment by anaesthetising anaesthetist has improved to 100% (91% in 2017 and 80% in 2015) as a result of adhering to 4 National Audit Project (NAP) standards. This is the largest study of major complications of airway management every performed, and following previous audit recommendations.
Audit of Low Grade Smears	Improvement in offer of appointments within 6 weeks (99.8% vs 91% in previous audit). Improvement in achieving suitable biopsy for histopathology (98.6% vs 96% in previous audit). Improvement for communication of results to patient; (87.5% within 4 weeks (best practice) compared to average of 46% last year). This was achieved following lengthy discussion and raised awareness at the audit meeting regarding the recommendations.
uDNACPR 2019	Improvement in overall compliance as a result of actions taken by the Task and Finish Group following MIAA Internal Audit Results.

Audit Actions are monitored at monthly audit meetings as well as at Divisional Quality Executive meetings. Actions are signed off as complete (on the audit database) when feedback is relayed back to the audit department by those responsible for implementing the actions.

National clinical audits are primarily funded by the Department of Health and commissioned by the Healthcare Quality Improvement Partnership (HQIP) which manages the National Clinical Audit and Patients Outcome Programme (NCAPOP). Although National Clinical Audits are not mandatory, organisations are strongly encouraged to participate in those that relate to the services they deliver. It is mandatory to publish participation in National Clinical Audits in a Trust's Quality Report. A high level of participation provides a level of assurance that quality is taken seriously and that participation is a requirement for clinical teams and individual clinicians as a means of monitoring and improving their practice. Local Clinical Audit is also important in measuring and benchmarking clinical practice against agreed standards of good professional practice.

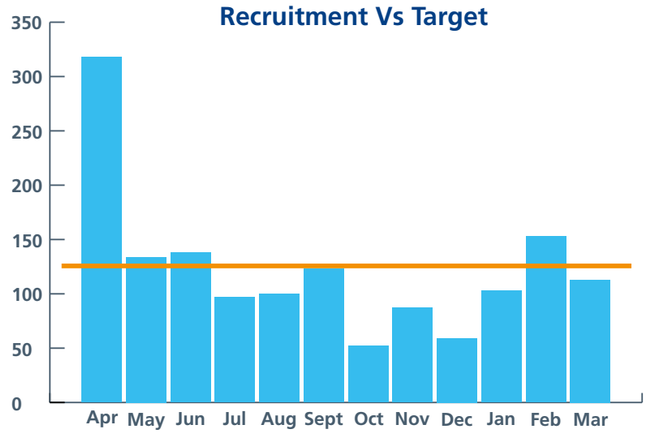
2.2.3 Research

Participation in Clinical Research

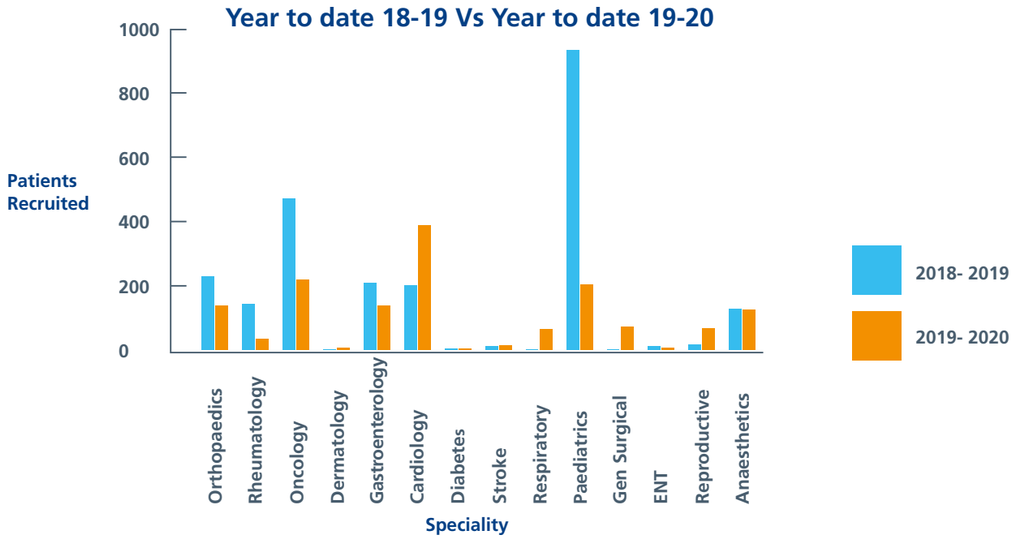
The number of patients receiving relevant health services provided or sub-contracted by WWL in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee registered and adopted onto the 'National Institute for Health Research (NIHR) Portfolio') was 1477 an average of 123 patients per month. The Trust target agreed with the National Institute for Health Research (NIHR) was 1455 recruits (an average of 122 per month).

Patient Recruitment 2019/20

The following chart illustrates target recruitment versus actual recruitment to research studies in 2019/20.

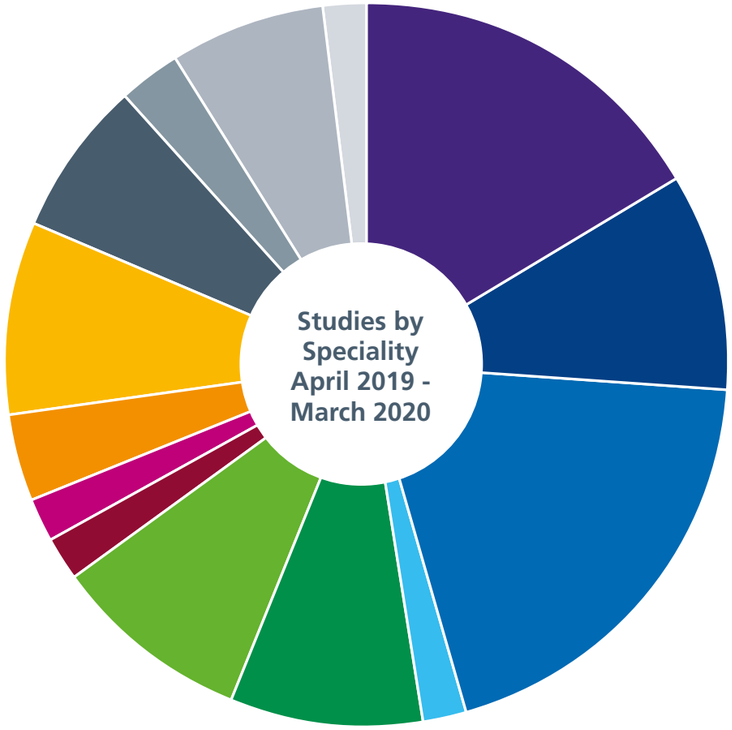


Participation in clinical research demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff are continually updated about the latest treatments. We were involved in conducting 102 NIHR Portfolio clinical research studies in addition to Non Portfolio studies in a variety of specialities during the year 2019/20.
The chart below illustrates the recruitment by speciality.



2019/20 saw the successful application for funding via the National Institute for Health Research (NIHR). Two Orthopaedic Surgeons received substantial funding awards totalling more than £2million.

The chart below illustrates the variety of disease areas where the Trust has participated in National Institute for Health Research registered studies between 1st April 2019 and 31st March 2020.



It is globally recognised that a commitment to clinical research leads to better outcomes for patients. We are continuously scrutinised and the data provided is monitored by recognised, expert teams who ensure that confidentiality and the conduct of every trial meets European Legislation.

An example of the esteem held for our work at WWL is illustrated in the comment below:

"I just wanted to give you a little bit of feedback on the study after I've spent the day here monitoring. The patient notes and source data for the study are absolutely brilliant – the worksheets that you have created for every visit are invaluable too – every data point can be verified and this makes the patient notes so much easier to monitor. I honestly wish that I could use your site as an example to other sites because you have achieved a level of attention to detail for the trial data that we are constantly asking sites to strive towards."

Once again the Trust has been recognised at a regional awards ceremony in a number of categories. This includes engagement with our Patient Public team led by Dr Jane Martindale.

Our Research Strategy aims to include all clinical staff in research. Every year the Research Department identifies a clinical area for promoting and supporting research. This has proved successful and areas of interest have greatly increased with strong recruitment in the following clinical specialities:

Rheumatology, Cardiology, Diabetes, Surgery, Respiratory, Paediatrics, Obstetrics, Cancer, Ear Nose and Throat (ENT), Gastroenterology, Dermatology, Musculo-skeletal and Infection Control, Fertility and Ophthalmology.
The Trust was one of the first in the country to set up an interventional

trial for finding a suitable treatment for COVID-19 and we are continuing to support the fight going into year 2020/2021.

Training and Development opportunities are provided by the Research Department to support staff in conducting quality research studies in a safe and effective manner. All staff that support clinical research activity are trained in Good Clinical Practice (GCP) which is an international quality standard transposed into legally required regulations for clinical trials involving human subjects.

The development of our Research Patient Public Involvement (PPI) group influences the way that research is planned. They help to identify which research questions are important.

By influencing the way research is carried out we aim to improve the experience of people who take part in research.

Publications have resulted from both our engagement in NIHR Portfolio research and Foundation Trust supported research, which has secured Ethical Approval.

It is important that we continue to support both pilot studies in preparation for larger research projects and smaller research studies which do not qualify for adoption onto the NIHR Portfolio because they do not require access to a funding stream. This shows our commitment to transparency and our strong desire to improve patient outcomes and experience across the NHS.

The clinical research team supports all clinical teams conducting research studies, ensuring the safe care of patients and adherence to the European Directive, Good Clinical Practice guidelines and data collection standards. As a result of this expert support, the larger clinical community within the Foundation Trust is in a position to conduct a wide variety of clinical research which will ultimately provide better access to research for our patients.

Research is a core part of the NHS, enabling the NHS to improve the current and future health of the people it serves. 'Clinical research' refers to research that has received a favourable opinion from a Research Ethics Committee within the National Research Ethics Service (NRES). Trusts must keep a local record of research projects.

2.2.4 Goals agreed with Commissioners

2.2.4 Use of the Commissioning for Quality and Innovation (CQUIN) Payment Framework

A proportion of WWL's income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between WWL and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. Further details of the agreed goals for 2019/20 and for the following 12 month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

WWL received £3.3m in relation to CQUINS for 2019/20, in comparison with £5.5 million in 2018/19 although it should be noted that the total available reduced and therefore this is not a fair comparison. In addition due to the Covid-19 pandemic quarter 4 activities were suspended resulting in an estimate of the final position.

For acute services all of the schemes in 2019/20 were nationally mandated and covered the following areas:

1. Antimicrobial Resistance – Lower Urinary Tract Infections in Older People
2. Antimicrobial Resistance - Antibiotic Prophylaxis in Colorectal Surgery
3. Staff Flu Vaccinations
4. Alcohol and Tobacco Screening
5. Tobacco Brief Advice
6. Alcohol Brief Advice and Onward Referral
7. Three High Impact Actions to Prevent Hospital Falls
8. Same Day Emergency Care for the following conditions
    - **a.** Pulmonary Embolus
    - **b.** Tachycardia
    - **c.** Community Acquired Pneumonia

Whilst the schemes were suspended during quarter 4 significant progress was made in a number of areas during the year particularly in relation to antibiotic prophylaxis in colorectal surgery and high impact actions to prevent hospital falls. Throughout the year the Trust reported full compliance with alcohol and tobacco screening, alcohol brief advice and onward referral and same day emergency care.

For community services the schemes were locally agreed and were as follows:

1. Reducing Deterioration of Pressure Ulcers (PURA Form) – District Nursing Service
2. Preventing ill health by Risky Behaviours – 0-5's Health Visiting Service
3. Implementing Specialist Falls Prevention Training – Community Response & Falls Teams
4. Reducing the Impact of Serious Infections: Timely Identification of Patients with Sepsis by District Nursing Services

As with the acute service schemes, good progress was made until much of the activity was suspended during quarter 4. Progress in relation to the sepsis scheme was slow due to the lack of some key equipment in the community but this was resolved in quarter allowing for some work to be done during that period.

Schemes for 2020/21 were launched during March 2020 but all work on them was suspended as the pandemic took hold in the UK.

The CQUIN payment framework aims to embed quality at the heart of commissioner-provider discussions and indicates that we are actively engaged in quality improvements with our commissioners. Achievement of the CQUIN quality goals impacts on income received by WWL.

"The CQC notes how both leaders and staff are proud of their services and to work for the Trust and staff are praised on their dedication, patient focus and the way in which staff treat patients with compassion and kindness."

2.2.5 What others say about WWL

Statements from the Care Quality Commission (CQC)

WWL is required to register with the Care Quality Commission and its current registration status, at the end of 2019/20, is registration without conditions on the registration.

The Care Quality Commission (CQC) has not taken enforcement action against WWL during 2019/20.

WWL has not participated in any special reviews or investigations by the CQC during the reporting period.

During 2019/20 the CQC undertook a core service inspection between 22 and 24 October 2020. The CQC inspected the Surgery, Maternity and Critical Care Core Services and visited Leigh Infirmary, Wrightington Hospital and the Royal Albert Edward Infirmary sites.

The Use of Resources Inspection occurred on 11 November 2019 and the Well-Led Inspection between 26 and 28 November 2019.

The CQC subsequently published a combined quality and resource rating report on 26 February 2020. The reports can be accessed via the link on the Trust's website or by accessing the CQC's website via **https://www.cqc.org.uk/provider**

The overall CQC rating for WWL was 'Good' and WWL has maintained a rating of 'Good' for every domain (safe, effective, caring, responsive and well-led). Our Use of Resources was also rated as 'Good'.

An astonishing 100% of our services and locations are now rated either 'Outstanding' or 'Good' by the CQC, the two highest ratings. We are immensely proud of this and it is a reflection of the hard work, compassion and professionalism of all our staff.

The CQC notes how both leaders and staff are proud of their services and to work for the Trust and staff are praised on their dedication, patient focus and the way in which staff treat patients with compassion and kindness.

The CQC inspected three core services across the RAEI, Wrightington and Leigh hospital sites including; Surgery, Maternity and Critical Care, all of which were rated 'Good' overall.

The CQC highlighted examples of outstanding practice in all three services including:-

Maternity:

The CQC highlighted an "Emergency Response Station" developed by one of our senior midwives, improving the quality of care in an obstetric or neonatal emergency, and the support the service provides to women who had delivered and were being cared for in the critical care unit.

Maternity services improved in three of the five domains (safe, effective and well-led) and is now rated 'Good' overall, an improvement from the 2017 CQC inspection and a credit to our staff that work in and support this service.

Critical Care:

The CQC highlighted the "TEA-ching" training programme developed by our practice educators, involving a 10 minute teaching break each day, and also the critical care patient acuity and staffing risk assessment tool the service has designed, helping to ensure that nurse staffing on the unit was safe and adequate for the patient and unit's needs. The Critical Care service maintained a rating of 'Good' overall and in all five domains.

Surgery:

At the RAEI site the CQC highlighted the use of innovative approaches within the service to ensure the highest quality of care we provide to our patients, including alarm clocks for those patients who require time sensitive and critical medicines. They also highlighted the innovation seen by the 10 successful 'Dragons Den' bids within the service to help deliver improvements in patient care, staff experience and financial benefits. This includes the Wrightington Hospital which was praised on their work around piloting the day case hip replacement surgery and Leigh Infirmary with the successful funding for Holmium laser equipment to provide day case treatment for patients with prostate cancer. Both of these initiatives have a positive impact on patient care through less invasive surgery and less time in hospital.

Our Surgery core service maintained a rating of 'Good' overall at all three locations (RAEI, Leigh Infirmary and Wrightington). However, we were rated 'Requires Improvement' for the 'safe' domain at RAEI and Wrightington. The Trust acknowledges and recognises the commitment and dedication of staff working within this service, both for WWL and the quality of patient care you provide.

WWL always welcomes feedback and inevitably the inspection did identify some areas for improvement. Action plans are already in place to address these, with some already underway following the initial feedback. These include; a Trust-wide review of the storage of cleaning products, addressing a number of issues identified by the CQC regarding the Theatre environment, consistency of risk management processes, storage of patient records, paediatric resuscitation training compliance and the visibility of senior leaders.

The Trust continues on our improvement journey to be Outstanding in everything that we do, working together to ensure that our patients and community continue to receive the best possible care.

Below are some of the highlighted CQC comments included in the final report:

- "Leaders and staff were patient focussed and proud to work for the Trust";
- "The trust had a culture of openness and honesty and processes to support people speaking up";
- "The trust had transparent, collaborative and open relationships with all relevant stakeholders, particularly in the Wigan borough";
- "The trust had an integrated governance structure with processes to support ward to board assurances. Structures, processes and systems of accountability were clear and understood by staff, and were going to be reviewed shortly";
- "The trust had a strong track record of financial performance and delivery of most national performance standards";
- "The trust's performance reporting gave a holistic understanding of quality, performance and finance and incorporated the views of patients";
- "The trust had a track record of using improvement methods and skills which is used at all levels of the organisation".

A review of how the Trust uses its resources concluded that the Trust has been able to demonstrate an improvement across a range of metrics together with an increase in collaborative working, both across the local health economy and wider systems, and in particular a greater use of technology to drive efficiencies and provide high quality care.

All NHS Trusts are required to register with the Care Quality Commission. The CQC undertakes checks to ensure that Trusts are meeting the Fundamental Standards and Key Lines of Enquiry (KLOE) under safe, effective, caring, responsive and well-led. If the CQC has concerns that providers are non-compliant there are a wide range of enforcement powers that it can utilise which include issuing a warning notice and suspending or cancelling registration.

2.2.6 NHS Number and General Medical Practice Code Validity

WWL submitted records during 2019/20 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS number was:

- 99.9% for admitted patient care,
- 100% for outpatient care, and
- 99.5% for accident and emergency care.

- which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care,
- 100% for outpatient care, and
- 99.8% for accident and emergency care.

The patient NHS number is the key identifier for patient records. Accurate recording of the patient's General Medical Practice Code (Patient Registration) is essential to enable the transfer of clinical information about the patient from a Trust to the patient's General Practitioner (GP).

2.2.7 Data Security Protection Toolkit

In 2019/20 submission of the Data Security and Protection Toolkit was delayed due to the COVID response. This is based on the National Data Guardian's ten data security standards. In 2019/20 the Trust did not meet all of the Data Security Plans; however an action plan has been submitted and agreed with NHS Digital.

Information Governance ensures necessary safeguards for, and appropriate use of, patient and personal information. The Data Security and Protection Toolkit is a performance tool produced by the Department of Health (DH) and now hosted by NHS Digital. It draws together the legal rules and central guidance related to Information Governance and data security.

2.2.8 Clinical Coding Error Rate

WWL was not subject to the Payment by Results clinical coding audit during 2019/20 by NHS Improvement. WWL commissioned an external audit by Blackpool Teaching Hospitals NHS foundation Trust to comply with Data Security and Protection. The audit was conducted in December 2019 for assurance of clinical coding quality.

- Primary Diagnosis incorrect 4.0%
- Secondary Diagnosis incorrect 5.66%
- Primary Procedures incorrect 1.43%
- Secondary Procedures incorrect 5.08%

The Trust achieved the advisory assertion levels for both Clinical Coding Standards of

- Data Security Standard 1 Audit and
- Data Security Standard 3 Training

The results should not be extrapolated further than the actual sample. 200 finished consultant episodes (FCEs) were selected by the auditor across the range of specialities and these cases were reviewed in terms of clinical coding accuracy.

Clinical coding translates the medical terminology written by clinicians to describe a patient's diagnosis and treatment into standard recognised codes. The accuracy of this coding is a fundamental indicator of the accuracy of patient records.

2.2.9 Statement on relevance of Data Quality and your actions to improve your Data Quality

Accurate and timely data is essential to good intelligence and making sound clinical and strategic decisions. Although the Trust already has historically had good Data Quality however 2019/2020 has seen a notable reduction in this from the top 7th percentile to the bottom 23rd percentile with the Model Hospital, which in part is a result of taking on the Community Service provision in April 2019. The Trust recognises this and will always acknowledge where improvements can be made.

Over the last 12 months the Trust has a continuing programme of work for the development and improvement of the Data Quality. The Trust is getting ready to release the latest iteration of the (DQ) app with in the Acute setting with a view to include the Community Division in the coming months. The purpose of the app is to provide frontline services with clear visibility on where there are issues or areas of concern. Again this will allow the individuals and services entering the data to investigate and remedy any issues, as well also learning for the future.

This supports the NHS Get It Right First Time (GIRFT) approach and is aligned to Article 5 of the General Data Protection Regulation (GDPR) WWL will be taking the following actions to improve data quality: The Trust will continue to develop and roll out the next interation of DQ app ensuring that Key Performance Indicators across all services are reviewed, amended, added to and utilised to support the Trusts ability to give assurance and continue improvement against the DQ Programme.

Good quality information underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made. The Board of Directors is required to sign a 'Statement of Directors' Responsibilities in respect of the Quality Report part of which is to confirm that data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.

2.2.10 Learning from Deaths

During 2019/20 (1.2%) (Q1, Q2, Q3, Q4) of WWL patients died (1222). This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 312 in the first quarter;
- 270 in the second quarter;
- 330 in the third quarter;
- 310 in the fourth quarter.

WWL has had a process for reviewing deaths for over ten years. WWL commenced the review of deaths in a structured way that met the Learning from Deaths Guidance published in March 2017.

By March 2020, 627 case record reviews and 627 investigations have been carried out in accordance with the Learning from Deaths Guidance in relation to 51% of the deaths referenced in the introduction. In 627 cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was;

- 108 in the first quarter;
- 174 in the second quarter;
- 226 in the third quarter;
- 209 in the fourth quarter.

7 representing, 0.5% of 1222 deaths in 2019/20, of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- 1 representing, 0.3% of deaths which occurred for the first quarter;
- 2 representing, 0.3% of deaths which occurred for the second quarter;
- 2 representing, 0.6% of deaths which occurred for the third quarter;
- 3 representing, 0.9% of deaths which occurred for the fourth quarter,

These numbers have been estimated using a version of the Royal College of Physicians Structured Judgement Review methodology supported by the Learning from Deaths Guidance. A summary of what WWL has learnt from case record reviews, and investigations conducted in relation to deaths identified above, is as follows:

- Concerns were highlighted regarding Vascular access.
- Drug omissions are a known area for improvement. There are continued episodes of drug omissions despite the evidence of improvement from previous interventions.
- Care of sepsis remains a priority for the Trust and includes escalation as well as response to sepsis where it occurs.
- Non Invasive Ventilation (NIV) and overnight Continuous Positive Airway Pressure (CPAP) has been omitted in some cases.
- Bleeding where the source is hidden. This has been noted previously and is usually related to Gastrointestinal Bleeding or intra-abdominal bleeding.
- Problems with discharge have become increasingly evident.
- Complex system failure is a recognised problem. Difficulties with transfer across organisations is typically present. Significant examples are in Dialysis, PPCI, Vascular Surgery, Neurosurgery and Stroke.
- Complications of surgery are well recognised, but there were significant complications. Perforation of oesophagus required further investigation. There was a death related to surgery that was considered to be of limited benefit.
- Overload is a significant theme to the cases that have been noted. It is typically present as a contributory factor rather than the only issue. It links to NIV beds, to recognition of pelvic bleeds and to extended stay in A/E. Its also linked to omitted drugs and to sepsis care. When considered across organisations its also linked to complex system failure where beds are too full to receive transfers.

A description of the actions WWL has taken in the reporting period and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period: Some of the actions taken include the following:

- To address issues with vascular access, the Trust has extended the Vascular Access Team to include two whole time equivalents. Along with other services the COVID pandemic has brought changes and alterations to the clinical needs of patients. Reassessment will be needed.
- The recent COVID pandemic has altered the landscape for ventilatory support across the organisation. Significant increases in non ventilatory support (in the form of CPAP) were needed in order to manage the outbreak. Reassessment of the service provision will be needed in the light of changed clinical landscape.
- There are initiatives being implemented throughout the Trust to support staff in clinical areas with timely administration of medications. Pharmacy technicians are now assisting with medication rounds on assessment areas and also Practice Educators are based on wards to support staff in medication administration training. These initiatives should result in a reduction of drug commissions which will be monitored during 2020/21.
- There is on-going work with sepsis care with the implementation of an electronic pathway.
- To ensure safe care of patients in A&E, the emergency care bundle has been implemented.
- The Trust held a themed SIRI panel focusing on patient discharge. This event identified areas of learning. A task and finish group has been established and actions taken from this event are progressing. The Trusts Chief AHP will lead these actions during 2020/21.

In the time since the work was done the landscape of clinical care in hospitals has been immeasurably changed by the COVID outbreak. There are different models of care and different expectations. It is unlikely that the clinical landscape will return to its previous normal. Rather a new normal will evolve and require new understanding and new clinical developments. The work will be similar but its outcomes likely to be different.

