Board of Directors

29 July 2020, 14:30 to 15:30
By videoconference

Agenda

10. Declarations of interest

Information

Robert Armstrong

11. Minutes of previous meeting

Approval

Robert Armstrong

Minutes - Board - Jun 2020.pdf (6 pages)

12. Chief Executive's update 10 minutes

Verbal item

Information

Silas Nicholls

13. Committee chairs' reports 10 minutes

Verbal item

Information

Committee chairs

14. Performance report 10 minutes

Information

Helen Richardson/Mary Fleming/Sanjay Arya

Performance report.pdf (4 pages)

15. Safe staffing report 5 minutes

Information

Helen Richardson

Safe staffing report.pdf (14 pages)

16. Mortality report 10 minutes

Information

Sanjay Arya

Mortality report.pdf (6 pages)

17. Guardian of Safe Working report 5 minutes

Information

Shams Khan

GoSW report.pdf (4 pages)

18. Freedom to Speak Up Guardian's report 5 minutes

Information

Kyle Collum

FTSU report.pdf (13 pages)

19. Consent agenda

19.1. Finance report

Information

Public finance report.pdf (2 pages)

19.2. Audit Committee terms of reference

Approval

Audit Committee ToRs.pdf (8 pages)

19.3. Modern slavery statement

Approval

Modern slavery statement.pdf (4 pages)

19.4. Review of COVID-19 risk appetite statement

Approval

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

20. Date of next meeting

30 September 2020

Information

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

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

HELD ON 24 JUNE 2020, 3.00PM

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 S Nicholls	Chief Executive
	Ms H Richardson	Chief Nurse
	Prof T Warne	Non-Executive Director
In attendance:	Mrs N Guymer	Deputy Company Secretary
	Mr P Howard	Director of Corporate Affairs
	Mr C Knights	Deputy Director of Strategy and Planning
	Mrs L Sykes	Public Governor (observer)

82/20 Chair and quorum

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

83/20 Apologies for absence

Apologies for absence were received from Mr R Mundon, Director of Strategy and Planning.

84/20 Declarations of interest

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

85/20 Minutes of the previous meeting

The minutes and confidential minutes of the previous meetings held on 27 May 2020 and 5 June 2020 were **APPROVED** as a true and accurate record.

With regard to the action log, note was made that the first two items had been included on the agenda and were therefore complete. The third action, for the Director of

Strategy and Planning to provide some information to Mrs Lobley, remained outstanding and would be followed up outside the meeting.

With regard to the fourth action, relating to identifying the best way to share information on decisions taken at a system level with directors, the Director of Corporate Affairs noted that he was due to meet with colleagues from organisations across Greater Manchester in the following week and suggested that it may be beneficial to seek to devise a single approach rather than each organisation doing things in a different way. The board therefore agreed to extend the deadline for this action to 27 July 2020 to allow these discussions to be held.

With regard to the final action, Lady Bradley confirmed that this had been completed and could therefore be closed. She summarised her discussions and confirmed that she had agreed to keep the board informed of developments, particularly around psychological safety.

86/20 Committee chairs' updates

The Chair of the Audit Committee, Mr Haythornthwaite, provided a verbal summary of business transacted by the committee at its meeting on 5 June 2020. The committee had received feedback from the internal and external auditors on progress with their respective plans and highlighted the fact that the internal auditors had experienced some challenges in undertaking a number of audits as a result of restrictions on site attendance. As a result, a number of the audits had been deferred to a later point in time.

Mr Haythornthwaite confirmed that he had met with the Council of Governors' task and finish group around the external audit contract and advised that a recommendation had been formulated for the Council of Governors to consider at its meeting on 9 July 2020 that the current external auditors be reappointed to the final year of their current contract for FY2020/21 and that a competitive procurement exercise be undertaken in respect of the audits FY2021/22 onwards.

The Acting Chief Finance Officer took the opportunity to confirm that all year-end documents had been submitted to NHS England and NHS Improvement in advance of the stipulated deadline and the Board recorded its thanks to the finance team for its work; particularly under less than ideal circumstances imposed as a result of the COVID-19 pandemic.

Prof Warne updated the Board following the meeting of the Pandemic Assurance Committee on 10 June 2020. He summarised the business that had been transacted and highlighted a number of key areas of assurance received. A comprehensive report had been provided by the Medical Director on mortality and note was made that the data had been shared within Greater Manchester to obtain a clear benchmark position. Prof Warne also noted that the Committee had received an update on the 12-month investment to deliver a psychological support programme, with recruitment having been commenced. The need to undertake additional risk assessments for BAME employees had been acknowledged and confirmation had been received that the

foundation trust had undertaken 89% of such assessments as at the date of the Committee meeting.

An increase in the number of pressure ulcers had been escalated to the Committee as a concern and the Chief Nurse had presented a clear action plan to demonstrate how this would be addressed. The Committee had also been briefed on a breach of regulations around safeguarding reporting and an action plan had been presented to set out the intended remedial action. Clarification was provided that no patient harm had occurred.

The Committee had received the Infection Prevention and Control Board Assurance Framework and the associated action plan. Prof Warne advised that this had now been adopted by the Care Quality Commission as the way that it will assess infection prevention and control performance.

The Board received and noted the verbal update.

87/20 Update from the executive team

The Chief Executive opened this item by noting that there had been a continued and sustained reduction in COVID-19 cases since the previous meeting but confirmed that the organisation continued to operate at Level 2. A summary of the regional position was also provided.

The Chief Executive made particular reference to the work that is being undertaken to ensure the provision of psychological support to staff who may have been adversely affected through dealing with the pandemic. He also noted the move towards a focus on recovery, with increased emphasis being anticipated on a number of key performance standards.

The Chief Operating Officer provided a summary of the work that had been undertaken around the recovery plan and the associated capital bid to facilitate 20 Seacole beds on the Leigh Infirmary site. An increased focus on outpatients was noted with a national desire to ensure that the majority of outpatient appointments are undertaken remotely. Key issues for the system were identified as workforce constraints and the anticipated length of recovery. The Chief Operating Officer noted that a shared approach to the management of waiting lists had been developed across Greater Manchester, based on risk stratification and identification of patients in priority order. Any patients who exceed their recommended waiting time will be subject to clinical review.

A Greater Manchester proposal to develop a dedicated clinical assessment service which sits underneath NHS 111 and which has knowledge of local services. The intention is for all acute providers to implement collectively by August 2020.

In response to a question from the Chair around the care for patients who cannot access technological solutions, the Chief Operating Officer confirmed that patients who are unable to access remote appointments are still able to access face-to-face service, although virtual clinics remained the national preference.

In response to a question from Mr Haythornthwaite, the Chief Operating Officer summarised the process by which patients whose original appointments had been deferred as a result of COVID-19 are able to escalate any issues if they are concerned.

The Board received and noted the verbal update.

88/20 COVID-19 mortality

The Medical Director presented a report which had been circulated in advance of the meeting.

Mrs Lobley noted that deaths in the North West had increased significantly and sought to understand this issue better. In response, the Medical Director noted that issues such as deprivation, co-morbidities and other factors play a key part in the overall mortality and that these issues were more prevalent in the North West than in other areas of the country.

The Medical Director drew the Board's particular attention to slide number 6 in the pack and highlighted the decision to separate invasive and non-invasive intervention across two areas of the foundation trust. He noted that it is therefore not possible to directly compare mortality performance with other intensive care units where the intensive and non-invasive ventilation patients are treated together.

The Chair iterated that the foundation trust remains open for business and confirmed that patients who require emergency care should continue to attend as usual.

The Board received the report and noted the content.

89/20 Transformation in recovery

The Deputy Director of Strategy and Planning presented a report which had been circulated with the agenda to highlight the importance of transformation as part of the foundation trust's recovery from COVID-19 and summarised the challenges around the recovery plan. A summary of the work to capture the significant transformation that had taken place over recent weeks and months was also included in the report.

In response to a question from Mrs Lobley, the Chief Executive summarised the way that hot and cold sites are being introduced across the region and noted the intention for Wrightington to be used as the local cold site.

Mr Guymer commended the graphs shown on pages 45 and 46 of the bundle but queried the difference between physical capacity and current bed capacity as shown in the charts. In response, the Chief Operating Officer advised that the latter relates to the number of beds that can be safely staffed in accordance with the national standards and offered to explain this further outside the meeting.

Prof Austin noted the earlier discussions around health inequalities and enquired what action was being taken to ensure patients aren't disproportionately impacted. The Deputy Director of Strategy provided a number of examples of how this has been taken into account, particularly in relation to ensuring the ability for face-to-face treatment to

be provided. The Chief Executive also noted that a trial was underway in endoscopy around a shared system approach to ensuring that resources in the borough are available where they are needed.

The Director of Workforce confirmed that agreement had been reached with trade union colleagues that all recovery work would be underpinned by equality impact assessments to ensure that such issues were identified and addressed at an early stage.

The Board received the report and noted the content.

90/20 Performance report

The Chair noted that the performance report had been considered by the Pandemic Assurance Committee earlier in the month and the Chief Operating Officer gave a summary of the key metrics. The use of a balanced scorecard was highlighted.

The Chief Operating Officer confirmed that the priority 2 elective plan had recommended in many areas and that additional capacity was being used where possible. She also summarised the way in which operational demand is being managed.

The Chair noted the need to develop the report further to include quantitative and qualitative metrics as well as including the commentary in future reports.

The Board received the report and noted the content.

91/20 Review of COVID-19 risk appetite statement

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

92/20 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 changes to committee arrangements set out in the paper that had been circulated with the agenda be **APPROVED**.

2. THAT the hot debrief feedback be received and noted.

3. THAT the finance report be received and noted and that the changes to the Standing Financial Instructions be **APPROVED**.

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

93/20 Date time and venue of the next meeting

The next meeting of the Board of Directors will be held on 27 July 2020, 1.30pm by videoconference.

Action log

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
27 May 2020	62/20	Chair and Chief Executive's opening remarks	Provide Mrs Lobley with supporting documentation around regional governance	Director of Strategy and Planning	ASAP	Verbal update to be provided.

Title of report:	Performance Report
Presented to:	Board of Directors
On:	29 July 2020
Presented by:	Director of Strategy and Planning
Prepared by:	Analytic Services Manager, Business Intelligence
Contact details:	BI.Performance.Report@wwl.nhs.uk

Executive summary

This paper is an interim report as Business Intelligence continues to automate the production of a Balanced Scorecard. A more visual format of the report is presented this month along with commentary. Work is continuing to develop new metrics, to agree appropriate RAG ratings where not currently in place and to improve support for commentary provision. This report contains the high level Balanced Scorecard and associated narrative. The detail for each section will be discussed at the appropriate assurance committee.

Link to strategy

Whilst a meaningful performance report is essential for every organisation, WWL is increasingly adopting a balanced scorecard approach to high level metrics to enable the Board and Committees to have greater visibility on the inherent connections between quality, activity, people and finance. In doing this we are also aiming to make the report more meaningful at the right level of governance, organised according to our priorities. This is inevitably an iterative process as we move through the stages of COVID recovery.