In March 2017 the National Quality Board published a document called 'National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care'. The purpose of the guidance was to help initiate a standardised approach to learning from deaths.

2.2.11 Seven Day Services

The latest available data for compliance against the priority clinical standards for seven days services was published in November 2019 although comparator data is no longer available so it is not possible to undertake a peer comparison. The November submission measured performance against the 4 four priority standards listed below and a self-assessment against the other six standards for continuous improvement.

- Standard 2: Time to first consultant review
- Standard 5: Access to diagnostic tests
- Standard 6: Access to consultant-directed interventions
- Standard 8: Ongoing review by consultant twice daily if high dependency patients, daily for others

The performance since March 2016 is shown below (gaps are where the data wasn't part of the national data collection tool)

WWL Results	Weekday Results				Weekend Results			
	Standard 2	Standard 5	Standard 6	Standard 8	Standard 2	Standard 5	Standard 6	Standard 8
Mar-16	61%			100%	58%			97%
Sep-16	74%				59%			
Mar-17	81%	100%	100%	98%	84%	68%	89%	64%
Sep-17	82%				94%			
Jun-18	89%	100%	100%	100%	71%	83%	100%	100%
Jun-19	96%	100%	100%	100%	95%	83%	100%	100%
Nov-19	91%	100%	100%	100%	82%	83%	100%	100%

In relation to Standard 2 at the weekend it should be noted that this is based on a small sample of patients (28), 5 of whom did not see a Consultant within 14 hours. All patients have been reviewed by the Medical Director and no harm was identified. The sample was too small to identify themes and a wider audit was planned but this was put on hold due to the Covid-19 pandemic.

In relation to standard 5 access to echocardiography remains available via informal arrangement only at the weekend. Patients who need this test urgently will have it carried out but the standard requires there to be a formal agreement to be in place. There are no plans to change the Trust approach at present.

The Trust is compliant with all six of the standards for continuous improvement. Reporting on Seven Day Service standards has now been suspended indefinitely and there is no indication that this will be reinstated.

Ten clinical standards for seven day services in hospitals were developed in 2013. These standards define what seven day services should achieve, no matter when or where patients are admitted. Four of the ten clinical standards were identified as priorities on the basis of their potential to positively affect patient outcomes. NHS Trusts are required to include a statement in their Quality Report regarding implementation of the priority clinical standards for seven day hospital services.

2.2.12 Speaking up

#SpeakUp ToMe

WHO CAN YOU SPEAK UP TO?

The Trust aims to ensure that staff feel comfortable and safe to raise concerns with their line managers in the first instance. Concerns may relate to quality of care, patient safety or bullying and harassment. We recognise that by valuing our staff who raise concerns, listening and acting on the issues, speaking up can really make a difference to staff wellbeing and patient safety. When a concern is raised with managers it is important that they know how to handle the concern and have the correct escalation processes to ensure action is taken to resolve those concerns.

If staff do not feel able to raise concerns with their managers or they are unsatisfied with any feedback they have been given there are other routes available to staff. Staff can raise concerns with their Union, Human Resources or with the Trusts Freedom the Speak Up Guardian. One of the critical roles of the Freedom to Speak Up Guardian is to ensure that staff raising concerns do not suffer detriment. The Freedom to Speak Up Guardian can also provide the following support:

- an independent route and safe space for staff to raise concerns;
- report or escalate concerns on the behalf of the staff;
- act as an advocate for staff and protect identity of staff wishing to remain anonymous;
- obtain information or act as a 'go between' within any investigation into a concern;
- agree support, ongoing communications and feedback on the progress of any investigation.

The Trust is committed to ensuring that concerns raised by staff are treated seriously and dealt with in a sensitive, positive manner and as quickly as possible. In 2019/20 the Trust appointed a fulltime Freedom to Speak Up Guardian.

In its response to the Gosport Independent Panel Report, the Governance committed to legislation requiring all NHS Trusts to report annually on staff who speak up. Ahead of such legislation NHS Trusts are required to provide details of ways in which staff can speak up, and how it is ensured that staff do not suffer detriment as a result of speaking up.

2.2.13 NHS Doctors in Training

This section is intended to illustrate the number of exception reports raised against the vacancy rate by the grade of doctor. Fill rates for ad hoc shifts are provided to illustrate how successfully vacant shifts are filled. This section also illustrates the actions taken to mitigate the risk of having unfilled shifts and any adverse impact on the training experience of Doctors in Training whilst on rotation to WWL

High level data

Number of doctors and dentists in training (total):	**176**
Number of doctors and dentists in training on 2016 Terms and Conditions of Service (total):	**156**
Annual vacancy rate among this staff group:	**6.41%**

Annual data summary

Specialty	Grade	Exception Report Raised				Total gaps (average WTE)	Number of shifts uncovered (over the year)	Average no. of shifts uncovered (per week)
		Quarter 1	Quarter 2	Quarter 3	Quarter 4			
General Surgery	FY1	11	42	27	13	0	4	0.5
General Surgery	FY2/ST1-2	1	1	4	1	2	42	43
General Medicine								
	FY1	25	99	45	66	1	11	1
General Medicine	FY2/ ST1-2	1	23	15	3	2	536	79
Orthopaedics	FY1	0	5	4	4	0	0	0
Orthopaedics	Fy1	0	30	7	0	0	0	0
Paediatrics	ST1-2		1	0	0	2	8	2
Obstetrics and Gynecology	FY2/ ST1-3	1	2	0	0	0	154	30
Psychiatry	Fy2/ST1-2	2	0	1	0	0	3	0.5
Palliative Care	FY2/ST1-2	2	23	10	0	0	0	0
Total	FY2	0	0	1		0	0	0
		41	**226**	**114**	**87**	**5**	**758**	**156**

For this report we have the results of two quarters work of Exception Report data and some comments from face to face meetings with Junior Doctor representatives for the BMA.

For General Medicine many of the issues related to understaffing, deteriorated patients and heavy workloads. Most Exception Reports were a mixture of all of these. In General Surgery during this quarter it was clear that there were delays due to handovers but also issues with staff shortages and issues with weekend cover.

The bulk of Surgical Exception Reports in this quarter were by FY1's and lack of support was the common theme.

In Trauma and Orthopaedic in this quarter all Exception Reports were by FY1's and the bulk of these were due to staffing issues and high workload due to ward work.

In contrast on the 8th January 2020 the next quarterly report showed a substantial reduction in Exception Reports with 60 in General Medicine, 27 in General Surgery and Trauma and Orthopaedics having 7. This was encouraging to see, however, we would caution against an assumption that problems have been fixed as we think it is wise to make judgments over a much longer period of time than to react to results from one individual quarter.

Issues arising

In General Medicine the bulk of Exception Reports were due to late finishes and these are best illustrated by example. Stayed an hour late on Monday evening due to a scan returning at 4 pm showing a patient having an acute stroke. Due to the patients age this needed escalating to Salford to discuss management plan and then putting this plan in place. This was again urgent and inappropriate for the On Call F1 to take the jobs because the jobs were urgent and I had to complete them in order to ensure patient safety and quality of care. I stayed 1 hour and 30 minutes late due to having to finish ward jobs. There was an unforeseeable work load with patient's family members turning up after 4 pm and thus prioritising patient care. Additionally the scan reports returned at 4 pm with results needing actioning and was too urgent to hand over to the F1 on call.

From these examples one can see clearly the difficulty that Junior Doctors are having leaving on time particularly with the results of tests returning quite late in the afternoon. The often complex medical action which is required to respond to this takes time and is difficult to hand over to an On Call Clinician due to the complexity of medical intervention. It is not always clear and easy to do a simple handover and the interventions are best done by the day referring clinicians. The actions of these Doctors were therefore commendable however they do therefore result in delays in going home which therefore contributes to Exception Reports and puts Junior Doctors at risk of burn out.

Looking at General Surgery this quarter again the Exception Reports were predominantly with either late finishes or early starts or inability to take breaks. In this quarter there appear to be some variation in the starting times of some of the most Senior Doctors and Middle Grade Doctors particularly at weekends and there also appear to be a lack of post take ward round support. Also during the last quarter a meeting was held with the Junior Doctors BMA reps and with FY1's from Shevington Ward and also for General Surgery.

The main issues expressed by the FY1 Doctors are that the ward can have up to 40 patients on a round with a Registrar often having to finish late and excessive workload leading to the concerns from the FY1's. There have also been concerns about variation in the starting times of the middle grade surgical doctors covering the wards at weekends. This view was backed up by the Exception Reports submitted in the quarter leading to the January report.

Concerns from Shevington:

The Shevington rota looks good on paper however in practice often some of the medical staff down to cover the wards are not available for very legitimate reasons but this is not reflected on the paper rota. Some of these reasons are Senior Doctors being in Endoscopy or Clinics which may be off site. The main concern for the FY1's is that they are often left without support.

Nearly all ERs are by Foundation Trainees. I do not see any from core trainees or higher trainees from other spaecialities.

Actions taken to resolve issues

The actions taken to resolve these issues were as follows:

Meetings between the Clinical Director in Surgery and BMA reps to address rota needs for General Surgery

Active interaction and meetings between the Divisional Medical Director for Medicine and BMA reps to look at the issues behind Shevington Ward

Request for increased staffing levels (FY3 / IMTs) by the Medical Director to strengthen staff numbers for medicine, surgery and emergency medicine.

Meetings with FY1s and FPD Alison Quinn to examine issues and look at coping strategies and resilience of Foundation Trainees. Further engagement with core and higher trainees – opportunities are at induction and during teaching sessions (eg CMT teaching)

Summary

We have seen a drop in Exception Reports over one quarter. General Medicine has the most reports followed by surgery. The reports are about late arrival of results, sudden worsening of patients on word rounds and inconsistencies in staffing levels. Exception Reporting is almost exclusively performed by Foundation Trainees.

Active involvement from the Clinical Director of General Surgery, Divisional Medical Director of Medicine and Medical Director (with regards to rota restructuring and additional medical recruitment) is taking place. Foundation Programme Directors are actively engaging with Foundation Trainees with regards to resilience and safe handover technique.

One of the functions which oversee the safety of NHS Doctors in Training is the Guardian of Safe Working Hours. The guardian ensures that issues of compliance with safe working hours are addressed by the doctor and/ or employer/host organisation, as appropriate. The guardian provides assurance to the Board that doctors' working hours are safe. NHS Trusts are required to provide plan for improvement to reduce these gaps.

PART 2.3:
REPORTING AGAINST CORE INDICATORS

We are required to report performance against a core set of indicators using data made available to us by NHS Digital. For each indicator, the number, percentage, value, score or rate (as applicable) for at least the last two reporting periods, is presented in the table below. In addition, where the required data is made available by NHS Digital, a comparison is made of the numbers, percentages, values, scores or rates of each of the NHS Trusts indicators with:

a) National average for the same, and;
b Those NHS Trusts with highest and lowest for the same.

We are required to include formal narrative outlining reasons why the data is as described and any actions to improve the data.

Mortality

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
(a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period	October 2017 - September 2018	Value: 1.1025, Banding : 2	Value: 1.0034	**Best:** HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST (RQX) - Value: 0.6917, Banding: 3 **Worst:** SOUTH TYNESIDE NHS FOUNDATION TRUST (RE9) - Value: 1.2681, Banding: 1
	October 2018 - September 2019	Value: 1.1649, Banding : 1	Value: 1.0026	**Best:** IMPERIAL COLLEGE HEALTHCARE NHS TRUST (RYJ) - Value: 0.6979, Banding: 3 **Worst:** DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST (RBD) - Value: 1.1877, Banding: 1
(b) The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period.	October 2017 - September 2018	36.6%	33.6%	**Best:** THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST (RCX) - Value : 14.3% **Worst:** ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST (RA2) - Value: 59.5%
	October 2018 - September 2019	42.0%	36.0%	**Best:** SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST (RK5) - Value : 14.3% **Worst::** ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST (RA2) - Value: 59.0%

Assurance Statement

Mortality data from the year follows the pattern of years past. SHMI has been higher than average. Palliative care coding is more relevant to HSMR and is monitored because it was used as a way of reducing HSMR values. It is in clinical terms better to have more palliative care. There has been extensive work on mortality once again this year. That has included the weekly deaths audits and various areas of deeper investigation to seek areas for improvement. The role of Medical Examiner has been developed and was implemented toward the end of the data time period. This allows for further examination of cases where patient have died. The system supports the Learning From Deaths programme that already runs in the Trust. The role of "total bed numbers" has been discussed within the organisation. Mathematically, the lower the number of beds per head of population served, the higher the SHMI value across Greater Manchester. There are multiple reasons that greater capacity would be linked to a lower SHMI, but the increase in capacity for the organisation is a clinical necessity given the pressure on beds and A/E flow problems. Plans for increased capacity were made and accelerated by the arrival of COVID-19.

The data time period for this report ends just as the COVID-19 pandemic arrived. Mortality data is significantly altered by COVID-19. There is uncertainty about future reporting of SHMI, but it is unlikely to include COVID-19 deaths.

WWL considers that this data is as described for the following reasons:

WWL intends to take the following actions to improve these indicators and, so the quality of its services, by:

Patient Reported Outcome Measures Scores (PROMs)

The Trust's patient reported outcome measures scores during the reporting period for:

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
i) Groin Hernia Surgery	April 2016 - March 2017	0.060	0.086	**Best:** NEW HALL HOSPITAL (NVC09) & POOLE HOSPITAL NHS FOUNDATION TRUST () - Value: 0.135 **Worst:** BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST (RXL) - Value: 0.006
	April 2017 - March 2018	0.058	0.089	**Best:** CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST (RQM) - Value: 0.137 **Worst:** SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST (RXK) - Value: 0.029
ii) Varicose Vein Surgery	April 2016 - March 2017	N\A	0.092	**Best:** TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST (RMP) - Value: 0.155 **Worst:** ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST (RBN) - Value: 0.010
	April 2017 - March 2018	N\A	0.096	**Best:** THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST (RTD) - Value: 0.134 **Worst:** BUCKINGHAMSHIRE HEALTHCARE NHS TRUST (RXQ) - Value: 0.035
iii) Hip Replacement Surgery	April 2017 - March 2018	0.470	0.468	**Best:** SHEPTON MALLET NHS TREATMENT CENTRE (NTPH1) - Value: 0.566 **Worst:** ONE HEALTH GROUP CLINIC - THORNBURY (NTX11) - Value: 0.376
	April 2018 - March 2019	0.460	0.465	**Best:** HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST (RQX) - Value: 0.557 **Worst:** SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST (RVY) - Value: 0.348
iv) Knee Replacement Surgery	April 2017 - March 2018	0.350	0.338	**Best:** NUFFIELD HEALTH, CAMBRIDGE HOSPITAL (NT209) - Value: 0.417 **Worst:** LEWISHAM AND GREENWICH NHS TRUST (RJ2) - Value: 0.234
	April 2018 - March 2019	0.405	0.338	**Best:** SPIRE SOUTHAMPTON HOSPITAL (NT304) - Value: 0.405 **Worst:** SPIRE LITTLE ASTON HOSPITAL (NT321) - Value: 0.266

Assurance Statement

WWL considers that this data is as described for the following reasons:
The hip and knee PROMs compliance rate has been 99% again this year, once again passing the target for best practice tariff. However it does look like our patient improvement in general has dipped slightly.

WWL intends to take the following actions to improve these indicators and, so the quality of its services, by:
We have non to little control over the national PROMs however we are working towards developing/ updating our own system in order to provide better data then we can compare that against what is collected nationally.

Hospital Readmission

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
The percentage of patients readmitted to a hospital which forms part of the trust within 30 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 0-15	April 2016 - March 2017	9.0	11.6	**Best:** SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST (RXX) - Value: 1.6 **Worst:** WEST LONDON NHS TRUST (RKL) - Value: 68.4
	April 2017 - March 2018	10.1	11.9	**Best:** SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST (RXX) - Value: 1.3 **Worst:** BIRMINGHAM COMMUNITY HEALTHCARE NHS FOUNDATION TRUST (RYW) - Value: 32.9
The percentage of patients readmitted to a hospital which forms part of the trust within 30 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 16 to 75	April 2016 - March 2017	14.1	13.6	**Best:** NUFFIELD HEALTH, WARWICKSHIRE HOSPITAL (NT224) - Value: 0.9 **Worst:** SPIRE YALE HOSPITAL (NT338) - Value: 121.5
	April 2017 - March 2018	15.9	14.1	**Best:** HATHAWAY MEDICAL CENTRE (NXP04) - Value: 2.6 **Worst:** MERSEY CARE NHS FOUNDATION TRUST (RW4) - Value: 33.0

Assurance Statement

WWL considers that this data is as described for the following reasons:
The data displayed above is out of date.

WWL has taken the following actions to improve this indicator and so the quality of services by:

WWL continues to work with system partners to reduce Hospital Readmissions which include the following programs of work:

- Multi Agency complex multi-disciplinary MDT to review high intensity users and provide community based support.
- Community Response Team provide a follow up for all patients discharged aged 65 and over.
- Ongoing work in respect of End of Life pathways. Recent developments include integration of Hospice Staff in care planning within community and Primary Care.
- Revised discharge pathway will see an improved discharge process with increased wrap around support and home based assessments.

Responsiveness to Personal Needs

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
The Trust's responsiveness to the personal needs of its patients during the reporting period	National Inpatient Survey 2017 - 2018	66.9%	68.6%	**Best:** The Royal Marsden NHS Foundation Trust (RPY) - Value: 85.0% **Worst:** Barts Health NHS Trust (R1H) - Value: 60.5%
	National Inpatient Survey 2018 - 2019	65.6%	67.2%	**Best:** Queen Victoria Hospital NHS Foundation Trust (RPC) - Value: 85.0% **Worst:** Croydon Health Services NHS Trust (RJ6) - Value: 58.9%

Assurance Statement

WWL considers that this data is as described for the following reasons:
The Trust acknowledges that our results are slightly below the national average for results in this category. Disappointingly there is also a slight decline on last year's results which does reflect the national situation. Following an inspection in late 2019, the CQC rated the trust as good for caring and noted that staff treated patients with kindness and compassion whilst taking account of their individual needs.

WWL has taken the following actions to improve this indicator and so the quality of services by:

- Continuous monthly scrutiny of the monthly internal real time patient survey programme to drive improvements based on patient feedback. The survey which asks 12 key questions of patients' experience of person centred, compassionate care. The results have been consistently improving and positive.
- There has been significant investment into nursing to increase numbers of trained staff within clinical areas along with a commitment to increase more senior presence and leadership.
- An Admiral Nurse role has been introduced into the trust with a planned second nurse recruitment to support the service. Admiral Nurses are specialist dementia nurses who give expert practical, clinical and emotional support; they are continually trained, developed and supported by Dementia UK. An Admiral Nursing service in an acute setting represents an opportunity to improve outcomes for people with dementia, facilitate improvements in staff understanding of dementia through training and quality improvement projects.
- The Palliative Care team are now able to provide a seven day service following trust investment to support patients and their families who are at the end of their life and ensure their personal needs and choices are met.

The trust has successfully introduced a discharge to assess model to support and facilitate more effective discharge for patients .It is based on a partnership approach, centred around collaborative working between organisations, individual and family members to ensure the best outcome for the patient on discharge.

Friends and Family Test (Staff)

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends (Acute Trusts only)	National NHS Staff Survey 2018	71.00%	70.00%	**Best:** St Helens and Knowsley Teaching Hospitals NHS Trust (RBN) Value - 87% **Worst:** Isle of Wight NHS Trust (acute sector) (R1F1) - Value: 41%
	National NHS Staff Survey 2019	77.00%	71.00%	**Best:** The Newcastle upon Tyne Hospitals NHS Foundation Trust (RTD) Value - 90% **Worst:** Walsall Healthcare NHS Trust (RBK) - Value: 49%

Assurance Statement

WWL considers that this data is as described for the following reasons:
We have triangulated the data with our internal survey, where we asked the same question at a similar time point. These results were comparable (78.43%). Furthermore, this result has remained relatively stable (within 3%) every quarter for the past 15 months.

WWL intends to take the following actions to improve this percentage and, so the quality of its services, by:
We have again performed better than the national average for staff recommending us to friends and family as a place to be treated. We have also scored above average for staff recommending us as a place to work (71.7% against the sector average of 64.0%). Results for both measures have increased since 2018.

This is a positive result not only because we are above the National sector average, but also because our results have increased significantly since last year in both metrics (up from 2018 scores of 70.7% recommending the Trust as a place to receive care, and 63.6% recommending as a place to work). We have continued to invest in three main areas of staff experience: engagement, health and wellbeing, and learning and development. Key activities to improve staff experience over the next 12 months include:

- Redevelopment of the annual appraisal system (My Route Plan)
- The launch of training for line managers
- Broadening the health and wellbeing offer to staff
- A relaunch of the intranet site to make it more user-friendly
- Re-aligning the way staff surveys are fed back to local areas to maximise usefulness

Venous Thromboembolism

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	July 2019 - September 2019	96.64%	95.40%	**Best:** Essex Partnership University NHS Foundation Trust (R1L) & Lincolnshire Community Health Services NHS Trust (RY5) - Value: 100% **Worst:** Blackpool Teaching Hospitals NHS Foundation Trust (RXL) - Value: 71.72%
	October 2019 - December 2019	96.40%	95.25%	**Best:** Essex Partnership University NHS Foundation Trust (R1L) & Lincolnshire Community Health Services NHS Trust (RY5) - Value: 100% **Worst:** Northern Devon Healthcare NHS Trust (RBZ) - Value: 71.59%

Assurance Statement

WWL considers that this data is as described for the following reasons:
I am confident that the figures are correct as they are obtained from our VTE app that pulls data directly from HIS in real-time.

WWL has taken the following actions to improve this percentage and so the quality of its services by:
We are always trying to improve our assessment scores through staff education in particular promotion of the Medical/Surgical Assessment Documents and Trust Inductions where I inform new medical staff of the importance of VTE assessments.

Clostridium difficile (C. difficile)

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
The rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.	April 2017 – March 2018	16.1	13.7	**Best:**Liverpool Women's (REP), Moorfields Eye Hospital (RP6) & Queen Victoria Hospital (RPC) - Value: 0.00 **Worst:** The Royal Marsden (RPY) - Value: 91.0
	April 2018 - March 2019	7.3	12.2	**Best:** Liverpool Womens (REP), Moorfields Eye Hospital (RP6) & Queen Victoria Hospital (RPC) - Value: 0.00 **Worst:** The Royal Marsden (RPY) - Value: 79.7
	April 2019 – March 2020	31.3	National average 22 North West average 24.9	**Best in NW:** Liverpool Women's 0, Alder Hey 8, East Cheshire 9 **Worst in NW:** Christie 57, Blackpool 55, Lancashire 46

Assurance Statement

WWL considers that this data is as described for the following reasons:
In 2018/19 WWL had the lowest ever numbers of C.diff cases (11) and just 4 lapses in care.

In 2019/20 the national definition changed; the number of days to identify hospital associated cases reduced from ≥3 to ≥2 days after admission and also included cases that occurred in the community when the patient had been an inpatient in the previous 4 weeks. Therefore, rates have increased for most hospitals this year and the national average has increased from 12 to 22.

WWL have however, seen a greater number of cases than expected with peak levels in December 2019. In total there were 48 cases in 2019/20 but only 11 resulted in Lapses in care (awaiting confirmation from CCG).

Ribotyping was carried out on every specimen to help identify any linked cases; there could have been some cross infection in July in the stroke ward so an outbreak was declared and a StEIS report submitted. A number of changes were made to improve the environment and practice on the ward. There have been no cases of cross infection in the Trust since then.

The reasons for the higher C.diff rates are unclear but are likely to be multi-factorial and include not being able to give the general wards a full Deep clean this year, high activity and acuity levels on the wards and an ongoing lack of side rooms which was exacerbated in December due to caring for high numbers of patients with Flu that month.

WWL intends to take the following actions to improve this percentage and so the quality of its services by:
Full RCAs continue to be carried out on each C.diff case but there have been no obvious similarities or conclusions with regards location, speciality and antibiotic use identified to date but in 4 cases staff were late to send a sample so actions are being taken to raise awareness about this. Comprehensive action plans are drawn up to address any learning that results from these RCAs and progress is monitored at the IPC Committee.

The risk assessment score on C.diff was increased to 20, a C.diff reduction plan put in to place and an external review was undertaken by NHSI in September 2019 who did not identify any significant additional actions.

IPC continue to reinforce standard IPC precautions including hand hygiene, use of PPE and ensuring equipment and beds are fully decontaminated between patients. A new e-learning programme for level 2 went live in December and compliance with cleaning of commodes and completion of stool charts improved.

A full IPC audit was carried out in January on the 8 wards with the highest numbers of C.diff cases and a number of recommendations taken forward. A training day for Housekeepers took place in December; 41 attended with excellent evaluations; the importance of cleaning and hand hygiene for staff and patients was emphasised. A plan is being drawn up to ensure all general wards receive a full Deep clean in 2020.

The rate of C.diff cases has dropped since December; there were just 8 cases in the whole of Q4. .

Patient Safety Incidents

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
The number, and where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death	April 2018 - September 2018	4236 Incidents Reported (Rate per 1000 Bed Days 56.7) / 11 Serious Incidents (0.26%)	731348 Incidents Reported (Rate per 1000 Bed Days 44.1) / 2488 Serious Incidents (0.34%)	**Best:** Weston Area Health NHS Trust (RA3): Incidents Reported 566 (Rate per 1000 bed days 13.1) / 3 Serious Incidents (0.53%) **Worst:** Croydon Health Services NHS Trust (RJ6): Incidents Reported 9467 (Rate per 1000 bed days 107.4) / 14 Serious Incidents (0.15%)
	October 2018 - March 2019	3674 Incidents Reported (Rate per 1000 Bed Days 48.2) / 14 Serious Incidents (0.38%)	765221 Incidents Reported (Rate per 1000 Bed Days 45.2) / 2458 Serious Incidents (0.32%)	**Best:** North Tees and Hartlepool NHS Foundation Trust (RVW): Incidents Reported 1580 (Rate per 1000 bed days 16.9) / 15 Serious Incidents (0.95%) **Worst:** Croydon Health Services NHS Trust (RJ6): Incidents Reported 8289 (Rate per 1000 bed days 95.9) / 28 Serious Incidents (0.34%)

Assurance Statement

WWL considers that this data is as described for the following reasons:
We reported a higher number of patient safety incidents in the first reporting period in comparison with the second reporting period. Our rate of incidents reported per 1000 bed days does not show any evidence for under reporting and our rate is higher than the national average. Patient Safety has reviewed the data to better understand why there has been a drop in the number of incidents uploaded during the second period. This is mainly related to the time it takes for the incidents to be reviewed, investigated and shut down. We aim to promote a just culture to ensure that staff feel confident to report incidents. This is reflective in the numbers of incidents reported, particularly near misses and incidents resulting in low harm.

WWL intends to take the following actions to improve this indicator further and so the quality of services:
Performance in the investigation and closure of incident is now monitored via the Datix Quality Improvement Group. Performance reports are distributed monthly to the Divisions for their information / action, this performance is also detailed within the Quarterly Safe Effective Caring report. We continue to consider ways to improve our incident reporting processes to ensure staff feel confident and able to report incidents. This year we will be trying to improve the timeliness of our incident investigation so to enable a more robust learning process and subsequently improve the quality of our uploaded incidents to NRLS.

PART 3:
STATEMENTS OF ASSURANCES FROM THE BOARD

Part 3: Other Information

PART 3.1:
REVIEW OF QUALITY PERFORMANCE

This section of the Quality Report provides information on our quality performance during 2019/20. Performance against the priorities identified in our previous quality report and performance against the relevant indicators and performance thresholds set out in NHS Improvement's Oversight Framework are outlined. We are proud of a number of initiatives which contribute to strengthening quality governance systems. An update on progress to embed these initiatives is also included in this section.

Performance against priorities identified for improvement in 2019/20

We agreed a number of priorities for improvement in 2019/20 published in last year's Quality Report. These were selected following the development of our Quality Strategy 2017/21 in conjunction with internal and external stakeholders.

Patient Safety (Safe)

Priority 1:	**To achieve an overall Hospital Standardised Mortality Ratio (HSMR) of 95 and a Band 2 Summary Hospital Level / Mortality Indicator (SHMI)**
Where we were in 2018/19	Our benchmarked position for mortality had improved during 2018/19; however, learning from deaths and analysis of mortality data remained a quality priority for the Trust.
Where we are at the end of 2019/20 ✘ **HSMR: Not Achieved** ✘ **SHMI: Not Achieved**	Regulators are increasing their emphasis on SHMI, particular since NHS Digital has moved to monthly reporting. The Trust is now scrutinising the NHS Digital data regularly for clinical pathways requiring further review. At the end of March 2020 the Trusts SHMI was 119.6 to November 2019 (latest data available). HSMR for the same time period is 101.1. Actions to improve mortality data are ongoing and include: • The Medical Director has sought a GP Fellow who is reviewing deaths within 30 days of discharge to include primary and community care provision; • The establishment of a Medical Examiner role as required for all Trusts by April 2020. This will impact on how the Trust reviews deaths and identifies learning. • The Trust is shortly implementing the sepsis triggering component on HIS which should bring a step change in the way the Trust is able to monitor and manage sepsis. The Medical Director has scheduled a meeting with Public Health and the Trust clinicians in relation to Alcoholic Liver Disease, highlighted as an 'outlier' for SHMI.

Priority 2:	**To reduce grade 3 and 4 pressure ulcers contributed to by lapses in care**
Where we were in 2018/19	WWL became an integrated acute and community NHS Trust, following the transfer of Wigan Borough Community services from April 2019. We wanted to continue the work that has been commenced to reduce grade 3 and 4 pressure ulcers occurring in the community that may be the result of lapses in care.
Where we are at the end of 2019/20 ✘ **Not Achieved**	A Task and Finish Group was established in July 2019 to develop a pressure ulcer reduction plan, monitored via Harm Free Care Committee. A Themed SIRI Panel was held in November 2019 and was well attended by staff from across all clinical areas. A pressure ulcer review panel was commenced in December 2019 chaired by the Deputy Chief Nurse to review all **Hospital Acquired Pressure Ulcers (HAPU's)** regardless of grade. This replicates a forum established within the community division. This forum has identified further areas for improvement in practice, process and equipment availability which have been incorporated in to the Trusts improvement plan. There were 0 category 3 and 4 HAPU's reported to StEIS in December 2019 and January 2020, 1 in February 2020 and 0 in March 2020. Three wards where the majority of pressure ulcers have been reported have moved, on a trial basis, back to paper records for the SSKIN bundle. Audits of practice are being undertaken monthly and a report on the trial with subsequent recommendations is scheduled to be presented in March 2020 to Harm Free Care Committee. 25 HAPU's were reported to STEIS in 2019/20. It should be noted for **Community Hospital Acquired Pressure Ulcers (CAPUs)** that this year, it is difficult to benchmark this with data with Bridgewater Community Health Care NHS Trust data for the same time period last year as their reporting would include all localities and the criteria for reporting to STEIS was different at WWL. 20 CAPU's were reported to STEIS in 2019/20.

Priority 3:	**To reduce the numbers of falls resulting in serious harm or death.**
Where we were in 2018/19	From April 2018 – March 2019 there were 7 serious falls, the same number as we had in 2017/18. Further work was required to reduce this number.
Where we are at the end of 2019/20 ✔ **Achieved**	**Q4** 2019/20 there were 2 serious falls, so in comparison to the same period last year there has been a **66.6 %** reduction in the number of falls reported which resulted moderate severe or catastrophic harms on the wards or adjacent areas. Comparing the financial years 2018-19 and 2019-20 we have had a **45.8%** reduction in moderate, severe and catastrophic harms from falls, which significantly exceeds the WWL goal of reducing the level of said harms by 15%. This significant reduction in harms has been achieved through excellent team working of the Falls Improvement Group (FIG), along with the trust's commitment and support of the Clinical Quality Team as it strives to reduce harms from falls. Work has continued to be undertaken during Q4 by the Quality and Governance Team in conjunction with the FIG which has supported the reduction in falls resulting in serious harms. This includes: • Weekly emails to ward manager reminding them of the importance of checking that staff have completed the lying & standing BP on all appropriate patients. • Raising awareness of falls by teaching on the Clinical Induction and Cavendish course, highlighting the importance of a lying and standing BP • Working with the HIS team to add the lying and standing BP to the tracking board, to make it easier for the ward managers to monitor. • Falls Improvement Group members are monitoring for compliance in their own areas and offering support to staff in completing the lying and standing BP for all appropriate patients. Compliance with the Falls Improvement CQUIN in Q4 is **62%** which is a significant improvement from Q1 which was just 14%. Future work: a trial of innovative falls technology, relaunching of the falls champions, campaign to keep patients hydrated to reduce orthostatic hypotension, review of hourly rounding tool, and training/ awareness with junior doctors on wards to highlight medications that can cause an increase in falls and working with the Chief AHP to launch the next PJ paralysis campaign.

Patient Safety (Safe) contd.

Priority 4:	**To achieve 95% of patients found to have sepsis receiving IV antibiotics within 1 hour in Accident and Emergency (A&E)**	
Where we were in 2018/19	Compliance for patients with sepsis receiving IV antibiotics within 1 hour in A&E was 39.70% in Q4 2017-18. This initially improved significantly up to the end of Q2 2018-19; however, compliance declined during Q3 to 79.8%. This quality priority was selected due to this decline in compliance and the further work required to improve this.	
Where we are at the end of 2019/20 ✘ **A&E: Not Achieved**	**A&E/Inpatient** A&E: The percentage of patients who present with suspected sepsis to emergency departments, and were administered intravenous antibiotics within 1 hour.	**Q4 2019-20 data** Jan 2020 – 80% compliant Feb 2020 – 87.5% compliant March 2020 – 93.75 compliant = 87.1% compliant for Q4
	It is important that the Trust progresses the development of the sepsis pathway on the Trust's electronic patient record (HIS). This has been delayed due to pressures related to the COVID-19 pandemic; however this remains a priority for the Trust. There continues to be variability in A&E for patients being administered antibiotics within 1 hour of suspected sepsis, however Q3 data (73.3%) shows an improvement on Q1 (65.8%). Inpatient time to antibiotic continues to be sustained over 95%. QI methodology is being considered to improve these measures with realistic trajectories in place and regular evaluation.	

Clinical Effectiveness (Effective)

Priority 1:	**To improve Fractured Neck of Femur (#NOF) Time to Appropriate Bed**
Where we were in 2018/19	It is best practice to support optimal care for patients with fractured neck of femur (NOF) and that they are transferred to an orthopaedic bed within 4 hours of admission. In 2018 WWL achieved 45.8% for NOF orthopaedic patients to access and orthopaedic bed in 4 hours. There had been no significant improvement despite the work that had been undertaken to improve this
Where we are at the end of 2019/20 ✘ **Not Achieved**	A review of the #NOF ring fenced beds SOP has been undertaken and implemented. Time to Aspull Ward (appropriate bed) within 4 hours for January 2020 is 15%, a decrease from 25% however, the average time to Aspull which is calculated manually was 5.5 hours in December 2019 and 6 hours in January 2020. It was over 18 hours prior to November 2019. In January 2020 there were 40 #NOF patients, compared to a previous monthly average of 30 patients. Other metrics have demonstrated improvement. Achievement of Best Practice Tariff YTD is 54.2%. Since November 2019 (when the ring fenced #NOF beds were allocated) it is 77.7%.Time to Theatre % within 36 hours YTD is 66.42%. Since November 2019 this has improved 80.8%.

Priority 2:	**To achieve 95% compliance with the triggering on NEWS2 (National Early Warning Score) escalation of the deteriorating patient.**
Where we were in 2018/19	The Trust completed the actions required to meet the patient safety alert issued in relation to the implementation of NEWS2 (replacing MEWS – Modified Early Warning Score) by the end of March 2019. NEWS2 had been implemented on the Trusts electronic patient record (HIS). The first audit conducted for NEWS2 following its implementation unfortunately resulted in a deterioration in compliance. Further work was required to improve this.
Where we are at the end of 2019/20 ✘ **Not Achieved**	Audits results are now produced by an app utilising data directly inputted by clinical staff into HIS. Overall compliance with recording all elements of NEWS2 for Q3 2019-20 is **91%**. Compliance with escalation and recording of observations in a timely manner in accordance with the algorithm is **71%**; however it should be noted that a request has been made to the HIS Team to amend NEWS2 to reflect medically led exemptions to completion of NEWS2 (for example, if a patient is at end of life) and the frequency that observations are performed. This will then permit the App to pull through accurate data to provide assurance of compliance with escalation. This change will be implemented following the upgrade of the HIS system. It is also recognised that the App only gives cold data therefore it has been agreed that the Lead for Critical Care Outreach will audit 50 patients quarterly to ensure quality and identify themes that will be reported back at the Harm Free Care Committee.

Clinical Effectiveness (Effective) contd.

Priority 3:	**To embed actions required in response to recommendations from NHS Improvements review of reported Never Events.**
Where we were in 2018/19	We reported 5 Never Events in 2018/19 and commissioned a review by NHS Improvement. We were committed to responding to the findings from this review and ensuring that actions are embedded across the Trust. This commitment had been reinforced by the selection of this quality priority in our Quality Reports.
Where we are at the end of 2019/20 ✔ **Achieved**	We end the year on 4 Never Events. To date there is one outstanding action from NHS Improvements review and this relates to the audit of LOCCSIP's. There have been 17/19 LocSSIPs audited. This was on track to be completed but due to the COVID Pandemic this action remains outstanding. The completion of these audits will be rescheduled and undertaken during 2020/21.

Priority 4:	**To reduce the number of sharps incidents by increased usage of safer sharps devices and improved clinical practice.**
Where we were in 2018/19	Staff incidents related to injuries from sharps had been high in number during 2018/19. We commissioned an audit from Mersey Internal Audit Agency (MIAA) and received 'limited assurance'. Actions were required to reduce the number of sharps incidents and therefore this quality priority was selected.
Where we are at the end of 2019/20 ✘ **Not Achieved**	We end the year on 4 Never Events. To date there is one outstanding action from NHS Improvements review and this relates to the audit of LOCCSIP's. There have been 17/19 LocSSIPs audited. This was on track to be completed but due to the COVID Pandemic this action remains outstanding. The completion of these audits will be rescheduled and undertaken during 2020/21. The number of sharps related incidents continued to rise throughout the current financial year and as at the end of Q3 2019-20 the numbers in the current financial year were comparable to those for the entire previous financial year; however actions recently taken following the MIAA audit should now begin to have a positive impact on the number of sharps injuries reported. An Audit of compliance with European Directive on Prevention from Sharps Injuries (2010/32/EU) was undertaken by MIAA in 2018/19. This demonstrated "limited assurance". A detailed action plan was developed to improve compliance which included actions to replace non-safe sharps where possible. The number of sharps-related incidents has continued to be closely monitored and reported in the quarterly SEC report. The Trust's Health and Safety Manager chairs the Medical Sharps Management Meeting which is overseeing this improvement work. The Trust now has a Medical Sharps Management Policy and flowchart on the actions to take following a contaminated sharps incident. An investigation proforma is issued to an employee who completes it with their line manager. This proforma is a reflective exercise designed also as a training tool to improve practice where this is possible. The proforma is also reviewed by a multi-disciplinary team and where potential for learning is identified or where retraining is required, this is acted upon. A database of non-safe sharps is now available and being used to swap unsafe varieties to safe ones where possible. It is hoped that the introduction of safer varieties will assist in reducing the number of incidents and this is a focus of the meeting. A campaign is planned for the new financial year, which is hoped will raise awareness of the personal impact of poor practices that result in a sharps incident and contribute to a decrease in the number of sharps incidents.

Patient Experience (Caring)

Priority 1:	**To achieve 90% of patients reporting that they received information on medicines at discharge.**
Where we were in 2018/19	The patient survey results for Trust's using an organisation called Picker for their national surveys had demonstrated that we had further work to do to improve this indicator.
Where we are at the end of 2019/20 ✔ **Achieved**	This metric has been monitored via feedback from patients who have participated in the Discharge Always Events Audits. For the current financial year compliance with this measure is as follows: • RAEI: **92.6%** • Wrightington: **92.6%** The Trust has recently introduced Pharmacy Technicians onto the assessment wards who have a specific role regarding medicines administration and education of patients to improve concordance with treatment regimes. The pilot is to be expanded to other areas of the Trust.

Priority 2:	**To achieve an improvement in patients reporting that they were treated with kindness and understanding during the care received in hospital after the birth of their baby.**
Where we were in 2018/19	The results of our National Patient Survey 2018 for Maternity Services were very good; however, patients reporting that they were treated with kindness and understanding during the care received in hospital after the birth of their baby was one of areas requiring improvement.
Where we are at the end of 2019/20 ✔ **Achieved**	In October 2019 it was reported that the Trust had received the 2019 Maternity Survey results for Trusts that utilise Picker for their patient surveys. The results demonstrated that the Trust has achieved an improvement. In 2018 93% reported that they were treated with kindness and understanding. In 2019 this has improved to 97% which is in line with the national average. The full national maternity survey results were published in January 2020 which also identified an improvement for WWL to **97%** which is in line with the national average

Priority 3:	**To achieve a reduction in the number of complaints related to discharge.**
Where we were in 2018/19	There was an increase in the number of formal complaints during 2018/19, in comparison with the previous year. We wanted to focus on a reduction of complaints related to discharge.
Where we are at the end of 2019/20 ✔ **Achieved**	Figures to the end of January 2020 demonstrate a reduction in the number of complaints related to discharge by **73%**. This demonstrates the collaborative work undertaken by stakeholders.

Performance against the relevant indicators and performance thresholds set out in NHS Improvement's Single Oversight Framework

The following indicators are set out in NHS Improvement's Single Oversight Framework. Please note Summary Hospital-level Mortality Indicator (SHMI) and Venous Thromboembolism (VTE risk assessment) are reported in Part 2.3: Reporting against core indicators.

Key

	Performing on or above target
	Performing below trajectory; robust recovery plan required
	Failed target or significant risk of failure
↑	**Improved position**
↓	**Worsening position**
←→	**Steady position**

Indicator	2017-18		2018-19		2019-20	
Infection Control						
Clostridium difficile (C. difficile): variance from plan	25 Threshold = 19	↑	11 Threshold = 18	↓	**48 Threshold = 20**	↑
Methicillin-resistant Staphylococcus aureus (MRSA) Bacteraemia (Threshold =0)	12	↓	2	←→	**2**	↓

C.difficile
The rules governing how to identify Hospital Acquired Cases changed on 01/04/19, resulting in an increase in Hospital Reportable Cases. In addition, the threshold set by the Department of Health for 2019/20 was based on 2018/19 data, where WWL had the lowest ever number of cases.

We continue to undertake a detailed individual patient review collaboratively with our commissioners on each case. Comprehensive action plans are drawn up to address any learning that results from these RCAs and progress is monitored at the IPC Committee. There were 11 'Lapses in Care' identified, 4 of these were related to samples being taken later than they should have been, the other reasons for lapses were all different. Actions are ongoing to remind staff of the importance of timely sampling.

MRSA Bacteraemia.
There were no MRSA bacteraemias in 2019/20. Work to standardise the approach to ANTT (Aseptic Non-Touch Technique) across the Trust is ongoing and the new teaching package and assessment documentation was rolled out. There are now over 115 staff trained to carry out assessments with monthly training sessions continuing until the COVID outbreak. The aim in 2020/21 is to make ANTT assessments part of the annual mandatory training schedule and put the blood culture documentation on to HIS which should support compliance with the SOPs.

Data Source: National Health Protection Agency data collection, as governed by standard national definitions.

Indicator	2017-18		2018-19		2019-20	
Never Events						
Number of Incidents Reported as Never Events (Threshold= 0)	4	↑	5	↑	**4**	↓

The Trust has reported 4 Never Events during 2019/20. Previously Never Events have occurred in various locations, sites and specialties; however, 3 of the most recent incidents did occur within the theatre setting.

Following the review of all our Never Events by NHSI the report and actions were shared via CQEC / Quality and Safety Committee. To date there is one outstanding action from this review and this relates to the audit of LOCCSIP's. There have been 17/19 LocSSIPs audited. This action was on track to be completed but due to the COVID Pandemic this action remains outstanding. Our action for 2020/2021 is to ensure that the learning from the NHSI review is embedded in practice through both qualitative and quantitative audits of the Trusts LocSSIPs.

Data Source: Datix Risk Management System. 'Never Events' are governed by standard national definitions.

Indicator	2017-18		2018-19		2019-20	
Accident and Emergency (A&E)						
Maximum waiting time of four hours from arrival to admission/transfer/discharge (Threshold= 95%)	80.57%* 86.04%**	↓	82.11% * 87.48%**	↑	**84.00%**	↑

Attendances to Accident & Emergency Department rose by 4% compared with the previous year, this is an increase of over 3,000 patients. Following the successful implementation of the Frailty at the Front door pathway in collaboration with AQUA and Same Day Emergency Care pathways we say a reduction in the number of Admissions through A&E which reduced by 3% compared with 18/19. We also treated and discharged in excess of 99% of patients within four hours in our Type 3 Walk in Centre. Despite the overall increase in demand within A&E, WWL was the highest performing unscheduled care system in Greater Manchester. We also saw a notable improvement in Ambulance Handover Times following collaboration with NWAS as part of the 'Super 6 programme'. We also saw improvements to our Urgent Treatment Centre with the integration of GP Out of Hours services and the introduction of a Mental Health Suite on the Acute Hospital site in collaboration with North West Boroughs Healthcare NHS Foundation Trust to improve services for patients presenting to Urgent care Services with Mental Health related conditions

As we move into 20/21 WWL is looking forward to the expansion of the A&E unit which will provide increased capacity for the expansion of the Initial Senior Assessment Triage (ISAT). The continued roll out the ED safety checklist and continued collaboration with local and regional partners as we work meet the increased challenges of COVID 19, maintaining safe services for patients and staff and meeting the national objective to reduce A&E attendances to 75% of 19/20 demand

Data Source: Management Systems Services (MSS), as governed by national standard definitions.

Indicator	2017-18		2018-19		2019-20	
Cancer Waits						
All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer (Threshold= 85%)	92.58% 94.28%	↑* ↑**	88.08% 89.53%	↓* ↓**	**85.34%**	↓
All cancers: 62-day wait for first treatment from NHS Cancer Screening Service Referral (Threshold= 90%)	98.75% 98.5%	↓* ↓**	97.04% 97.52%	↓* ↓**	**92.92%**	↓

Please note where there are two percentages for one year, one represents * after repatriation and one represents ** before repatriation. After repatriation are Greater Manchester agreed figures using the new national policy for allocation of breaches and compliances. From April 2019 the national system NHS digital which all trusts are required to upload their data to will automatically re-allocate which should result in just one set of figures for 2019/20.

WWL's overall performance for all standards related to the 62 day cancer waiting times in 2019/20 were maintained above the national threshold. This year has again been challenging, with more complex pathways and greater demand for diagnostics. We continue to collaborate with our partners across Greater Manchester to improve patient pathways and deliver the best possible outcomes for our patients.

In April 2020 we have the introduction of the 28-day diagnosis standard. This standard requires that patients are informed of either a cancer diagnosis or the ruling out of cancer by day 28 from a GP suspected cancer referral or referral from a national screening programme. It has been mandatory to collect this data from April 2019, performance to be reported from April 2020. To help deliver this standard there have been 4 National best-timed pathways introduced, mapping the various milestones within the pathway to achieve a diagnosis or ruling out by day 28.

Data Source: National Open Exeter System, as governed by standard national definitions.

Indicator	2017-18		2018-19		2019-20	
Referral to Treatment (RTT)						
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate-patients on an incomplete pathway (Threshold= 92%)	94.80%	↓	93.25%	↓	**90.53%**	↓

While WWL continues to perform well in comparison with Greater Manchester ending the year as the 2nd top performing Trust, the organisation failed to achieve the 18 week referral to treatment time for the first time in 19/20. The number of patients receiving their first definitive treatment within 18 weeks of GP referral continues to fall year on year primarily within specialties where demand for both elective and non-elective care exceeds capacity within an organisation which has the lowest bed base in Greater Manchester. However, specialties primarily outpatient focused or operating out of the Trust's elective treatment sites consistently perform within the top quartile in the country. The last time England achieved the standard was February 2016.

Data Source: Patient Administration System (PAS), as governed by standard national definitions.

Indicator	2017-18		2018-19		2019-20	
Diagnostic Procedures						
Maximum 6-week wait for diagnostic procedures (Threshold=99%)	98.99%	↓	99.21%	↑	**98.83%**	↓

We continue to maintain the national standard of 99% of patients receiving diagnostics within 6-weeks.

The largest volume of procedures is undertaken in imaging and Radiology performs extremely well against this standard; this is despite rising numbers of referrals and increasing complexity of examinations. The standard does not measure all Radiology examinations, but some of the main tests fall within Magnetic Resonance (MR), Computer Tomography (CT), Non Obstetric Ultrasound (NOUS) and DEXA which equates to about 10,200 examinations per month. Overall we undertake approximately 330,000 examinations per year.

Patients receiving endoscopy within 6 weeks remains challenging due to high levels of demand and environment on the RAEI site which require investment to meet National accreditation standards, however, patients are prioritised from a patient safety perspective according to clinical need and with the input of senior clinicians.