Risks associated with this report and proposed mitigations

The production of a new performance report needs to refocus on those metrics that are relevant and contemporary and there is a risk that some traditional metrics that members want are relegated to subordinate reports at Committee level – although to mitigate this, there is a process to engage with key stakeholders to ensure that all key data are available at the right governance level.

Some required metrics are not currently automated and production places a burden upon the BI team and with tight turnaround timescales may result in missing or old data – although this is mitigated by a plan to automate all key metrics.

Some of the data flows rely on the performance of the data warehouse technology, which is end of life and can result in slow turnaround times and delay in data availability – although this is mitigated by a priority investment in the data warehouse.

Financial implications

None currently highlighted.

Legal implications

None identified.

People implications

None identified.

Wider implications

Changes in STP/ICS, regional and national requirements may impact on the relevance of the metrics for external reporting purposes. Our iterative approach will respond to these changing demands to ensure as far as possible line of sight and comparability. There is increased scrutiny on certain metrics and tools to support validation in these areas. Increasingly the core suite of metrics will be supplemented with applications that enable operational teams to access much more granular data and modelling tools that are consistent with high level reporting.

Recommendation(s)

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

Report

Overall Trust Performance - Balanced Scorecard from 1 April to 30 June 20

QUALITY & SAFETY

	Month	ON/OFF Track	Why?
Protecting Patients Metrics			
Number of Serious Incidents	M3	Off Track	6 Incidents in month, 11 YTD
Never Events	M3	Off Track	1 Incident in month, 1 YTD
Patient Safety Incident Reporting	M3	On Track	781 in month, 2071 YTD
National Patient Safety Alerts (CAS)	M3	On Track	0 YTD
Infection Prevention and Control (Grouped)	M3	Off Track	2 / 6 M3 and 5 / 6 YTD Metrics Off Track
SHMI Rolling 12 months	M11 1920	Off Track	Latest position: 117.95
Patient Experience (Grouped)		Not currently collected	

ACTIVITY & EFFECTIVENESS

	Month	ON/OFF Track	Why?
A&E Performance (Single)	M3	On Track	96.2% M3, 96.8% YTD against 95% Target
Cancer Performance (Grouped)	M2	Off Track	2 / 7 Metrics Off Track
RTT Performance (18 Weeks)	M3	Off Track	51.3% against 92% Incomplete Target;
RTT Performance (52 Weeks)	M3	Off Track	160 patients waiting 52+ weeks
Diagnostics Patients seen within 6 weeks	M3	Off Track	54.5% against 99% Target

PEOPLE

	Month	ON/OFF Track	Why?
Protecting Patients Metrics			
Safe care / e-roster (nursing & AHPs) - RN	M3	On Track	M3 118.0%, YTD 111.9% - above the 95% target
Safe care / e-roster (nursing & AHPs) - Unregistered	M3	On Track	M3 132.7%, YTD 120.2% - above the 95% target
Absence SITREP	M3	To be agreed	M3 17.3%, YTD 24.8%
Absence - Covid related	M3	To be agreed	M3 6.8%, YTD 15.2%
Mandatory Training	M3	Just below target	M3 92.3% YTD 91.8%; Target 95%
Protecting Staff Metrics			
Risk stratification - Shielded		To be agreed	
RIDDOR reporting & investigation status		To be agreed	

FINANCE

Financial Position (Variance)	**M3**	**YTD**
Income	35,884	35,884
Expenditure	(34,849)	(34,849)
Financing / Technical	(1,048)	(1,048)
Surplus / Deficit	(13)	0
Adjusted Financial Performance	0	0
Other	28	28
SAVI	771	771
Agency Spend	64,554	64,554
Cash Balance		
Capital Spend	201	201

Overall Trust Performance - Balanced Scorecard from 1 April to 30 June 20 : Commentary

QUALITY & SAFETY	**Protecting Patients Metrics** **Board are asked to note that further work is being undertaken to further strengthen the quality safety and patient experience metrics within this report.** During the month of June 2020, the Trust reported 6 incidents to StEIS (Strategic Executive Information System) 1 of which was a Never Event this was related to wrong route of medication, the patient did not to experience any harm. Action has been taken to strengthen the use of oral syringes. Further action is being taken with regards to medicines administration. The remaining incidents were related to a Ward Closure due to Covid, a Serious patient Fall, and trust acquired Pressure Ulcers 4 Clostridium Difficile (CDT) cases were reported this month. Ribotyping results to date do not suggest there is any link between recent cases. Root Cause Analysis has restarted on earlier cases delayed by COVID. Early review suggests and increase in antibiotic prescribing. There have been no reportable trust attributable MRAS bacteraemia . Escherichia Coli (E.Coli) Bacteraemia cases continue to be reported with analysis identifying that these are predominantly community related WWL have not received any National Patient Safety Alerts (CAS) during the quarter April - June 20. **Patient Experience** The formal complaints process was paused on the 16 March 2020 in line with GM approach it was recommenced on 30 June 2020, with the function of PALS continuing to provide the service - approximately 140 concerns dealt with in this period. In addition to 'clinical treatment' subject featuring in these concerns, other themes were 'communication', 'appointments' and 'loss of property'. The message to my loved one email service functioning 7 days a week, received approximately 490 messages during this period all of which were delivered to the ward During Q1 - 57 complaints were due a response in this period; 21% responded within timescale agreed impacted by covid 19 pandemic a recovery plan is now in place The Trust'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. This is marginally better than the previous update of 1.20 in Jan 2020. Several actions are being undertaken to understand the reasons and put systems and processes in place to improve our position.	**See Operational Report**	ACTIVITY & EFFECTIVENESS
PEOPLE	**Protecting Patients Metrics** Safe staffing for March 20 was above the WWL target of 95%. YTD sickness levels overall 24.8%. Sickness absence reduced in month to 17.6%, compared to 23.2% in May, Covid 19 related absences in June were 6.8%, reducing from 12.5% in May, YTD position now 15.2 %. Please note attendance figures are currently reported from sitrep reports and there is some disparity between these and ESR figures. Following a signifcant drop in overall mandatory training compliance last year with the TUPE transfer from Bridgewater, progress continues towards our Trust target, compliance is 92.3% in month 3, 91.8% YTD.	**Financial Position (Variance)** As per the current national funding arrangement the Trust receives 'top up' income which results on a break-even position every month. This arrangement is due to be reviewed 31st July 2020. Capital spend dropped in month 03, the Trust has a £23m capital threshold for 2020/21 and it is important that this is achieved. Cash balance stands at £64.5m	FINANCE

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Safe Staffing Report
Presented to:	Board of Directors
On:	29 July 2020
Presented by:	Chief Nurse
Prepared by:	Deputy Chief Nurse
Contact details:	T: 01942 82 2176 E: allison.luxon@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.

The board were previously advised that the national safer staffing reporting process was paused during the onset of the covid pandemic. This national process has now recommenced. As such this report covers the months of April May and June 2020.

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 reduction in District Nursing vacancies from 24% to 14%.
- The recent restrictions on international recruitment has delayed the implementation of the plan to minimise band 5b vacancies by September this trajectory is indicating this will not be achieved until the end of the financial year and is dependent on lifting on constraints to international travel.
- The temporary nationally agreed changes to the ratio of registered nurses to patients as part of the pandemic surge plan and the current national directive to revert back to Trust agreed levels from June 2020.
- COVID pandemic and redeployment of staff across clinical areas has impacted positively on fill rates as face to face community, outpatient and departmental activity reduced and staff were redeployed to inpatient ward areas and community services. However fill rates are only one indicator and skills and competencies and staff feedback need to be considered separately.

- Within the Community Division nursing vacancies have reduced to 16.99 WTE; this represents a reduction in the vacancy factor from 24% in the last report received to 14%. .
- There has been a reduction in the reporting of red flags within nursing which reflects the improved fill rates and the ongoing uptake of additional shifts by substantive, bank and agency staff and those on the temporary register. No red flags have been raised with respect to Maternity Services within the reporting period.
- There has been an increase in the number of Trust acquired pressure ulcers in this period following a reduction in Q4 19/20. A 'Brilliant Basics' campaign is being planned alongside the development of an accountability framework.
- 1 Never Event was reported in relation to the administration of medication via the wrong route. A programme of education and audit has been introduced to address the learning points identified during the initial review of the incident.

Link to strategy

Delivery of safe care

Risks associated with this report and proposed mitigations

- Registered nurse vacancies particularly at B5 level within the division of Medicine and resulting high use of temporary staff. A plan has been developed to reduce B5 vacancies by the end of the financial year with a combination of proactive recruitment of 3rd year student nurses, international recruitment through GTEC and recommencement of virtual recruitment events. This is dependent on lifting on constraints to international travel.
- Increase in the number of hospital acquired pressure ulcers reported. A 'Brilliant Basics' campaign is being launched to address both the nursing culture and the professional practice issues identified within the report to include links to temporary staffing.

Financial implications

Temporary staffing costs related to high vacancy level

Legal implications

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

People implications

- Potential as shortfalls in nursing establishments become more apparent with the resumption of services during COVID recovery.
- 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.

Report

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 – April to June 2020

The current reporting period reflects the staffing position throughout COVID escalation and the reinstatement of services in June in accordance with the risk stratification agreed by Gold Command.

In response to the pandemic staff from departments, outpatient areas and specialist nursing roles were redeployed to inpatient and critical care areas in accordance with the agreed escalation plan whilst maintain core essential services. In agreement with the GM escalation plan and national direction, there was an agreement to reduce the ratio of registered nurses at WWL within inpatient areas from 1:8 to 1:12. E roster staffing levels were adjusted to reflect this change until the end of June 2020 although divisions were directed to return to pre-COVID staffing levels from the beginning of June 2020.

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.

In line with national guidance shielding of staff was implemented alongside redeployment of at risk staff to low risk areas following the implementation of a robust risk assessment process. During the reporting period Community Services have had 6 registered and 3 unregistered staff shielding; the acute Trust has 51 registered and 25 unregistered staff shielding.

At the end of June 2020 the Trust had 350.72 WTE nurse vacancies, 264.77 WTE registered nurse vacancies (Appendix 2 Table 2).

Of these 180.03 WTE are at B5 level with the greatest number of vacancies (104.06 WTE) being within the Division of Medicine (Appendix 2 Table 3). 63.97 WTE posts are associated with the uplift in staffing as approved by Trust Board in response to the nursing establishment review.

A plan is in place to reduce the B5 vacancies by the end of the financial year which includes the early recruitment of student nurses and offer of substantive posts, international recruitment and the commencement of virtual recruitment events.

This plan will be overseen by the Chief Nurse and Director of Human Resources as part of the workforce plan.

Within the Community Division there are 40.33 WTE registered nurse vacancies. 16.99 WTE of these are within District Nursing Services; this represents a reduction in the vacancy factor from 24% in the last report received to 14%.

Various other staff groups, through redeployment, have supported the District Nursing teams throughout the quarter and temporary staffing has also been utilised to fill gaps.

This mitigation has allowed the services to continue with a review of skill mix on a daily basis. In response to the pandemic, the division initiated a daily reporting process whereby all DN teams declare their activity, complex and active, staffing numbers, redeployment of staff. A daily rag rated report was also developed which allowed the division to actively move staff when need to provide cover associated with activity or skill mix.

There was no patient safety or staffing concerns in the Community Division with respect to Childrens Services. There are 2.71 WTE vacancies within Childrens Services which are split between Children's Community Nursing Team and Safeguarding ALW Looked After Children; there are no reported vacancies within the Health Visiting or School Nursing Service.

In April 2020 there was in an increase in the number of wards rated red from a registered nurse staffing perspective particularly at nights (Appendix 2, Table 1). The Board should note that this is measured against the increase in registered nurse staffing levels approved by Board following the nurse staff review undertaken in 2019.

Redeployed staff's existing roster patterns were honoured in April 2020 resulting in the discrepancy in registered nurse fill rates throughout the month demonstrated in Appendix 1. Risk to patients was mitigated at night as a consequence of reduced bed occupancy throughout the month thereby maintaining and at times exceeding the agreed ratio of staff to patient.

Throughout the reporting period Rainbow Ward has remained red for registered nurse staffing. It should be noted that the bed base on Rainbow Ward was reduced by 18 beds throughout this period of time and a ratio of 1:6 (RN to patient) was maintained during quarter 1 of the financial year.

CHPPD data from the Model Hospital is provided in Appendix 2 Table 6; this data was refreshed in February 2020. The Trust continues to compare favourably for CHPPD for overall staffing against peers and national benchmarking data and this was reflected in the improved fill rates for registered staff in February 2020.

The number of nursing red flags has reduced significantly in Q1 which is to be expected given the increasing fill rates reflected earlier in the report (Appendix 2 Table 4). 1 red flag was raised on Orrell ward in April 2020 indicating that there was less than 1 registered nurse on duty, however this risk was mitigated by the redeployment of staff to the clinical area; there were no reported patient harms at this time.

There have been no red flags raised within Q1 2020 in Maternity services.

The quality metrics provided within Appendix 1 demonstrate an increase in the number of harms across the bedded areas of the Trust from pressure ulcers. 3 Unstageable and 1 Category 3 pressure ulcer were escalated to StEIS in May (MAU, ICU and Standish Ward); de-escalation of the ICU incident has been requested as the investigation report did not identify any lapses in care or learning.

A further 3 pressure ulcers were reported to StEIS in June 2020 (2 unstageable (MAU and ward A) and a category 4 on Orrell ward). At the time of writing the report there has been no escalation of pressure ulcers to StEIS from the Community Division.

All pressure ulcers regardless of grade are subject to concise investigation and scrutinised for lapses in care by the Pressure Ulcer Improvement Panel which was reinstated in May 2020. Further information has been requested on a number of pressure ulcer reports submitted to panel to enable an informed decision for escalation to StEIS and to identify learning points. Common themes arising from the reviews are a lack of registered nurse oversight of direct patient care. Further scrutiny suggests that this is potentially a cultural issue associated with lack of registered nurse accountability and understanding of the delegation of tasks to unregistered staff.

In addition there has been a delay in the consideration of safeguarding. Safeguarding training and processes are to be reviewed to address this. In addition the Senior Nursing Team are currently developing an accountability framework for clinical divisions and a '*Brilliant Basics'* campaign to address these issues and the wider harm free care agenda.

A Never Event relating to wrong route administration was reported to StEIS on Winstanley Ward where a patient received liquid oral medication via an IV route in June 2020 which is currently subject to concise investigation; there was no patient harm and were no reported staffing issues at the time of this incident. Initial review of this incident identified a need to strengthen the use of oral medication syringes across trust and supervision of new registrants. A programme of education and audit has been instigated in response to this incident.

The increase in registered nurse fill rates has also correlated to a reduction in to the number of delays in the administration of pain relief. 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 July 2020.

10 CDT's have been reported within the first quarter of 2020. 8 have been subject to internal review, a further 2 are outstanding. From the reviews there have been 3 identified lapses in care relating to correct antibiotic prescribing and incorrect labelling of specimens and management of environment. Where learning has been identified action plans have been developed.

One fall resulting in moderate harm was reported StEIS in June occurring on MAU. At the time of the fall there were no reported staffing concerns within the clinical area. The Falls Improvement has identified a need to standardise the falls risk assessment tool in use in the Emergency Department and within inpatient areas as there is lack of consistency as a point of learning.

4.0 ACTIONS BEING TAKEN

A plan has been developed to aim close the gap in B5 vacancies by the end of the current financial year this is dependant on international recruitment.

Nurse staffing levels returned to Pre-COVID status from June 2020; changes to e roster become effective from the July roster period.

A review of availability of temporary nursing workforce to support the covid recovery plan.

A review of redeployment process in preparation for a future covid surge plan if required.

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

Brilliant Basics campaign for pressure ulcer management and general nursing care standards.

Review of safeguarding awareness training and accountability.

Programme of audit and education in the use of oral syringes has been instigated.

Action plans have been developed in response to the learning points following Executive Review of CDT's.

5.0 RECOMMENDATIONS

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

Appendices

Appendix 1 Safe Staffing Exception Reports

April 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	216.0%	106.8%	4.2	154.1%	172.0%	7.2	5.54%	0.00%	0.00%			0/3		0/1		
Astley	155.7%	85.9%	5.5	152.1%	134.4%	8.5	7.38%	4.75%	0.00%			0/1		0/1		
Coronary Care Unit	144.6%	137.5%	12.2	83.6%		3.3	3.04%	5.37%	0.94%			0/1				
Highfield	115.2%	56.0%	8.0	107.3%	95.4%	9.5										
Ince	162.5%	79.5%	7.9	130.2%	79.8%	9.0	5.55%	1.71%	8.65%			0/3				
Pemberton	101.8%	72.4%	6.0	72.2%	85.5%	7.2	7.38%	5.61%	7.27%			1/6				
Shevington	142.6%	89.9%	4.7	143.0%	108.3%	6.7	15.48%	16.45%	28.95%			0/3				
Standish	112.8%	73.7%	2.7	151.6%	120.0%	5.5	3.86%	5.60%	8.46%			0/5		0/5		
Winstanley	148.2%	84.8%	8.5	141.4%	92.2%	8.7	8.90%	6.39%	14.70%			0/3	1/0	0/3		

Division of Surgery

	Average Fill Rates (%) & CHPPD						Staff Availability			Staff Experience	Nurse Sensitive Indicators				Patient Experience % (Number surveyed)	
	RN / RM			CSW												
Ward	Day shift (%)	Night shift (%)	CHPPD	Day shift (%)	Night shift (%)	CHPPD	Sickness (%)	Vacancies (%)	Vacancies (%) - Registered Nursing Band 5-8	Datix Incidents - related to staffing/Red Flags	CDT	Falls (Harm / No Harm)	PU (Grade 1&2 / Grade 3 & 4)	Drug Admin Errors (Harm / No Harm)	Do you think the hospital staff did everything they could do to control your pain?	Have you been given the care you felt you required when you needed it most?
ICU/HDU	113.4%	113.2%	25.8	117.8%		3.8	8.76%	0.00%	0.00%	5			4/0			
Langtree	126.6%	78.9%	4.8	116.0%	93.1%	6.4	18.72%	8.26%	25.26%			0/6		0/1		
Orrell	158.0%	80.6%	5.2	156.1%	127.3%	8.2	3.24%	11.90%	20.88%	1		0/4		0/2		
Swinley	132.4%	82.0%	3.9	100.4%	102.7%	5.2	14.41%	9.90%	22.52%			0/5				
Maternity Unit	100.4%	96.7%	19.9	75.8%	95.0%	5.5	8.68%	0.00%	0.00%							
Neonatal Unit	93.3%	90.9%	16.6	85.0%		2.1	12.68%	2.12%	0.00%					0/1		
Rainbow	82.0%	71.3%	14.2	48.6%	30.6%	7.2	9.50%	0.00%	0.00%			0/1				

Division of Specialist Services

	Average Fill Rates (%) & CHPPD						Staff Availability			Staff Experience	Nurse Sensitive Indicators				Patient Experience % (Number surveyed)	
	RN / RM			CSW												
Ward	Day shift (%)	Night shift (%)	CHPPD	Day shift (%)	Night shift (%)	CHPPD	Sickness (%)	Vacancies (%)	Vacancies (%) - Registered Nursing Band 5-8	Datix Incidents - related to staffing/Red Flags	CDT	Falls (Harm / No Harm)	PU (Grade 1&2 / Grade 3 & 4)	Drug Admin Errors (Harm / No Harm)	Do you think the hospital staff did everything they could do to control your pain?	Have you been given the care you felt you required when you needed it most?
Aspull	152.6%	79.5%	4.1	127.2%	106.9%	5.55	11.71%	15.56%	32.58%	2	2	0/1				
Ward A	138.7%	77.3%	33.7	118.9%	95.3%	46.49	14.91%	12.89%	17.63%							
Ward B	198.9%	88.9%	5.5	133.1%	85.1%	6.29	7.52%	4.76%	8.73%	1						
JCW	25.7%	15.1%	0.0	21.3%	5.0%	0.0	11.09%	17.71%	23.01%							

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	96.1%	110.5%		103.7%	178.4%		8.94%	20.02%	27.77%			1/3				
A&E Paeds	133.2%	97.2%					0.00%	31.65%	31.65%							
A&E NP's	154.4%	0.0%														
CDW	92.4%	83.3%		85.2%	48.4%		12.48%	19.25%	24.68%							
Lowton	150.4%	87.4%		102.0%	89.8%		9.09%	9.06%	18.57%			0/3		0/1		
Medical Assessment Unit	148.4%	87.8%		113.9%	94.5%		4.92%	12.03%	18.74%		1	0/3		0/1		

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

May 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	239.9%	122.9%	3.9	225.7%	198.4%	6.9	10.17%	0.00%	6.73%			1/5		0/1		
Astley	152.4%	98.5%	4.8	198.8%	130.7%	8.4	16.43%	4.22%	15.94%		1			0/1		
Coronary Care Unit	146.7%	142.3%	8.3	119.5%		2.5	3.47%	28.83%	27.91%			1/0				
Highfield	184.8%	76.9%	10.5	199.1%	148.8%	14.0						0/2				
Ince	143.1%	110.3%	7.0	134.9%	95.7%	8.9	10.96%	24.85%	41.26%			0/2				
Orrell	161.0%	73.9%	5.2	159.9%	145.6%	9.1	10.29%	8.70%	14.34%	1	1	0/5		0/1		
Pemberton	112.1%	86.5%	7.2	102.5%	87.0%	9.2	18.94%	4.93%	8.21%			0/3				
Shevington	115.1%	96.1%	4.5	110.1%	99.6%	5.8	17.29%	20.31%	38.26%			0/5				
Standish / Bryn Ward North	100.8%	78.3%	3.4	80.3%	92.9%	4.4	16.91%	9.87%	26.57%			0/3	1/1	0/4		
Winstanley	159.4%	146.1%	11.3	159.7%	95.7%	9.6	6.41%	10.27%	30.57%			0/2				