COMPLAINTS, PATIENT ADVICE AND **LIAISON SERVICE AND THE OMBUDSMAN**

"We welcome complaints to learn and reflect on how we work and to make the appropriate improvements."

Patient Relations and Patient Advice and Liaison Service (PALS) are dedicated to enhancing the patient, carer and relative's experience. We welcome complaints and concerns to ensure that continuous improvement to our services takes place and to improve experience through lessons learned.

The department continues to work closely with the Divisions to promote a positive patient experience and to actively encourage a swift response to concerns which may be received by letter, e-mail, telephone or visitor to PALS, providing resolution in real time.

All complaints and concerns are shared at our Executive Scrutiny Committee which is held on a weekly basis. The more complex and serious complaints are reviewed and discussed in detail to ensure that a prompt decision is made regarding the progression of these complaints and, where appropriate, instigation of a concise or comprehensive investigation. These meetings also provide the opportunity to triangulate information with previous incidents, possible claims or HM Coroner Inquests.

Statistical information in respect of complaints and concerns is collected and monitored to identify trends. We continue to share statistical information from formal complaints nationally (KO41a) which is required on a quarterly basis. This includes information on the Subject of Complaint, the Services Area (in-patient; out-patient; A&E and Maternity), amongst other information for each individual site under our responsibility.

We welcome complaints to learn and reflect on how we work and to make the appropriate improvements. Whilst we provide an apology to our complainants, the following outlines actions taken and lessons learned from a sample of complaints received. Below are the lessons identified from complaints closed within the period of Q4

In light of the Covid-19 pandemic, the Trust suspended responding to formal complaints received from mid-March 2020; this was consistent with national guidance.

Complaints Theme and Brief Summary	Actions Taken and Lessons Learned
Appointments Patient is unhappy with referral delays concerning her baby being referred to the tongue tie service which meant it was too late to start breast feeding. She would also like to know the outcome of the discussion with the midwife who falsely recorded observations.	To help improve the referral system it has been agreed with breastfeeding together peer support services that it would be beneficial for the infant feeding team to confirm they have received any future referrals. If they have not heard confirmation within 72 hours they would then follow up the referral to ensure the email had been received. It will also be requested that if a tongue tie is noted at any point that the midwives inform the infant feeding team so that are able to offer additional support should this be required.
Clinical treatment History of patient having orthopaedic surgery had a fall at home; attended A&E and a x-ray but did not reveal fracture, however some time later it was discovered there was a fracture and the patient had to undergo revision surgery.	A full review of systems and processes undertaken of how reporting of radiological findings are done in A&E.
Clinical treatment Mum not happy with misdiagnosis when her daughter attended leigh walk in centre.	Department to communicate that consideration to wider differentials during clinical assessments in patients with symptoms suggestive of PE, and information on PE recognition cascaded to the whole team. Patients presenting with symptoms suspicious of PE must be discussed with the A&E consultant
Patient Care Patient unhappy with the events which happened whilst waiting for a bed on the ward. Patient was then sent to delivery suite, whilst suffering a miscarriage which cause upset and distress.	Division to review a protected area within the Ward were women in the same situation can be cared for more appropriately.
Communication Complainant is unhappy with the lack of communication and believes that there has been conflicting information given to family.	Consultant has reflected thoroughly on what and how he communicates with families to try to ensure them and their loved one have as full a picture as possible.
Communication Patient is not happy with the amount of time it takes for the pharmacy to have the prescribed drugs delivered to the PIU ward, which she attends regularly.	Pharmacy and PIU undertaking a review of the process of dealing with prescriptions for these presentations.

Improvement Plans as a result of complaints referred to the Parliamentary Health Service Ombudsman

The role of the Parliamentary and Health Service Ombudsman (PHSO) is to provide a service to the public by undertaking independent investigations into complaints that government departments, a range of other public bodies in the UK, and the NHS England, have not acted properly or fairly or have provided a poor service.

The aim of the PHSO is to provide an independent, high quality complaint handling service that rights individual wrongs, drives improvement in the public service and informs public policy.

During 2019/20 the PHSO requested information regarding 5 complaints. Decisions have been received within this period for 8 cases which were: 4 partially upheld, and 2 not upheld, 2 not investigating. These cases relate to 2015 through to 2018. 4 remain with the PHSO with no further correspondence received to date.

In addition the Trust received notification from the PHSO that they are re-investigator one of their own investigation, and the Trust awaits any instructions.

Final reports for investigations concluded in 2019/20 have not required financial redress.

Patient Experience

We have continually achieved excellent scores for cleanliness throughout the hospitals placing us in the top 20% of Trusts in this area of assessment in the National Inpatient Survey 2019.

The Patient and Public Engagement Team continue to obtain feedback from inpatients using the Real Time Patient Experience Survey. The surveys are undertaken by our hospital volunteers and governors. The results are presented to the Board of Directors every month to monitor the corporate objective of over 90% of a positive patient experience.

As a result of this monitoring there has been significant improvement in patients being involved in decisions about their care and treatment and patients being offered a choice of food during their stay, leading to a much improved experience for our patients. Overall we have scored slightly lower than the previous year in the Real Time Patient Experience Survey. In 2018-19 we scored an average 92.78% and in 2019-20 we scored an average 92.71% so a slight drop in the overall score of 0.08%.

This year we have struggled to improve the question "Do you know which consultant is currently treating you". We introduced this question in 2013. During this time the scores have struggled to achieve the 90% benchmark score. The trust has only achieved the 90% benchmark on seven occasions during the six years. Discussion have taken place with patients on many occasions about them knowing what their doctors name is and many respond that they are not bothered about the doctors name, they just want to get better. Our proposal to change the question to "Do you have confidence and trust in the Consultant/ Doctor treating you" we feel this is a more appropriate question for our patients and in line with national patient surveys.

Following the National Cancer Survey 2019 results the report again tells us that Black and Minority Ethnic (BME) cancer patients have poorer experiences of cancer services than their White British patients. Following this we undertook our second yearly survey BME Cancer Survey to engage with our BME community. Overall our patients reported that they had a good experience of our cancer services. They felt respected and cared for and had trust in our staff.

Patient and Public Engagement

Patients and carers attended an 'Experience Based Design'(EBD) event to assist with the design of the new Community Assessment Unit. The public were asked what they wanted the environment and facilities to look like in the new unit. The results of the EBD group work demonstrated some really good ideas and thoughts for the environment and facilities for the new Community Assessment Unit. To enable the unit to be of a gold standard and service to our patients we should consider those ideas and recommendations that members of the public have put forward to us today.

Some of those key gold standards are below:

- The names of the doors to be themed either with names of local areas, nature, garden themes or flowers.
- Good accessibility, wheelchair access.
- The colours to be calming. Water or garden scenes. Landscape artwork. A tropical fish tank.
- Lowery prints, Flat screen TV, Local Landmarks, mural, clean colours, black and white pictures.
- Old shop, pub, sweet shop, bus stop scenes, reminiscence memorabilia.
- Bedside lights, Trial Alexa so it reminds us when to take our medication or get up out of our chair to exercise, dimmer switches so the patient can control the lighting.
- Chairs to have arm rests which will aid weakened elderly patients to lift themselves out or to move to a more comfortable position. NB not too low of a seat. Assisted reclining chairs. Durable clean chairs but not plastic.
- Windows with good ventilation but must be secure. Clocks, leisure activities, menus designed like you get in a restaurant, TVs in the rooms, access to books and magazines, information board.
- Polite helpful friendly staff.

Members of the public also attended an event to assist with the development of the Trusts new 2030 Strategy. One idea suggested for the new strategy was to have more patients self-managing their own health.

We have worked in partnership with Wigan Borough Clinical Commissioning Group on the Maternity Voices Partnership. We have increased the awareness of skin to skin contact. We have done this by midwives emphasising the importance of skin to skin at the antenatal appointments along with the infant feeding team who are working with families. Skin to skin information is included in information packs for partners.

The Patient and Public Involvement Team worked with members of the Support for Wigan Arrivals Project (SWAP) for refugees and asylum seekers asking their views on receiving their appointment letter via a mobile phone or device. Some of the members thought it was a good idea to receive the letters by a mobile device but what if we have no money for phones? Reassurance was given that if the letter is not accessed a paper copy of the letter would be posted to them automatically.

The patient and public engagement campaign on "Shared Decision Making – Ask 3 Questions" continues to be successful by engaging with patients, public and staff through touch points. The touch points include all patient information leaflets including information on Ask 3 Questions. The continued campaign informs and empowers patients to be involved in decisions about their care and treatment.

We value the contribution of lay representatives who attend the Divisional Quality Executive Committees, Quality Champion Committee, Discharge Improvement Committee, Children's Clinical Cabinet, Infection Control Committee, and PLACE assessment, to give the patients' perspective.

We have reviewed the Trusts Patient Engagement Committee and formed a new Patient Experience and Improvement Committee. The Committee's remit is to ensure that Patient and Public Involvement remain integral to us and all Trust activity. A lay representative attends the committee. Achieving a positive patient experience and improving services for our patients remains a key priority for us.

Consultation with Local Groups and Partnerships

Wigan Borough Clinical Commissioning Group (CCG), Healthwatch Wigan and Leigh, local voluntary groups such as Healthwatch, Think Ahead and the Local Authority work in partnership with us on the Improving Discharge Committee. Some of the improvement work implemented includes discharge prescribing for the Re-enablement Team, pharmacy information leaflet and signposting of the service on discharge medication, introduction of extra pharmacy resource at weekends to ensure that patients receive a safe, effective and caring provision of medication for discharge on Saturdays and Sundays.

Some examples of how the Trust has listened to our patient feedback/comments and made improvements are as follows:

SERVICE	YOU SAID	WE LISTENED
Accident and Emergency Department	I was not told when I could resume normal activities (Type 1).	At each contact opportunity the dedicated member of staff providing care and treatment or any form of support will discuss with the patient when they can resume normal activities. The relevant staff member will support the patient.
Inpatient - Discharge	I was not told who to contact if worried.	We reviewed the discharge booklets. We reviewed external websites for information and added this to discharge information. We reviewed the Clinical Nurse Specialist answerphone message and the quality of information provided.
Cancer Services	I did not have all the information needed about chemotherapy treatment before it commenced.	We ensured all information is given at a pre chemotherapy talk and available in Macmillan Information Centres.
General	I feel like I received an excellent level of care. Thanks to all involved.	We welcome your comments. Thank you.
General	I feel the nurse that dealt with me on most visits has been extremely pleasant and helpful and I would highly recommend her to anybody.	We are delighted you have had such a positive experience.

PART 3.2:
QUALITY INITIATIVES

We have introduced a number of initiatives to strengthen quality governance systems and improve the care, treatment and support provided to patients across the organisation. A summary of progress during 2019/20 is outlined below.

Ward Accreditation

WWL's ward accreditation system ASPIRE (Accreditation System Providing Improvement and Recognition in the care Environment) continues to provide assurance that the care provided by the Trust is of a high standard. ASPIRE also continues to act as an early warning system to highlight any area of concern in a ward or department.

During 2019/20 the Clinical Quality Team have continued to support wards to maintain their bronze awards, prepare for silver awards and most importantly support the white wards in their efforts to achieve bronze. 20 areas have met the standard for bronze; most of the areas which did not achieve bronze on the first visit were successful on the revisit. One ward remains identified as white, and as such, a number of different support mechanisms have been employed. The Clinical Quality team have provided the ward with a suggested improvement plan, which is monitored by the division.

The progress of ASPIRE is monitored by the Harm Free Care Board, which receives its quarterly reports. These reports are also shared via the Senior Nurse Meetings and Corporate Quality and Safety, which allows the learning from ASPIRE visits to be shared across the organisation. The reports highlight any emerging themes

across wards and departments; this allows the trust to make appropriate focused improvements. This reporting process also allows the ward teams to celebrate their successes and share good ways of working and new ideas across the organisation.

Accreditation visits can be used to aid preparation for CQC inspections, with each element of the framework now aligned to a Key Line of Enquiry (KLOE). The ASPIRE visits have seen an increase in staff confidence in showcasing their good work, much of which may have been previously accepted as 'just what we do'. ASPIRE has given direction and support to drive improvements within areas. The use of Appreciative Inquiry during ASPIRE visits has seen staff embrace improvement work, as has the healthy competition to see who will be the first to achieve silver ASPIRE!

A period of reflection allows the team to review the ASPIRE process and the framework and make improvements required. A significant amount of work was undertaken to adapt the framework to work within an App, however, it was decided to continue the accreditation process on paper at present due to challenges experienced during the initial trials.

Measures for silver are currently being trialled to ensure that the targets set are a suitable 'stretch' to drive improvement further. The framework will continue to change over time through lessons learnt and in order to reflect quality improvements required.

2019/20 has seen the development of the matron's audit. This audit was developed out of ASPIRE, focusing on themes or trends which required monitoring for improvement. This audit sits within the Perfect Ward App and is completed monthly, providing further assurance that standards of care are being monitored for improvement. High level reports may be produced and they themselves are used as an improvement measure feeding back into ASPIRE.

2019/20 saw the Clinical Quality Team expand, with the employment of a Clinical Quality Practitioner (CQP) and most recently a Clinical Quality officer (CQO). The CQP provides more 1:1 support to the clinical teams. This support includes using the Ward Performance App, which has been developed by the trust to support teams to monitor their team's performance. The CQO will collect pre visit intelligence and help to collate post visit reports, which will speed up the accreditation process and see it expand to other areas.

Accreditation at WWL is still relatively new, and it continues to be developed to ensure that it is a truly multidisciplinary (MDT) improvement system, which recognises the quality of care provided by all at WWL. ASPIRE results are now proudly displayed in the main entrance on the acute site, and includes images of some of the MDT leaders for the areas visited. This makes a very prominent and positive statement about how the Trust assesses and recognises excellence on the wards and other clinical areas.

Staff Engagement the WWL Way

Staff engagement and experience continues to be high on the agenda at WWL. The 2019 National Staff Survey highlighted a slight improvement in staff engagement since 2018, however the picture overall remains mixed – the scores remain lower than pre-2018, and overall we are within the average range, below our ambitions to be the best for staff engagement.

We measure staff engagement using both the National Staff Survey and a quarterly 'pulse' survey – 'Your Voice'.

Looking at the available data in more detail, the indication is that we have a number of areas of strength regarding staff experience:

- Working relationships within teams are generally positive.
- Staff generally feel trusted to do their jobs with autonomy.
- Staff generally look forward to coming to work at the Trust.

There are also indications of a need for continued development, with certain areas scoring below the national average:

- Quality of appraisals.
- Equality, diversity and inclusion.
- Enabling of development via non-mandatory training.
- Line managers.

Ongoing and upcoming activities to improve these areas, as well as staff experience more generally, include:

- The quarterly staff pulse survey, 'Your Voice', to accurately identify organisational and divisional trends in staff engagement and the factors which enable and hinder this. This leads to both organisational and local plans to tackle issues raised.
- A revision and redesign of the annual appraisal system (My Route Plan).
- Formation of a work stream dedicated to improving equality, diversity and inclusion within the workplace, particularly with regards to opportunities for progression and development opportunities.
- Development of training and of the support available for line managers, as well as continuation of previous offers such as the day Leadership and Management Modules, and Leadership Masterclasses (with the latter being available to all staff).
- Realignment of the training budgets.
- Expansion of the wellbeing offer to staff (Steps for Wellness), with activities including the mindful living programme, roll-out of physical 'health checks', and of the 'power pause', as well as resilience offers.
- Ongoing close local partnerships, such as the Healthier Wigan Partnership.
- Debriefing offers to increase, with an expansion of the Critical Incident Stress Management (CISM) programme.
- Delivery of staff recognition programmes such as Going the Extra Mile, Employee/Team of the Month, and the Recognising Excellence Awards.
- The re-launch of the staff intranet platform, in response to staff feedback.
- Delivery of targeted support and intervention within areas identified as potentially benefitting from OD support.
- 'Focus' magazine, the staff magazine which is produced and distributed quarterly.
- The celebration of national and local initiatives such, as national awareness days, by walkabouts, giveaways and promotion.
- Bespoke learning and development learning opportunities in addition to the corporate offer.
- Delivery of the highly successful Pre-employment and Apprenticeship programmes.
- Partnership working with local schools and colleges to promote careers in the NHS.

Our locally-developed staff engagement programme, Go Engage, continues to be utilised by other organisations, with 14 organisations currently using the system. A dedicated team continues to work on developing and growing this as a commercial product, as well as supporting the internal staff engagement team with engagement within the Trust.

Continued Recruitment and Development of the Quality Faculty

2019-20 Overview of Trust-Wide Quality Improvement Training within the Transformation Team

The Transformation Team visited each of the Trust's three sites at the end of summer 2019 and undertook a survey to seek feedback from current and past Quality Champions (QC) regarding the Quality Champion course content, delivery method and support provided. Findings from this fact-finding exercise indicated the need to provide more structured training around managing the project life-cycle, including Quality Improvement (QI) project sponsor sign-off, project scoping, stakeholder management, data collection and analysis, problem solving, root cause analysis, process mapping, future state improvements using action plans and sustaining achievements. The feedback was taking on board and improvements made to the Quality Champion programme. The newly designed programme was tested, refined and rolled-out in January 2020. In addition to this, the Transformation Team now runs regular 'drop-in' coaching sessions to provide on-going support as needed for those completing their first or subsequent QI projects.

The new QC training programme is now modular based. A new format and delivery method has been developed and rolled out during January 2020 This has been extended by an extra day, to three days, to include new advanced QI tools and techniques missing from the condensed two day programme to ensure projects fully deliver their goals. The new programme has been designed to walk employees through their sponsor signed-off Quality Improvement project, from project improvement idea through to project completion and close-out.

Benefits and impact of the changes made to the new QC training programme:

- QI Projects now require sponsor 'sign-off' from their senior manager to ensure project objectives are aligned to WWLs strategic priorities
- An A3 Project Charter (one page) is now used to clearly define and communicate project objectives, thus reducing future conflict between key stakeholders and team members
- The data collection and analysis process provides more focus on establishing baseline metrics to demonstrate performance improvement
- Ensures correct use of mapping activities clearly identifying customer driven value streams
- Using an action plan to manage future state process improvement, ensuring projects deliver sustainable results over time
- Modular based training (each module can be delivered independently of each other to meet specific needs e.g. Value Stream Mapping a departments current state processes)
- More emphasis and 'hands-on' use of QI tools and techniques resulting in better project outcomes and success

The Quality Champions Training Programme has continued to attract increasing numbers of Quality Champions from both clinical and non-clinical divisions. In summary for 2019-2020:

- Three Quality Champions training courses completed
- Two QC courses in progress
- Two QC course pending
- 84 employees undertaking the QC training course
- There is now no waiting list for QC training
- There are now 450 Quality Champions who have completed the QC training programme
- There are 343 completed QI projects from Quality Champions to date

All Quality Champions who complete the training programme and commence an improvement project are awarded a bronze badge. Silver and gold badges are awarded to those Quality Champions who sustain their improvements and disseminate them to other organisations.

In 2019-20 the awards have now increased to:

433 **Bronze awards,**

89 **Silver awards,**

31 **Gold awards across the Trust.**

In the year there were 15 Silver and 4 Gold badges awarded.

The Quality Champions conference took place in October 2019 attracting both Trust and external delegates to experience and share best practise on Quality Improvement. Key note speakers were Helen Bevan, NHS Horizon, and Roy Lily from the Fab Academy. Quality Champions led and delivered their projects and badges were awarded to the Gold and Silver project team leads. We also had fourteen Quality Champion posters displayed around the conference room highlighting specific Quality Champion projects for delegates to view throughout the day.

The Transformation Team have introduced 'lunch and learn' one hour introductory QI sessions at all three Trust sites. These have been designed to introduce employees to methodologies and tools they could use in improving their workplace environment. In addition to this, as a member of Advancing Quality Alliance (AQuA), we have taken advantage of three one day 'Essential Quality Improvement Planning' (EQuIP) training sessions offered to Trust employees. Offering these two additional options to Trust employees, it is expected to attract more interest onto the QC training programme throughout 2020-21.

The Transformation Team have provided assistance to Astley Ward (Wigan), Upper Limb Ward 1 and Orthopaedic Wards 1 and 2 at Wrightington set up and manage the introduction of weekly Quality Improvement MyQ Boards. These are designed to identify 'day-to-day' quality improvement opportunities, address these problems and record outcomes on a weekly tracker. To date MyQ boards have identified and made over 56 small scale improvements during a six months period.

The Transformation Team continue to provide QI training and support on SAVI Schemes e.g. MSK, GP Out of Hours and Estates. The support ranged from Idea for Improvement generating sessions to leading teams as they map out their service pathways to developing improvement action plans.

The Quality Champions training programme and support programmes will continue to adapt and evolve to meet our diverse and changing stakeholder needs throughout 2020-21 and improved alignment in enabling the achievement of corporate priorities and objectives.

Leadership Walkrounds

There have been scheduled Leadership Quality and Safety Rounds throughout 2019/20. These involve Executive Directors, Non-Executive Directors and Governors. Visits took place in the following areas: Maternity Ward, Leigh Walk in Centre, Dermatology, Endoscopy Wigan, Theatre Wigan, Paediatric Out Patients, Theatres Leigh, Accident and Emergency, Planned Investigation Unit and John Charnley Wing.

The HELPline

The HELPline continues to be a useful method of communication for families and carers to be able to contact a senior nurse when they need to discuss aspects of their loved one's care. It is intended to be a way of escalating concerns that families may feel have not been addressed adequately by ward or department staff. HELPline is a mobile phone that is carried on a rota basis between all operational divisions. The number of calls has remained fairly constant, and the majority of calls are resolved either during that point of contact or very soon afterwards.

APPENDIX A:
NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES

The National Clinical Audits and National Confidential Enquiries that WWL has participated in during 2019/20 are as follows:

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Eligible to partnership Y/N	Participated	Number eligible	Actual submissions
Pulmonary embolism	Y	Y	4	3 (75%)
Acute bowel obstruction	Y	Y	5	4 (80%)
Long term ventilation	Y	Y	2	2 (100%)
Young people's mental health study	Y	Y	None eligible	NA
Dysphagia in Parkinson's Disease	Y	Y	8	8 (100%)
In Hospital Management of Out of Hospital Cardiac Arrests	Y	Y	5	3 (60%)

National Audits (NCAPOP)	Eligible	Participated	Number submitted	Actual submissions %
Falls and Fragility Fractures Audit programme (FFFAP) (Comprises 3 audits, as below):				
• Fracture Liaison Service Database (FLS-DB)	Y	Y	140	100%
• National Hip Fracture Database (NHFD)	Y	Y	346	100%
• National Audit of Inpatient Falls (NAIF)	Y	Y	5	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme	Y	Y	Ongoing data collection Up to date	Ongoing
National Asthma and Chronic Audit Programme (NACAP) Comprises following 3 audits below:				
• COPD	-	-	536	Ongoing
• Asthma	-	-	124	Ongoing
• Paediatric Data	Y	Y	34	Ongoing
National Audit of Breast Cancer in Older People (NABCOP)	Y	Y	Ongoing data collection Up to date	Ongoing
National Audit of Care at the End of Life (NACEL)	Y	Y	41	100%
National Audit of Dementia (Care in general hospitals)	Y	N	-	-
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Y	Y	73	100%
National Cardiac Audit Programme (NCAP) Comprises the following audits below:				
• Heart Failure (Heart Failure audit)	Y	Y	308	Ongoing
• Adult Percutaneous Coronary Interventions (Angioplasty audit)	Y	Y	614	Ongoing
• Cardiac Rhythm Management (Arrhythmia audit)	-	-	347	100%
• Myocardial Ischaemia/MINAP (Heart Attack audit)	Y	Y	530	Ongoing
National Diabetes Audit – Adults	Y	Y	Data collection ongoing	Ongoing
National Early Inflammatory Arthritis Audit (NEIAA)	Y	Y	75	Ongoing
National Emergency Laparotomy Audit (NELA)	Y	Y	153 (2019 data)	100%
National Gastro-intestinal Cancer Programme	Y	Y	Ongoing data collection Up to date	Ongoing
National Lung Cancer Audit (NLCA)	Y	Y	Ongoing data collection Up to date	Ongoing
National Maternity and Perinatal Audit (NMPA)	Y	Y	Ongoing data collection Up to date	Ongoing
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Y	Y	Ongoing data collection Up to date	Ongoing
National Ophthalmology Audit (NOD)	Y	Y	1176	Ongoing
National Paediatric Diabetes Audit (NPDA)	Y	Y	154	Ongoing
National Prostate Cancer Audit	Y	Y	Ongoing data collection Up to date	Ongoing
Sentinel Stroke National Audit programme (SSNAP)	Y	Y	275	92%

Non-NCAPOP commissioned	Eligible	Participated	Number submitted	Actual Audit Submissions %
BAUS Urology Audit - Female Stress Urinary Incontinence	Y	Y	13	100%
BAUS Urology Audit - Percutaneous Nephrolithotomy	Y	Y	12	100%
Case Mix Programme (CMP)	Y	Y	469	100%
Elective Surgery - National PROMs Programme	Y	Y	See part 2.3: Reporting against core indicators	-
Endocrine and Thyroid National Audit	Y	N	-	-
Head and Neck Audit (HANA)	Y	N	-	-
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	Y	N	-	-
Major Trauma Audit	Y	Y	153	72%
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	Y	Y	Ongoing data collection	Ongoing
National Audit of Seizure Management in Hospitals (NASH3)	Y	Y	Data not available	-
National Cardiac Arrest Audit (NCAA)	Y	Y	124	100% (awaiting validation)
National Joint Registry (NJR)	Y	Y	3700	99%
Perioperative Quality Improvement Programme (PQIP)	Y	Y	34	-
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Y	Y	Ongoing data collection	Ongoing
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Y	Y	3	100%
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Y	Y	Submission of audit	100%
Surgical Site Infection Surveillance Service	Y	Y	Ongoing data collection	Ongoing
UK Cystic Fibrosis Registry	Y	Y	22	100%
UK Parkinson's Audit	Y	Y	Ongoing data collection	-

Note: The figures above represent the information provided to the Clinical Audit Department by the relevant audit leads/ departments. Data collection for some of the audits extends beyond the date of this report therefore the figures contained within the report may not correspond with the actual validated figures published in the final audit reports.