Division of Surgery

	Average Fill Rates (%) & CHPPD						Staff Availability			Staff Experience	Nurse Sensitive Indicators				Patient Experience % (Number surveyed)	
	RN / RM			CSW												
Ward	Day shift (%)	Night shift (%)	CHPPD	Day shift (%)	Night shift (%)	CHPPD	Sickness (%)	Vacancies (%)	Vacancies (%) - Registered Nursing Band 5-8	Datix Incidents - related to staffing/Red Flags	CDT	Falls (Harm / No Harm)	PU (Grade 1&2 / Grade 3 & 4)	Drug Admin Errors (Harm / No Harm)	Do you think the hospital staff did everything they could do to control your pain?	Have you been given the care you felt you required when you needed it most?
ICU/HDU	105.8%	98.5%	39.1	100.9%		5.1	14.16%	0.00%	0.00%				1/1	0/3		
Langtree	114.1%	92.4%	4.0	122.6%	112.2%	5.9	23.84%	11.08%	26.33%			0/3		0/1		
Swinley	168.8%	102.5%	4.1	143.6%	120.8%	5.6	7.09%	9.79%	22.52%			0/3	2/0			
Maternity Unit	104.1%	99.3%	18.0	75.2%	93.5%	4.8	2.76%	0.00%	0.00%					0/1		
Neonatal Unit	91.2%	94.7%	14.3	119.4%		2.5	7.98%	1.36%	0.00%							
Rainbow	81.4%	77.5%	12.6	50.9%	39.4%	7.1	11.43%	0.00%	0.00%			0/1		0/1		

Division of Specialist Services

	Average Fill Rates (%) & CHPPD						Staff Availability			Staff Experience	Nurse Sensitive Indicators				Patient Experience % (Number surveyed)	
	RN / RM			CSW												
Ward	Day shift (%)	Night shift (%)	CHPPD	Day shift (%)	Night shift (%)	CHPPD	Sickness (%)	Vacancies (%)	Vacancies (%) - Registered Nursing Band 5-8	Datix Incidents - related to staffing/Red Flags	CDT	Falls (Harm / No Harm)	PU (Grade 1&2 / Grade 3 & 4)	Drug Admin Errors (Harm / No Harm)	Do you think the hospital staff did everything they could do to control your pain?	Have you been given the care you felt you required when you needed it most?
Aspull	151.4%	97.2%	3.6	142.0%	157.1%	5.91	17.34%	19.42%	36.21%	2	1	0/2		1/2		
Ward A	167.9%	119.4%	4.7	159.4%	121.2%	6.26	26.36%	14.67%	12.81%					1/2		
Ward B	209.8%	106.6%	4.7	171.5%	126.9%	6.43	12.82%	14.81%	17.61%							
JCW	6.5%	1.6%	0.0	4.0%	0.0%	0.0	19.79%	18.26%	23.01%							

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	96.8%	118.8%		138.1%	167.5%		6.15%	23.57%	31.87%			0/3		1/2		
A&E Paeds	116.5%	103.4%					0.00%	16.79%	16.79%							
A&E NP's	151.1%	0.0%														
CDW	94.0%	103.4%		140.1%	85.8%		9.15%	27.63%	31.35%			0/1				
Lowton	130.6%	115.1%		146.2%	102.9%		12.54%	13.31%	27.78%			0/4		0/1		
Medical Assessment Unit	156.5%	100.8%		116.5%	104.9%		2.51%	21.36%	36.57%			1/7	0/2	0/1		

Other – Community Covid

	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?
Leigh Covid Recovery Unit	242.0%	157.4%	17.0	175.5%	101.6%	14.7										

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

June 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	239.9%	122.9%	3.7	225.7%	198.4%	6.6	9.80%	0.00%	6.73%			0/3	2/0	0/1		
Astley	152.4%	98.5%	4.5	198.8%	130.7%	7.7	7.34%	2.49%	11.34%				1/0	0/1		
Bryn North	152.4%	98.5%	4.2	198.8%	130.7%	7.3	2.70%	Unable to report vacancies as there is no budget recorded for this department				0/2	1/0	0/1		
Bryn South	152.4%	98.5%	4.8	198.8%	130.7%	8.3						0/2				
Coronary Care Unit	146.7%	142.3%	8.0	119.5%		2.4	1.31%	26.45%	27.91%							
Highfield	184.8%	76.9%	16.5	199.1%	148.8%	21.9										
Ince	143.1%	110.3%	5.3	134.9%	95.7%	6.8	4.94%	31.66%	54.45%		1	0/2	0/1	0/3		
Orrell	161.0%	73.9%	4.8	159.9%	145.6%	8.4	2.19%	5.81%	7.71%		1	0/3	0/1	0/2		
Pemberton	112.1%	86.5%	6.6	102.5%	87.0%	8.4	14.80%	6.50%	9.01%			0/2		0/1		
Shevington							11.26%	16.19%	34.34%					0/1		
Standish							15.30%	9.39%	31.31%					0/1		
Winstanley	159.4%	146.1%	14.1	159.7%	95.7%	12.1	4.76%	7.63%	26.75%							

Division of Surgery

	Average Fill Rates (%) & CHPPD						Staff Availability			Staff Experience	Nurse Sensitive Indicators				Patient Experience % (Number surveyed)	
	RN / RM			CSW												
Ward	Day shift (%)	Night shift (%)	CHPPD	Day shift (%)	Night shift (%)	CHPPD	Sickness (%)	Vacancies (%)	Vacancies (%) - Registered Nursing Band 5-8	Datix Incidents - related to staffing/Red Flags	CDT	Falls (Harm / No Harm)	PU (Grade 1&2 / Grade 3 & 4)	Drug Admin Errors (Harm / No Harm)	Do you think the hospital staff did everything they could do to control your pain?	Have you been given the care you felt you required when you needed it most?
ICU/HDU	105.8%	98.5%	78.6	100.9%		10.2	7.92%	0.00%	0.00%	11						
Langtree	114.1%	92.4%	3.3	122.6%	112.2%	4.9	19.93%	15.71%	32.02%		1	0/6	1/1	0/6		
Swinley	168.8%	102.5%	3.8	143.6%	120.8%	5.2	4.56%	10.09%	22.52%			0/6	2/0	0/3		
Maternity Unit	104.1%	99.3%	17.7	75.2%	93.5%	4.7	0.81%	0.00%	0.00%							
Neonatal Unit	91.2%	94.7%	14.3	119.4%		2.5	4.78%	0.00%	0.00%							
Rainbow	81.4%	77.5%	11.6	50.9%	39.4%	6.5	13.97%	0.00%	0.00%					0/1		

Division of Specialist Services

	Average Fill Rates (%) & CHPPD						Staff Availability			Staff Experience	Nurse Sensitive Indicators				Patient Experience % (Number surveyed)	
	RN / RM			CSW												
Ward	Day shift (%)	Night shift (%)	CHPPD	Day shift (%)	Night shift (%)	CHPPD	Sickness (%)	Vacancies (%)	Vacancies (%) - Registered Nursing Band 5-8	Datix Incidents - related to staffing/Red Flags	CDT	Falls (Harm / No Harm)	PU (Grade 1&2 / Grade 3 & 4)	Drug Admin Errors (Harm / No Harm)	Do you think the hospital staff did everything they could do to control your pain?	Have you been given the care you felt you required when you needed it most?
Aspull	151.4%	97.2%	3.7	142.0%	157.1%	6.10	12.27%	21.50%	35.81%			0/2		0/4		
Ward A	167.9%	119.4%	4.9	159.4%	121.2%	6.57	14.84%	14.44%	12.81%	1		0/5		0/1		
Ward B	209.8%	106.6%	5.6	171.5%	126.9%	7.69	13.17%	17.46%	20.09%		1	0/3		0/2		
JCW							10.41%	10.16%	17.06%							

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	92.0%	119.8%		164.4%	189.7%		3.47%	20.31%	29.66%			0/7		0/1		
A&E Paeds	114.5%	106.5%					0.00%	24.22%	24.22%							
A&E NP's	142.2%	0.0%														
CDW	107.5%	100.1%		151.8%	103.8%		6.54%	28.14%	31.35%							
Lowton	185.4%	96.9%		160.7%	112.4%		6.45%	9.99%	27.78%			0/4	1/0	0/3		
Medical Assessment Unit	188.6%	106.8%		129.6%	102.5%		2.03%	19.16%	36.02%			0/3	1/0	0/3		

Other – Community Covid

	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?
Leigh Covid Recovery Unit	242.0%	157.4%	24.6	175.5%	101.6%	21.3	3.2%	Unable to report vacancies as there is no budget recorded for this department								

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

Appendix 2

	April 2020		**May 2020**		June 2020	
No of areas	Red Metrics Registered Staff Days	Red Metrics Registered Staff Nights	Red Metrics Registered Staff Days	Red Metrics Registered Staff Nights	Red Metrics Registered Staff Days	Red Metrics Registered Staff Nights
24	**2**	**13**	2	5	1	3

Table 1. Red Metrics in Inpatient Areas April to June 2020

Month	Registered WTE	Unregistered WTE
June	264.77	85.95

Table 2. Nurse Vacancies June 2020 Trust Wide)

	June 2020
Specialty	B5 vacancies
Medicine	104.06
Surgery	34.62
Specialist Services	22.66
Community Services	16.99
Corporate	1.7
Total	**180.03**

Table 3. B5 Nurse Vacancies June 2020 by Division

Red Flag Category	**No. of Incidents April 2020**	**No. of Incidents May 2020**	**No of Incidents June 2020**
Shortfall of more than 8 hours or 25% of registered nurses in a shift	7	2	12
Delay of 30 minutes or more for the administration of pain relief	1	1	0
Delay or omission of intentional rounding	0	0	0
Less than 2 registered nurses on shift	1	1	0
Vital signs not assessed or recorded as planned	0	0	0
Unplanned omission of medication	0	0	0
Total	**9**	**3**	**12**

Table 4. Nursing Red Flags April to June 2020

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

Table 5. Maternity Red Flags April to June 2020.

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

Title of report:	Mortality report
Presented to:	Board of Directors
On:	29 July 2020
Presented by:	Medical Director
Prepared by:	Nichola Halpin and Alison Unsworth
Contact details:	Sanjay.Arya@wwl.nhs.uk

Executive summary

The Trust'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 (NHS Digital data published in July 2020). This is marginally better than the previous update of 1.20 in May 2020.

The purpose of the report is to provide assurances around what measures WWL have in place to ensure the SHMI data is accurate, what measures are in place to monitor quality of care, and what actions are being taken to address the Trust's high SHMI position.

Link to strategy

- Patients
- Performance

Risks associated with this report and proposed mitigations

- Patients – There could be increased risk to patient safety
- Performance – Failure to improve the Trust's SHMI could affect the Trusts reputation, and concerns have been raised by the Trust's regulators
- SHMI is currently a risk on the Trust's Corporate Risk Register

Financial implications

None known

Legal implications

None known

People implications

Reputation of the Trust / public perception

Wider implications

None known

Recommendation(s)

The Board of Directors is asked to note the content of the report and actions being taken to address the SHMI position.

Report

1. Background

SHMI (Summary Hospital Mortality Index) is a standardised mortality rate produced by NHS Digital which seeks to provide Trusts with information regarding the number of expected deaths verses observed deaths within their Trusts, and those who die within 30 days of discharge.

SHMI bands Trusts in 3 ways:

- Band 3: Lower than expected
- Band 2: As expected
- Band 1: Higher than expected

National benchmarking for SHMI is '1.00'. The higher the score, the worse the SHMI. Current data is for the reporting period March 2019 – February 2020.

WWL is currently in Band 1 showing higher than expected deaths according to SHMI, with a SHMI of 1.17 (observed deaths at 1760, and expected deaths at 1495). This puts WWL in the third worst national position as demonstrated in Diagram 1 below. [*WWL is indicated by the red dot on the graph.*]

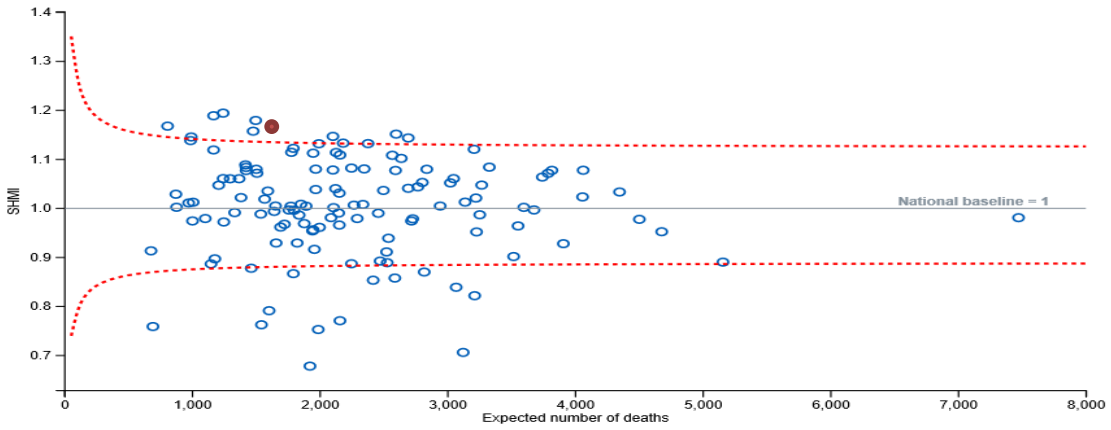


Diagram 1

Out of seven Trusts within Greater Manchester, four are currently showing higher than expected SHMI. However WWL has the highest SHMI within Greater Manchester as demonstrated in Diagram 2 below.

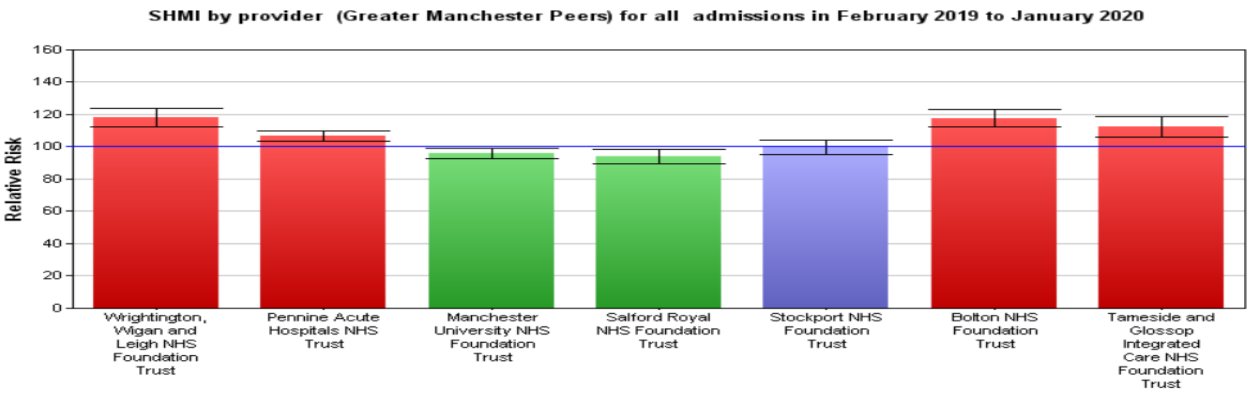


Diagram 2

The purpose of the report is to provide assurances around what measures WWL have in place to ensure the SHMI data is accurate, what measures are in place to monitor quality of care, and what actions are being taken to address the Trust's high SHMI position.

2. What impacts SHMI and what measures WWL can take to ensure the data is accurate?

There are a number of factors outlined below that have an impact on SHMI.

a. Bed Base

Data shows that Trusts with a higher number of beds per population served tend to have a lower SHMI than those with a lower bed base. As indicated in Diagram 3 below, WWL has a bed base of 1.5 per 1000 population with a SHMI of 1.17, compared to Salford's SHMI of 0.92 (band 2) with a bed base of 3.

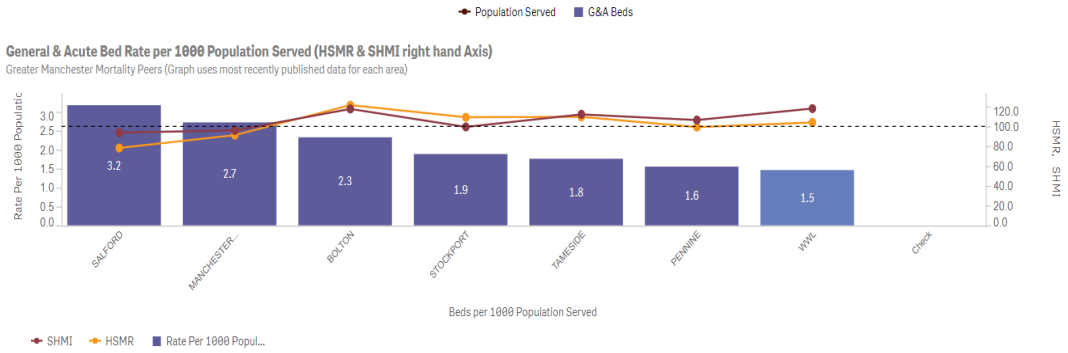


Diagram 3

As WWL now has an additional 50 beds on Bryn ward (open since 18 May 2020) and will shortly be opening the Community Assessment ward in October 2020, this will impact the Trust's SHMI. As WWL will have a higher number of beds per population served, this may reduce the Trust's SHMI position. As indicated above, the current SHMI data is for the reporting period March 2019 – February 2020. Therefore WWL may have to wait until the end of the year before the true impact of increasing the bed base is shown.

N.B. COVID cases will be excluded completely from SHMI by NHS Digital. Therefore it is not known yet whether this will have a positive or negative impact on the Trust's SHMI position.

b. Percentage of patients brought in to die

The Trust's SHMI figures will be affected by the number of patients who are brought into the hospital and die shortly after admission. A recent audit by the Trust's Clinical Audit team has shown that 1,047 patients were admitted from care homes in 2020. Out of those admissions 215 patients died, and from that figure 24 patients died within 1 day of admission. This will have an impact on the Trust's SHMI position as it is likely those patients should have stayed at their care home rather than be brought into hospital to die. Further clinical review is currently being undertaken to understand the reasons for admission and if anything could have been done differently.

It is essential that patients receive appropriate End of Life care and a Place Based Mortality Improvement Group is taking place within the next few weeks to review this further, not just at

WWL but right across the Wigan Borough. The Medical Director and Chief Nurse from WWL will be leading on those discussions.

In addition to the above, the Trust's Clinical Audit team are also carrying out an audit reviewing deaths within the Community division, by looking at patients who die within 30 days of discharge. The Trust is also looking to appoint a Medical Examiner within the Community division as well.

c. Co-Morbidities, Diagnosis and Secondary diagnosis coding

Factors that can influence mortality rates for SHMI are sex, gender, year, admission method, comorbidity, diagnoses groups and secondary diagnosis coding. There are currently measures in place to ensure the robust recording of data to allow accurate reporting of mortality rates.

Sex, gender, year and admission method are all data pulled through via HIS and/or EPR.

Co-morbidity coding is used to evaluate risk. Comorbidity codes will present as part of the patients medical history and be available to record from within the clinical record if the patient presents for admission. This will assist in identifying and recording past history and ensure accurate risk rating. A patient with a higher number or relevant comorbidities will have a higher calculated risk of death.

The Clinical Coding external audits at WWL have had continuous excellent results. The Clinical Coding team have an audit plan in place to ensure accurate recording of all codes. A system of identifying comorbidities on HIS is currently on going and is expected to be in place by 20th August 2020.

d. Signs and Symptoms Codes ("R Codes")

Signs and symptoms codes (also known as 'R Codes') are used by clinical coders when there has been no definitive diagnosis made. Such examples would be chest pain, abdominal pain and would be rarely used in patient deaths. These codes attribute a lower risk of death as patients would be expected to have a definitive diagnosis.

The Clinical Coding Manager is currently undertaking an audit on R codes to ensure accuracy.

e. Triggers of high mortality

WWL are currently showing a higher than expected number of deaths in one diagnostic group; septicaemia. During the period of March 2019 to February 2020 the Trust had 145 deaths from sepsis, when 115 were expected. An audit by the Trusts Sepsis Lead is currently underway to establish if there are any concerns around this increased number.

Despite having a high SHMI, the number of deaths as calculated by SHMI has shown a reduction from January 2018 to February 2020. Diagrams 4 and 5 below shows the SHMI values produced quarterly since April 2016 and the observed deaths over the same time period.