ANNEX A:

Statements from Wigan Borough Clinical Commissioning Group, Healthwatch Wigan and Leigh and Wigan Health and Social Care Scrutiny Committee

This section outlines the comments received from stakeholders on this Quality Account prior to publication.

Wigan Borough Clinical Commissioning Group

Wigan Borough Clinical Commissioning Group Response to Wrightington Wigan and Leigh Teaching Hospitals NHS Foundation Trust Quality Account 2019/20

Wigan Borough Clinical Commissioning Group (the CCG) welcomes the opportunity to comment on the twelfth Quality Account for Wrightington, Wigan and Leigh NHS Foundation Trust.

The CCG acknowledges the level of partnership working that has been undertaken by WWLFT during 2019/20 to improve the quality, safety and experience of care for our residents and more latterly to support the Boroughs response to the COVID-19 pandemic.

In respect of the 2019/20 quality priorities, the CCG acknowledges progress has been made in a number of areas; of particular note is:

- A reduction in the number of falls reported which resulted moderate, severe or catastrophic harms on the wards or adjacent areas
- An increase in the number of patients reporting that they received information on medicines at discharge
- An increase in the number of patients reporting that they were treated with kindness and understanding during the care received in hospital after the birth of their baby
- A reduction in the number of complaints related to discharge

The CCG notes some of the objectives for 2019/20 were not achieved including a reduction in the number of sharps incidents and improving the time to appropriate bed for patients with a fractured neck of femur and although these objectives have not been carried over into 2020/21 the CCG does not want the Trust to lose sight of these targets.

Challenges in year have included an increase in:

- Hospital acquired pressure ulcers
- Summary Hospital Level Mortality Indicator (SHMI)
- Clostridium difficile cases
- Serious incidents

The CCG supports the quality priorities identified for 2020/21 and welcomes the focus on:

- Increasing to 95%, the percentage of patients with Red Flag sepsis receiving antibiotic treatment within 1 hour in both Accident and Emergency (A&E) and on wards
- Reducing the number of category 3, 4 and unstageable pressure ulcers contributed to by lapses in care by 50%
- Reducing the number of Clostridium difficile infections by 20% where there have been lapses in care
- Achieving a SHMI within the expected range. This will be supported by a review of pathways across the system
- Improving patients experience of discharge

In recognising the Trust's exceptional response to the first wave of the COVID-19 pandemic the CCG would ask the Trust to concert its efforts to meet the needs of all other patients during 2020/21, in order to reduce unmet need and tackle health inequalities. Undertaking harm reviews for all long waiters must also be a priority for 2020/21.

The CCG will continue to work closely with the Trust to support the Wigan Borough response to the COVID-19 pandemic and the delivery of the Wigan Borough Recovery Plan.

The CCG looks forward to working in partnership with the Trust and other stakeholders during 2020/21 to ensure the continuous focus upon quality improvement in both acute and community services in order to provide the best possible care for our residents.

Dr Tim Dalton,
Chairman, Wigan Borough Clinical Commissioning Group
23 September 2020

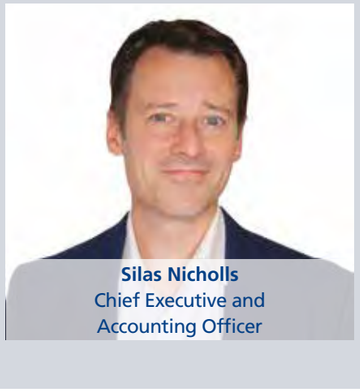
Healthwatch Wigan and Leigh

Healthwatch thanked the Trust for giving them sight of the draft Quality Accounts and the opportunity to comment. Unfortunately, on this occasion Healthwatch would not be providing feedback on the Accounts, however will work with the Trust going forwards to ensure future involvement.

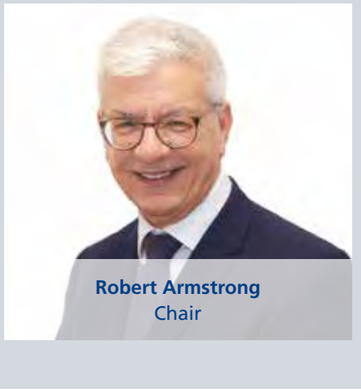
Health and Social Care Scrutiny Committee

Comments were sought from Overview and Scrutiny Committee; however, none were received.

ANNEX B:
STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY REPORT



Silas Nicholls
Chief Executive and
Accounting Officer



Robert Armstrong
Chair

The Directors of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust ("WWL") are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that the NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2019/20 and supporting guidance Detailed requirements for quality reports 2019/20;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2019 to March 2020.
  - Papers relating to Quality reported to the Board over the period April 2019 to March 2020.
  - Feedback from commissioners dated 29 September 2020.
  - Feedback from governors dated (Commentary not received).
  - Feedback from local Health Watch dated 2 October 2020.
  - Feedback from Overview and Scrutiny Committee (Commentary not received).
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated September 2020.
  - The 2019 national patient survey July 2020.
  - The 2019 national staff survey dated 30 January 2020.
  - The Head of Internal Audit's annual opinion over the Trust's control environment (Opinion not received).
  - CQC inspection report dated 26 February 2020.

- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate ;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and;
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Silas Nicholls
Chief Executive and Accounting Officer
7 October 2020

Robert Armstrong
Chair
7 October 2020

ANNEX C:
HOW TO PROVIDE FEEDBACK ON THIS REPORT

Feedback on the content of this report and suggestions for the content of future reports can be provided by calling the Foundation Trust Freephone Number 0800 073 1477 or by emailing: foundationstrust@wwl.nhs.uk

Visit our website

View our Qualityl Report 2019/20 online:
www.wwl.nhs.uk

ANNEX D:
EXTERNAL AUDITORS LIMITED ASSURANCE REPORT

We have been advised by our External Auditors that there is no requirement for the Trust's Quality Accounts to be audited this year, as NHSE/NHSI removed the requirement as part of the changes they made in response to COVID.

THANK YOU
NHS

NHS

Wrightington, Wigan and
Leigh Teaching Hospitals

NHS Foundation Trust

Title of report:	Infection prevention and control annual report 2019/20
Presented to:	Board of Directors
On:	25 November 2020
Presented by:	N/A – Consent agenda
Prepared by:	Deputy Director of Infection Prevention and Control
Contact details:	Rebecca.Gerrard@wwl.nhs.uk

Executive summary

The attached annual report was considered by the Quality and Safety Committee (as the assurance committee on behalf of the board) at its meeting on 29 September 2020 and is presented for the board's information.

Link to strategy

N/A

Risks associated with this report and proposed mitigations

Risks are identified within the attached report.

Financial implications

There are no specific financial implications to bring to the board's attention.

Legal implications

All legal implications are detailed in the attached report.

People implications

N/A

Wider implications

There are no wider implications to bring to the board's attention

Recommendation(s)

The Board are asked to receive and note the report.

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

DIRECTOR OF INFECTION PREVENTION AND CONTROL ANNUAL REPORT 2019/2020

Author: Director of Infection Prevention and Control
Date: August 2020

Prepared by: Dr R Nelson, Ms R Gerrard, Mr N Bastow, Mr S Mellor

The WWL Way

AT ALL TIMES, STAFF MUST TRE
AT EVERY INDIVIDUAL WITH RESPECT
AND UPHOLD THEIR RIGHT TO PRIVACY AND DIGNITY.

1 EXECUTIVE SUMMARY

This is the sixteenth Director of Infection Prevention and Control's (DIPC) report, covering the period April 2019 to March 2020. The DIPC Report is produced on an annual basis and incorporates the Trust's Annual Infection Prevention and Control Report. The DIPC Report consists of an overview and progress report on the Infection Prevention and Control management arrangements (including budgetary control), together with other Infection Prevention and Control activities. This document also provides summary reports on the following:-

- Description of Infection Prevention and Control Team Arrangements
- Infection Prevention and Control Budgetary allocation
- Healthcare Associated Infection statistics
- Decontamination
- Cleaning Services
- Audit
- Targets and Outcomes

2 DESCRIPTION OF INFECTION PREVENTION AND CONTROL TEAM ARRANGEMENTS

See: Appendix 2, Wrightington, Wigan and Leigh NHS Foundation Trust: Infection Prevention and Control Policy and Appendix 3 for the Infection Prevention and Control Committee Terms of Reference.

3 DIPC REPORTS TO THE TRUST BOARD

The Director of Infection Prevention and Control has presented the Trust Board with the following agenda items on Infection Prevention and Control in 2019/2020.

- The DIPC Annual Report 2018/2019 – endorsed.
- Infection Prevention and Control Committee Annual Programme 2019/2020 – endorsed.
- Bimonthly Infection Prevention and Control Committee minutes highlighting outbreaks and areas of concern and progress.
- The Trust MRSA Bacteraemia trajectory progress and areas of concern.
- The Trust *Clostridium difficile* trajectory progress and areas of concern.
- Trust MSSA and Gram-negative bacteraemia results.

The Director of Infection Prevention and Control acts as the liaison between the Trust Board, Infection Prevention and Control Committee and Infection Prevention and Control Team.

4 BUDGET ALLOCATION TO INFECTION PREVENTION AND CONTROL ACTIVITIES

- The Infection Prevention and Control budget for 2019/2020: (£386,204) (non-pay = (£9,145)).
- Microbiology services were provided as part of the PAWS Consortium and individual budget information is not available.
- Infection Prevention and Control staff: = 5.72 WTE.
- Infection Prevention and Control Doctor = 0.5 WTE.
- Consultant Microbiologist = 1.5 WTE.
- Antimicrobial Pharmacist = approximately £49,000 per annum.

5 INFECTION PREVENTION AND CONTROL ANNUAL PROGRAMME 2019/2020 AND REVIEW OF PROGRESS – SEE APPENDIX 4

6 HEALTH CARE ASSOCIATED INFECTION STATISTICS

Results of Mandatory Reporting of Health Care Associated Infection:

- See Table 1.

Trends in Health Care Associated Infection Statistics:

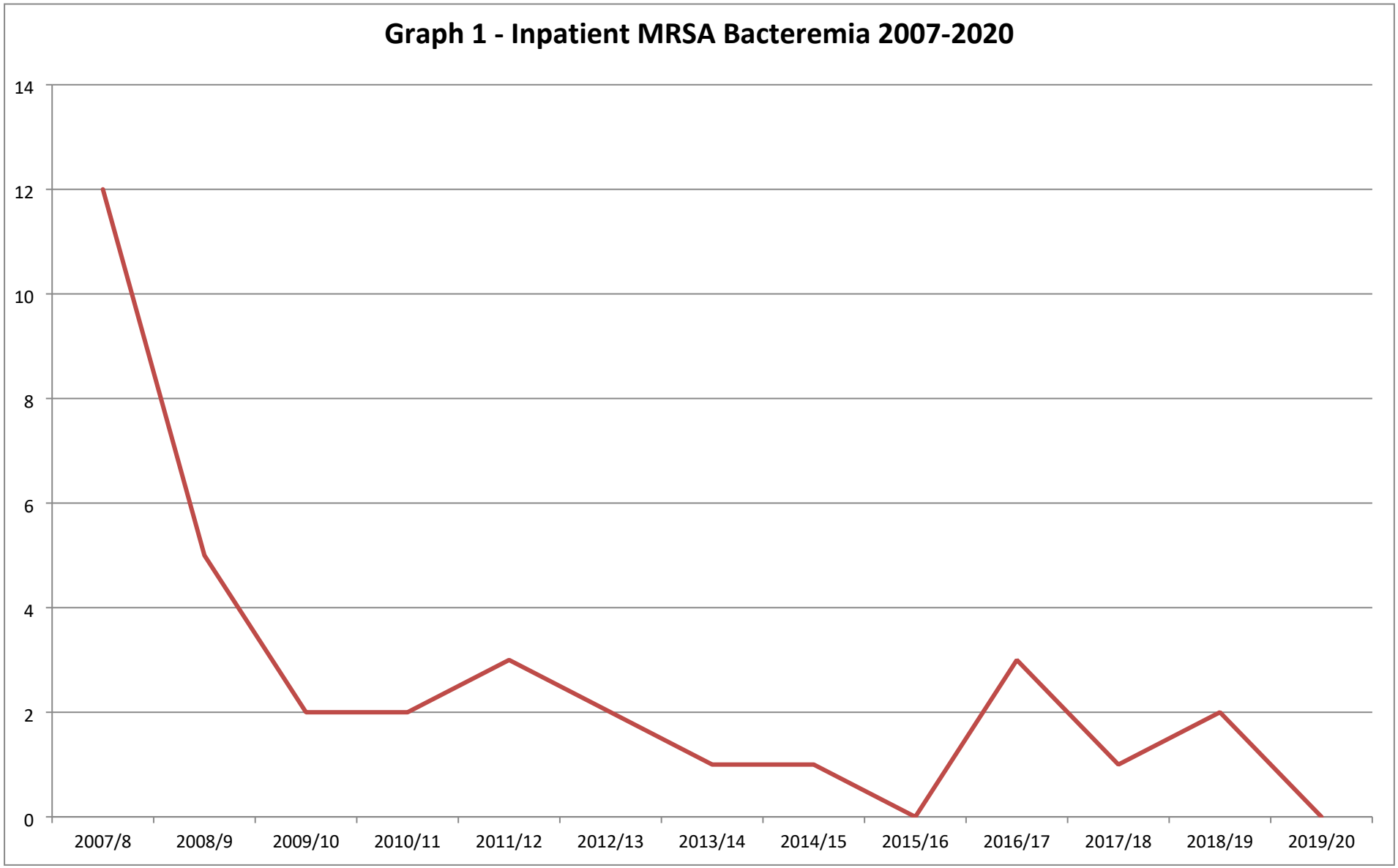
- MRSA bacteraemia – See Graph 1.
- *Clostridium difficile* diarrhoea – See Graph 2.

Trust performance against Health Care Associated Infection reduction targets:

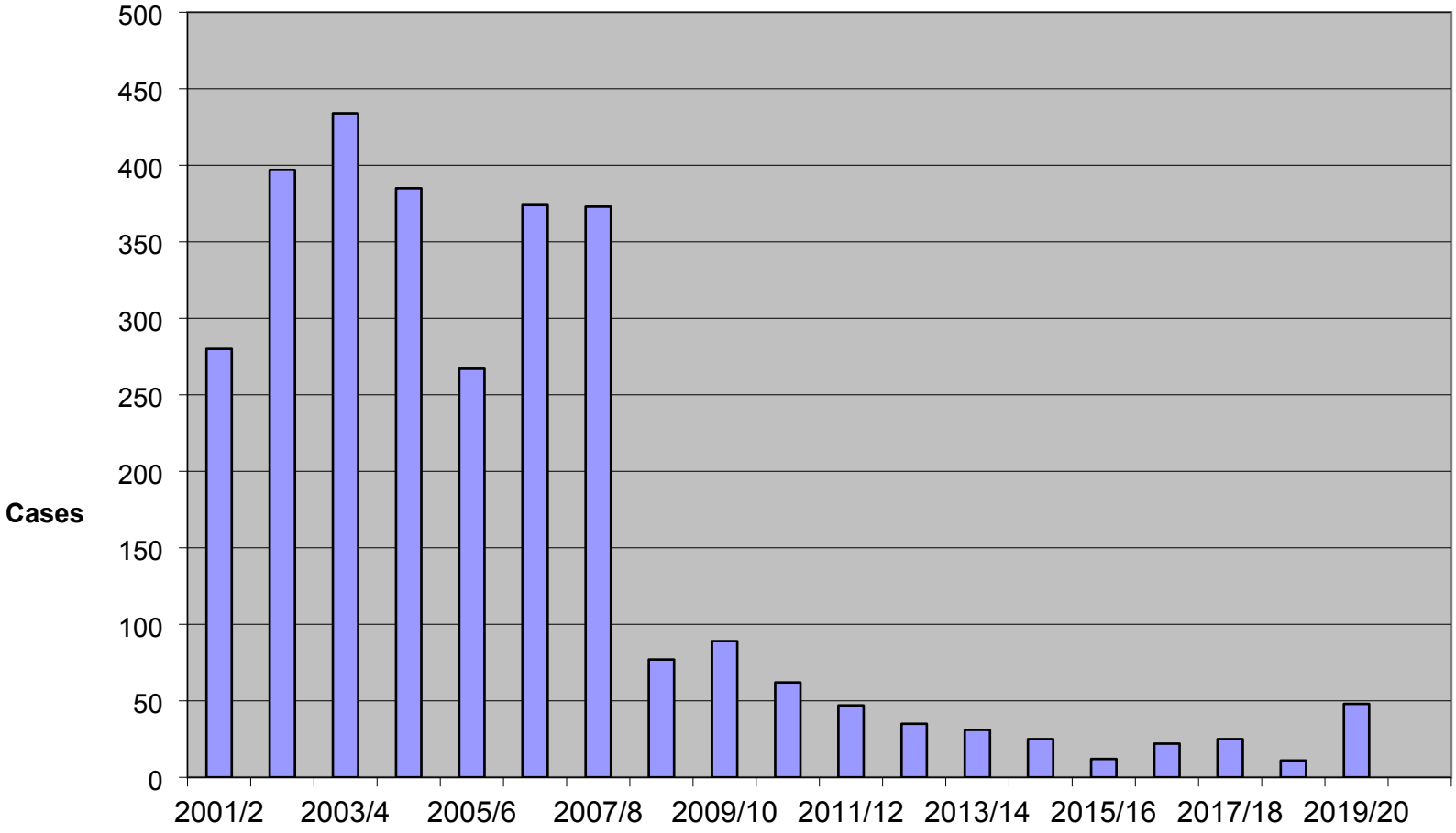
- *Clostridium difficile* diarrhoea – See Graph 3.

TABLE 1 – RESULTS OF MANDATORY REPORTING – INDIVIDUAL CASES

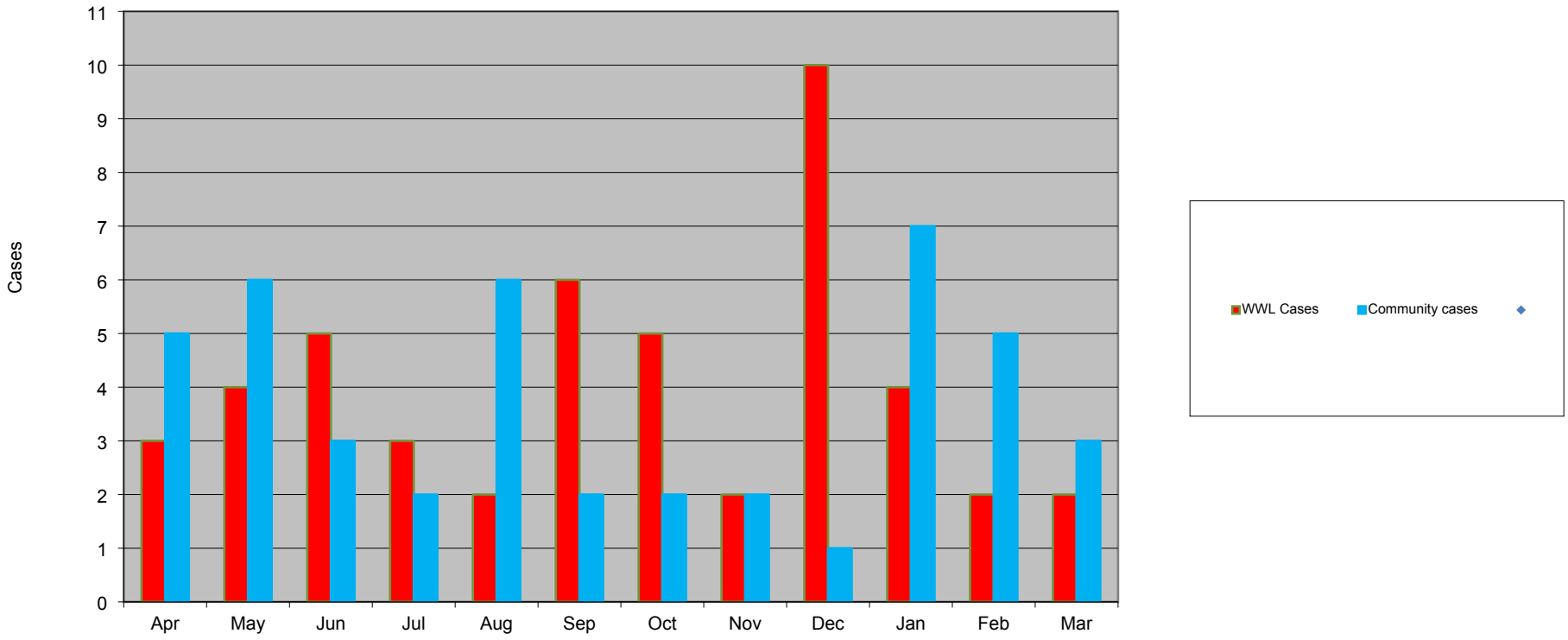
YEAR		2019			2020	TOTAL
Quarter		2	3	4	1	
MRSA Bacteraemia (cases)	Community onset	0	2	2	1	5
	Acute Trust case	0	0	0	0	0
MSSA Bacteraemia (cases)	Within 48 hours of admission	6	13	6	8	33
	> 48 hours post admission	0	3	3	3	9
E. coli Bacteraemia (cases)	Within 48 hours of admission	26	19	14	24	83
	>48 hours after admission	9	5	7	6	27
Klebsiella Bacteraemia (cases)	Within 48 hours of admission	6	4	8	3	21
	>48 hours after admission	3	3	3	1	10
Pseudomonas aeruginosa Bacteraemia (cases)	Within 48 hours of admission	3	0	1	0	4
	>48 hours after admission	0	2	1	0	3
*Clostridium difficile (*cases)	Within 2 days of admission or taken in the community	14	10	5	15	44
	> 2 days post admission	12	11	17	8	48
Orthopaedic surgical site Infection - % of cases	Hip replacement	0.5%	1.2%	0.2%	Data awaited	
	Long bone fracture	0%	5.3%	0%	Data awaited	
	Fractured neck of femur	0%	1.2%	0%	Data awaited	
	Knee replacement	0.3%	0.9%	1.3%	Data awaited	


Graph 1 - Inpatient MRSA Bacteremia 2007-2020
14
12
10
8
6
4
2
0
2007/8
2008/9
2009/10
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
2019/20

Graph 2 - Inpatient C.difficile 2001-2020



Graph 3 - Clostridium difficile - Monthly Performance 2019/20



7 UNTOWARD INCIDENTS (INCLUDING OUTBREAKS)

2019 Second Quarter

- The Acute Stroke Unit was closed to admissions following evidence of transmission of flu between staff and patients. Index case was an unvaccinated member of staff who introduced the virus. The Ward was closed for seven days. There was no evidence of adverse outcome amongst staff or patients.

- An individual had a bacteraemia with Carbapenem Producing Enterobacteriaceae (CPE). This individual was symptomatic on admission and had recent contact with a neighbouring Trust with an increased incidence of CPE bacteria. The individual was treated with a new antibiotic – Ceftazidime/Avibactam and responded well.

2019 Third Quarter

- A case of Pseudomonal Endophthalmitis was detected following cataract surgery at Leigh Infirmary. A serious case review was performed. No obvious cause was detected and no further cases occurred.