Chart 2	**April 16 - Mar 17**	**July 16 - June 17**	**Oct 16 - Sept 17**	**Jan 17 - Dec 18**	**April 17 March18**	**July 17 - June 18**	**Oct 17 - Sept 18**	**Jan 18 - Dec 18**	**April 18 March19**	**July - 18 June 19**	**Oct 18 - Sept 19**	**Jan 19 - Dec 19**	**Mar-19 – Feb 20**
SHMI	1.2	1.22	1.2	1.17	1.13	1.12	1.1	1.09	1.14	1.16	1.16	1.2	1.17
Observed Deaths	1838	1883	1888	1905	1906	1893	1745	1758	1741	1750	1770	1820	1760

Expected	1527	1540	1570	1624	1680	1692	1674	1616	1531	1510	1520	1515	1495
Discharged	40087	40626	41371	43381	45358	47291	47871	47727	45969	46000	46470	46605	46245

Diagram 4

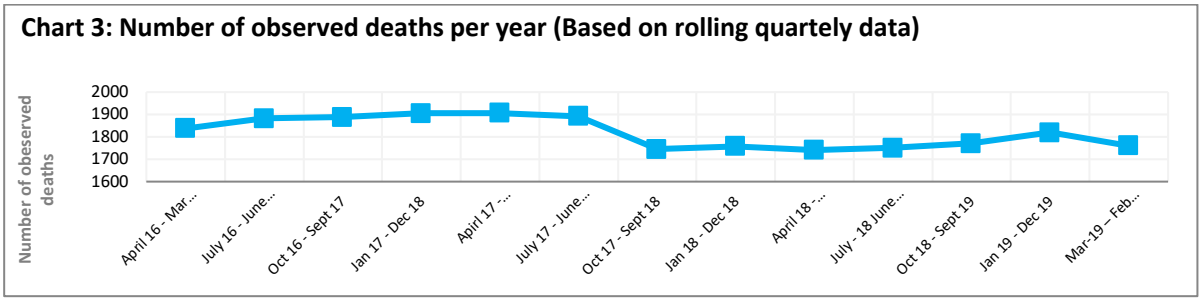


Diagram 5

3. Measures in place to monitor quality of care:

Along with measures in place to ensure accurate recording of data, there are also systems to review deaths to ensure appropriate care.

a. Weekly Corporate Mortality Review
   A weekly mortality report is distributed across WWL and there is escalation to Executive Scrutiny Group (ESG) if potentially preventable deaths have been identified.
b. Divisional escalation to Corporate Mortality Review team
   Any issues highlighted within the Divisions are reviewed by the corporate mortality review teams.
c. Monthly Mortality Meetings (chaired by Medical Director)
   Review of Dr Foster and SHMI data with representatives from BI, Clinical Audit, Clinical Coding, Governance and Dr Foster.
d. Quarterly Trust Mortality Board (Chaired by Medical Director)
   Attended by key stakeholders, AquA and Dr Foster.
e. Divisional Mortality Review
   Review of cases by individual teams. New process for general surgical team implemented from August 2020
f. Medical Examiners
   Review of cases as point of death certification

4. Additional actions taken

In addition to the above, WWL have requested AquA (Advancing Quality Alliance) to conduct a deep dive into the Trust's current SHMI position. A meeting is planned for 3rd August 2020.

Therefore by undertaking the actions outlined above, such as increasing the Trust's bed base, carrying out internal audits and working with colleagues within the wider Wigan Borough, it is hoped that the Trust's SHMI position will continue to improve. It will be kept under constant review by the Medical Director, Clinical lead for mortality, Head of Legal Services and Clinical Audit & Effectiveness Manager, and regular updates can be provided at future meetings.

Title of report:	Guardian of Safe Working Annual Report
Presented to:	Board of Directors
On:	29 July 2020
Presented by:	Guardian of Safe Working
Prepared by:	Shams Khan, GOSW and Vicky Bateson – Senior HRBP
Contact details:	T: 01942 773874 E: victoria.bateson@wwk.nhs.uk

Executive summary

This 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

Risks associated with this report and proposed mitigations

Potential breach of Terms and conditions of service or WTR if rota rules are not complied with, mitigated by rota reviews where required in specific specialties.

Financial implications

Fines and additional shifts worked attract a financial cost to the organisation details contained within the report.

Legal implications

N/A

People implications

Staff Engagement / Recruitment and Retention, may be impacted if issues are not addressed to support the experience of doctor sin training at WWL.

Report

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		41	226	114	87	5	758	156

May 7 2020

For this report I have the results of two quarters work of Exception Report data and some comments from face to face meetings with Junior Doctor reps 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 where 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, I would caution against an assumption that problems have been fixed as I 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 I had a meeting with the Junior Doctors BMA reps and I met with FY1's from Shevington Ward and also for General Surgery. The concerns expressed to me by the FY1's are as follows: General Surgery:

FY1 from 8 am to 8 pm
Registrar from 8 am to noon: this is ward cover.
A & E/Admissions: Consultant Registrar and SHO Grade, EPR Doctor is an FY1 – 8 am to 3 pm and is a locum.

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 been concerns about variation in the starting times of the middle grade surgical doctors covering the wards at weekends.

From my perspective 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 Mr Alam and BMA reps to address rota needs for General Surgery

Active interaction and meetings between Ashish Abdul and BMA reps to look at the issues behind Shevington Ward

Request for increased staffing levels (FY3 / IMTs) by 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

Victoria, Suzi and I will engage further 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

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Freedom to Speak Up Guardian's report
Presented to:	Board of Directors
On:	29 July 2020
Presented by:	Freedom to Speak Up Guardian
Prepared by:	Kyle Collum, Freedom to Speak Up Guardian
Contact details:	E: kyle.collum@wwl.nhs.uk

Executive summary

The report provides an update from the Trust's Freedom to Speak Up Guardian (FTSUG), Kyle Collum, on national or local developments on matters considered as Speaking Up in 2019/20.

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

Finally, the report provides a brief summary of the cases referred to the FTSUG, Fraud Specialist Manager, or HR in relation to matters that are under the auspices of Speaking Up during 2019/2020 and to provide assurance these are being managed appropriately and in accordance with the Trust's Freedom to Speak Up Policy.

Link to strategy

There is no direct link to the foundation trust's strategy.

Risks associated with this report and proposed mitigations

There are no direct risks associated with this report.

Financial implications

There are no financial implications associated with this report.

Legal implications

There are no legal implications directly associated with this report.

People implications

There are no direct people implications arising from this report.

Wider implications

There are no wider implications directly associated with this report.

Recommendation(s)

The Board is recommended to receive the report and noted the content.

Report

In the previous report to the board, it was reported that the number of contacts received by the FTSUG in 2018/19 had increased significantly. During 2019/20, 44 concerns have been raised, averaging at 11 per quarter. This is in line with the level of activity reported in 2018/19. This can be seen as a positive effect of ongoing promotional activity and focus over the past 12 months. The majority of contacts have been related to attitudes and behaviours, and the impact this has on staff particularly regarding their health and wellbeing. The involvement of the FTSUG in each contact varies. An important element of the role is providing staff with support and signposting for appropriate advice.

Since the last report to the board, a review of speaking up arrangements at Whittington Health NHS Trust has been published. Due to the recent release of the review, we are still in the process of review locally. The recommendations within the report are being reviewed against WWL provision, and any further actions required will be incorporated into the FTSU action plan. The board is reminded that Trusts or individuals can refer cases to the NGO for review if it is considered that the concerns raised were not managed appropriately.

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

A positive development within the last 12 months has been the agreement to appoint a substantive, full time FTSUG. This is great news for the organisation and staff members as this will enable true dedication and focus on Speaking Up. The dedicated role will enable more timely progress to be made on plans to develop a FTSU network across the Trust, including FTSU Ambassadors.

The new substantive FTSUG started in the role fully at the end of April, as the previous guardian stepped down. The benefit of the role being substantive is the opportunity for progress to be made on some of the long-standing plans, as well as for new and refreshed promotion of FTSU. The FTSUG has set objectives for the first six months in post, and there are a number of plans in place to improve the visibility and accessibility of FTSU:

- Staff Briefing via webinar, covering FTSU and linking in with psychological safety. This took place on 16th July 2020, and will be distributed through the internal communication channels.
- Dedicated time for drop in sessions across the trust sites where feasible. There are some spaces identified, and further consideration is being made regarding timeframes and appropriate dates.
- Implementation of the FTSU Ambassador project, with alignment to ED&I.
- Implementation of three levels of training, covering all staff, management and board. This is awaiting the release of the first level of training by the NGO.
- Creation of a feedback survey, to be sent where possible after case resolution.
- Promotional materials to be developed in liaison with the Communications and PR team.
- Identification of lessons learned where appropriate for a ‘you said, we did’ update.

As the Board will be aware, a review of FTSU arrangements had been planned as part of the Mersey Internal Audit Agency (MIAA) audit plan for 19/20. Whilst work on this had commenced, it was

initially suspended due to the Covid-19 outbreak. There is confirmation that this will be resumed as a priority, and this is now in the early stages.

The FTSU Guardian also continues to attend the twice yearly National FTSU conferences and North West Network events. Events are now running via videoconferencing due to the impact of Covid-19, but this has allowed for monthly regional meetings to be developed.

FREEDOM TO SPEAK UP ACTION PLAN / NGO CASE REVIEWS

NGO Case review in relation to Whittington Health NHS Trust – copy available at https://www.nationalguardian.org.uk/wp-content/uploads/2020/06/casereviewwhittington.pdf

As described earlier in the report, there has been a further case review undertaken by the NGO in June 2020. The latest case review was in relation to Whittington Health NHS Trust. The report made 14 recommendations against which the Trust is currently undertaking a gap analysis against local provision. This will be included in the next board report.

Anecdotal evidence has been received in the past that not all staff are familiar with the many avenues open to them to raise concerns or with the availability of the FTSUG. With this in mind, a number of actions have been undertaken over the past 12 months to raise the profile of raising concerns in general:

- FTSU walkabouts at RAEI, Wrightington and TLC;
- Promotion across the Trust of Speak Up month;
- Articles in News Brief and Focus;
- FTSU information included in the electronic induction and Go Engage Teams information packs;
- Re-branding of the Raising Concerns Policy to become the Freedom to Speak Up Policy;
- Commencement of work streams such as Just Culture, Civility Saves Lives and Compassionate Leadership;
- FTSU leadership masterclass with Dr Nick Harper which took place on 5 July 2019.
- 'Feeling safe to speak up at work' webinar which took place on 16 July 2020.

The uncertainty around the avenues available to raise concerns is still relevant, and as described earlier in the report, the objectives set out by the FTSUG will help to address this. As the trust moves into the recovery plan, face to face promotion via walkabouts is expected to resume following relevant guidance on PPE.

There has been a huge amount of enthusiasm and support for the action plan within the Workforce Directorate with Counter Fraud, Staff Side colleagues and the FTSUG working together in partnership on delivery. With the appointment of a full time FTSUG work has started to drive the action plan forward.

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

Points of learning from local case review

At the request of an individual, there was a case review by the Non-Executive Director lead for FTSU. The review has not been formally signed off at the time of the report, but there are a few points of learning that have been identified:

- There did not appear to be clear information given regarding next steps, timeframes, and agreed arrangements to provide regular feedback.
- There did not always appear to have been appropriate discussion of concerns/challenges in the spirit of continuous improvement.
- At the time of the case, the role of FTSUG was undertaken by the then Director of Governance, and there appears to have been some uncertainty regarding which role was being referred to. It should be noted that the FTSUG role is now independent.
- There should be a review of the process associated with FTSU policy, with a clear identification of responsibility.

There may be further points of learning identified as the review process draws to a close.

2019/20 FULL YEAR UPDATE

Reported concerns

The recorded contacts during 2019/20 total 47. These contacts are those that have been raised to the FTSUG, HR team or Fraud Specialist Manager. Within the stages of the Freedom to Speak Up Policy there is the opportunity for individuals to raise matters informally initially. This informal process has been promoted with the Trust's open culture however in terms of capturing data we are unable to report the number of concerns that are raised and resolved informally, at source, via line management or another route such as Staff Side.

Concerns relating to bullying or harassing behaviour within employment may currently be raised via the Trust's Grievance process and/or via the Freedom to Speak Up process therefore may be recorded via separate methods and reported as such, however all data is held within the HR department. It should be noted that, due to an update in the NHS terms and conditions in respect of Dignity at work, the handbook advises as follows:

Section 32.8 The procedure for dealing with complaints against members of staff should be seen as separate and different from the grievance procedure, and should recognise the difficulties being experienced by complainants.

In respect of this the HR team are currently working on production of a separate Dignity at Work policy so that matters around attitudes and behaviours are likely to fall under this policy rather than grievance. The Trust actively promotes the raising of all employee concerns and therefore is happy to record matters according to the process under which they are reported.

Formal concerns

47 matters have been recorded formally under the auspices of raising concerns during 2019/20.

The Fraud Specialist Manager has received 3 formal cases, 18 information/referrals which have been uploaded to the FIRST portal (the formal NHS Counter Fraud Authority portal), in addition the Fraud Specialist Manager has received 15 advice/guidance referrals, this type of enquiry is not uploaded to the FIRST system, and 2 DATIX referrals.

Out of the 3 formal cases that have been reported via the Fraud Specialist Manager:

- 1 individual allegedly obtained payment for travel expenses dishonestly and committing timesheet fraud - Fraud by False Representation - Contrary to section 2 Fraud Act 2006

- 1 individual allegedly working whilst off sick – Fraud by False Representation - Contrary to section 2 Fraud Act 2006
- 1 individual allegedly committed fraud by attending private services in NHS time - Fraud by false representation; Contrary to section 2 Fraud Act 2006

Of these, all matters were raised anonymously.

The Fraud Specialist Manager has recovered **£42,532** in redress monies for 2019/20. The Fraud Specialist Manager provides an annual report on matters to the Audit Committee; a bi-monthly update report to Audit Committee and monthly updates to the Director of Finance. Included within the updates and reports are outcomes from investigations; ongoing investigations; breaches of the Trust's Standing Financial Instructions; and financial redress from matters.

There are 44 remaining concerns, all of which were initially received by, or referred in the first instance to, the Trust's FTSUG.

Of these 44 concerns:

- 8 concerns related to matters that could be categorised as Quality and Safety;
- 35 concerns related to matters that could be categorised as Attitudes and Behaviours.
- 1 concern could not be categorised as the individual did not respond further.

Of these 44 concerns:

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

Of these 44 concerns:

- 25 matters were raised anonymously;
- 19 matters were raised by individuals who provided permission for them to be identified.

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

- The promotion and embedding of the Behaviours Framework across the organisation;
- The implementation and embedding of Just Culture, Civility Saves Lives and Compassionate Leadership.

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

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

Matters raised in accordance with PIDA

Whilst the Trust's Freedom to Speak Up policy embraces but is not limited to those concerns or disclosures raised in accordance with the PIDA it should be noted which matters would qualify under this Act for the purposes of reporting. Qualifying disclosures are disclosures of information where

the worker reasonably believes (and it is in the public interest) that one or more of the following matters is either happening, has taken place, or is likely to happen in the future.

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

In this regard the Trust would report that during 2019/20 3 concerns have been reported which could qualify under the Act.

Out of all concerns reported in 2019/20 there have been no conclusions that any reports or concerns raised have been made maliciously.

Conclusion

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

Recommendations

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

Appendix: Freedom to Speak Up action plan

	Action	Responsible	Timescale	Update	Completion date
1.	**A reminder to be provided to all staff of the availability of the Raising Concerns Policy and the role of the FTSU Guardian:**				
	• Message on the intranet site and a reminder article to be placed in News Brief	Workforce Governance Manager	Q1 2018/2019 – revised timescale for FTSU webpage Q2 2019/20	• Plans to develop a dedicated FTSU web page with links to Raising Concerns policy, latest updates etc.; • An article to be provided for team brief promoting the availability of FTSU; • Screensaver message • Banner to be included on Wally	**Completed**
	• A stand publicising FTSU to be arranged for all sites during the course of the year	Workforce Governance Manager	Q1 2018/2019	• Stand at the Medical Education Centre open day on the 14 June 2018; • Dates to be agreed for visits to all sites.	**Completed**
	• Posters / contact cards to be produced for distribution and display	Workforce Governance Manager	Q1 2018/2019	• Posters designed for printing and laminating; • Contact cards printed; • Pens produced for use on stands; • Pop up banners created for stands / events; • FTSU video has been updated.	**Completed**

	Action	Responsible	Timescale	Update	Completion date
	• Discussion to take place with Caroline Greenhalgh to ensure that Raising Concerns is covered as part of the Executive Safety Walkabouts	Workforce Governance Manager	Q1 2018/2019	• Discussed with C Greenhalgh and it has been confirmed that Raising Concerns will form part of the Executive Safety Walkabouts.	**Completed**
	• Consideration to be given to the use of the WWL Ambassadors to relay the message around Raising Concerns	Workforce Governance Manager	Q3/4 2020/21	• Plans for network of FTSU Ambassadors to raise awareness, and for promotion in local areas. • FTSUG to consider how to implement.	
	• Consideration to be given to including FTSU speakers as part of upcoming Leadership Masterclasses	Workforce Governance Manager	Q1 2018/2019 – revised timescale Q3/ Q4 2019/20	• Speaking Up Leadership Masterclass with Dr Nick Harper held on 5 July 2019.	**Completed**
	• Raising Concerns Policy to be rebranded as the Freedom to Speak Up Policy in line with NGO best practice	Workforce Governance Manager	Q3 2018/2019	• Full review of policy has taken place in line with the 3 year cycle – undertaken by Deputy Director of HR, FTSU Guardian and Counter Fraud; • Name of policy changed to Freedom to Speak Up Policy.	**Completed**

	Action	Responsible	Timescale	Update	Completion date
	• Development of a FTSU network	FTSU Guardian / Workforce Governance Lead	Q3/Q4 2020/21	• FTSU Ambassadors to be appointed across the Trust, from a variety of staff groups; • Role of FTSU Advocate created to provide support to the Guardian; • Dedicated champion role identified from the staff side reps. • FTSUG to link in with ED&I to ensure groups that are less likely to speak up have an ambassador.	
	• Development of a service user feedback mechanism	FTSU Guardian / Workforce Governance Lead	Q3/Q4 2020/21	• Potential to implement a very brief survey monkey for those that utilise the FTSU service. • FTSU Guardian to finalise details and implement.	
	• Development of an effective way to measure the success of FTSU promotional campaigns	FTSU Guardian	Q3/4 2020/21	• Awaiting appointment of substantive FTSU Guardian to accelerate this. • There is an expectation that this will lead to an uptake in the number of contacts made. • FTSU Guardian considering options to measure formally, there is a possibility to utilise Survey Monkey via internal channels, or a poll over the staff Whatsapp/Facebook group.	

	Action	Responsible	Timescale	Update	Completion date
	• Implement training across the organisation to raise awareness and to ensure that managers responding to speaking up matters have the appropriate skills to enable them to handle difficult conversations.	FTSU Guardian	Q3/4 2020/21	• The NGO have been asked to produce a level 1 basic awareness training package that is relevant for all staff; • The FTSU Guardian network is looking to produce a training package for senior managers; • Local FTSU Guardian will produce a training package for board members. • There is a delay to the release of level 1 training by the NGO, expected by Q2/3. This is awaited as will form the basis of local training.	
2.	**Consideration to be given to making all new starters aware of the Raising Concerns policy:**				
	• Information within the electronic handbook to be further developed to include Raising Concerns and to sign post the various routes available for reporting / advice	Workforce Governance Manager	Q2 2018/19	• It is not possible to update the electronic handbook at this time so a separate flyer has been created to circulate as an addition to this – the electronic handbook will be updated when possible; • FTSU slide and video included in the electronic induction pack.	**Completed**
	• A six monthly communication plan to be implemented to ensure regular promotion of Raising Concerns to capture new starters	Workforce Governance Manager	Q2 2018/19	• To be diarised on a 6 monthly basis for the Workforce Governance Manager to take forward; • FTSU slide and video incorporated into corporate and medical induction and the staff handbook to ensure new starters captured.	**Completed**

	Action	Responsible	Timescale	Update	Completion date
	• Raising Concerns video to be included in the Corporate Induction and the Junior Doctor induction	Workforce Governance Manager	Q2 2018/19	• FTSU video has been updated; • Video included in the electronic induction pack for new starters; • Also forwarded to the Medical Education Centre for inclusion in the junior doctor induction sessions.	**Completed**
3.	**The Trust to consider the development of an anti-bullying programme of training or awareness sessions for staff**				
	• Work to be undertaken to develop anti-bullying training or awareness sessions	Workforce Governance Manager / Deputy Director of HR	Q3/Q4 2020/21	• In progress – working group established to take this forward.	
4.	**Consideration to be given to the visibility of the Executive and Senior Leaders:**				
	• Discussion to take place with Caroline Greenhalgh to ensure that the schedule of Safety Walkabouts covers all sites equally	Workforce Governance Manager	Q1 / Q2 2018/19	• Have reviewed the current schedule for walkabouts and this covers all sites	**Completed**
	• A programme of Deputy level walkabouts to be developed to increase Senior Management exposure	Staff Engagement Manager	Q3/ Q4 2020/21	• Deputy walkabouts were discussed at the Staff Engagement Steering Group and it was felt that 'Back to the Floor' would be a good approach from which good news stories could be gathered and shared. Staff Engagement Team taking forwards.	

	Action	Responsible	Timescale	Update	Completion date
	• Ensure that CEO weekly updates, Team Brief and Podcasts are used effectively as an opportunity to publicise FTSU	Workforce Governance Manager	Q1 / Q2 2018/19	• A podcast could be delivered to tie in with this; • FTSU slide to be included in team brief for cascade to teams; • Slide also forwarded for inclusion in news brief.	**Completed**
5.	**To ensure the active promotion of mediation services available in the Trust:**				
	• A promotional campaign to be designed to increase awareness of the service for informal and confidential resolution to work relationship issues.	Mediation Co-ordinator	Q1 / Q2 2018/19	• Senior HR BPs will promote to the senior managers in the divisions. • Training for additional mediators has been secured	**Completed**

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Finance report
Presented to:	Board of Directors
On:	29 July 2020
Presented by:	Acting Chief Finance Officer
Prepared by:	David Hughes, Acting Deputy Chief Finance Officer
Contact details:	T: 01942 773736 E: david.a.hughes@wwl.nhs.uk

Executive summary

	In Month			Year to Date		
	Actual £000's	Plan £000's	Var £000's	Actual £000's	Plan £000's	Var £000's
Income	35,884			106,681		
Expenditure	(34,849)			(103,574)		
Financial Performance	0			0		
Cash Balance	64,554			64,554		
Capital Spend	483			9,628		

Key Messages:

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

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

The WWL Way

- The Trust is reporting a break even position in Month 3 and year to date. This is as per the instruction from NHSI due to the block funding and financial arrangements in place during the Covid pandemic.