- There had been an increased incidence of *Clostridium difficile* infection on the Acute Stroke Unit. Two of these cases shared a common ribotype suggesting a possible link. Multiple interventions were undertaken including resiting of staff rest area and improving equipment storage.

2019 Fourth Quarter

- No significant incidents.

2020 First Quarter

- COVID-19 cases began to be detected in late March 2020. This resulted in a significant restructuring of patient management with defined cohorts set up for symptomatic, asymptomatic, negative and confirmed COVID-19 cases. ICU capacity was vastly expanded and an additional 57 bedded unit built to accommodate COVID-19 positive patients requiring ventilation.

8 DECONTAMINATION

Decontamination of Surgical Instruments

Background

The Sterile Services and Decontamination Unit (SSDU) based near Horwich in Bolton was opened in December 2010 and provides a Surgical Instrument Decontamination Service to all theatres/wards/clinics in WWL and Salford Royal (SRFT) Trusts. SSDU provides all re-usable surgical instruments that are required as Sterile or Disinfected at point of patient use to enable a patient treatment episode to be performed, as a Shared Service between both organisations.

Capacity

Table to Demonstrate Activity and SMV:						
Year	Activity			SMV		
	SRFT	WWL	Total	SRFT	WWL	Total
2010/11	Activity only collated from April 2011 when both trusts officially transferred.					
2011/12	169,258	148,440	317698	2,729,969	2,539,878	5,269,847
2012/13	163,654	145,613	309267	2,846,809	2,599,952	5,446,761
2013/14	163,962	143,406	307,368	2,619,806	2,390,493	5,010,299
2014/15	141911	142486	284397	2,579,613	2,555,438	5,135,051
2016/17	148576	136528	285104	2,681,395	2,429,418	5,110,813
2017/18	126052	126385	252437	2,247,111	2,403,406	4,650,517
2018/19	88541	123085	211626	1,554,519	2,444,838	3,999,357
2019/20	117716	128328	246044	2,315,554	2,665,062	4,980,616

Validation

SSDU has been audited by Intertek (notified body) on 1 occasion this year:
October 2019 recertification audit to Production Quality Assurance , Directive 93/42/EEC for Medical Devices, Annex V .

To the following standards:

- EN ISO 13485:2016 (The decontamination, assembly, packing, inspection and sterilisation of Sterile instruments sets/trays and ward packs.

  The unit successfully completed the audit and no non-conformances were raised.

Issues

The European Union Medical Device Regulation repeals the existing directives on medical devices: Medical Devices Directive [93/42/EEC] and Active Implantable Medical Device Directive [90/385/EEC]. The regulation was published on 5 May 2017 was due to come into force on 25 May 2020, however a 12 month extension to this date has been given. A gap analysis has been produced and Fiona Kennedy quality consultant for medical devices has been invited to review the gaps and help with improvements to our quality system. We did not intend to convert to the new standard in our external audit scheduled for October 2019 and have requested an extension to continue under the scope of Medical Device Directive [93/42/EEC] is due to expire on October 2024 but may transition to the new regulations before this date. Whilst regulated to the MDD and

for the remaining period until its expiry SSDU has appointed an EC representative in preparation for the 1st January 2021 where the UK leaves the European Market. It is likely that the UK will have its own regulation. Currently the UK Medical Device Regulations (2002) are under review and once published SSDU plan to transition to implement the UK Medical Device regulations with a UK Conformity Assessment Body.

There are two risks on the Divisional Risk Register the first relates to injury to staff caused by contaminated sharps and the second relates to Failure of washer disinfectors and sterilising equipment impacting on productivity. There are currently no risks scored to corporate level.

The SUI (Serious Untoward Incident) that was reported on the 12th December 2018, where SSDU despatched 12 products to customers where incorrect sterilisation information had been associated to each product, has been audited by Intertek and the corrective action has been closed.
There have been no new SUI reported in the last 12 months.

The major Health and Safety item remains sharps and single use item returns from the users, in particular needles and blades. No serious accidents resulting in clinical care for staff have yet occurred with all technicians trained to spot and deal with all such incidents. The return of single use instruments has remained high over the past 12 months whilst SSDU procedures are robust and to date have we captured and disposed of all single use instruments, there is an increased risk related to the current levels that are being sent back.

Endoscopy Processing

An Endoscopy project, led by Estates has been completed and has centralised endoscopy decontamination at RAEI by employing a standalone decontamination facility situated in the Christopher home building. Go live was June 2017.This year the facility has taken on board services for Orrell Ward, ICU and Wigan Theatres. The facility has processed between 170-200 scopes per week. The Steris machines that were located in theatre have now been decommissioned.

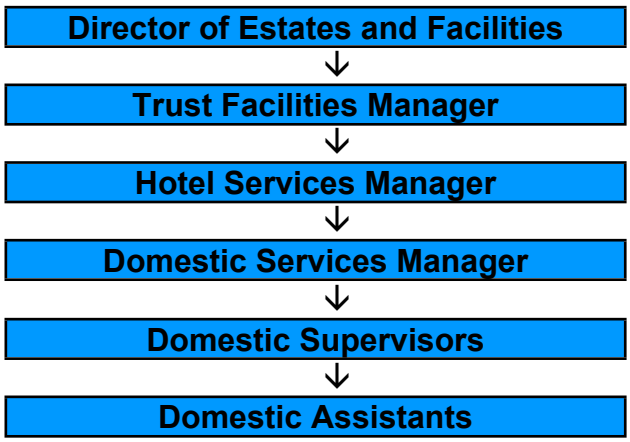
The Hanover Diagnostic and Treatment Unit opened in June 2013 with SSDU managing the decontamination of flexible endoscopes used on site in a dedicated state of the art unit.
It processes, on average, 250 endoscopes per week for the relevant departments within the Hannover building.

The two sites will provide business continuity for each other in the event of failure.

ENT scopes at Thomas Linacre Centre (TLC) are currently being decontaminated manually under a risk assessment using a 3-stage wiping system. A business case to decontaminate these wipes at RAEI was rejected and an option to use a UV light system to disinfect scopes at TLC is being considered.

9 CLEANING SERVICES

The domestic management structure is as follows:



The Director of Performance is the designated director who has the strategical responsibility for the domestic services provided throughout the organisation, who engages in one to one meetings with the Director of Estates and Facilities.

The Trust Facilities Manager is able to access the clinical access through the Director of Nursing and regular meetings with the associate director of Infection Prevention and Control Team. The Trust Facilities Manager has the overall the strategic management responsibility for the services provided implementing initiatives and guidelines, monitoring the National Cleaning standards promoting a proactive service meeting the needs of the Trust and in turn reporting to the Associate Director of Estates and Facilities.

The Hotel Services Manager manages the Domestic provision operationally Trust-wide, who in turn reports to the Trust Facilities Manager. They engage in one to one meetings improving methods and maintaining the standards of cleanliness.

The two Domestic Services Managers based on designated sites have the day to day operational management responsibility for their respective sites and reports in their structure to the Hotel Services Manager.

The Domestic Assistants/Supervisors work to planned rotas, providing the cleaning service requirements of our patient environment; this in in turn is measured by the National Cleaning standards on a monthly basis and monitored by service level agreements' which are tailored to every ward within the organisation. Outpatient areas within the Trust are monitored in line with the National Cleaning Standards on a 6 monthly basis. There is a mobility agreement in place to transfer Domestic assistants within the organisation to other hospital sites and outpatient clinics to undertake cleaning duties if required to meet our patient's needs.

Environmental Cleaning Standards Forum

The Trust has a regenerated 'Environmental Cleaning Standards Forum' chaired by the Deputy Director of Nursing and Patient Services. The forum comprises of members from multi-disciplinary backgrounds and patient representatives. The group's remit is to improve the Trust Cleaning Standards, domestic provision and associated services delivered to the Trust. It also Implements quality measures, innovations and uniformity in Cleaning Practices.

Examples include:

- Monitoring the Deep Clean schedule.

- Reviewing methodology, monitoring, developing and enhancing the standards of cleanliness within the Trusts Clinical areas. Fulfilling the organisations aspirational target of 95% and maximising on its staff efficiency costs.

- Reviewing the Service Level Agreements supplied to the clinical areas within the Trust.

- Evaluating and standardising the cleaning products and equipment currently used across the Trust.

National Cleaning Standards

The Trust maintains the National Cleaning Standards code and monitors its standards using the Service track monitoring system. The domestic supervisors audit the clinical areas on a monthly basis supplemented with daily and weekly visual checks. The Ward Manager receives the audit sheet and accompanies the Domestic Supervisor to assess the levels of hygiene and environmental standards within their area. The Heads of Nursing and Matrons can accompany the Deputy Hotel Services Manager on a quarterly basis ensuring that the ward areas are maintained to a high standard.

The average annual National Cleaning Standard Trust score for its clinical areas has met its internal aspirational target of 95%.

The 2017 PLACE verification inspection was accompanied by an external validator who supported the Trusts submission as good and noted the many excellent practices held for patient environment and food on the RAEI, Wrightington and Leigh sites. This year the Trust has attained 100% cleanliness for Leigh and Wrightington sites for the fourth year running, with the RAEI site achieving 99.98%. WWL is ranked 5th in the Country; this was reflected by the annual Information Centre for Health and Social Care publication. The assessment team who asses the patient environment is once again a Multi-disciplinary Team with a ratio of 50% patient volunteer assessors working in partnership who promote independent good practice across our sites. Picker results showed our results patients scored the Cleanliness as Excellent at 99% within the 75 Trusts benchmarked.

The Domestic provision budget is £ 4,494,861 (pay) and £ 439,389 (non-pay) totalling £4,848,250, which is managed by an in-house service. All the domestic frequencies and hygiene scores are publically displayed at the entrances of the wards as in line with good practice. The Trust Facilities Manager has evaluated the Model Hospital NHS Improvement information and measured the Trust performance against the report's recommendations. The Domestic service has demonstrated a high performance approach to its standards of quality at £40.00 per square metre undertaking the cleaning of high risk areas such as Theatres, Intensive care and specialist care units. The cost of 24 hour provision with the planed deep cleaning of the wards and enhanced by annual cleans of outpatients areas, which provide a National benchmark evidence to demonstrating value for money.

Disposable Curtains

The Trust continues to have disposable cubicle curtains which are date stamped and changed routinely every 6 months unless damaged or stained, this maintains a quality standard facility throughout all of its wards. This quality innovative decision has improved the privacy and dignity of its patients due to the strap line message displayed through the curtain.

24 hour Cleaning Team

The Trust has a 24 hour cleaning team on the main acute site which targets high usage areas such as the Emergency Care Floor, Clinical Decisions Ward and the out of hour's bed space cleaning. A hydrogen peroxide vapour decontamination process also takes place on the discharge of patient's rooms with a known CPE+, positive CDT & PCR+ status.

Additional Toilet Cleans

The Trust continues its additional toilet cleans which takes place across all the wards during the afternoons and evenings once again maintaining the Trust quality standards. This has been received as a quality measure by our patients whom in the recent patient survey put the toilet cleanliness score consistently at 99%.

Deep Clean Team

The Trust has a designated deep cleaning team, which works across the sites, striving to provide the very best patient environment and working towards the reduction of Hospital Acquired Infections. The deep/enhanced clean schedule is produced at the beginning of the financial year in conjunction with the Infection Prevention and Control Team. The Trust has achieved in 2018/19 the deep cleaning of its wards. This work is undertaken by a designated Multi-disciplinary Cleaning/Estates Team.

The deep clean process undertakes the environmental restoration, cleaning and steam sanitising of the clinical environment including the cleaning of the lighting and ventilation equipment. There is a secondary enhanced ward clean which takes place six months after the deep clean on medical wards. This scheduled enhanced clean is tailored to meet the individual needs and activity of the wards.

A detailed programme of the deep cleans are displayed at the entrances of the sites advising our patients and visitors of the progress. The scheduled dates are prioritised throughout the year to meet the organisations winter pressures.

Satisfaction Surveys

The Domestic Services department participates with patient satisfaction surveys. The indications show our patients are happy with the standard of cleanliness delivered the independent score is currently standing at good to excellent at above 99%. The Trust Domestic Services Department regularly meet with to assess the patient's scores and comments to look at ways of improving the services provided. There have been no formal complaints received detailing the standard of cleanliness within clinical areas levied against the Trust again this year.

10 ANTIMICROBIAL STEWARDSHIP

Antimicrobial Stewardship activity undertaken in 2019/20 is detailed in the Annual Antimicrobial Stewardship Report – see Appendix 1.

11 AUDIT

The following Audits undertaken include:

- Hand washing audit – compliance with hand washing guidelines performed on a monthly basis on all clinical areas within Trust.
- Continuous audit of all *Clostridium difficile* patient deaths within 30 days of diagnosis.
- Quarterly audit of compliance with MRSA elective screening policy.
- Monthly audit of compliance with MRSA emergency screening policy.
- Monthly audit of blood culture contamination rates.
- Continuous audit of *Clostridium difficile* specimen transport.
- Audit of blood culture species transport times.
- Audit of compliance with Trust antimicrobial prescribing guidelines.
- Audit of side room occupancy.
- CQC IPC spot audits at a minimum of every two months on each ward and a minimum of annually in all departments.
- Monthly stool chart audits since August 2018.

12 SEASONAL FLU IMMUNISATION PROGRAMME

Occupational Health commenced the Trust's annual vaccination programme in October 2019 as the season's vaccine was released. Uptake amongst front line staff was 71% which compares to 67% in 2018/19.

13 TARGETS AND OUTCOMES

MRSA Bacteraemia

Zero cases were ascribed to the Trust in 2019/20:

Clostridium difficile Diarrhoea

Ninety-two episodes of *Clostridium difficile* infection were reported via the Mandatory Surveillance System in 2019/20. This includes both hospital and community patients. This compares with 55 episodes in 2018/19. Hospital acquired cases (onset more than two days following admission or less than 28 days from discharge) stood at 48 episodes in 2019/20.

MRSA Screening of Elective Admissions

Preoperative screening of elective admissions to hospital became mandatory for Trust in England from 01st April 2009. The Trust has continued to work closely with community services to develop pathways to manage patients found to be carrying MRSA to ensure treatment was not delayed. Regular audits of compliance with the MRSA screening policy are performed with at least 95% coverage of elective admissions being achieved each month.

Gram negative bacteraemia

A national target requires a 50% reduction in Gram-negative bacteraemia cases by 2021 compared to a 2016 base line.

Inpatient cases stood at 37 in 2019/20, a 3% decrease from 2016/17. Total cases (community plus hospital) decreased by 26% compared to 2018/19. Work is ongoing to determine risk factors for Gram-negative bacteraemia.

14 TRAINING ACTIVITIES

Induction

- All staff, including medical staff, had Infection Prevention and Control training included within their induction sessions. This includes instruction on handwashing, use of Infection Prevention and Control Guidance and accessing Infection Prevention and Control advice. In addition, medical staff received instruction on antimicrobial prescribing.

CPD for all Staff

- Annual updates on Infection Prevention and Control are mandatory for all staff and are delivered via the electronic mandatory training system. Compliance is monitored regularly.
- Junior medical staff received educational sessions on Infection Prevention and Control and prudent antimicrobial prescribing as part of their educational programme.
- Consultant Microbiologists regularly contributed to staff training, giving educational sessions on Infection Prevention and Control, Infection Management and Antimicrobial Prescribing.

Training for Infection Prevention and Control Specialists

- Infection Prevention and Control Doctor is fully up to date with CPD requirements.
- Infection Prevention and Control Team members attended national and local courses and updates as required.

Training for the DIPC

- Attended Department of Health meetings/updates as required.

15 CONCLUSION

Addressing the challenge of Healthcare Acquired Infections remains a key priority for the Trust, its Board members and the senior Divisional teams. The Trust understands that accountability for Infection Prevention and Control lies with each and every employee and also raises awareness with visitors, patients and their relatives. The Trust is compliant with the Hygiene Code, the Key Core Standards of the Healthcare Commission and has completed a robust Deep Clean Programme.

16 RECOMMENDATION

The Trust Board is asked to note the contents of this report and approve the forward programme.

Wrightington, Wigan and Leigh NHS Foundation Trust

ANTIMICROBIAL STEWARDSHIP PROGRAMME 2018/2019

12 MONTH REVIEW – MARCH 2019

Author Dr R Nelson, Dr C Faris, Mr J Gwilliam

Date March 2019

The WWL Way

	Stewardship Component	Programme of Work 2018/2019	By Whom (lead)	(Date) To be Achieved by	Outcome
1	Audit	a) Audit of compliance with Trust Prescribing guidance to be performed on each ward at a minimum of two occasions in 2018/19.	Antimicrobial Pharmacist	March 2019	Achieved
		b) Point Prevalence Audit of antibiotic use and prescribing practices to be performed at a minimum of one occasion across the Trust.	Antimicrobial Pharmacist	March 2019	Achieved October 2018
2	Antimicrobial Ward Rounds	a) Multidisciplinary (minimum of Antimicrobial Pharmacist plus Consultant Microbiologist) Antibiotic Round to be performed at a minimum frequency of monthly throughout 2018/19.	Antimicrobial Pharmacist/Consultant Microbiologist	March 2019	Partly achieved (Pharmacist post vacant December 2017 – June 2018
		b) Consultant Microbiologist plus/minus Antimicrobial Pharmacist to perform an Antimicrobial Ward Round on one or more of the Admission Units at a minimum of monthly.	Consultant Microbiologist	March 2019	Achieved
		c) Multidisciplinary round (minimum of Consultant Microbiologist, Infection Prevention and Control Nurse and/or Consultant Gastroenterologist) to review *Clostridium difficile* PCR positive patients to be performed at a minimum frequency of weekly throughout 2018/19.	Consultant Microbiologist	March 2019	Achieved
3	Education	a) Junior Doctors to be provided with a session on prudent antimicrobial prescribing.	Consultant Microbiologist	March 2019	Achieved
		b) Ad hoc sessions to be delivered as required by Team.	Antimicrobial Pharmacist/Consultant Microbiologist	March 2019	Achieved
4	Antimicrobial Stewardship Team	a) Team to hold a minuted meeting at a minimum frequency of six times per year.	Consultant Microbiologist/ Antimicrobial Pharmacist	March 2019	Achieved
		b) Feedback of issues to be made at each scheduled meeting of the Trust Infection Prevention and Control Committee.	Antimicrobial Pharmacist/Consultant Microbiologist	March 2019	Achieved
		c) Member of Team to attend Trust's Medicine Management meeting at a minimum frequency of four times per year.	Consultant Microbiologist	March 2019	Achieved

	Stewardship Component	Programme of Work 2018/2019	By Whom (lead)	(Date) To be Achieved by	Outcome
5	Evidence Based Prescribing Guidance	a) Trust Antimicrobial guidelines to be maintained in an appropriate and up to date format.	Consultant Microbiologist/ Antimicrobial Pharmacist	Throughout 2018/19	Achieved
		b) Relevant changes to National Guidance to be incorporated into Trust guidelines as appropriate.	Consultant Microbiologist/ Antimicrobial Pharmacist	As required throughout 2018/19	
6	Provision of Information to Prescribers	a) Annual Report on Antimicrobial use and Healthcare Associated Infection on ICU/HDU to be provided for 2018 calendar year.	Consultant Microbiologist	31st March 2019	Achieved
		b) Summary resistance data for 2017/18 to be published on Intranet site for prescribers.	Consultant Microbiologist	June 2018	Achieved
		c) Work with HIS to determine method for identifying prolonged antibiotic courses.	Antimicrobial Pharmacist/Consultant Microbiologist	March 2019	Initial work undertaken. No progress made
7	Other items	a) Work with CCG to determine the most appropriate method to assess compliance with the 2018/19 CQUIN Antimicrobial Reduction Targets.	Consultant Microbiologist/ Antimicrobial Pharmacist/Chief Pharmacist	June 2018	Achieved
		b) Work to achieve the 2018/19 CQUIN Antimicrobial Reduction Target within available resources.	Consultant Microbiologist/ Antimicrobial Pharmacist/Chief Pharmacist/Clinical Directors	March 2019	Work undertaken. Not all aspects achieved

POLICY NAME	**INFECTION PREVENTION AND CONTROL POLICY**
POLICY ID NUMBER	**TW10-042**
VERSION NUMBER	**9.1**
APPROVING COMMITTEE	**INFECTION PREVENTION AND CONTROL COMMITTEE**
DATE THIS VERSION APPROVED	**JANUARY 2019**
RATIFYING COMMITTEE	**PARC (Policy Approval and Ratification Committee)**
DATE THIS VERSION RATIFIED	**February 2019**
AUTHOR(S)	**INFECTION PREVENTION AND CONTROL DOCTOR/DEPUTY DIRECTOR OF INFECTION PREVENTION AND CONTROL (DIPC)/ ASSISTANT DIPC**
DATE THIS VERSION AMENDED	Page 4 – Point 3.8.3 added. (September 2019) Page 13 – Appendix 4 updated.
DIVISION/DIRECTORATE	**CORPORATE**
LINKS TO OTHER POLICIES/PROCEDURES	**See Appendix 4**
CONSULTED WITH	**INFECTION PREVENTION AND CONTROL COMMITTEE MEMBERS**

DATE(S) PREVIOUS VERSION(S) APPROVED	**Version:** **1** **2** **3** **4** **5** **6** **7** **7.1** **8** **9**	**Date :** **October 2000** **April 2002** **August 2006** **July 2008** **November 2008** **September 2010** **July 2012** **May 2014** **January 2016** **February 2019**
NEXT REVIEW DATE	**February 2022**	
MANAGER RESPONSIBLE FOR REVIEW	**Infection Prevention and Control Doctor/ Deputy Director of Infection Prevention and Control (DIPC)/Assistant DIPC**	

AT ALL TIMES, STAFF MUST TREAT PATIENTS WITH RESPECT AND UPHOLD THEIR RIGHT TO PRIVACY AND DIGNITY.

CONTENTS PAGE

1. INTRODUCTION

This policy details the provision of Infection Prevention and Control services within the Trust.

2. POLICY STATEMENT AND KEY PRINCIPLES

1.1. Wrightington, Wigan and Leigh NHS Foundation Trust provides a range of high quality health care for the local community, in which the Executive Trust Board endorse a zero tolerance towards Healthcare Associated Infections (HCAI). This policy is in line with the Duties of Care set out in the Healthcare Act 2006 and the Health and Social Care Act 2008 Code of Practice of the Prevention and Control of Infections and Related guidance (updated July 2015).

1.2. Wrightington, Wigan and Leigh NHS Foundation Trust has developed this overarching policy underneath which will be Infection Prevention and Control procedures, policies and Standard Operating Procedures (SOPs) which will be reviewed at least every two years or as nationally agreed guidance dictates. It is the policy of Wrightington, Wigan and Leigh NHS Foundation Trust to ensure that all policies, SOPs and procedures are available on the intranet and accessible to all staff.

1.3. To work effectively the Infection Prevention and Control Team needs the collaboration and active support of all Trust staff. The Infection Prevention and Control Committee (IPCC) represents the main forum for regular consultation between the Infection Prevention and Control Team, the Trust Directorates and local Health Protection Units. This process generates the Annual Infection Prevention and Control Programme for the Trust. The Infection Prevention and Control Committee meets bi-monthly and is responsible for approval of policies/guidance and monitoring of progress against the Trust's Annual Infection Prevention and Control Programme. The committee reports to the Quality and Safety Committee. Policies and procedures will reflect current evidence based practice.

3 ROLES AND RESPONSIBILITIES

3.1 Trust Board:

3.1.1 The Trust Board has overall responsibility for ensuring there are effective strategic, corporate and operational arrangements in place to maintain an effective Infection Prevention and Control programme and that appropriate financial resources are place to support that programme. The Trust board ensures that appropriate arrangements are in place to identify, prevent and control where necessary any healthcare associated infections that may occur within the environment (building/clinical) or services.

3.2 Director of Infection Prevention and Control (DIPC):

3.2.1 To oversee local control of Infection Prevention and Control policies and procedures.

3.2.2 To report directly to the Chief Executive and the Board.

3.2.3 To have the authority to challenge inappropriate clinical hygiene practice as well as inappropriate antibiotic prescribing decisions.

3.2.4 To assess the impact of all existing policies on Healthcare Associated Infection (HCAI) and make recommendations for change.

3.2.5 To be an integral member of the organisations clinical governance and patient safety teams and structures.

3.2.6 To produce an annual report on the state of HCAI in the organisation for which he/she is responsible and release it publicly.

3.2.7 To be responsible for the IPCC within the organisation.

3.3 Deputy/Assistant DIPC:

3.3.1 To guide and support clinical staff in preventing and controlling infection.

3.3.2 To develop in conjunction with the DIPC, Infection Prevention and Control Doctor, (IPCD) and IPCC the strategy for Infection Prevention and Control monitoring and reporting of HCAI as required by national guidelines.
3.3.3 To identify and lead control of outbreaks in conjunction with IPCD and the Infection Prevention and Control Team (IPCT).
3.3.4 To facilitate education across the Care Trust, including independent Contractors.
3.3.5 To prepare Infection Prevention and Control (IPC) policy documents in collaboration with the IPCD.
3.3.6 To provide in collaboration with the IPCD, an annual report to the Trust Board (after approval by the IPCC).
3.3.7 To liaise with the Occupational Health Department on relevant staff or patient health issues.
3.3.8 To develop local IPC standards as agreed by the IPCC and agree on an appropriate audit cycle.
3.3.9 To promote good hand hygiene within the Trust.
3.3.10 To provide advice to the Trust on purchases or procurement to ensure Infection Prevention and Control issues are considered.
3.3.11 To be involved at an early stage and throughout in re-development/building projects within the Trust.
3.3.12 To advise and support the safe handling of sharps and clinical waste in compliance with local policies.

3.4 Infection Prevention and Control Doctor (IPCD):
3.4.1 To guide and support clinical staff in preventing and controlling infection.
3.4.2 To identify and lead on controlling outbreaks in conjunction with the Director of Infection Prevention and Control Nurse (DIPC) Deputy and Assistant Director of Infection Prevention and Control.
3.4.3 To develop in conjunction with the DIPC and IPCC the strategy for Infection Prevention and Control monitoring and reporting of HCAI as required by national guidelines.
3.4.4 To collate, enter and verify monthly data returns required for mandatory *Methicillin resistant Staphylococcus aureus* (MRSA), Methicillin-sensitive Staphylococcus aureus (MSSA), *Clostridium difficile* (CDT) and Gram-negative bacteraemia reporting.
3.4.5 To provide education on Infection Prevention and Control issues to medical staff at induction and during training programmes.
3.4.6 To be involved at an early stage and throughout in re-development/building projects within the Trust.
3.4.7 To prepare IPC policies and SOPs in conjunction with the IPCT.
3.4.8 To ensure regular, minuted meetings of the Infection Prevention and Control Team occur.
3.4.9 To liaise with the Occupational Health Department on relevant staff or patient health issues.

3.5 Infection Prevention and Control Committee (IPCC):
3.5.1 IPCC members to have clear lines of responsibility and accountability within their areas of practice to implement the Trust's annual Infection Prevention and Control programme.
3.5.2 To ensure effective training programme in place to meet identified needs.
3.5.3 To receive a report at each meeting on outbreaks/adverse incidents.
3.5.4 IPCC members will feedback to the IPCC on progress within their area of practice.
3.5.5 To formulate and monitor the annual Infection Prevention and Control programme.
3.5.6 To identify to the Trust the necessary resources to implement the annual Infection Prevention and Control programme.

3.5.7 To ensure the Trust is aware of and responds to the external 'drivers' of Infection Prevention and Control for example: Department of Health (Department of Health), National Clinical Standards, NHS Resolution, (NICE), The epic Project: Developing National Evidence-based Guidelines for Preventing Healthcare Associated Infections, Public Health England Mandatory Surveillance schemes, "Getting ahead of the Curve" and "Winning Ways", The Health Act 2006 and NHS Improvement.

3.5.8 Divisional Infection Prevention and Control Committee members in combination with their General Manager must develop a communication framework within their Division to ensure a two-way transmission of information between the Division and the Infection Prevention and Control Committee. This will ensure compliance with Infection Prevention and Control SOPs, advice and Root Cause Analysis etcetera.

3.5.9 The Infection Prevention and Control Committee will ensure that all advice and SOPs are in line with the Health Act 2006 and Infection Prevention and Control best practice or national guidance.

3.6 Infection Prevention and Control Team:
Wrightington, Wigan and Leigh NHS Foundation Trust has an Infection Prevention and Control Team which has the primary responsibility to advise on all aspects of prevention and control of infection across the Trust.

3.7 Managers' Roles and Responsibility:
Divisional Managers, Clinical Directors and Heads of Nursing have a prime responsibility to ensure that the Infection Prevention and Control Committee's findings, Infection Prevention and Control Guidance, audit results and Infection Prevention and Control advice is operationally implemented and documented within their Divisional communication structures.

3.8 All Healthcare Workers:

3.8.1 All healthcare workers have a responsibility to comply with all Infection Prevention and Control policies, SOPs and procedures.

3.8.2 External staff or contractors who are contracted to provide support/cover/treatment in Trust hospitals must abide by all Trust IPC policies and SOPs.

3.8.3 The pre-registration health care student who has received the theoretical underpinning knowledge from their Higher Education Institute (HEI), and can evidence this, and as part of the pre-registration curriculum will be able to practice under direct supervision of a registered healthcare professional competent in the skill. The pre-registration health care student must have read and adhere to the relevant clinical policies. The pre-registration health care student must complete 5 supervised competencies before being signed as competent by their Practice supervisor / practice assessor. The learner will continue to work under the supervision of a registered health care professional once deemed competent.

3.9 Patients/Service Users/Visitors:
Patients, service users and visitors will be requested to comply with Trust IPC policies and SOPs to reduce risk of HCAI for themselves and others.

4. WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST DUTIES IN RELATION TO INFECTION PREVENTION AND CONTROL (Under the Health and Social Care Act 2008 Code of Practice on the Prevention and Control of Infections and Related Guidance - Henceforth Referred to as the Code)

4.1 Wrightington, Wigan and Leigh NHS Foundation Trust has a duty to have in place appropriate management systems for Infection Prevention and Control. These arrangements include:

4.1.1 A Board level agreement outlining its collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risk (this policy).

4.1.2 The designation of an individual as Director of Infection Prevention and Control (DIPC) accountable directly to the Board.

4.1.3 The mechanisms by which the Board ensures that adequate resources are available to secure effective prevention and control of Health Care Associated Infection (HCAI). These include implementing an appropriate assurance framework, Infection Prevention and Control programme and Infection Prevention and Control infrastructure.

4.1.4 Ensuring that relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with patient care receive suitable and sufficient training, information and supervision on the measures required to prevent and control risks of infection, as identified within the Trust's training needs analysis.

4.1.5 A programme of audit to ensure that key policies and practices are being implemented appropriately.

4.1.6 A document addressing, admission, transfer, discharge and movement of patients between departments, and within and between health care facilities.

4.1.7 Infection Prevention and Control Committee members must ensure that there is an effective programme and communication strategy for Infection Prevention and Control within the sphere of their responsibility, in order to provide a Divisional Assurance Framework.

4.2 Wrightington, Wigan and Leigh NHS Foundation Trust has a duty to assess risk of acquiring HCAI and to take action to reduce or control such risks.

4.2.1 To ensure a suitable and sufficient assessment of the risks to patients in receipt of health care with respect to HCAI.

4.2.2 To identify the steps that need to be taken to reduce or control those risks.

4.2.3 To record its findings in relation to items (4.2.1) and (4.2.2).

4.2.4 To implement the steps identified.

4.2.5 To ensure that appropriate methods are in place to monitor the risks of infection such that it is able to determine whether further steps need to be taken to reduce or control HCAI.

4.3 Wrightington, Wigan and Leigh NHS Foundation Trust has a duty to provide and maintain a clean and appropriate environment for health care.

4.3.1 "The environment" means the totality of a patient's surroundings when in Trust premises. This includes the fabric of the building and related fixtures, fittings and services such as air and water supplies.

4.3.2 Wrightington, Wigan and Leigh NHS Foundation Trust will, with a view to minimising the risk of HCAI, ensure that:

4.3.2.1 There are policies for the environment which make provision for liaison between the members of any Infection Prevention and Control Team (IPCT) and the persons with overall responsibility for facilities management.

4.3.2.2 It designates lead managers for cleaning and decontamination of equipment used for treatment.

4.3.2.3 All parts of the premises in which it provides care are suitable for the purpose, are kept clean and are maintained in good physical repair and condition.

4.3.2.4 The cleaning arrangements detail the standards of cleanliness required in each part of its premises and that a schedule of cleaning frequencies is publicly available.

4.3.2.5 There is adequate provision of suitable hand wash facilities and antibacterial hand rubs.

4.3.2.6 There are effective arrangements for the appropriate decontamination of instruments and other equipment.
4.3.2.7 The supply and provision of linen and laundry supplies reflects Health Service Guidance HSG (95) 18, Hospital Laundry Arrangements for used and infected linen.
4.3.2.8 Clothing worn by staff when carrying out their duties (including uniforms) is clean and fit for purpose. (See: TW13-005 Uniform Policy).
4.3.2.9 Divisional Matrons (in conjunction with Domestic Supervisors/Ward Managers) will ensure effective monitoring arrangements are in place for their areas of responsibility to provide assurance to their Heads of Nursing and Divisional Leads.

4.4 Wrightington, Wigan and Leigh NHS Foundation Trust has a duty to ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

4.4.1 Wrightington, Wigan and Leigh NHS Foundation Trust will, with a view to ensuring appropriate antibiotic use:

4.4.1.1 Manage and monitor the use of antimicrobials to minimise inappropriate and harmful use in accordance with the 'Start Smart then Focus' framework.
4.4.1.2 Maintain an Antimicrobial Management Group to develop and monitor antimicrobial stewardship activities.
4.4.1.3 Maintain an antimicrobial stewardship policy.
4.4.1.4 Report antimicrobial sensitivity data and antimicrobial consumption data centrally as required.
4.4.1.5 Train prescribers in prudent antimicrobial use.
4.4.1.6 Provide timely access to microbiology testing and diagnosis. Prescribers will have access at all times to microbiology advice to guide the appropriate choice of antimicrobial therapy.

4.5 Wrightington, Wigan and Leigh NHS Foundation Trust has a duty to provide information on HCAI to patients and the public.

4.5.1 Wrightington, Wigan and Leigh NHS Foundation Trust will ensure that it makes suitable and sufficient information available to:

4.5.1.1 Patients and the public about the organisation's general systems and arrangements for preventing and controlling HCAI.
4.5.1.2 An Annual Director of Infection Prevention and Control Report, consisting of progress and performance against the Infection Prevention and Control Annual Programme, Department of Health's Healthcare Associated Infection (HCAI)Targets, Department of Health's Deep Clean Programme, Outbreaks of Infection and Untoward Adverse Incidents, and Decontamination.

4.5.2 To each patient concerning:

4.5.2.1 Any particular considerations regarding the risks and nature of any HCAI that are relevant to their care.
4.5.2.2 Any preventative measures relating to HCAI that a patient ought to take after discharge.

4.6 Wrightington, Wigan and Leigh NHS Foundation Trust has a duty to ensure prompt identification of people who have, or are at risk of developing infection so they receive timely and appropriate treatment.

4.6.1 Wrightington, Wigan and Leigh NHS Foundation Trust will endeavour to ensure prompt identification and treatment of people who have, or are at risk of developing infection to ensure they receive timely and appropriate treatment.

4.7 Wrightington, Wigan and Leigh NHS Foundation Trust has a duty to provide information when a patient moves from the care of one health care body to another Wrightington, Wigan and Leigh NHS Foundation Trust will ensure that it provides suitable and sufficient information on each patient's infection status whenever it arranges for a patient to be move from the care of one organisation to another so that any risks to the patient and others from infection may be minimised.

4.8 Wrightington, Wigan and Leigh NHS FoundationTrust has a duty to ensure co-operation Wrightington, Wigan and Leigh NHS Foundation Trust so far as reasonably practicable will ensure its staff, contractors and other involved in the provision of health care co-operate with it, and with each other, so far as necessary to enable the body to meet its obligations under this Code.

4.9 Wrightington, Wigan and Leigh NHS Foundation Trust has a duty to provide adequate isolation facilities. Wrightington, Wigan and Leigh NHS Foundation Trust will endeavour to provide or secure the provision of adequate isolation facilities for patients sufficient to prevent or minimise the spread of HCAI.

4.10 Wrightington, Wigan and Leigh NHS Foundation Trust has a duty to ensure adequate laboratory support. The Trust Microbiology Laboratory at Salford Royal provides services in relation to Infection Prevention and Control. The Laboratory will have in place appropriate protocols and will be accredited by Clinical Pathology Accreditation (UK) Ltd.

4.11 Wrightington, Wigan and Leigh NHS Foundation Trust has a duty to adhere to policies and protocols applicable to Infection Prevention and Control. The core documents are:

4.11.1 Standard Infection Prevention and Control precautions.
4.11.2 Aseptic Non-touch technique (ANTT).
4.11.3 Major outbreaks of communicable infection.
4.11.4 Isolation of patients.
4.11.5 Safe handling and disposal of sharps.
4.11.6 Prevention of occupational exposure to blood-borne viruses (BBVs), including prevention of sharps injuries.
4.11.7 Management of occupational exposure to BBVs and post-exposure prophylaxis.
4.11.8 Closure of wards, departments and premises to new admissions.
4.11.9 Disinfection Policy.
4.11.10 Antimicrobial prescribing.
4.11.11 Reporting HCAIs to the Public Health England (PHE) as directed by the Department of Health.
4.11.12 Control of infections with specific alert organisms: MRSA, *Clostridium difficile* infection and transmissible spongiform encephalopathies.
4.11.13 Hand washing SOPs.
4.11.14 Inoculation Accident SOPs.
4.11.15 The Trust will ensure that there is a rolling programme of audit, revision and update.
4.11.16 All documents will be clearly marked with a review date.

4.12 Wrightington, Wigan and Leigh NHS Foundation Trust has a duty to ensure, so far as is reasonably practicable, that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably

educated in the prevention and control of HCAIs. The Trust will ensure that policies and procedures are in place in relation to the prevention and control of HCAIs such that:

4.12.1 All staff can access relevant Occupational Health services.
4.12.2 Occupational Health policies on the prevention and management of communicable infections in healthcare workers, including immunisation, are in place.
4.12.3 Prevention and control of infection is included in induction programmes for new staff, and in training programmes for all staff.
4.12.4 There is a programme of ongoing education for existing staff (including support staff, agency/locum staff and staff employed by contractors).
4.12.5 There is a record of training and updates for all staff.
4.12.6 The responsibilities of each member of staff for the prevention and control of infection is reflected in their job descriptions and in any personal development plan or appraisal.

5. ASSURANCE FRAMEWORK

This demonstrates that Infection Prevention and Control is an integral part of clinical and corporate governance:

5.1 Regular presentations from the DIPC to the Board.

5.2 Review of statistics on incidence of alert organisms (MRSA, *Clostridium difficile* MSSA, Gram-negative bacteraemias).

5.3 Evidence of appropriate actions taken to deal with infection occurrences.

5.4 An audit programme to ensure that policies and SOPs have been implemented.

6. INCIDENTS OF HEALTH CARE ASSOCIATED INFECTION (HCAI)

Incidents of HCAI will be reported through the risk management system Datix, following the TW10-020 Incident Reporting Policy and Procedure. This reporting will be in addition to local and national reporting requirements as set by the Clinical Commissioning Group (CCG) and Department of Health.

7. INTRODUCTION OF NEW INFECTION PREVENTION AND CONTROL STANDARD OPERATING PROCEDURES (SOP)s

Infection Prevention and Control SOPs will be endorsed by the Infection Prevention and Control Committee and adopted by the Trust Board. All Infection Prevention and Control SOPs will be accessible via the Policy Library Intranet site. The launch of new SOPs will be undertaken via means of a global e-mail, roadshows where applicable, via Divisional Quality Executive Committee and Induction and Mandatory Training. Local training will be undertaken in conjunction with Divisional Managers and the Infection Prevention and Control Team.

8. INFECTION PREVENTION AND CONTROL ANNUAL PROGRAMME

8.1 The Infection Prevention and Control programme will:

8.1.1 Set objectives.
8.1.2 Identify priorities for action.
8.1.3 Provide evidence that relevant policies have been implemented to reduce HCAI.

9. REPORTING SYSTEMS

9.1 IPCC Meeting minutes to be circulated for action to committee members and from them to relevant personnel within their Directorate/Division.

9.2 Infection Prevention and Control Annual report from the IPCC to go to Trust Board via the Quality and Safety Committee.

9.3 Reporting of outbreaks/adverse incidents.

9.4 Outbreak reporting to Greater Manchester PHEC, Health Protection Team.

10. HUMAN RIGHTS ACT

Implications of the Human Rights Act have been taken into account in the formulation of this policy and they have, where appropriate, been fully reflected in its wording.

11. EQUALITY AND DIVERSITY

The Policy has been assessed against the Equality Impact Assessment Form from the Trust's Equality Impact Assessment Guidance and as far as we are aware, there is no impact on any Equality Target Groups.

12. MONITORING AND REVIEW

12.1 Infection Prevention and Control within Wrightington, Wigan and Leigh NHS Foundation Trust will primarily be audited in compliance with reducing Healthcare Associated Infections, Annual Health Check and Infection Prevention and Control Audit Programme and the results will be actioned and monitored via the Quality and Safety Committee, Infection Prevention and Control Committee and the Trust Board.

12.2 Trust Induction / Infection Prevention and Control Mandatory Training as per the Trust Training Needs Analysis (TNA) will be monitored as documented within the Corporate and Local induction policy and the Mandatory Training Policy.

12.3 The Infection Prevention and Control Policy and Infection Prevention and Control SOPs will be reviewed every two years or sooner if required and approved by the Infection Prevention and Control Committee.

12.4 The Infection Prevention and Control SOPs will be monitored minimum monthly using the internal Care Quality Commission (CQC) audit tool.

12.5 Hand Hygiene Guidelines clinical application is assessed by the "WHO" 5 moments audit tool, a minimum of monthly monitoring to the Divisions and bi-monthly by the Prevention Control Committee. Action Plans are completed by the Divisions.

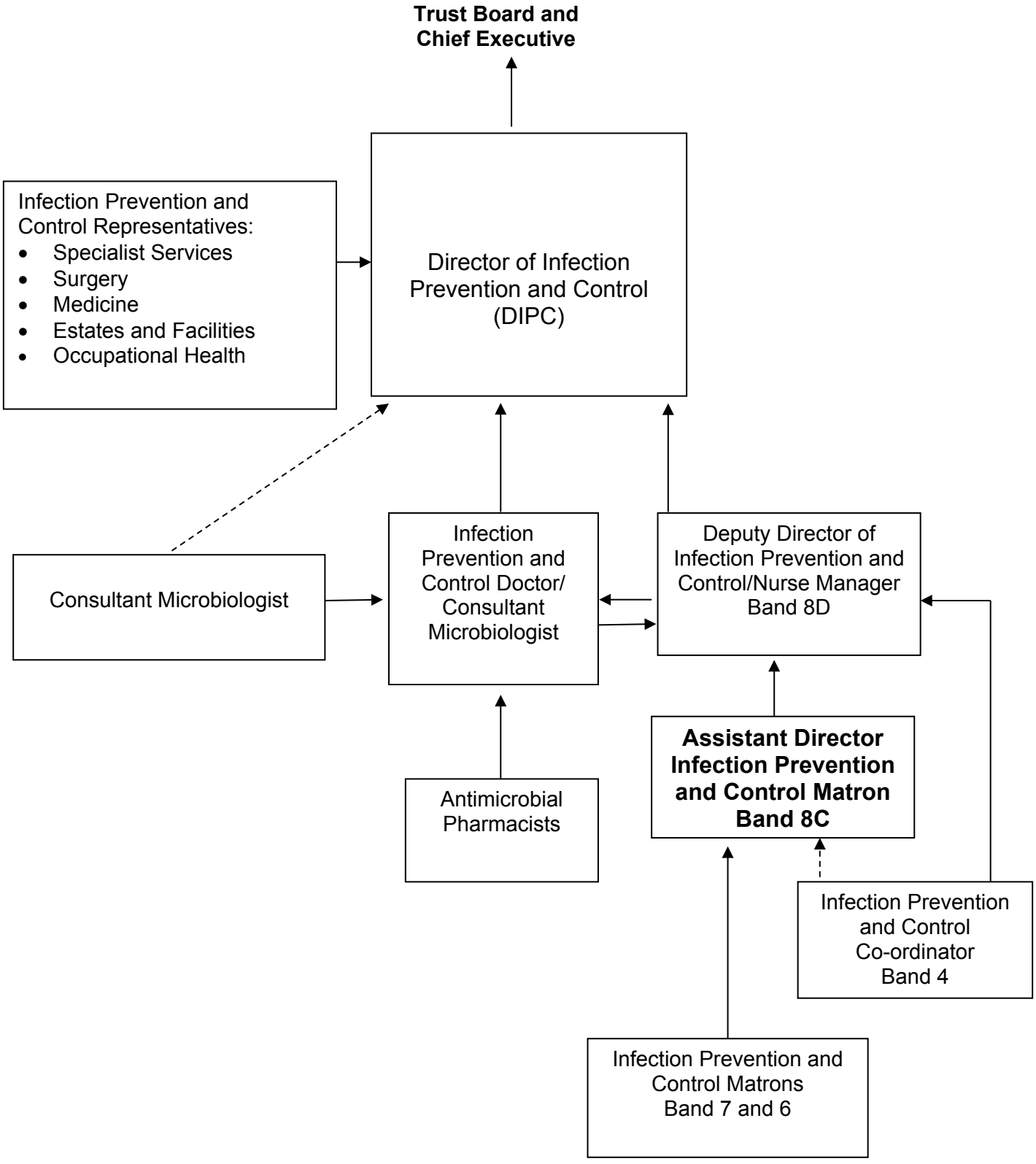
12.6 Hand Hygiene Training compliance will be audited in line with the audit and monitoring arrangements contained in the Mandatory Training Policy TW10/010. The results of audits undertaken will be monitored via Divisional Quality Executive Committees and reviewed at the Risk and Environmental Management Committee.

13. ACCESSIBILITY STATEMENT

This document can be made available in a range of alternative formats, for example: large print, Braille and audio cd. For more details please contact the Human Resources Department on 01942 77 (3766) or email equalityanddiversity@wwl.nhs.uk.

APPENDIX 1

INFECTION PREVENTION AND CONTROL ORGANISATIONAL CHART



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Department of Health. Saving Lives: reducing infection, delivering clean and safe care. June 2007 (accessed at: national archives 27th December 2017).

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APPENDIX 3

GLOSSARY OF TERMS

CDT: *Clostridium difficile.*

HCAI: Health Care Associated Infection. Infection acquired in hospitals or as a result of other healthcare interventions. Also known as nosocomial infection.

MRSA: Methicillin resistant *Staphylococcus aureus.*

MSSA: Methicillin-sensitive *Staphylococcus aureus*.