- Cash is £64.6m at the end of Month 3.

- Capital spend is £9.6m year to date. This includes £6.1m on COVID-19 associated projects which will be fully reimbursed via non-interest bearing PDC.

Title of report:	Audit Committee terms of reference
Presented to:	Board of Directors
On:	29 July 2020
Presented by:	Director of Corporate Affairs
Prepared by:	Paul Howard
Contact details:	T: 01942 822027 | E: paul.howard@wwl.nhs.uk

Executive summary

The terms of reference of the Audit Committee are appended to this report. They have been reviewed and aligned with best practice guidance from NHS Providers in its *Compendium of Good Governance* publication and they were supported by the Audit Committee when it reviewed them on 5 June 2020.

Best practice set out in the NHS Foundation Trust Code of Governance recommends that the Council of Governors should also be consulted on the terms of reference. The Council endorsed the terms of reference at its meeting on 6 July 2020.

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 associated with this report.

Legal implications

There are no legal implication arising from this report.

People implications

There are no people implications arising from this report.

Wider implications

This report is intended to ensure that the organisation complies with best practice in corporate governance.

Recommendation(s)

The Board is recommended to approve the terms of reference as presented.

Appendix

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST
AUDIT COMMITTEE

TERMS OF REFERENCE

1. AUTHORITY

1.1. The Audit Committee ("the Committee") is constituted as a standing committee of the Foundation Trust's Board of Directors ("the Board"). Its constitution and terms of reference shall be as set out below, subject to consultation with the Council of Governors and amendment at future Board meetings.

1.2. The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.3. The Committee is authorised by the Board to obtain outside legal or other independent professional advice. It is also authorised by the Board to request the attendance of individuals and authorities from outside the foundation trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

2. MAIN PURPOSE

2.1. The Committee has primary responsibility for monitoring the integrity of the financial statements, assisting the Board in its oversight of risk management and the effectiveness of internal control, oversight of compliance with corporate governance standards and matters relating to the external and internal functions.

2.2. The Committee shall provide the Board with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Foundation Trust's activities both generally and in support of the annual governance statement.

2.3. The Board is responsible for ensuring effective financial decision-making, management and internal control including:

(a) Management of the Foundation Trust's activities in accordance with statute and regulations; and

(b) The establishment and maintenance of a system of internal control to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided and reliable financial information produced, and that value for money is continuously sought.

3. MEMBERSHIP

3.1. The Committee shall be composed of four (4) independent Non-Executive Directors and the Committee shall ensure that it has sufficient skills to discharge its responsibilities. At least one (1) member should have recent and relevant financial experience.

3.2. The Chair of the Foundation Trust shall not chair nor be a member of the Committee.

3.3. A quorum shall be formed on the attendance of three (3) Non-Executive Directors.

4. SECRETARY

4.1. The Company Secretary or his/her nominated deputy shall be secretary to the Committee.

5. ATTENDANCE

5.1. Only members of the Committee have the right to attend meetings of the Committee but the Chief Finance Officer, the Medical Director, the Counter-Fraud Specialist and the internal and external auditors shall generally be invited to attend routine meetings of the Committee.

5.2. Other executive directors and staff shall be invited to attend those meetings in which the Committee will consider areas of risk or operation that are their responsibility.

5.3. Other persons may be invited by the Committee to attend a meeting or part of a meeting so as to assist in deliberations.

6. FREQUENCY OF MEETINGS

6.1. Meetings shall be held at least four (4) times per year, with additional meetings being convened as necessary.

6.2. The external auditor shall be afforded the opportunity at least once per year to meet with the Committee without executive directors present.

7. DUTIES

7.1. With respect to the financial statements and the annual report:

(a) Monitor the integrity of the financial statements of the Foundation Trust, any other formal announcements relating to the Foundation Trust's financial performance and reviewing the significant financial reporting judgments contained in them;

(b) Review the annual statutory accounts before they are presented to the Board, in order determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

(i) the meaning and significance of the figures, notes and significant changes;

(ii) areas where judgment has been exercised;

(iii) adherence to accounting policies and practices;

(iv) explanation of estimates or provisions having material effect;

(v) the schedule of losses and special payments;

(vi) any unadjusted statements; and

(vii) any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.

(c) Review the annual report and annual governance statement before they are submitted to the Board to determine completeness, objectivity, integrity and accuracy;

(d) Review each year the accounting policies of the Foundation Trust and make appropriate recommendations to the Board; and

(e) Review all accounting and reporting systems for reporting to the Board, including in respect of budgetary control.

7.2. With respect to internal control and risk management:

(a) Review the Foundation Trust's internal financial controls to ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance;

(b) Review and maintain an oversight of the Foundation Trust's general internal controls and risk management systems, liaising with the Risk and Environmental Management Group where necessary;

(c) Review processes to ensure appropriate information flows to the Committee from executive management and other committees in relation to the Foundation Trust's overall internal control and risk management position;

(d) Review the adequacy of the policies and procedures in respect of all counter-fraud work;

(e) Review the adequacy of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks; and

(f) Review the adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and conduct requirements.

7.3. With regard to corporate governance:

(a) Monitor corporate governance compliance (e.g. compliance with the terms of the licence, constitution, codes of conduct, Standing Orders, Standing Financial Instructions and maintenance of registers of interests).

7.4. With regard to internal audit:

(a) Monitor and review the effectiveness of the Foundation Trust's internal audit function, taking into consideration relevant UK professional and regulatory requirements;

(b) Review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation;

(c) Oversee on an ongoing basis the effective operation of internal audit in respect of:

(i) adequate resourcing;

(ii) its coordination with external audit;

(iii) meeting relevant internal audit standards;

(iv) providing adequate independence assurances; and

(v) it having appropriate standing within the Foundation Trust.

(d) Consider the major findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations; and

(e) Consider the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal of internal audit staff; and

7.5. With regard to external audit:

(a) Review and monitor the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements;

(b) The Council of Governors should take the lead in agreeing with the Committee the criteria for appointing, reappointing and removing external auditors. To support them in this task, the Committee should:

(i) provide information on the external auditor's performance, including details such as the quality and value of the work, the timeliness of reporting and fees;

(ii) make recommendations to the Council of Governors in respect of the appointment, reappointment and removal of an external auditor and related fees as applicable. To the extent that a recommendation is not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

(c) Discuss with the external auditor, before the audit commences, the nature and scope of the audit;

(d) Assess the external auditor's work and fees each year and, based on this assessment, make the recommendation to the Council of Governors will respect to the reappointment or removal of the auditor. This assessment should include the review and monitoring of the external auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards;

(e) Oversee the conduct of a market testing for the appointment of an auditor at least once every five (5) years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the auditor;

(f) Review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations; and

(g) Develop and implement a policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance.

7.6. With regard to Standing Financial Instructions:

(a) Review on behalf of the Board the operation of, and proposed changes to, the Standing Financial Instructions;

(b) Examine the circumstances of any significant departure from the requirements of Standing Financial Instructions; and

(c) Review the Scheme of Reservation and Delegation.

7.7. With regard to other matters:

(a) Review performance indicators relevant to the remit of the Committee;

(b) Examine any other matter referred to the Committee by the Board and initiate investigation as determined by the Committee;

(c) Develop and use an effective assurance framework to guide the Committee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from directors and managers and other investigatory outcomes so as to fulfil its functions in connection with these terms of reference;

(d) Review the work of all other foundation trust committees in connection with the Committee's assurance function; and

(e) Consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health sector and professional bodies with responsibilities that relate to staff performance and functions.

8. MINUTES AND REPORTING

8.1. Formal minutes shall be taken of all Committee meetings.

8.2. The Committee will report to the Board after each meeting. The report shall include details of any matters in respect of which actions or improvements are needed.

8.3. The foundation trust's annual report shall include a section describing the work of the Committee in discharging its responsibilities. The report shall include:

(a) the significant issues that the Committee considered in relation to financial statements, operations and compliance and how these were addressed;

(b) an explanation of how the Committee has assessed the effectiveness of the external audit process and the approach taken to the appointment or reappointment of the external auditor, the value of external audit services and

information on the length of tenure of the current audit firm and when a tender was last conducted; and

(c) if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.

9. PERFORMANCE EVALUATION

9.1. As part of the Board's annual performance review process, the Committee shall review its collective performance.

10. REVIEW

10.1. These terms of reference of the Committee shall, in consultation with the Council of Governors, be reviewed by the Board at least annually.

Title of report:	Modern slavery statement
Presented to:	Board of Directors
On:	29 July 2020
Presented by:	Director of Corporate Affairs
Prepared by:	Director of Corporate Affairs
Contact details:	T: 01942 822027 E: paul.howard@wwl.nhs.uk

Executive summary

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

Link to strategy

There is no direct link to the foundation trust's strategy.

Risks associated with this report and proposed mitigations

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

Financial implications

There are no financial implications arising from this report.

Legal implications

This report mitigates the risk of non-compliance with relevant legislation.

People implications

There are no people implications arising from this report.

Wider implications

There are no wider implications arising from this report.

Recommendation(s)

The Board of Directors is recommended to approve the Modern Slavery Statement as presented.

Slavery and human trafficking statement

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

Policies and initiatives

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

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

At WWL, we:

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

For our workforce, we:

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

For procurement and our wider supply chain, we:

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

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

The procurement team will:

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

During the financial year 2020/21, we will:

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

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ending 31 March 2021.

The Board approved this statement at its meeting on 29 July 2020.

Signed:_____

Silas Nicholls
Chief Executive

Title of report:	Review of COVID-19 risk appetite statement
Presented to:	Board of Directors
On:	29 July 2020
Presented by:	Director of Corporate Affairs
Prepared by:	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 executive team has reviewed the current risk appetite statement in advance of today's meeting and whilst it does not recommend that the statement be amended at this time, it nonetheless notes the need to keep the matter under close review and suggests that the board may wish to consider revising some of the risk appetite statements at the next board meeting, subject to consideration of the local and national position at that time.

Link to strategy

There is no direct link to the foundation trust's strategy.

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 from this report.

Legal implications

There are no legal implications arising from this report.

People implications

There are no people implications arising from this report.

Wider implications

There are no wider implications arising from this report.

Recommendation(s)

The Board of Directors is recommended to endorse the continuation of the COVID-19 risk appetite statement as presented.

COVID-19
Risk appetite statement

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Introduction

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

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

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

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

Underlying principles

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

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

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

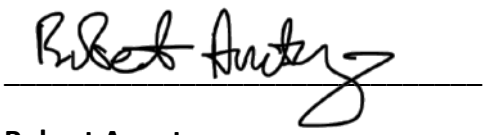
Our risk appetite

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

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

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

This statement was approved by the Board of Directors at its meeting on 25 March 2020.



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

Appendix: Risk appetite matrix

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