APPENDIX 4

STANDARD OPERATING PROCEDURES RELATING TO THE TW10-042 INFECTION PREVENTION AND CONTROL POLICY

SOP NAME	SOP NUMBER
Inoculation Incident	TW10-042 SOP 1
Post Exposure Prophylaxis for Healthcare Workers Occupationally Exposed to HIV	TW10-042 SOP 2
Prevention and Management of Body Fluid Exposure	TW10-042 SOP 3
Standard Infection Prevention and Control Procedures	TW10-042 SOP 4
Single Use Devices	TW10-042 SOP 5
Varicella and Herpes Zoster	TW10-042 SOP 6
Respiratory Viruses (RSV and Influenza) - Infection Prevention and Control	TW10-042 SOP 7
Viral Haemorrhagic Fever	TW10-042 SOP 8
Spillage of Potentially Infectious Material	TW10-042 SOP 9
Handwashing	TW10-042 SOP 10
Aseptic Non-touch Technique for all Clinical Aseptic Procedures	TW10-042 SOP 11
Control of Outbreaks of an Infectious Conditions	TW10-042 SOP 12
Clostridium difficile Treatment (CDI) for Adults	TW10-042 SOP 13
Decontamination of Reusable Medical Nursing Equipment	TW10-042 SOP 14
Diarrhoea (Infectious) Infection Prevention and Control	TW10-042 SOP 15
Funding of Outbreaks of an Infectious Nature	TW10-042 SOP 16
Bed Closure for Infectious Control Purposes	TW10-042 SOP 17
Isolation of Patients with Infectious Conditions	TW10-042 SOP 18
Sharps, Safe Use and Disposal	TW10-042 SOP 19
Surveillance of Communicable Diseases	TW10-042 SOP 20
PVL Toxin Producing Staphylococcus aureus – Infection Prevention and Control Management	TW10-042 SOP 21
Respiratory Protective Equipment (RPE) Training Guidance for Selection and Testing for Infection Prevention and Control Purposes	TW10-042 SOP 22
Tuberculosis - Infection Prevention and Control	TW10-042 SOP 23
Clostridium difficile – Infection Prevention and Control	TW10-042 SOP 24
Scabies – Infection Prevention and Control	TW10-042 SOP 25
Carbapenemase Producing Organism – Infection Prevention and Control	TW10-042 SOP 26
Protection of Healthcare Workers and Patients from Hepatitis B	TW10-042 SOP 27
Protection of Healthcare Workers and Patients from Hepatitis C	TW10-042 SOP 28
Influenza – Infection Prevention and Control (covers seasonal influenza H1N1/"Swine 'flu' Virus")	TW10-042 SOP 29
Neonatal Unit: Screening for Management of Antibiotic Resistant Organisms	TW10-042 SOP 30
Streptococcus Group A: For the Investigation, Control and Prevention of Infection within Trust Premises	TW10-042 SOP 31
Viral Gastroenteritis (Norovirus): Management of Hospital Outbreaks	TW10-042 SOP 32
Admission and Transfer of Infected or Potentially Infected Patients with Transmissible Conditions	TW10-042 SOP 33
Asplenic and Hyposplenic Patients Management	TW10-042 SOP 34
Middle East Respiratory Syndrome (MERS-CoV) Infection Prevention and Control	TW10-042 SOP 35
Animal Visits (excluding guide dogs and other assistance animals) to Trust Premises – Infection Prevention and Control Precautions	TW10-042 SOP 36
Antibiotic Resistant Organisms	TW10-042 SOP 37

SOP NAME	SOP NUMBER
Blood borne Viruses (Hep B, C and HIV)	TW10-042 SOP 38
CJD Transmissible Spongiform Encephalopathy	TW10-042 SOP 39
Glove Selection for Clinical Purposes	TW10-042 SOP 40
Measles Management and Control	TW10-042 SOP 41
Parvovirus B19 Infection	TW10-042 SOP 42
Pertussis Management and Investigation of Suspected Cases	TW10-042 SOP 43
Cadaver Bags – Infectious Conditions Requiring their Use	TW10-042 SOP 45
Pseudomonas Aeruginosa Infection Prevention and Control Areas	TW10-042 SOP 46
Post Exposure Prophylaxis for HIV Following Sexual Exposure or Following Non-Occupational Needle Stick or Bite Injury	TW10-042 SOP 47
Herpes Simplex Oral Infections	TW10-042 SOP 48
Collection, Validation and Submission of Trust Data to Public Health England's Agency HCAI Data Capture System (includes MRSA/MSSA/E. Coli bacteraemia and Clostridium difficile Infection)	TW10-042 SOP 49
Faecal Microbiota Transplantation for Treatment of *Clostridium difficile* Infection	TW10-042 SOP 50
Meningococcal Infection Prevention and Control and Prophylaxis Procedure	TW10-042 SOP 51
Control and Prevention of Tuberculosis	TW10-042 SOP 52
Immunisation of Healthcare Workers	TW10-042 SOP 54
Candida Auris: Infection Prevention And Control Management	TW10-042 SOP 56
Staphylococcus Aureus - Excluding Methicillin Resistant Staphylococcus Aureus (MRSA) - Bacteraemia: Procedure for Investigation	TW10-042 SOP 57
Plague: Management of Suspected Cases.	TW10-042 SOP 58
ENT: Procedure for Naso-Endoscopes Cleaning and Disinfection – Business Continuity at Thomas Linacre Centre (TLC)	TW10-042 SOP 59
Gram-negative Bacteraemia: Procedure for Investigation – Escherichia Coli (E. coli), Pseudomonas aeruginosa and Klebsiella Species	TW10-042 SOP 60
ENT Naso-Endoscope Cleaning and Disinfection in the Outpatient Department at Leigh Infirmary as Part of Business Continuity Plan (BCP) Only, for Instance: When Steris and Endoscopy Reprocessing Unit (ERU) are Not Available	TW10-042 SOP 61
Cleaning and Disinfection for Endocavity Ultrasound Probe and Prostate Biopsy	TW10-042 SOP 62

Equality Impact Assessment Form

STAGE 1 - INITIAL ASSESSMENT

APPENDIX 5

For each of the protected characteristics listed answer the questions below using **Y** to indicate Yes and **N** to indicate No	**Sex** (male / female / transgender)	**Age** (18 years+)	**Race / Ethnicity**	**Disability** (hearing / visual / physical / learning disability / mental health)	**Religion / Belief**	**Sexual Orientation** (Gay/Lesbian/ Bisexual)	**Gender Re-Assignment**	**Marriage / Civil Partnership**	**Pregnancy & Maternity**	**Carers**	**Other Group**	**List Negative / Positive Impacts Below**
Does the policy have the potential to affect individuals or communities differently in a negative way?	n	n	n	n	n	n	n	n	n	n	n	
Is there potential for the policy to promote equality of opportunity for all / promote good relations with different groups – Have a positive impact on individuals and communities.	y	y	y	y	y	y	y	y	y	y	y	
In relation to each protected characteristic, are there any areas where you are unsure about the impact and more information is needed?	n	n	n	n	n	n	n	n	n	n	n	**If Yes**: Please state how you are going to gather this information.

Job Title	Consultant Microbiologist		**Date**	February 2019

IF 'YES a NEGATIVE IMPACT' IS IDENTIFIED - A Full Equality Impact Assessment STAGE 2 Form must be completed. This can be accessed via http://intranet/Departments/Equality_Diversity/Equality_Impact_Assessment_Guidance.asp

Please note: As a member of Trust staff carrying out a review of an existing or proposal for a new service, policy or function you are required to complete an Equality Impact Assessment. By stating that you have NOT identified a negative impact, you are agreeing that the organisation has NOT discriminated against any of the protected characteristics. Please ensure that you have the evidence to support this decision as the Trust will be liable for any breaches in Equality Legislation

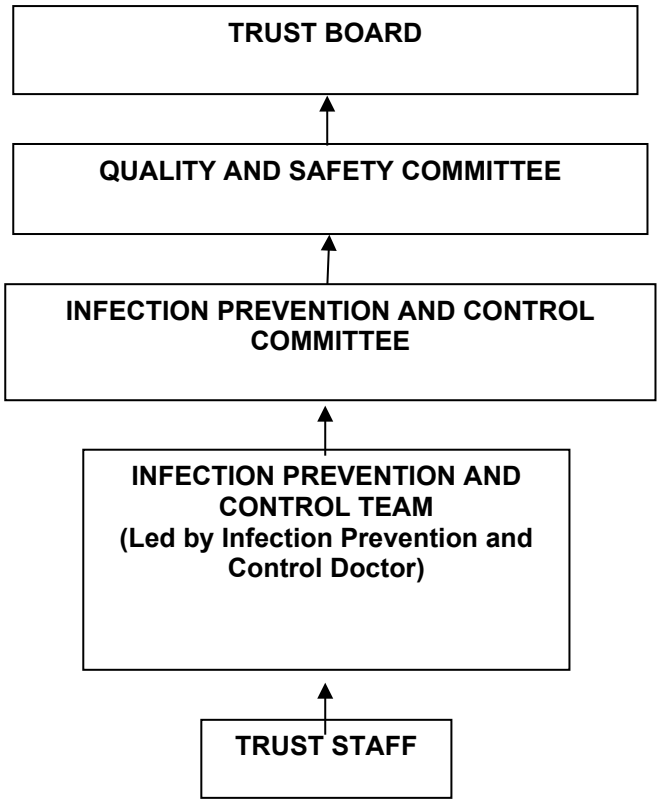
APPENDIX 6

POLICY MONITORING AND REVIEW ARRANGEMENTS

NAME OF POLICY/SOP or CLINICAL GUIDELINE:

Para	Audit / Monitoring requirement	Method of Audit / Monitoring	Responsible person	Frequency of Audit	Monitoring committee	Type of Evidence	Location where evidence is held
TW10/042 Infection Prevention and Control Policy	Policy is monitored and reviewed every two years.	Via relevant policy approval processes	Policy author	Two yearly	Infection Prevention and Control Committee / PARC	Minutes of meeting	Microbiology Department RAEI
12.4	Infection Prevention and Control SOPs	CQC Audit Tool	Deputy DIPC	Monthly	ADIPC & Infection Prevention & Control Committee & DQEC	Minutes of Meetings	Infection Prevention Control Office
12.5	Hand Hygiene SOPs training clinical application	WHO 5 moments audit tool	Deputy DIPC	Monthly	Infection Prevention Control Committee & DQEC	Minutes of Meetings	Infection Prevention Control Office
12.6	Hand Hygiene Training compliance	Compulsory Training Compliance Audit Tool	Training Dept	Monthly	DQEC	Minutes of Meetings	Divisional Governance Office

APPENDIX 3

Terms of Reference	
Committee Name:	Infection Prevention and Control Committee
Chairperson	Infection Prevention and Control Doctor or Nominated Deputy
Date:	January 2020
Version:	11
Reports to:	
Receives reports/minutes from:	Antibiotic Stewardship Management Group/Occupational Health Department/Ventilation Working Group/Water Safety Group.
Meeting/attendance Frequency:	Maximum six times per year, minimum four times per year.
Definition of Quorum:	Six members, including senior member of Infection Prevention and Control Team.
Membership:	Available from the Secretary to Consultant Microbiologist on request.

Core Membership: (must attend should the relevant director not be able to attend)	1 Infection Prevention and Control Doctor. 2 Director of Infection Prevention and Control/Director of Nursing. 3 Medical Director or Representative. 4 Deputy Director of Nursing. 5 Deputy Director of Infection Prevention and Control. 6 Consultant Microbiologist. 7 Infection Control Representatives: Wigan Council. 8 Infection Control Nurse: Northwest Boroughs Mental Health Trust. 9 Consultant in Communicable Disease Control (CCDC): Greater Manchester. 10 Occupational Health Physician. 11 Divisional Consultant Representative(s). 12 Divisional Heads of Nursing/Midwifery. 13 Community Division Representative – Adult Services. 14 Community Division Representative – Paediatric Services. 15 Patient Representative. 16 Staff Governor. 17 Senior representatives from Estates and Facilities. 18 Antimicrobial Pharmacist. 19 Wigan Clinical Commissioning Group, Infection Control Representative(s). 20 Manager HSDU. 21 Non-executive Directors have an open invitation to attend any meeting of the Committee.
Associate Membership: (must attend on an ad hoc basis dependent on the agenda)	Other members may be co-opted as appropriate. For example: Catering Manager. T B Nurse. Environmental Health Officer.
In Attendance: (to support the committee)	
Authority:	The Trust Board devolves and discharges this responsibility through the Infection Prevention and Control Committee, which is thereby bound by these Terms of Reference that follow.
Scope of Responsibilities (duties)	1. To provide strategic direction for the prevention and control of Healthcare Associated Infections (HCAI) for the Trust. 2. To provide a key role in monitoring the organisation's performance against the Trust's Infection Prevention Strategy. 3. To ensure there is a strategic response to new legislation and national guidelines.

Other Matters:	1 To receive and review reports from the Infection Prevention and Control Team against national and local HCAI targets. 2 To approve the Infection Prevention and Control Annual Report from the Director of Infection Prevention and Control in the first quarter of the following financial year for submission to the Trust Board for their endorsement. 3 To receive, consider and endorse the Trust Annual Infection Prevention and Control Programme for submission for approval by the Trust Board, including the development and review of priorities and strategies in relation to Infection Prevention and Control ensuring most effective utilisation of resources. 4 To review progress against the Trust Annual Infection Prevention and Control Programme, and assist in its effective implementation, and to review the final results. 5 Endorse the targeted surveillance of Infection Prevention and Control programmes developed by the Infection Prevention and Control Team, and agree on objectives and priorities in this area. 6 To advise on, ratify and monitor the implementation of Trust Infection Prevention and Control policies, procedures and SOPs. 7 To provide assurance to the Trust Board through bi-monthly reports of progress by the Director of Infection Prevention and Control against the annual activity plan and performance targets. 8 To draw to the attention of the Chief Executive and Trust Board, any serious problems or hazards relating to Infection Prevention and Control. 9 To discuss and review all matters relating to outbreaks of infection on Trust premises and make recommendations to address shortcomings and avoid recurrences. 10 To discuss, evaluate and action initiatives and developments relating to Infection Prevention and Control and ensure matters are taken forward at a local level. 11 To promote and facilitate education and the application of evidence based practice in relation to Infection Prevention and Control. 12 To circulate the Infection Prevention and Control Committee minutes widely to the relevant Trust Committees, senior medical and nursing staff. 13 To work collaboratively with Clinical Commissioners Groups and associated service providers to consider the impact of their service developments for the Trust.
Review Date:	January 2022
Monitoring of T of R:	Bi-annually

APPENDIX 4

Wrightington, Wigan and Leigh NHS
NHS Foundation Trust

INFECTION PREVENTION AND CONTROL PROGRAMME 2020/2021

Author:	**Dr R Nelson, Ms R Gerrard, Ms H Richardson**
Date:	**September 2020**
Approving Committee:	**Infection Prevention and Control Committee**
Date:	**September 2020**

INTRODUCTION

The implementation of the Trust's Annual Infection Prevention and Control Programme 2020-2021 was significantly delayed by the impact of the COVID-19 pandemic in the first half of 2020.

The programme has been truncated and streamlined to reflect the challenges and new working practices produced by COVID.

	Code of Practice Point	Programme of Work 2020/2021	By Whom (lead)	(Date) To be Achieved by	Outcome
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessment and consider the susceptibility of service users and any risks that their environment and other users may pose to them.	a) Infection Prevention and Control Programme for 2020/2021 to be disseminated by Infection Prevention and Control Committee members throughout their Directorate. Programmed actions to involve all staff members and Directorates, not solely members of the Infection Prevention and Control Team.	Infection Prevention and Control Committee (IPCC)/Directorate Representatives	30/11/20	
		b) Quarterly reporting by DIPC to Trust Board on Infection Prevention and Control issues.	DIPC	31/03/21	
		c) DIPC to present the DIPC Annual Report for 2019/20 to the Trust Board.	DIPC	30/11/20	
		d) DIPC to present the Infection Prevention and Control Programme for 2020/21, to the Trust Board.	DIPC	30/11/20	
		e) Divisions to ensure they are represented at all Infection Prevention and Control Committee meetings held September 2020 – March 2021.	Divisional Chair/Head of Nursing	31/03/21	
		f) Infection Prevention and Control Committee to be quorate and to meet on a minimum of four occasions in 2020/21.	IPCC Chairman	31/03/21	
		g) Infection Prevention and Control Committee to consider all outbreaks and adverse incidents relating to infection and disseminate findings/recommendations via Directorate representatives.	IPCC	31/03/21	
		h) Infection Prevention and Control audits of all wards to be performed at a minimum of twice, covering adherence to Infection Prevention and Control policies and guidelines.	Senior IC Nurse Manager	31/03/21	
		i) Infection Control audits of departments to be performed a minimum of once.	Senior IC Nurse Manager	31/03/21	
		j) Continue MSSA bacteraemia surveillance in line with national requirements and monitor totals of hospital acquired cases.	Consultant Microbiologist/Senior IPC Nurse	31/03/21	
		k) Gram-negative bacteraemia surveillance meeting national requirements to be performed on a continuous basis.	Consultant Microbiologist/Senior IPC Nurse	31/03/21	

	Code of Practice Point	Programme of Work 2019/2020	By Whom (lead)	(Date) To be Achieved by	Outcome
1	Continued	l) Adapt and implement national COVID-19 infection control guidance as this is published.	DIPC/IPC Doctor/IPC Nurse Manager	As required in 2020/21	
		m) Monitor mortality rate within 30days of *Clostridium difficile* infection for inpatients and update Infection Prevention and Control Committee on an annual basis. Relevant cases to be reported via 'STEIS' system.	IPC Doctor	31/03/21	
2	Provide and maintain a clean and appropriate environment that facilitates the prevention and control of infections.	a) Continue with hand hygiene '5 Moments' programme.	DIPC/Senior ICN	31/03/21	
		b) Reuse and perform a reduced Trust 'Deep Clean' programme, focussing on areas of highest risk.	DIPC/Senior ICN/Director of Estates	31/03/21	
		c) Maintain sampling programme for Pseudomonas in water supplies to augmented care areas in accordance with national guidance.	IPC Team/Estates and Facilities Manager	31/03/21	
		d) Monitor results from validation and verification of operating theatre ventilation systems across the Trust and advise on necessary remedial actions.	Director of Estates and Facilities/Senior IPC Nurse/IPC Doctor	31/03/21	
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	a) Antimicrobial Stewardship Programme for 2020/21 to be published.	Consultant Microbiologist/Antimicrobial Pharmacist	31/10/20	
		b) Antimicrobial Stewardship Programme for 2020/21 to be followed and results reviewed.	Consultant Microbiologist/Antimicrobial Pharmacist	31/03/21	
4	Provide suitable, accurate information on infections to service users and their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.	a) DIPC Annual Report for 2019/20 to be published.	DIPC	30/09/20	
		b) Communicate results of public health significance to the relevant Health Protection Unit as these occur.	IPC Team/ Consultant Microbiologist	As required	

	Code of Practice Point	Programme of Work 2019/2020	By Whom (lead)	(Date) To be Achieved by	Outcome
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	a) Maintain continuous surveillance of MRSA/MSSA /Gram-negative bacteraemias and *Clostridium difficile* diarrhoea cases.	IPC Team	31/03/21	
		b) Maintain continuous surveillance for alert organisms defined in Trust Surveillance Policy.	IPC Team	31/03/21	
		c) Continue to implement revised high impact intervention for *Clostridium difficile* where one or more new, hospital-acquired cases are detected on a ward.	IPC Team, Ward Manager	31/03/21	
		d) Identify and screen for Carbapenemase Producing Organisms for at risk admissions in accordance with Trust guidance.	Clinical Teams/IPC Team	31/03/21	
		e) Implement appropriate COVID-19 triage systems for admissions to ensure appropriate and timely identification, isolation and testing of symptomatic admissions.	IPC Team	31/03/21	
		f) Controls to be maintained at Trust entrances to detect and manage individuals with COVID-like symptoms.	IPC Team/HR	31/03/21	
		g) Clostridium difficile Reduction plan to meet quality priority 'to reduce the number of CDT infections by 20% where there have been lapses in care'.	IPC Team	31/03/21	
6	Systems to ensure that all care workers are aware of and discharge their responsibilities in the process of preventing and controlling infection.	a) Infection Prevention and Control training to be included in Trust Mandatory Training programme for all staff groups. Compliance to be monitored.	IPC Team/General Managers	31/03/21	
		b) Directorates to monitor compliance with hand hygiene. Action plans being provided where deficiencies are found.	IPC Team/General Managers/DIPC/ Medical Director	31/03/21	
		c) Infection Prevention and Control to be included in all Trust induction programmes for new staff.	IPC Team/Consultant Microbiologist	31/03/21	
7	Provide or secure adequate isolation facilities.	a) Monitor isolation of patients with transmissible conditions to determine any deficiencies in isolation provision.	IPC Team	31/03/21	
		b) Recommend plans for new clinical areas contain sufficient isolation facilities.	IPC Team	31/03/21	
		c) Investigate expansion of single room capacity on Bryn North Ward.	IPC Team/Estates/ DIPC	31/03/20	
8	Secure adequate access to laboratory support as appropriate.	a) Ensure Microbiology services provided off site by PAWS remain appropriate and timely.	Consultant Microbiologist/PAWS Manager	31/03/21	
		b) Ensure appropriate information continues to be available to the Infection Prevention and Control Team from offsite laboratory.	Consultant Microbiologist/Senior IC Nurse	31/03/21	
		c) Explore introduction of near patient testing for COVID-19 +/- influenza at RAEI.	Consultant Microbiologist	31/10/20	

	Code of Practice Point	Programme of Work 2019/2020	By Whom (lead)	(Date) To be Achieved by	Outcome
9	Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.	a) Update of Infection Prevention and Control Guidance as necessary before expiry date.	Senior IC Nurse Manager/ Consultant Microbiologist	31/03/21	
		b) Update Occupational Health Guidance maintained on Infection Prevention and Control Intranet site.	Consultant Occupational Health	31/03/21	
		c) Infection Prevention and Control audits of all wards to be performed at a minimum frequency of twice, covering adherence to Infection Prevention and Control policies and guidelines.	IPC Team	31/03/21	
		d) *Clostridium difficile* Multi-disciplinary Team to meet weekly to ensure patients with C. difficile infection are managed in accordance with local and national policy. Remote reviews may be substituted at times of increased COVID activity.	Consultant Microbiologist/ IPC Team/Ward Manager, Pemberton Ward		
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	a) Occupational Health services in place and to be maintained.	Consultant Occupational Health	31/03/21	
		b) Audits of needle stick injuries and relevant corrective action to be presented at least annually to Infection Prevention and Control Committee.	Consultant Occupational Health Medicine	31/03/21	
		c) Influenza vaccination programme to be in place during 2020/21 flu season and uptake monitored by Infection Prevention and Control Committee.	Consultant Occupational Health		

Responsible people: DIPC – Director of Infection Prevention and Control.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Register of referrals received by the Clinical Ethics Group
Presented to:	Board of Directors
On:	25 November 2020
Presented by:	Not applicable – consent agenda
Prepared by:	Paul Howard, Director of Corporate Affairs
Contact details:	T: 01942 822027 | E: paul.howard@wwl.nhs.uk

Executive summary

It was agreed at the Pandemic Assurance Committee meeting on 13 May 2020 that a high-level summary of cases referred to the Clinical Ethics Group would be reported to the Board at each meeting. The attached table summarises the referrals that have been received from the group since its inception and is presented for information only.

Link to strategy

There is no direct link to the organisation's strategy.

Risks associated with this report and proposed mitigations

There are no risks associated with this report.

Financial implications

There are no financial implications arising out of this report.

Legal implications

There are no legal implications arising out of the content of this report.

People implications

There are no people implications in this report.

Wider implications

The establishment of a Clinical Ethics Group is intended to support decision-making.

Recommendation(s)

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

Register of referrals made to the Clinical Ethics Group
23 April 2020 to 20 November 2020

Ref.	Date of referral	Time of referral	Urgent or routine referral	Date CEG convened	Time CEG convened	Summary of case	CEG recommendation	Issues escalated to management
CEG-001	1 May 2020	2045hrs	Urgent	1 May 2020	2120hrs	Request for elderly parents to be allowed to visit patient receiving end-of-life care where death was considered to be imminent. Balancing risk to the visitors against desire to visit their relative.	Recommended that visiting be permitted provided risks are explained and PPE is available and can be provided.	Noted that there are conflicting visiting policies in existence. Management to address and have one single policy.
CEG-002	3 May 2020	0942hrs	Retrospective for assurance	7 May 2020	0800hrs	Request to review the care of a now deceased patient, with particular reference to the DNACPR decision-making.	Noted that the referral did not require consideration of ethics in the current sense but comments on the case provided to the Medical Director by way of peer review. No concerns around decision-making or documentation identified.	Nil
CEG-003	3 Jun 2020	0900hrs	Retrospective for assurance	4 Jun 2020	0800hrs	Request to consider the use of best interests around antibody testing for patients without the capacity to consent	Matter referred to the Executive Scrutiny Group with feedback from the Clinical Ethics Group	To be considered by Executive Scrutiny Group
CEG-004	29 Jul 2020	1815hrs	Retrospective for assurance	6 Aug 2020	0800hrs	Request to consider applicability of duty of candour in a historic case.	Clinical Ethics Group view on the case was provided to the referring clinician.	Nil

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Monthly Trust Financial Report – Month 7 (October 2020)
Presented to:	Board of Directors
On:	25 November 2020
Presented by:	Chief Finance Officer
Prepared by:	Heather Shelton, Head of Financial Management
Contact details:	T: 01942 77 (3759) E: heather.shelton@wwl.nhs.uk

Executive summary

	In Month			Year to Date		
	Actual £000's	Revised Plan £000's	Var £000's	Actual £000's	Revised Plan £000's	Var £000's
Income	33,893	33,635	258	248,166	247,908	258
Expenditure	(35,904)	(36,106)	202	(243,821)	(244,023)	202
Financial Performance	(3,122)	(3,514)	392	(3,122)	(3,514)	392
Cash Balance	60,675	57,075	3,600	60,675	57,075	3,600
Capital Spend	1,236	1,805	569	14,649	13,882	(767)

Key Messages:

- NHSI/E have been very clear to NHS organisations that financial governance must remain during the COVID-19 pandemic. Informing the Public of the Trust's financial position is part of our governance and assurance process and as such the Financial Board Report will continue to be produced and issued.

- The Trust submitted a forecast to NHSI/E in October for the second half of the financial year. NHSI/E are using this forecast as a plan to monitor the Trust financial performance and this is shown in the table above.

The WWL Way

- National funding arrangements changed from month 7. The Trust has a fixed funding allocation instead of operating under a reimbursement model.

- The Trust is reporting a deficit of £3.1m in month and a deficit of £3.1m year to date.

- Cash is £60.7m at the end of Month 7.

- Capital spend is £14.6m year to date. This includes £5.7m on COVID-19 associated projects which will be fully reimbursed via non-interest bearing PDC.